



TEXAS
Health and Human
Services

Home and Community- based Services (HCS)

Program Billing Guidelines

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Section 1000, Introduction

Revision 19-1; Effective November 15, 2019

1100 General Information and Statutory Requirements

Revision 19-1; Effective November 15, 2019

Health and Human Services Commission (HHSC) rules at 40 TAC [§9.170](#) set forth requirements for Home and Community-based Services (HCS) Program providers to receive payment for HCS Program services. Specifically, 40 TAC §9.170(d) requires a program provider to prepare and submit service claims in accordance with the HCS Program Billing Guidelines. Also, Sections II. H. and II. T. of the HCS Program Provider Agreement require program providers to comply with the HCS Program Billing Guidelines. In addition, 40 TAC §9.170(k) sets forth circumstances under which a program provider will not be paid or Medicaid payments will be recouped from the program provider.

1200 Service Components

Revision 21-1; Effective January 1, 2021

The HCS Program consists of the following service components:

- (1) professional therapies, which consist of the following subcomponents:
 - (A) audiology services,
 - (B) dietary services,
 - (C) occupational therapy services,
 - (D) physical therapy services,
 - (E) behavioral support services,
 - (F) social work services,
 - (G) speech and language pathology services; and
 - (H) cognitive rehabilitation therapy;
- (2) day habilitation;
- (3) in-home day habilitation;
- (4) registered nursing;
- (5) licensed vocational nursing;
- (6) specialized registered nursing;

- (7) specialized licensed vocational nursing;
- (8) residential assistance, which consists of the following subcomponents:
 - (A) host home/companion care,
 - (B) residential support,
 - (C) supervised living, and
 - (D) supported home living (transportation);
- (9) respite;
- (10) in-home respite;
- (11) supported employment;
- (12) employment assistance;
- (13) adaptive aids;
- (14) minor home modifications;
- (15) dental treatment;and
- (16) transition assistance services.

1300 Billing and Payment Reviews

Revision 19-1; Effective November 15, 2019

Billing and payment reviews are conducted to determine if a program provider has complied with Health and Human Services Commission (HHSC) rules and these billing guidelines. Billing and payment reviews and residential visits are distinct from the reviews described in 40 TAC [§9.171](#), which are performed to determine a program provider's compliance with the program certification principles contained in 40 TAC [§§9.172-9.179](#). [Appendix I](#), Billing and Payment Review Protocol, describes how billing and payment reviews are conducted.

Section 2000, Definitions

Revision 21-1; Effective January 1, 2021

The following words and terms, when used in these billing guidelines, have the following meanings unless the context clearly indicates otherwise:

- (1) ADLs or activities of daily living** - Basic personal everyday activities including, but not limited to, tasks such as eating, toileting, grooming, dressing, bathing and transferring.
- (2) Adult** - A person who is 18 years of age or older.
- (3) Annual vendor** - A vendor that provides to a program provider, for a calendar year, one or more adaptive aids costing less than \$500.

- (4) Behavior support plan** - A written plan prescribing the systematic application of behavioral techniques regarding an individual that contains specific objectives to decrease or eliminate targeted behavior.
- (5) Billable activity** - An activity for which a service claim may be submitted for service components and subcomponents listed in [Section 3100](#), Applicable Service Components.
- (6) Calendar day** - Midnight through 11:59 p.m.
- (7) Calendar month** - The first day of a month through the last day of that month.
- (8) Calendar week** - Sunday through Saturday.
- (9) Calendar year** - January through December.
- (10) CFC PAS/HAB or Community First Choice Personal Assistance Services/Habilitation** - A state plan service that consists of:
- (A) personal assistance services that provide assistance to an individual in performing activities of daily living (ADLs) and instrumental activities of daily living (IADLs) based on the individual's person-centered service plan, including:
 - (i) non-skilled assistance with the performance of the ADLs and IADLs;
 - (ii) household chores necessary to maintain the home in a clean, sanitary and safe environment;
 - (iii) escort services, which consist of accompanying and assisting an individual to access services or activities in the community, but do not include transporting an individual; and
 - (iv) assistance with health-related tasks; and
 - (B) habilitation that provides assistance to an individual in acquiring, retaining and improving self-help, socialization, and daily living skills and training the individual on ADLs, IADLs and health-related tasks, such as:
 - (i) self-care;
 - (ii) personal hygiene;
 - (iii) household tasks;
 - (iv) mobility;
 - (v) money management;
 - (vi) community integration, including how to get around in the community;
 - (vii) use of adaptive equipment;
 - (viii) personal decision making;

- (ix) reduction of challenging behaviors to allow individuals to accomplish ADLs, IADLs, and health-related tasks; and
- (x) self-administration of medication.

(11) Clean claim —In accordance with Code of Federal Regulations, Title 42, §447.45(b), a claim for services submitted by a program provider that can be processed without obtaining additional information from the program provider or a party other than HHSC, including a claim with errors originating in the Texas claims management system, but not including a claim from a program provider under investigation for fraud or abuse, or a claim under review for medical necessity.

(12) Competitive employment - Employment in the competitive labor market, performed on a full-time or part-time basis, that pays an individual:

- (A) at or above the applicable minimum wage; and
- (B) not less than the customary wage and level of benefits paid by an employer to individuals without disabilities performing the same or similar work.

(13) Co-payment - A fixed fee an individual pays for a service at the time the service is provided.

(14) DADS - The Department of Aging and Disability Services.

(15) Deductible - Payment made by an individual in a specified amount for a service received before coverage begins for that service under the insurance policy.

(16) DFPS - The Department of Family and Protective Services.

(17) EVV - electronic visit verification

(18) Extended shift - During a 24-hour period, a combined period of time of more than 16 hours.

(19) Face-to-face - Within the physical presence of another person who is not asleep.

(20) Focused assessment - An appraisal of an individual's current health status that:

- (A) contributes to a comprehensive assessment conducted by a registered nurse;
- (B) collects information regarding the individual'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.

(21) Four-person residence - A residence approved in accordance with 40 TAC [§9.188](#):

- (A) that a program provider leases or owns;
- (B) in which at least one person but no more than four persons receive:
 - (i) residential support;
 - (ii) supervised living;
 - (iii) a non-HCS Program service similar to residential support or supervised living (for example, services funded by DFPS or by a person's own resources); or
 - (iv) respite;
- (C) that, if it is the residence of four persons, at least one of those persons receives residential support;
- (D) that is not the residence of any persons other than a service provider, the service provider's spouse or person with whom the service provider has a spousal relationship, or a person described in subparagraph (B) of this paragraph; and
- (E) that is not a dwelling described in [§9.155\(a\)\(5\)\(H\)](#) of this subchapter (relating to Eligibility Criteria and Suspension of HCS Program Services).

(22) GRO - General Residential Operation. As defined in Texas Human Resources Code, §42.002, a child-care facility that provides care for more than 12 children for 24 hours a day, including facilities known as children's homes, halfway houses, residential treatment centers, emergency shelters and therapeutic camps.

(23) Guardian - A guardian of the person or estate appointed for a person in accordance with state law.

(24) Health-related tasks - Specific tasks related to the needs of an individual, which can be delegated or assigned by licensed health-care professionals under state law to be performed by a service provider of [CFC PAS/HAB](#). These include tasks delegated by a registered nurse, health maintenance activities, as defined in 22 Texas Administrative Code (TAC) §225.4, Definitions, and activities assigned to a service provider of CFC PAS/HAB by a licensed physical therapist, occupational therapist or speech-language pathologist.

(25) HHSC - The Health and Human Services Commission.

(26) IADLs or instrumental activities of daily living - Activities related to living independently in the community, including meal planning and preparation; managing finances; shopping for food, clothing and other essential items;

performing essential household chores; communicating by phone or other media; traveling around and participating in the community.

(27) ICF/IID —Intermediate care facility for individuals with an intellectual disability or related conditions. An ICF/IID is a facility in which ICF/IID Program services are provided and that is licensed in accordance with Texas Health and Safety Code Chapter 252 or certified by DADS.

(28) ID/RC assessment - A form used by HHSC for making an LOC determination and LON assignment.

(29) Implementation plan - A written document developed by the program provider for an individual that, for each HCS program service on the individual's IPC not provided through the CDS option, includes:

- (A) a list of outcomes identified in the PDP that will be addressed using HCS Program services;
- (B) specific objectives to address the outcomes required by subparagraph (A) of this paragraph that are:
 - (i) observable, measurable, and outcome-oriented; and
 - (ii) derived from assessments of the individual's strengths, personal goals, and needs;
- (C) a target date for completion of each objective;
- (D) the number of HCS Program units of service needed to complete each objective;
- (E) the frequency and duration of HCS Program services needed to complete each objective; and
- (F) the signature and date of the individual, LAR, and the program provider.

(30) Individual - A person enrolled in the HCS Program.

(31) Integrated employment - Employment at a work site at which an individual routinely interacts with people without disabilities other than the individual's work site supervisor or service providers. To the same extent that people without disabilities in comparable positions interact with other people without disabilities, integrated employment does not include:

- (A) groups of people with disabilities working in an area that is not part of the general workplace where people without disabilities work; or
- (B) a mobile crew of people with disabilities working in the community.

(32) IPC or individual plan of care - A written plan that:

- (A) states the type and amount of each HCS Program service to be provided to the individual during an IPC year;

- (B) states the services and supports to be provided to the individual through non-HCS Program resources, including natural supports, medical services, and educational services; and
- (C) is authorized by HHSC.

(33) IPC year - A 12-month period of time starting on the date an authorized initial or renewal IPC begins.

(34) Legally authorized representative - A person authorized by law to act on behalf of an individual and may include a parent, guardian or managing conservator of a minor, or the guardian of an adult.

(35) Licensed vocational nurse - A person licensed to practice vocational nursing in accordance with Texas Occupations Code, [Chapter 301](#).

(36) Local Authority - An entity to which HHSC's authority and responsibility, as described in Texas Health and Safety Code, §531.002(11), has been delegated.

(37) LOC or level of care - A determination given to an individual by HHSC as part of the eligibility determination process based on data submitted on the [ID/RC Assessment](#).

(38) LON or level of need - An assignment given to an individual by HHSC upon which reimbursement for day habilitation, in-home day habilitation, host home/companion care, residential support and supervised living is based. The LON assignment is derived from the service level score obtained from the administration of the Inventory for Client and Agency Planning (ICAP) to the individual and from selected items on the ID/RC Assessment.

(39) Managing conservator - a managing conservator appointed for a minor in accordance with state law.

(40) Minor - An individual under 18 years of age.

(41) PDP or person-directed plan - A written plan, based on person-directed planning and developed with an applicant or individual in accordance with [Form 8665](#), Person-Directed Plan, that describes the supports and services necessary to achieve the desired outcomes identified by the applicant or individual (and LAR on the applicant's or individual's behalf) and ensure the applicant's or individual's health and safety.

(42) Pre-enrollment minor home modifications —Minor home modifications completed before an applicant is discharged from a nursing facility, an ICF/IID or a GRO and before the effective date of the applicant's enrollment in the HCS Program.

- (43) Pre-enrollment minor home modifications assessment** —An assessment performed by a licensed professional as required by [Appendix X](#), Billable Minor Home Modifications, to determine the need for pre-enrollment minor home modifications.
- (44) Preselection visit** - An individual’s temporary stay in a residence in which the individual receives the residential assistance subcomponent of host home/companion care, residential support or supervised living and such subcomponent is different than the residential assistance subcomponent authorized by the individual’s IPC.
- (45) Program provider** - An entity that provides HCS Program services under a Medicaid Provider Agreement for the Provision of HCS Program Services with HHSC.
- (46) Registered nurse** - A person licensed to practice professional nursing in accordance with Texas Occupations Code, Chapter 301.
- (47) Residence** - An established place of bona fide and continuous habitation that is a single structure 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.
- (48) RN clinical supervision** - The monitoring for changes in health needs of the individual, 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 individual.
- (49) RN nursing assessment** - An extensive evaluation of an individual's health status that:
- (A) addresses anticipated changes in the conditions of the individual as well as emergent changes in the individual's health status;
 - (B) recognizes changes to previous conditions of the individual;
 - (C) synthesizes the biological, psychological, spiritual and social aspects of the individual's condition;
 - (D) collects information regarding the individual's health status;
 - (E) analyzes information collected about the individual's health status to make nursing diagnoses and independent decisions regarding nursing services provided to the individual;
 - (F) plans nursing interventions and evaluates the need for different interventions; and
 - (G) determines the need to communicate and consult with other service providers or other persons who provide supports to the individual.

- (50) Self-employment** - Work in which the individual solely owns, manages and operates a business, is not an employee of another person, entity or business, and actively markets a service or product to potential customers.
- (51) Service claim** - A request submitted by a program provider to be paid by HHSC for a service component or subcomponent.
- (52) Service coordination** - A service as defined in Chapter 2, Subchapter L of this title.
- (53) Service coordinator** - An employee of a local authority who provides service coordination to an individual.
- (54) Service planning team** - As defined in 40 TAC [§9.153](#), a planning team consisting of an applicant or individual, LAR, service coordinator and other persons chosen by the applicant or individual or LAR on behalf of the applicant or individual (for example, a program provider representative, family member, friend or teacher).
- (55) Service provider** - A staff member or contractor of the program provider who performs billable activity.
- (56) Staff member** - A full-time or part-time employee of the program provider.
- (57) Supervision** - The process of directing, guiding and influencing the outcome of an unlicensed staff's performance.
- (58) TAC** - Texas Administrative Code.
- (59) Three-person residence** - A residence:
- (A) that a program provider leases or owns;
 - (B) in which at least one person but no more than three persons receive:
 - (i) residential support;
 - (ii) supervised living;
 - (iii) a non-HCS Program service similar to residential support or supervised living (for example, services funded by DFPS or by a person's own resources); or
 - (iv) respite; and
 - (C) that is not the residence of any person other than an HCS service provider, the service provider's spouse or person with whom the service provider has a spousal relationship, or a person described in subparagraph (B) of this paragraph; and
 - (D) that is not a dwelling described in 40 TAC [§9.155\(a\)\(5\)\(H\)](#).
- (60) Transportation plan** - A written plan, based on person-directed planning and developed with an applicant or individual using [Form 3598](#), Individual Transportation Plan. An individual transportation plan is used to document

how transportation will be delivered to support an individual's desired outcomes and purposes for transportation as identified in the PDP.

(61) 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.

Section 3000, General Requirements for Service Components Based on Billable Activity

Revision 21-1; Effective January 1, 2021

3100 Applicable Service Components

Revision 21-1; Effective January 1, 2021

This section applies only to the following service components:

- (1) professional therapies, which consist of the following subcomponents:
 - (A) physical therapy,
 - (B) occupational therapy,
 - (C) speech and language pathology,
 - (D) audiology,
 - (E) social work,
 - (F) behavioral support,
 - (G) dietary services, and
 - (H) cognitive rehabilitation therapy;
- (2) day habilitation;
- (3) in-home day habilitation;
- (4) registered nursing;
- (5) licensed vocational nursing;
- (6) specialized registered nursing;
- (7) specialized licensed vocational nursing;
- (8) residential assistance, which consists of the following subcomponents:
 - (A) host home/companion care,
 - (B) residential support,
 - (C) supervised living, and
 - (D) supported home living (transportation);

- (9) respite;
- (10) in-home respite;
- (11) employment assistance; and
- (12) supported employment

3200 Service Claim Requirements

Revision 10-1; Effective June 1, 2010

3210 General Requirements

Revision 21-1; Effective January 1, 2021

Except as provided in Sections 3220, Service Claim for Residential Assistance Subcomponent During Preselection Visit, and 3230, Service Claim for Host Home/Companion Care, Residential Support or Supervised Living for Individual on a Visit with Family or Friend, a program provider must submit an electronic service claim that meets the following requirements. The claim must:

- (1) be for a service component or subcomponent that is authorized by an IPC that meets the requirements of 40 TAC [§9.159](#);
- (2) be for an HCS service component or subcomponent identified in an individual's PDP that is provided in accordance with the individual's implementation plan, as required by 40 TAC [§9.158\(q\)](#);
- (3) be for a service component or subcomponent provided during a period of time for which the individual has an LOC;
- (4) be based on the LON that is authorized by an ID/RC assessment that meets the requirements of 40 TAC [§9.163](#);
- (5) be based on billable activity, as described in [Section 4000](#), Specific Requirements for Service Components Based on Billable Activity, for the particular service component or subcomponent being claimed;
- (6) not be based on activity that is not billable, as described in [Section 3300](#), Activity Not Billable, and in Section 4000 for the particular service component or subcomponent being claimed;
- (7) must be based on activity performed by a qualified service provider as described in [Section 3400](#), Qualified Service Provider, and in Section 4000 for the particular service component or subcomponent being claimed;
- (8) be for a service component or subcomponent provided to only one individual;
- (9) be for a service component or subcomponent provided on only one date;

- (10) be for the date the service component or subcomponent was actually provided;
- (11) be for units of service determined in accordance with [Section 3600](#), Calculating Units of Service for Service Claim;
- (12) be supported by written documentation, as described in [Section 3800](#), Written Documentation, and in Section 4000 for the particular service component or subcomponent being claimed;
- (13) 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 component was provided; and
- (14) for a service claim for in-home day habilitation and in-home respite, match the EVV visit transaction as required by 1 TAC §354.4009(a)(4) (relating to Requirements for Claims Submission and Approval)

3220 Service Claim for Residential Assistance Subcomponent During Preselection Visit

Revision 10-0; Effective October 1, 2009

If a program provider submits an electronic service claim for a residential assistance subcomponent for an individual on a preselection visit, the service claim must meet the requirements described in [Section 4580](#), Submitting a Service Claim for Residential Assistance During a Preselection Visit.

3230 Service Claim for Host Home/Companion Care, Residential Support or Supervised Living for Individual on a Visit with Family or Friend

Revision 19-1; Effective November 15, 2019

If a program provider submits an electronic service claim for host home/companion care, residential support or supervised living for an individual on a visit with a family member or friend, the service claim must meet the requirements described in [Section 4550\(i\)](#), Host Home/Companion Care Subcomponent; in [Section 4560\(i\)](#), Residential Support Subcomponent; in [Section 4570\(i\)](#), Supervised Living Subcomponent.

3300 Activity Not Billable

Revision 19-1; Effective November 15, 2019

The following activities by a service provider do not constitute billable activity:

- (1) traveling by a service provider if the service provider is not accompanied by an individual;
- (2) documenting the delivery of a service component (for example, writing written narratives, completing forms and entering data);
- (3) reviewing an individual's written record, except as allowed by [Section 4220](#), Billable Activity; [Section 4420](#), Billable Activity; [Section 4471.2](#), Billable Activity; [Section 4472.2](#), Billable Activity; and [Section 4473.2](#), Billable Activity;
- (4) drafting an implementation plan;
- (5) performing an activity 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); and
- (6) performing an activity regarding the preparation, submission, correction or verification of service claims.

3400 Qualified Service Provider

Revision 10-1; Effective June 1, 2010

3410 General Requirements

Revision 20-1; Effective September 1, 2020

To be a qualified service provider, a person must:

- (1) be an adult;
- (2) be a staff member or contractor of the program provider;
- (3) be paid by the program provider to provide the particular service component or subcomponent being claimed;
- (4) not be disqualified by this section to provide the particular service component or subcomponent being claimed;
- (5) meet the minimum service provider qualifications described in Section 4000, Specific Requirements for Service Components Based on Billable Activity, for the particular service component or subcomponent being claimed;
- (6) not have been convicted of an offense listed under §250.006 of the Texas Health and Safety Code; and
- (7) not be designated in the [Employee Misconduct Registry](#) as unemployable or the [Nurse Aid Registry](#) as revoked or suspended.

3420 Service Provider Not Qualified

Revision 19-1; Effective November 15, 2019

(a) Service Coordinator Not Qualified as Service Provider

(1) Service Coordinator On Duty

During the time a service coordinator is on duty as a service coordinator, the service coordinator is not qualified to provide any service component or subcomponent to an individual.

(2) Service Coordinator Off Duty

During the time a service coordinator is off duty as a service coordinator, the service coordinator is not qualified to provide any service component or subcomponent to an individual if the individual is receiving service coordination from the service coordinator.

(b) Spouse Not Qualified as Service Provider

A service provider is not qualified to provide a service component or subcomponent to the service provider's spouse.

(c) Relative, Guardian or Managing Conservator Not Qualified as Service Provider for Certain Services

A service provider is not qualified to provide case management, residential support, supervised living, behavioral support services or social work services to an individual if the service provider is:

- (1) a relative of the individual (Appendix II, Degree of Consanguinity or Affinity, explains who is considered a relative for purposes of these guidelines);
- (2) the individual's guardian; or
- (3) the individual's managing conservator.

(d) Parent, Spouse of Parent or Contractor Not Qualified as Service Provider for Minor

A service provider is not qualified to provide a service component or subcomponent to a minor if the service provider is:

- (1) the minor's parent;
- (2) the spouse of the minor's parent; or
- (3) a person contracting with DFPS to provide residential child care to the minor, or is an employee or contractor of such a person.

(e) Contractor Not Qualified as Service Provider for an Adult Individual

A service provider is not qualified to provide to an adult individual:

- (1) a service component or subcomponent if the service provider is a person contracting with DFPS to provide residential child care to the individual, or is an employee or contractor of such a person; or
- (2) host home/companion care if the service provider is a person contracting with HHSC to provide adult host home care to the individual, or is an employee or contractor of such a person.

3430 Relative, Guardian or Managing Conservator Qualified as Service Provider

Revision 21-1; Effective January 1, 2021

If a relative, guardian or managing conservator is not otherwise disqualified to be a service provider as described in [Section 3420](#), Service Provider Not Qualified, or in [Section 4000](#), Specific Requirements for Service Components Based on Billable Activity, the relative, guardian or managing conservator may provide audiology services, dietary services, occupational therapy, physical therapy, speech and language pathology services, day habilitation, in-home day habilitation, registered nursing, licensed vocational nursing, specialized registered nursing, specialized licensed vocational nursing, transportation as a supported home living activity, host home/companion care, respite, in-home respite, employment assistance or supported employment if the relative, guardian or managing conservator is a qualified service provider for the particular service component or subcomponent being provided.

3440 Requirement for Service Provider Who Becomes Spouse of Individual To Inform Program Provider

Revision 20-1; Effective September 1, 2020

A program provider must require a service provider of any service component or subcomponent to immediately inform the program provider if the service provider becomes the spouse of the individual receiving services.

3500 Unit of Service

Revision 10-1; Effective June 1, 2010

3510 15-Minute Unit of Service

Revision 21-1; Effective January 1, 2021

The following service components and subcomponent have a unit of service of 15 minutes:

- (1) audiology services
- (2) dietary services;
- (3) occupational therapy;
- (4) physical therapy;
- (5) behavioral support services;
- (6) social work services;
- (7) speech and language pathology services;
- (8) cognitive rehabilitation therapy;
- (9) registered nursing;
- (10) licensed vocational nursing;
- (11) specialized registered nursing;
- (12) specialized licensed vocational nursing;
- (13) respite;
- (14) in-home respite;
- (15) supported employment;
- (16) employment assistance; and
- (17) transportation as a supported home living activity.

3520 Daily Unit of Service

Revision 21-1; Effective January 1, 2021

The following service components and subcomponents have a unit of service of one day:

- (1) day habilitation;
- (2) in-home day habilitation;
- (3) host home/companion care;
- (4) residential support; and
- (5) supervised living.

3600 Calculating Units of Service for Service Claim

Revision 10-1; Effective June 1, 2010

3610 15-Minute Unit of Service

Revision 21-1; Effective January 1, 2021

(a) Service Event

For service components and subcomponents that have a unit of service of 15 minutes, a service event:

- (1) is a discrete period of continuous time during which billable activity for one service component is performed by one service provider;
- (2) consists of one or more billable activities; and
- (3) ends when the service provider stops performing billable activity or performs billable activity for a different service component.

Example:

If a service provider performs billable activity for registered nursing from 12:00-12:30, performs activity that is not billable from 12:30-12:36, then performs additional billable activity from 12:36-12:48, two service events have occurred, one for 30 minutes (12:00-12:30), and another for 12 minutes (12:36-12:48).

(b) Service Time

- (1) **Professional Therapies, Nursing Service Components, Supported Employment and Employment Assistance**

A program provider must use the following formula for calculating the service time for professional therapies, registered nursing, licensed vocational nursing, specialized registered nursing, specialized licensed vocational nursing, supported employment and employment assistance:

Number of service providers x length of service event divided by the number of persons served = service time.

In this formula, "person" means a person who receives a service funded by HHSC, including an individual and a person enrolled in the intermediate care facilities for individuals with an intellectual disability or related conditions (ICF/IID) program or a waiver program other than HCS.

Example:

No. of Service Providers	X	Length of Service Event	÷	No. of Persons	=	Service Time Per Individual
1	X	20 min.	÷	3	=	6.66 min.
1	X	30 min.	÷	2	=	15 min.
2	X	30 min.	÷	2	=	30 min.
2	X	30 min.	÷	1	=	60 min.
1	X	45 min.	÷	4	=	11.25 min.
1	X	60 min.	÷	1	=	60 min.
1	X	60 min.	÷	2	=	30 min.
1	X	60 min.	÷	3	=	20 min.
2	X	120 min.	÷	6	=	40 min.

(2) Transportation as a Supported Home Living Activity

A program provider must determine service time for transportation as a supported home living activity in accordance with [Section 4540\(g\)](#), Determining Unit of Service for Transportation as a Supported Home Living Activity.

(3) Respite and In-home Respite

A program provider must use the length of the service event as the service time for respite and in-home respite.

(c) Units of Service for Service Claim

A program provider must convert a service time to a unit(s) of service for a service claim in accordance with [Appendix III](#), Conversion Table.

3620 Daily Unit of Service

Revision 21-1; Effective January 1, 2021

(a) Host Home/Companion Care, Residential Support, Supervised Living

A program provider may include only one unit of service per calendar day on a service claim for host home/companion care, residential support or supervised living.

(b) Day Habilitation and In-Home Day Habilitation

A program provider may include one-quarter (.25), one-half (.5), three-quarters (.75) or one unit of service per calendar day on a service claim for day habilitation and in-home day habilitation.

3700 Billing Service Components Provided at the Same Time and Billing Day Habilitation and In-Home Day Habilitation Provided at the Same Time as Service Coordination

Revision 21-1; Effective January 1, 2021

3710 One Service Provider

Revision 20-1; Effective September 1, 2020

Except as provided in [Section 4360\(2\)](#), Qualified Service Provider, one service provider may not provide different service components or subcomponents at the same time to the same individual.

3720 Multiple Service Providers

Revision 21-1; Effective January 1, 2021

(a) Providing Different Service Components or Subcomponents

(1) Compliance with this Subsection

Multiple service providers may provide different service components or subcomponents at the same time to the same individual only as provided in paragraphs (2)-(5) of this subsection.

(2) Service Provider of Day Habilitation and In-Home Day Habilitation

A service provider of day habilitation and in-home day habilitation may provide day habilitation and in-home day habilitation to an individual at the same time a service provider of licensed vocational nursing, registered nursing, or professional therapies provides a service to the individual only if the individual is assigned a LON 9.

Example:

An occupational therapist provides occupational therapy by interacting directly with an individual assigned a LON 9 while the individual receives day habilitation or in-home day habilitation. A program provider may submit a service claim for both occupational therapy and day habilitation or in-home day habilitation for the overlapping time period because billable activity for

both day habilitation or in-home day habilitation_and occupational therapy was occurring at the same time for an individual who was assigned a LON 9.

(3) Service Provider of Professional Therapies

Except as allowed in paragraph (2) of this subsection, a service provider of professional therapies may provide a service to an individual at the same time a service provider of any other service component or subcomponent is providing a service to the same individual only if:

- (A) the professional therapies activity is an assessment or observation of the individual; and
- (B) the assessment or observation is actually occurring at the same time the other service component or subcomponent is being provided.

Example:

An occupational therapist observes and assesses the fine motor skills of an individual who is assigned a LON 6 while the individual receives day habilitation services. A program provider may submit a service claim for both occupational therapy and day habilitation for the overlapping time period because billable activity for both day habilitation and occupational therapy was occurring at the same time.

Example:

A physical therapist conducts range of motion exercises with an individual who is assigned a LON 1 while the individual receives in-home day habilitation services. A program provider may not submit a service claim for both physical therapy and in-home day habilitation for the overlapping time period because the physical therapy activities were not an assessment or observation of the individual.

Example:

An individual receives day habilitation from 8:00 a.m.-9:00 a.m. A speech therapist provides speech therapy to an individual at the day habilitation site from 9:00 a.m.-10:00 a.m., but the individual is unable to participate in the day habilitation activities while the therapy is provided. The individual receives day habilitation again from 10:00 a.m.-11:00 a.m. A program provider may submit a service claim for speech therapy for the time period from 9:00 a.m.-10:00 a.m. (four units) and for day habilitation for the time periods from 8:00 a.m. 9:00 a.m. and 10:00 a.m.-11:00 a.m. (.25 units).

(4) Service Provider of Respite, In-Home Respite, Host Home/Companion Care, Residential Support or Supervised Living

A service provider of respite, in-home respite, host home/companion care, residential support or supervised living may provide a service to an individual at the same time a service provider of professional therapies, registered nursing, licensed vocational nursing, specialized registered nursing, specialized licensed vocational nursing, day habilitation or in-home day habilitation, employment assistance or supported employment provides a service to the same individual.

(5) Service Provider of Transportation as a Supported Home Living Activity

A service provider of transportation as a supported home living activity may perform a face-to-face service for an individual at the same time a service provider of professional therapies, registered nursing, licensed vocational nursing, specialized registered nursing, specialized licensed vocational nursing, and CFC PAS/HAB provides a service to the same individual.

(b) Multiple Service Providers of the Same Service Component or Subcomponent with a 15-Minute Unit of Service

Multiple service providers of the same service component or subcomponent with a 15 minute unit of service, as listed in [Section 3510](#), 15-Minute Unit of Service, may perform an activity at the same time for the same individual if multiple service providers are needed to perform the activity.

3730 Service Coordination and Day Habilitation or In-Home Day Habilitation Provided at the Same Time

Revision 21-1; Effective January 1, 2021

A service provider of day habilitation and in-home day habilitation may provide day habilitation to an individual at the same time a service coordinator is providing service coordination to the individual at the day habilitation or in-home day habilitation setting.

3800 Written Documentation

Revision 10-1; Effective June 1, 2010

3810 General Requirements

Revision 21-1; Effective January 1, 2021

(a) Legible

A program provider must have written, legible documentation to support a service claim.

(b) Required Content

- (1) All Service Components or Subcomponents (Except for Nursing Service Components, Some Professional Therapies and Transportation as a Supported Home Living Activity)

Except as provided in paragraphs (2) and (3), and (4) of this subsection, the written documentation to support a service claim for a service component or subcomponent must include:

- (A) the name of the individual who was provided the service component or subcomponent;
- (B) the day, month and year the service component or subcomponent was provided;
- (C) the service component or subcomponent that was provided; and
- (D) a written service log, as described in [Section 3820](#), Written Service Log and Written Summary Log, for each individual in accordance with the following:
 - (i) for professional therapies, residential support, supervised living, respite, in-home respite, employment assistance and supported employment, a written service log written by a service provider who delivered the service component or subcomponent; and
 - (ii) for host home/companion care, and day habilitation, and in-home day habilitation, a written service log or a written summary log by a service provider who delivered the service component or subcomponent.

(2) Nursing Service Components

- (A) The written documentation to support a service claim for the nursing service components of registered nursing, licensed vocational nursing, specialized registered nursing and specialized licensed vocation nursing must:
 - (i) be written after the service is provided;
 - (ii) include the name of the individual who was provided the nursing service component;

- (iii) include the day, month and year the nursing service component was provided;
 - (iv) include the nursing service component that was provided;
 - (v) include a detailed description of activities performed by the service provider and the individual that evidences the performance of one or more of the billable activities described in [Section 4000](#), Specific Requirements for Service Components Based on Billable Activity, for the particular nursing service component being claimed;
 - (vi) include a brief description of the location of the service event, as described in [Section 3610\(a\)](#), 15-Minute Unit of Service, such as the address or name of business;
 - (vii) include the exact time the service event began and the exact time the service event ended documented by the nurse making the written documentation;
 - (viii) include a description of the medical need for the activity performed during the service event;
 - (ix) include a 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;
 - (x) for any activity simultaneously performed by more than one registered nurse or more than one licensed vocational nurse, include a written justification in the individual's implementation plan for the use of more than one registered nurse or licensed vocational nurse; and
 - (xi) be supported by information that justifies the length of the service event, as described in [Section 3610\(a\)](#), such as an explanation in the documentation or implementation plan of why a billable activity took more time than typically required to complete.
- (B) The following are unacceptable as a description of the activities in written documentation to support a service claim for a nursing service component:
- (i) ditto marks;
 - (ii) words or symbols referencing:
 - other written documentation that supports a claim for nursing services; or
 - written service logs or written summary logs;
 - (iii) non-specific statements such as "had a good day," "did ok," or "no problem today;"

- (iv) a statement or other information that is photocopied from other completed or partially completed written service logs or written summary logs; and
- (v) a medication log.

(3) Transportation as a Supported Home Living Activity

A program provider must have written documentation to support a service claim for transportation as a supported home living activity that meets the requirements of [Section 4540\(j\)](#), Supported Home Living Billing Requirements.

3820 Written Service Log and Written Summary Log

Revision 20-1; Effective September 1, 2020

(a) Required Content and Timeliness

(1) Written Service Log

A written service log must:

- (A) be written after the service is provided;
- (B) for service components or subcomponents with a 15-minute unit of service, as listed in [Section 3510](#), 15-Minute Unit of Service, include:
 - (i) a description or list of activities performed by the service provider and the individual that evidences the performance of one or more of the billable activities described in Section 4000 for the particular service component or subcomponent being claimed; and
 - (ii) a brief description of the location of the service event, as described in [Section 3610\(a\)](#), 15-Minute Unit of Service, such as the address or name of business;
- (C) be supported by information that justifies the length of the service event, as described in Section 3610(a), such as an explanation in the written service log or implementation plan of why a billable activity took more time than typically required to complete;
- (D) for service components or subcomponents with a daily unit of service, as listed in [Section 3520](#), Daily Unit of Service, include:
 - (i) a description or list of activities performed by the service provider and the individual that evidences the performance of the billable activities described in Section 4000 for the

particular service component or subcomponent being claimed;
or

(ii) for host home/companion care, residential support and supervised living, if the individual was not available to receive services, an explanation for the unavailability;

(E) be made within 14 calendar days after the activity being documented is provided;

(F) include the signature and title of the service provider making the written service log; and

(G) be completed by the service provider providing the service.

(2) Written Summary Log

A written summary log must:

(A) be written after services have been provided;

(B) include information that identifies the individual for whom the written summary log is made;

(C) include a general description or list of activities performed during the calendar week in which the service component or subcomponent was provided;

(D) a brief description of the location of the service event, such as the address or name of the business;

(E) be made within 14 calendar days after the week being documented;

(F) include the signature and title of the service provider making the written summary log; and

(G) be completed by the service provider providing the service.

(b) Unusual Incidents or Progress Toward Objectives

The description of the activities in a written service log or written summary log must include a description of any unusual incident that occurs such as a seizure, illness or behavioral outburst, and any action taken by the service provider in response to the incident.

(c) Unacceptable Content

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

(1) ditto marks;

(2) references to other written service logs or written summary logs using words or symbols;

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

(d) Correction of Written Service Log or Written Summary Log

A program provider must comply with 40 TAC §49.305(i)(5) in making a correction to a written service log or written summary log.

(e) Separate Written Service Log or Written Summary Log for Service Component, Subcomponent or Service Event

A program provider must have a separate written service log or separate written summary log for each service component or subcomponent, as described in [Section 3810\(b\)\(1\)\(D\)](#), General Requirements, and for each service event as described in [Section 3610\(a\)](#), 15-Minute Unit of Service.

3830 Proof of Service Provider Qualifications

Revision 19-1; Effective November 15, 2019

A program provider must have the following documentation as proof that a service provider is qualified:

- (1) to prove the age of a service provider, a government issued document, such as a driver's license or birth certificate;
- (2) to prove the level of education of a service provider:
 - (A) a written document from an educational institution, such as a diploma; or
 - (B) a high school equivalency certificate issued in accordance with the law of the issuing state;
- (3) to prove the job experience of a service provider, a written record of where the job experience was obtained;
- (4) to prove competency to perform services:
 - (A) a successfully completed written competency-based assessment demonstrating the ability to provide the applicable service and document the provision of such service as required by the HCS Program Billing Guidelines; and
 - (B) written personal references which evidence the service provider's ability to provide a safe and healthy environment for the individual from at least three persons who are not relatives of

the service provider ([Appendix II](#), Degree of Consanguinity or Affinity, explains who is considered a “relative” for purposes of these billing guidelines); and

- (5) to prove that a service provider is properly licensed, a written document from the appropriate state licensing agency or board.

3840 Determining Location of Residence of Service Provider

Revision 21-1; Effective January 1, 2021

(a) Photo ID, Voter’s Registration Card, Lease or Utility Bill

Except as provided in paragraph (b) of this subsection, a program provider must have two documents from the following categories to assist HHCS in determining the location of the residence of a service provider of host home/companion care, transportation as a supported home living activity, respite services or in-home respite:

- (1) a driver’s license or other government issued photo identification of the service provider;
- (2) a voter’s registration card of the service provider;
- (3) a lease agreement for the time period in question with the name of the service provider as the lessee or an occupant; or
- (4) a utility bill for the time period in question in the name of the service provider.

(b) Other Proof

At its discretion, HHSC may accept other written documentation as proof of the location of the residence of a service provider of host home/companion care, respite, in-home respite or transportation as a supported home living activity.

3850 Example Forms

Revision 21-1; Effective January 1, 2021

[Form 4118](#), Respite/In-Home Respite Service Delivery Log, and [Form 4119](#), Residential Support Services (RSS) and Supervised Living (SL) Service Delivery Log, may be used to document a service component or subcomponent (except for day habilitation and in-home day habilitation for an individual receiving supported employment, employment assistance and for transportation as a supported home living activity) in accordance with this section. These documents are only examples. A program provider may document a service component or subcomponent in any way that meets the requirements of this section and the written documentation

requirements described in [Section 4000](#), Specific Requirements for Service Components Based on Billable Activity, for the particular service component or subcomponent being claimed.

Section 4000, Specific Requirements for Service Components Based on Billable Activity

4100 Reserved for Future Use

Revision 10-1; Effective June 1, 2010

4200 Professional Therapies

Revision 14-1; Effective March 21, 2014

4210 General Description of Service Component

Revision 19-1; Effective November 15, 2019

The professional therapies service component consists of the following subcomponents:

- (1) **Audiology Services** – The provision of audiology as defined in Texas Occupations Code, Chapter 401;
- (2) **Behavioral Support Services** – Specialized interventions that assist an individual in increasing adaptive behaviors and replacing or modifying maladaptive or socially unacceptable behaviors that prevent or interfere with the individual's inclusion in the community;
- (3) **Cognitive Rehabilitation Therapy** – Assists an individual in learning or relearning cognitive skills that have been lost or altered as a result of damage to brain cells or brain chemistry in order to enable the individual to compensate for lost cognitive functions; and includes reinforcing, strengthening or reestablishing previously learned patterns of behavior, or establishing new patterns of cognitive activity or compensatory mechanisms for impaired neurological systems.
- (4) **Dietary Services** – The provision of nutrition services as defined in Texas Occupations Code, Chapter 701;

- (5) **Occupational Therapy Services** – The practice of occupational therapy as described in Texas Occupations Code, Chapter 454;
- (6) **Physical Therapy Services** – The provision of physical therapy as defined in Texas Occupations Code, Chapter 453;
- (7) **Social Work Services** – The practice of social work as defined in Texas Occupations Code, Chapter 505; and
- (8) **Speech and Language Pathology Services** – The provision of speech-language pathology as defined in Texas Occupations Code, Chapter 401.

4220 Billable Activity

Revision 21-1; Effective January 1, 2021

The only billable activities for the professional therapies service component are:

- (1) interacting face-to-face or by video conference or speaking by telephone with an individual, based on the professional therapies subcomponent provided, to conduct assessments or provide services within the scope of the service provider's practice;
- (2) interacting face-to-face or by video conference or speaking by telephone with a person regarding a professional therapies subcomponent provided to an individual, but not with:
 - (A) a staff person who is not a service provider; or
 - (B) a service provider of any nursing service component (registered nursing, licensed vocational nursing, specialized registered nursing or specialized licensed vocational nursing) or professional therapies;
- (3) writing an individualized treatment plan for an individual's professional therapies that, for behavioral support services, is a behavior support plan;
- (4) reviewing documents to evaluate the quality and effectiveness of an individual's professional therapies;
- (5) training the following persons on how to provide professional therapies treatment, including how to document the provision of treatment:
 - (A) a service provider of host home/companion care, residential support, supervised living, CFC PAS/HAB, transportation as a supported home living activity, day habilitation, respite, supported employment or employment assistance; or
 - (B) a person other than a service provider who is involved in serving an individual;

- (6) reviewing documents in preparation for the training described in paragraph (5) of this subsection;
- (7) participating in a service planning team meeting;
- (8) participating in the development of an implementation plan;
- (9) participating in the development of an IPC;
- (10) for behavioral support services, in addition to the activities listed above:
 - (A) assessing the targeted behavior so a behavior support plan may be developed;
 - (B) training of and consulting with an individual, family member or other persons involved in the individual's care regarding the implementation of the behavior support plan;
 - (C) monitoring and evaluating the effectiveness of the behavior support plan;
 - (D) modifying, as necessary, the behavior support plan based on the monitoring and evaluation of the plan's effectiveness;
 - (E) educating an individual, family members or other persons involved in the individual's care about the techniques to use in assisting the individual to control maladaptive or socially unacceptable behaviors exhibited by the individual; and
- (11) for cognitive rehabilitation services, in addition to the activities listed above, provide and monitor the provision of cognitive rehabilitation therapy to the individual in accordance with the plan of care developed by a qualified professional following a neurobehavioral or neuropsychological assessment.

4230 Activity Not Billable

Revision 19-1; Effective November 15, 2019

(a) Activities in Section 3300

The activities listed in [Section 3300](#), Activity Not Billable, are not billable for the professional therapies service component.

(b) Activities Not Listed in Section 4220

Any activity not described in [Section 4220](#), Billable Activity, is not billable for the professional therapies service component.

(c) Examples of Non-billable Activities

The following are examples of activities that are not billable for the professional therapies service component:

- (1) providing services outside the scope of the service provider's practice;
- (2) providing services that are performed by a service coordinator or were performed by a former case manager;
- (3) scheduling an appointment;
- (4) transporting an individual;
- (5) traveling or waiting to provide a professional therapies subcomponent;
- (6) training or interacting about general topics unrelated to a specific individual, such as principles of behavior management, or general use and maintenance of an adaptive aid or equipment;
- (7) creating written documentation as described in [Section 4260](#); Written Documentation;
- (8) reviewing a written narrative or written summary of a service component as described in [Section 3820](#), Written Service Log and Written Summary Log except as allowed in [Section 4220\(4\)](#); and
- (9) interacting with:
 - (A) a staff person who is not a service provider; or
 - (B) a service provider of any nursing service component (registered nursing, licensed vocational nursing, specialized registered nursing or specialized licensed vocational nursing) or professional therapies, if not during a service planning team meeting or during the development of an IPC or an implementation plan.

4240 Qualified Service Provider

Revision 19-1; Effective November 15, 2019

In addition to meeting the requirements in [Section 3400](#), Qualified Service Provider, a qualified service provider of the professional therapies subcomponents must be as follows:

- (1) for audiology services, an audiologist licensed in accordance with Chapter 401 of the Texas Occupations Code;
- (2) for behavioral support services:
 - (A) a psychologist licensed in accordance with Chapter 501 of the Texas Occupations Code;
 - (B) a provisional license holder licensed in accordance with Chapter 501 of the Texas Occupations Code;
 - (C) a psychological associate licensed in accordance with Chapter 501 of the Texas Occupations Code;

- (D) a licensed clinical social worker in accordance with Chapter 505 of the Texas Occupations Code;
 - (E) a licensed professional counselor in accordance with Chapter 503 of the Texas Occupations Code;
 - (F) a person certified by DADS as described in 40 TAC §5.161; or
 - (G) a behavior analyst certified by the Behavior Analyst Certification Board, Inc.;
- (3) for cognitive rehabilitation therapy:
- (A) a psychologist licensed in accordance with Texas Occupations Code, Chapter 501;
 - (B) a speech-language pathologist licensed in accordance with Texas Occupations Code, Chapter 401; or
 - (C) an occupational therapist licensed in accordance with Texas Occupations Code, Chapter 454;
- (4) for dietary services, a licensed dietitian licensed in accordance with Chapter 701 of the Texas Occupations Code;
- (5) for occupational therapy services, an occupational therapist or occupational therapy assistant licensed in accordance with Chapter 454 of the Texas Occupations Code;
- (6) for physical therapy services, a physical therapist or physical therapist assistant licensed in accordance with Chapter 453 of the Texas Occupations Code;
- (7) for social work services, a social worker licensed in accordance with Chapter 505 of the Texas Occupations Code; and
- (8) for speech and language pathology services, a speech-language pathologist or licensed assistant in speech-language pathology licensed in accordance with Chapter 401 of the Texas Occupations Code.

4250 Unit of Service

Revision 19-1; Effective November 15, 2019

(a) 15 Minutes

A unit of service for the professional therapies service component is 15 minutes.

(b) Fraction of a Unit of Service

A service claim for professional therapies may not include a fraction of a unit of service.

(c) Service Time

Service time is calculated in accordance with [Section 3610\(b\)](#), 15-Minute Unit of Service, including when multiple persons are being served.

4260 Written Documentation

Revision 20-1; Effective September 1, 2020

A program provider must have written documentation to support a service claim for professional therapies that:

- (1) meets the requirements set forth in [Section 3800](#), Written Documentation;
- (2) includes the exact time the service event began and the exact time the service event ended documented by the service provider making the written service log; and
- (3) for any activity performed by multiple service providers at the same time for the same individual, includes a written justification in the individual's implementation plan for the use of multiple service providers.

4300 Day Habilitation

Revision 11-1; Effective September 1, 2011

4310 General Description of Service Component

Revision 10-0; Effective October 1, 2009

The day habilitation service component is the provision of assistance to an individual that is necessary for the individual to acquire skills to reside, integrate and participate successfully in the community.

4320 Requirements of Setting

Revision 21-1; Effective January 1, 2021

Day habilitation must be provided to an individual in a setting that is not the residence of the individual.

4330 Billable Activity

Revision 19-1; Effective November 15, 2019

The only billable activities for the day habilitation service component are:

- (1) interacting face-to-face with an individual to assist the individual in achieving objectives to:

- (A) acquire, retain or improve self-help skills, socialization skills or adaptive skills that are necessary to for the individual to successfully reside, integrate and participate in the community; and
- (B) reinforce a skill taught in school or professional therapies;
- (2) transporting an individual between settings at which day habilitation is provided to the individual;
- (3) assisting an individual with his or her personal care activities if the individual cannot perform such activities without assistance;
- (4) participating in a service planning team meeting;
- (5) participating in the development of an implementation plan; and
- (6) participating in the development of an IPC.

4340 Activity Not Billable

Revision 10-0; Effective October 1, 2009

(a) Activities in Section 3300

The activities listed in [Section 3300](#), Activity Not Billable, are not billable for the day habilitation service component.

(b) Activities Not Listed in Section 4330

Any activity not described in [Section 4330](#), Billable Activity, is not billable for the day habilitation service component.

(c) Meeting Vocational Production Goal Not Billable Activity

Assisting an individual for the purpose of meeting a vocational production goal is an example of an activity that is not billable for the day habilitation service component.

4350 Restrictions Regarding Submission of Claims for Day Habilitation

Revision 20-1; Effective September 1, 2020

A program provider may not submit a service claim for:

- (1) day habilitation for a day that the individual refuses to participate in day habilitation activities unless the individual has refused to participate for 45 calendar days or less since the beginning of the preceding three-month period or since the implementation plan was amended to address the individual's refusal (whichever is later) and:

- (A) the service provider of day habilitation has made repeated attempts to engage the individual in the activity throughout the day; and
- (B) those attempts have been documented;
- (2) day habilitation provided to assist an individual in achieving objectives not documented in the individual's implementation plan;
- (3) day habilitation provided to an individual in excess of five units of service per calendar week;
- (4) day habilitation provided to an individual in excess of 260 units of service per IPC year;
- (5) day habilitation provided to an individual that is funded by a source other than the HCS Program (for example, the Department of Assistive and Rehabilitative Services);
- (6) except as provided in [Section 4360\(2\)](#), Qualified Service Provider, day habilitation that is being provided by the individual's service provider who is providing another service component to the individual at the same time in violation of [Section 3710](#), One Service Provider;
- (7) day habilitation provided in the individual's residence by the individual's host home/companion care service provider; or
- (8) day habilitation provided in the individual's residence without prior justification in the PDP and implementation plan, in violation of [Section 4320](#), Requirements of Setting, and [Section 3210\(1\) and \(2\)](#), General Requirements.

4360 Qualified Service Provider

Revision 21-1; Effective January 1, 2021

In addition to meeting the requirements in [Section 3400](#), Qualified Service Provider, a qualified service provider of the day habilitation service component, must have one of the following:

- (1) a high school diploma;
- (2) a high school equivalency certificate issued in accordance with the law of the issuing state; or
- (3) both of the following:
 - (A) a successfully completed written competency-based assessment demonstrating the ability to provide day habilitation and the ability to document the provision of day habilitation in accordance with [Section 3800](#), Written Documentation, and [Section 4380](#), Written Documentation; and

- (B) written personal references which evidence the service provider's ability to provide a safe and healthy environment for the individual from at least three persons who are not relatives of the service provider ([Appendix II](#), Degree of Consanguinity or Affinity, explains who is considered a relative for purposes of these billing guidelines).

4370 Unit of Service

Revision 20-1; Effective September 1, 2020

(a) One Day

A unit of service for the day habilitation service component is one day.

(b) Service Claim for Unit of Service

(1) One-quarter Unit of Service

A program provider may submit a service claim for day habilitation for one-quarter (0.25) unit of service if the program provider provides at least one and one-quarter hours of day habilitation on a calendar day.

(2) One-half Unit of Service

A program provider may submit a service claim for day habilitation for one-half (0.5) unit of service if the program provider provides at least two and one-half hours of day habilitation on a calendar day.

(3) Three-quarters Unit of Service

A program provider may submit a service claim for day habilitation for three-quarters (.75) unit of service if the program provider provides at least three and three-quarter hours of day habilitation on a calendar day.

(4) One Unit of Service

A program provider may submit a service claim for day habilitation for one unit of service if the program provider provides at least five hours of day habilitation on a calendar day.

4380 Written Documentation

Revision 19-1; Effective November 15, 2019

A program provider must have written documentation to support a service claim for day habilitation that:

- (1) meets the requirements set forth in [Section 3800](#), Written Documentation;
- (2) includes a description of the location of the day habilitation site;
- (3) includes, for each calendar day, the exact time the day habilitation began and the exact time it ended documented by a staff person who is present at the day habilitation site during those times;
- (4) includes:
 - (A) a written service log, as described in [Section 3820](#), Written Service Log and Written Summary Log, of the calendar day for which the service claim is submitted; or
 - (B) a written summary log as described in Section 3820; and
- (5) includes a description from the individual's implementation plan of objectives the program provider is assisting the individual to achieve, as described in [Section 4330\(1\)](#), Billable Activity.
- (6) includes the signature of a service provider who provided all or a portion of the day habilitation during the period documented in accordance with paragraph (3) of this section.

4381 In-Home Day Habilitation

4381.1 General Description of Service Component

Revision 21-1; Effective January 1, 2021

The in-home day habilitation service component is the provision of assistance to an individual that is necessary for the individual to acquire skills to reside, integrate and participate successfully in the community.

4381.2 Requirements of Setting

Revision 21-1; Effective January 1, 2021

In-home day habilitation must be provided in the individual's residence.

4381.3 Requirement for Justification by a Licensed Professional or to be 55 Years of Age or Older

Revision 21-1; Effective January 1, 2021

An individual may receive in-home day habilitation only if:

- (1) a physician has documented that the individual's medical condition justifies the provision of in-home day habilitation; or
- (2) a licensed professional or behavioral supports service provider listed in [Section 4240\(2\)](#), Qualified Service Provider, has documented that the

- individual's behavioral issues justify the provision of in-home day habilitation; or
- (3) the individual is 55 years of age or older and requests to receive in-home day habilitation.

4381.4 EVV Requirements for In-Home Day Habilitation

Revision 21-1; Effective January 1, 2021

A program provider must comply with 1 TAC Chapter 354, Subchapter O, Electronic Visit Verification, regarding in-home day habilitation provided to an individual whose residential location is "own home/ family home."

4381.5 Billable Activity

Revision 21-1; Effective January 1, 2021

The only billable activities for the in-home day habilitation service component are:

- (1) interacting face-to-face with an individual to assist the individual in achieving objectives to:
 - (A) acquire, retain or improve self-help skills, socialization skills or adaptive skills that are necessary to for the individual to successfully reside, integrate and participate in the community; and
 - (B) reinforce a skill taught in school or professional therapies;
- (2) assisting an individual with his or her personal care activities if the individual cannot perform such activities without assistance;
- (3) participating in a service planning team meeting;
- (4) participating in the development of an implementation plan; and
- (5) participating in the development of an IPC.

4381.6 Activity Not Billable

Revision 21-1; Effective January 1, 2021

(a) Activities in Section 3300

The activities listed in [Section 3300](#), Activity Not Billable, are not billable for the in-home day habilitation service component.

(b) Activities Not Listed in Section 4330

Any activity not described in [Section 4381.5](#), Billable Activity, is not billable for the in-home day habilitation service component.

(c) Meeting Vocational Production Goal Not Billable Activity

Assisting an individual for the purpose of meeting a vocational production goal is an example of an activity that is not billable for the in-home day habilitation service component.

4381.7 Restrictions Regarding Submission of Claims for In-Home Day Habilitation

Revision 21-1; Effective January 1, 2021

A program provider may not submit a service claim for:

- (1) in-home day habilitation for a day that the individual refuses to participate in in-home day habilitation activities unless the individual has refused to participate for 45 calendar days or less since the beginning of the preceding three-month period or since the implementation plan was amended to address the individual's refusal (whichever is later) and:
 - (A) the service provider of in-home day habilitation has made repeated attempts to engage the individual in the activity throughout the day; and
 - (B) those attempts have been documented;
- (2) in-home day habilitation provided to assist an individual in achieving objectives not documented in the individual's implementation plan;
- (3) in-home day habilitation provided to an individual in excess of five units of service per calendar week;
- (4) in-home day habilitation provided to an individual in excess of 260 units of service per IPC year;
- (5) in-home day habilitation provided to an individual that is funded by a source other than the HCS Program such as (the Texas Workforce Commission);
- (6) in-home day habilitation that is being provided by the individual's service provider who is providing another service component to the individual at the same time in violation of [Section 3710](#), One Service Provider; or
- (7) in-home day habilitation provided by the individual's host home/companion care service provider.

4381.8 Qualified Service Provider

Revision 21-1; Effective January 1, 2021

In addition to meeting the requirements in [Section 3400](#), Qualified Service Provider, a qualified service provider of the in-home day habilitation service component;

- (1) must have one of the following:
 - (A) a high school diploma;
 - (B) a high school equivalency certificate issued in accordance with the law of the issuing state; or
 - (C) both of the following:
 - (i) a successfully completed written competency-based assessment demonstrating the ability to provide in-home day habilitation and the ability to document the provision of in-home day habilitation in accordance with [Section 3800](#), Written Documentation, and [Section 4380](#), Written Documentation;
 - (ii) written personal references which evidence the service provider's ability to provide a safe and healthy environment for the individual from at least three persons who are not relatives of the service provider ([Appendix II](#), Degree of Consanguinity or Affinity, explains who is considered a relative for purposes of these billing guidelines); and
- (2) must not be the individual's host home/companion care service provider.

4381.9 Unit of Service

Revision 21-1; Effective January 1, 2021

(a) One Day

A unit of service for the in-home day habilitation service component is one day.

(b) Service Claim for Unit of Service

(1) One-quarter Unit of Service

A program provider may submit a service claim for in-home day habilitation for one-quarter (0.25) unit of service if the program provider provides at least one and one-quarter hours of in-home day habilitation on a calendar day.

(2) One-half Unit of Service

A program provider may submit a service claim for in-home day habilitation for one-half (0.5) unit of service if the program provider provides at least two and one-half hours of in-home day habilitation on a calendar day.

(3) Three-quarters Unit of Service

A program provider may submit a service claim for in-home day habilitation for three-quarters (.75) unit of service if the program provider provides at least three and three-quarter hours of in-home day habilitation on a calendar day.

(4) One Unit of Service

A program provider may submit a service claim for in-home day habilitation for one unit of service if the program provider provides at least five hours of in-home day habilitation on a calendar day.

4381.10 Written Documentation

Revision 21-1; Effective January 1, 2021

A program provider must have written documentation to support a service claim for in-home day habilitation that:

- (1) meets the requirements set forth in [Section 3800](#), Written Documentation;
- (2) includes a description of the location where in-home day habilitation is provided;
- (3) includes, for each calendar day, the exact time the in-home day habilitation began and the exact time it ended documented by the service provider of in-home day habilitation;
- (4) includes:
 - (A) a written service log, as described in [Section 3820](#), Written Service Log and Written Summary Log, of the calendar day for which the service claim is submitted; or
 - (B) a written summary log as described in [Section 3820](#); and
- (5) includes a description from the individual's implementation plan of objectives the program provider is assisting the individual to achieve, as described in [Section 4381.5\(1\)](#), Billable Activity.
- (6) includes the signature of a service provider who provided the in-home day habilitation during the period documented in accordance with paragraph (3) of this section.

4400 Registered Nursing

Revision 10-1; Effective June 1, 2010

4410 General Description of Service Component

Revision 10-0; Effective October 1, 2009

The registered nursing service component is the provision of professional nursing, as defined in Texas Occupations Code, [Chapter 301 \(link is external\)](#), provided to an individual with a medical need.

4420 Billable Activity

Revision 21-1; Effective January 1, 2021

The only billable activities for the registered nursing service component are:

- (1) interacting face-to-face with an individual who has a medical need for registered nursing, including:
 - (A) preparing and administering medication or treatment ordered by a physician, podiatrist or dentist;
 - (B) assisting or observing administration of medication; and
 - (C) assessing the individual's health status, including conducting a focused assessment or an RN nursing assessment;
- (2) speaking by telephone with an individual who has a medical need for registered nursing, including assessing the individual's health status;
- (3) interacting by video conference with an individual who has a medical need for registered nursing, including:
 - (A) observing administration of medication; and
 - (B) assessing the individual's health status, including conducting a focused assessment or an RN nursing assessment;
- (4) at the time an individual receives medication from a pharmacy, ensuring the accuracy of:
 - (A) the type and amount of medication;
 - (B) the dosage instructions; and
 - (C) checking medications at the time they are received from the pharmacy for matching labels with the doctor's order and medication administration record sheet (MARS) for correct type and amount of medication;
- (5) if an error regarding an individual's medication has been documented or a lab result shows that an individual's therapeutic levels are abnormal:
 - (A) storing medication;
 - (B) counting medication;
 - (C) reordering medication; or
 - (D) refilling medication;

- (6) researching medical information for an individual who has a medical need for registered nursing, including:
 - (A) reviewing documents to evaluate the quality and effectiveness of the medical treatment the individual is receiving; and
 - (B) completing an RN nursing assessment;
- (7) preparing, documenting, or transmitting medical information to a physician or a licensed healthcare professional regarding an appointment the individual will have or had with the physician or licensed healthcare professional;
- (8) training the following persons how to perform nursing tasks:
 - (A) a service provider of host home/companion care, residential support, supervised living, Community First Choice Personal Assistance Services/Habilitation (CFC PAS/HAB), transportation as a supported home living activity, day habilitation, in-home day habilitation respite, in-home respite, supported employment or employment assistance;
 - (B) a person other than a service provider who is involved in serving an individual; or
 - (C) reviewing documents in preparation for the training described in paragraph (5) of this subsection;
- (9) interacting face-to-face or by video conference or speaking by telephone with a person regarding the health status of an individual, but not with:
 - (A) a staff person who is not a service provider;
 - (B) a service provider of professional therapies; or
 - (C) a service provider of registered nursing, licensed vocational nursing, specialized registered nursing, or specialized licensed vocational nursing, unless interacting during:
 - (i) an emergency involving the individual, including:
 - a medical emergency;
 - a behavioral emergency;
 - a natural disaster; and
 - a pandemic;
 - (ii) a change in the individual's medical or behavioral condition; or
 - (iii) a transition of nursing duties including:
 - a shift change;
 - a debriefing of on-call duties; and
 - a reassignment of caseloads;
- (10) interacting face-to-face or speaking by telephone with a pharmacist or representative of a health insurance provider, including the Social

Security Administration, about an individual's insurance benefits for medication if the registered nurse justifies, in writing, the need for the registered nurse to perform the activity;

- (11) instructing a service provider, except a service provider of registered nursing or specialized registered nursing, on a topic that is specific to an individual such as choking risks for an individual who has cerebral palsy;
- (12) supervising a licensed vocational nurse regarding an individual's nursing services or health status;
- (13) 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 Human Resources Code, §§161.091-.093, as applicable;
- (14) participating in a service planning team meeting;
- (15) participating in the development of an implementation plan;
- (16) participating in the development of an IPC; and
- (17) developing one annual nursing report.

4430 Activity Not Billable

Revision 20-1; Effective September 1, 2020

(a) Activities in Section 3300

The activities listed in [Section 3300](#), Activity Not Billable, are not billable for the registered nursing service component.

(b) Activities Not Listed in Section 4420

Any activity not described in [Section 4420](#), Billable Activity, is not billable for the registered nursing service component.

(c) Examples of Non-billable Activities

The following are examples of activities that are not billable for the registered nursing service component, regardless of whether they constitute the practice of registered nursing:

- (1) performing or supervising an activity that does not constitute the practice of registered nursing, including:
 - (A) transporting an individual;

- (B) waiting to perform a billable activity; and
- (C) waiting with an individual at a medical appointment;
- (2) making a medical appointment;
- (3) instructing on general topics unrelated to a specific individual, such as cardiopulmonary resuscitation or infection control;
- (4) preparing a treatment or medication for administration and not interacting face-to-face with an individual;
- (5) storing, counting, reordering, refilling or delivering medication except as allowed in [Section 4420\(4\) and \(5\)](#), Billable Activity;
- (6) creating written documentation as described in [Section 4470](#), Written Documentation;
- (7) reviewing a written service log or written summary log of a service component as described in [Section 3820](#), Written Service Log and Written Summary Log, except as allowed in [Section 4420\(6\)\(A\)](#), Billable Activity;
- (8) interacting with a staff person who is not a service provider or a provider of professional therapies and the interaction is not during a service planning team meeting or during the development of an IPC or an implementation plan; and
- (9) performing an activity for which there is no medical need.

4440 Qualified Service Provider

Revision 10-0; Effective October 1, 2009

In addition to meeting the requirements in [Section 3400](#), Qualified Service Provider, a qualified service provider of the registered nursing service component must be a registered nurse.

4450 Unit of Service

Revision 19-1; Effective November 15, 2019

(a) 15 Minutes

A unit of service for the registered nursing service component is 15 minutes.

(b) Fraction of a Unit of Service

A service claim for registered nursing may not include a fraction of a unit of service.

(c) Service Time

Service time is calculated in accordance with [Section 3610\(b\)](#), 15-Minute Unit of Service, including when multiple persons are being served.

4460 Accumulation of Service Times

Revision 12-2; Effective October 1, 2012

A program provider may accumulate service times, as described in [Section 3610\(b\)](#), 15-Minute Unit of Service, for registered nursing provided to one individual on a single calendar month. The service times of more than one registered nurse may be accumulated on the last day of the month. The service times of more than one registered nurse may be accumulated on the last day of the month.

Example:

A registered nurse provides registered nursing services to one individual three times during a single calendar month: July 1, 2012, 8:30-8:55 a.m. (25 minutes); July 6, 2012, 4:15-4:20 p.m. (5 minutes); and July 25, 2012, 8:00-8:05 p.m. (5 minutes).

Without accumulating service times, **two units of service for registered nursing are billable** for the service time of 25 minutes. The service times of five minutes are not billable because they are less than eight minutes each.

If all three service times are accumulated into one service time of 35 minutes (25 + 5 + 5), **two units of service for registered nursing are billable**.

If the first service time of 25 minutes is billed as two units of service on the day it was provided, and the second and third service times are accumulated into one service time of 10 minutes (5 + 5), which is billable as one unit of service on the last day of the month, July 31, 2012, **three units of service for registered nursing are billable** (2 + 1).

Example:

Nurse A provides 7 minutes of registered nursing to an individual. During the same month, Nurse B provides 7 minutes of licensed vocational nursing to the same individual. You could not accumulate the time and neither service would meet the minimum requirements for billing a unit of their respective nursing component.

4470 Written Documentation

Revision 11-1; Effective September 1, 2011

A program provider must have written documentation to support a service claim for registered nursing. The written documentation must meet the requirements set forth in [Section 3800](#), Written Documentation.

4471 Licensed Vocational Nursing

Revision 10-1; Effective June 1, 2010

4471.1 General Description of Service Component

Revision 10-0; Effective October 1, 2009

The licensed vocational nursing service component is the provision of licensed vocational nursing, as defined in Texas Occupations Code, [Chapter 301 \(link is external\)](#), to an individual.

4471.2 Billable Activity

Revision 21-1; Effective January 1, 2021

The only billable activities for the licensed vocational nursing service component are:

- (1) interacting face-to-face with an individual who has a medical need for licensed vocational nursing, including:
 - (A) preparing and administering medication or treatment ordered by a physician, podiatrist or dentist;
 - (B) assisting or observing administration of medication; and
 - (C) conducting a focused assessment of the individual's health status;
- (2) interacting by video conference, within the scope of practice of the licensed vocational nurse, with an individual who has a medical need for licensed vocational nursing, including:
 - (A) observing administration of medication; and
 - (B) conducting a focused assessment of the individual's health status;
- (3) at the time an individual receives medication from a pharmacy, ensuring the accuracy of:
 - (A) the type and amount of medication;
 - (B) the dosage instructions; and
 - (C) checking medications at the time they are received from the pharmacy for matching labels with the doctor's order and medication administration record sheet (MARS) for correct type and amount of medication;
- (4) if an error regarding an individual's medication has been documented or a lab result shows that an individual's therapeutic levels are abnormal:

- (A) storing medication;
 - (B) counting medication;
 - (C) reordering medication; or
 - (D) refilling medication;
- (5) researching medical information for an individual who has a medical need for licensed vocational nursing, including:
- (A) reviewing documents to evaluate the quality and effectiveness of the medical treatment the individual is receiving; and
 - (B) completing a focused assessment;
- (6) preparing, documenting, or transmitting medical information to a physician or a licensed healthcare professional regarding an appointment the individual will have or had with the physician or licensed healthcare professional;
- (7) training a service provider of CFC PAS/HAB, transportation as a supported home living activity, residential assistance, day habilitation, in-home day habilitation, respite, in-home respite, employment assistance or supported employment, or a person other than a service provider who is involved in serving an individual, regarding how to perform nursing tasks;
- (8) reviewing documents in preparation for the training described in the paragraph (7) of this section;
- (9) interacting face-to-face or by video conference or speaking by telephone with a person regarding the health status of an individual, but not with:
- (A) a staff person who is not a service provider; or
 - (B) a service provider of professional therapies;
 - (C) a service provider of registered nursing, licensed vocational nursing, specialized registered nursing, or specialized licensed vocational nursing, unless interacting during:
 - (i) an emergency involving the individual, including:
 - a medical emergency;
 - a behavioral emergency;
 - a natural disaster; and
 - a pandemic;
 - (ii) a change in the individual's medical or behavioral condition; or
 - (iii) a transition of nursing duties including:
 - a shift change;
 - a debriefing of on-call duties; and
 - a reassignment of caseloads;

- (10) interacting face-to-face or speaking by telephone with a pharmacist or representative of a health insurance provider, including the Social Security Administration, about an individual's insurance benefits for medication if the licensed vocational nurse justifies, in writing, the need for the licensed vocational nurse to perform the activity;
- (11) instructing a service provider, except a service provider of registered nursing or specialized registered nursing, on a topic specific to an individual such as choking risks for an individual who has cerebral palsy;
- (12) participating in a service planning team meeting;
- (13) participating in the development of an implementation plan; and
- (14) participating in the development of an IPC; and
- (15) developing one annual nursing report.

4471.3 Activity Not Billable

Revision 20-1; Effective September 1, 2020

(a) Activities in Section 3300

The activities listed in [Section 3300](#), Activity Not Billable, are not billable for the licensed vocational nursing service component.

(b) Activities Not Listed in Section 4471.2

Any activity not described in [Section 4471.2](#), Billable Activity, is not billable for the licensed vocational nursing service component.

(c) Examples of Non-billable Activities

The following are examples of activities that are not billable for the licensed vocational nursing service component, regardless of whether they constitute the practice of licensed vocational nursing:

- (1) performing or supervising an activity that does not constitute the practice of licensed vocational nursing, including:
 - (A) performing an activity that constitutes the practice of professional nursing and must be performed by a registered nurse;
 - (B) transporting an individual;
 - (C) waiting to perform a billable activity; and
 - (D) waiting with an individual at a medical appointment;
- (2) making a medical appointment;
- (3) instructing on general topics unrelated to a specific individual, such as cardiopulmonary resuscitation, or infection control;

- (4) preparing a treatment or medication for administration and not interacting face-to-face with an individual;
- (5) storing, counting, reordering, refilling or delivering medication except as allowed in [Section 4471.2\(4\) and \(5\)](#), Billable Activity;
- (6) creating written documentation as described in [Section 4471.7](#), Written Documentation;
- (7) reviewing a written service log or written summary log of a service component as described in [Section 3820](#), Written Service Log and Written Summary Log except as allowed in [Section 4471.2\(6\)\(A\)](#), Billable Activity;
- (8) interacting with a staff person who is not a service provider or a provider of professional therapies and the interaction is not during a service planning team meeting or during the development of an IPC or an implementation plan; and;
- (9) performing an activity for which there is no medical need.

4471.4 Qualified Service Provider

Revision 10-0; Effective October 1, 2009

In addition to meeting the requirements in [Section 3400](#), Qualified Service Provider, a qualified service provider of the licensed vocational nursing service component must be a licensed vocational nurse.

4471.5 Unit of Service

Revision 19-1; Effective November 15, 2019

(a) 15 Minutes

A unit of service for the licensed vocational nursing service component is 15 minutes.

(b) Fraction of a Unit of Service

A service claim for licensed vocational nursing may not include a fraction of a unit of service.

(c) Service Time

Service time is calculated in accordance with [Section 3610\(b\)](#), 15-Minute Unit of Service, including when multiple persons are being served.

4471.6 Accumulation of Service Times

Revision 12-2; Effective October 1, 2012

A program provider may accumulate service times, as described in [Section 3610\(b\)](#), 15-Minute Unit of Service, for licensed vocational nursing provided to one individual during a single calendar month. The service times of more than one licensed vocational nurse may be accumulated on the last day of the month.

Example:

A nurse provides licensed vocational nursing services to one individual three times during a single calendar month: July 1, 2012, 8:30-8:55 a.m. (25 minutes); July 6, 2012, 4:15-4:20 p.m. (5 minutes); and July 28, 2012, 8:00-8:05 p.m. (5 minutes).

Without accumulating service times, **two units of service for licensed vocational nursing are billable** for the service time of 25 minutes. The service times of five minutes are not billable because they are less than eight minutes each.

If all three service times are accumulated into one service time of 35 minutes (25 + 5 + 5), **two units of service for licensed vocational nursing are billable**.

If the first service time of 25 minutes is billed as two units of service on the day it was provided, and the second and third service times are accumulated into one service time of 10 minutes (5 + 5), which is billable as one unit of service on the last day of the month, July 31, 2012, **three units of service for licensed vocational nursing are billable** (2 + 1).

Example:

Nurse A provides 7 minutes of licensed vocational nursing to an individual. During the same month, Nurse B provides 7 minutes of registered nursing to the same individual. You could not accumulate the time and neither service would meet the minimum requirements for billing a unit of their respective nursing component.

4471.7 Written Documentation

Revision 11-1; Effective September 1, 2011

A program provider must have written documentation to support a service claim for licensed vocational nursing. The written documentation must meet the requirements set forth in [Section 3800](#), Written Documentation.

4472 Specialized Registered Nursing

Revision 10-1; Effective June 1, 2010

4472.1 General Description of Service Component

Revision 10-0; Effective October 1, 2009

The specialized registered nursing service component is the provision of professional nursing, as defined in Texas Occupations Code, [Chapter 301 \(link is external\)](#), to an individual who has a tracheostomy or is dependent on a ventilator.

4472.2 Billable Activity

Revision 21-1; Effective January 1, 2021

The only billable activities for the specialized registered nursing service component are:

- (1) interacting face-to-face with an individual who has a tracheostomy or is dependent on a ventilator and who has a medical need for registered nursing, including:
 - (A) preparing and administering medication or treatment ordered by a physician, podiatrist or dentist;
 - (B) assisting or observing administration of medication; and
 - (C) assessing the individual's health status, including conducting a focused assessment or an RN nursing assessment;
- (2) speaking by telephone with an individual who has a tracheostomy or is dependent on a ventilator and who has a medical need for registered nursing, including assessing the individual's health status;
- (3) interacting by video conference with an individual who has a tracheostomy or is dependent on a ventilator and who has a medical need for registered nursing, including:
 - (A) observing self-administration of medication; and
 - (B) assessing the individual's health status, including conducting a focused assessment or an RN nursing assessment;
- (4) at the time an individual receives medication from a pharmacy, ensuring the accuracy of:
 - (A) the type and amount of medication;
 - (B) the dosage instructions; and
 - (C) checking medications at the time they are received from the pharmacy for matching labels with the doctor's order and medication administration record sheet (MARS) for correct type and amount of medication;
- (5) if an error regarding an individual's medication has been documented or a lab result shows that an individual's therapeutic levels are abnormal:
 - (A) storing medication;
 - (B) counting medication;

- (C) reordering medication; or
 - (D) refilling medication;
- (6) researching medical information for an individual who has a tracheostomy or is dependent on a ventilator and who has a medical need for registered nursing, including:
- (A) reviewing documents to evaluate the quality and effectiveness of the medical treatment the individual is receiving; and
 - (B) completing an RN nursing assessment;
- (7) preparing, documenting, or transmitting medical information to a physician or a licensed healthcare professional regarding an appointment the individual will have or had with the physician or licensed healthcare professional;
- (8) training the following persons on how to perform nursing tasks for an individual who has a tracheostomy or is dependent on a ventilator:
- (A) a service provider of host home/companion care, residential support, supervised living, CFC PAS/HAB, transportation as a supported home living activity, day habilitation, in-home day habilitation, respite, in-home respite, supported employment or employment assistance; or
 - (B) a person other than a service provider who is involved in serving the individual;
- (9) reviewing documents in preparation for the training described in the paragraph (8) of this section section;
- (10) interacting face-to-face or by video conference or speaking by telephone with a person regarding the health status of an individual who has a tracheostomy or is dependent on a ventilator, but not with:
- (A) a staff person who is not a service provider;
 - (B) a service provider of professional therapies;
 - (C) a service provider of registered nursing, licensed vocational nursing, specialized registered nursing, or specialized licensed vocational nursing, unless interacting during:
 - (i) an emergency involving the individual, including:
 - a medical emergency;
 - a behavioral emergency;
 - a natural disaster; and
 - a pandemic;
 - (ii) a change in the individual's medical or behavioral condition; or
 - (iii) a transition of nursing duties including:
 - a shift change;
 - a debriefing of on-call duties; and

- a resassignment caseloads;
- (11) interacting face-to-face or speaking by telephone with a pharmacist or representative of a health insurance provider, including the Social Security Administration, about an individual's insurance benefits for medication if the registered nurse justifies, in writing, the need for the registered nurse to perform the activity;
- (12) instructing a service provider, except a service provider of registered nursing or specialized registered nursing, on a topic specific to an individual such as choking risks for an individual who has cerebral palsy;
- (13) supervising a licensed vocational nurse regarding an individual's nursing services or health status;
- (14) 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 Human Resources Code, §§161.091-.093, as applicable;
- (15) participating in a service planning team meeting;
- (16) participating in the development of an implementation plan;
- (17) participating in the development of an IPC; and
- (18) developing one annual nursing report.

4472.3 Activity Not Billable

Revision 20-1; Effective September 1, 2020

(a) Activities in Section 3300

The activities listed in [Section 3300](#), Activity Not Billable, are not billable for the specialized professional nursing service component.

(b) Activities Not Listed in Section 4420

Any activity not described in [Section 4420](#), Billable Activity, is not billable for the specialized registered nursing service component.

(c) Examples of Non-billable Activities

The following are examples of activities that are not billable for the specialized registered nursing service component, regardless of whether they constitute the practice of registered nursing:

- (1) performing or supervising an activity that does not constitute the practice of registered nursing, including:
 - (A) transporting an individual;
 - (B) waiting to perform a billable activity; and
 - (C) waiting with an individual at a medical appointment;
- (2) making a medical appointment;
- (3) instructing on general topics unrelated to a specific individual, such as cardiopulmonary resuscitation or infection control;
- (4) preparing a treatment or medication for administration and not interacting face-to-face with an individual;
- (5) storing, counting, reordering, refilling or delivering medication except as allowed in [Section 4472.2\(4\) and \(5\)](#), Billable Activity;
- (6) creating written documentation as described in [Section 4472.7](#), Written Documentation;
- (7) reviewing a written service log or written summary log of a service component as described in [Section 3820](#), Written Service Log and Written Summary Log, except as allowed in [Section 4472.2\(6\)\(A\)](#), Billable Activity;
- (8) interacting with a staff person who is not a service provider or a provider of professional therapies and the interaction is not during a service planning team meeting or during the development of an IPC or an implementation plan; and
- (9) performing an activity for which there is no medical need.

4472.4 Qualified Service Provider

Revision 10-0; Effective October 1, 2009

In addition to meeting the requirements in [Section 3400](#), Qualified Service Provider, a qualified service provider of the specialized registered nursing service component must be a registered nurse.

4472.5 Unit of Service

Revision 11-1; Effective September 1, 2011

(a) 15 Minutes

A unit of service for the specialized registered nursing service component is 15 minutes.

(b) Fraction of a Unit of Service

A service claim for specialized registered nursing may not include a fraction of a unit of service.

(c) Service Time

Service time is calculated in accordance with [Section 3610\(b\)](#), 15-Minute Unit of Service, including when multiple persons are being served.

4472.6 Accumulation of Service Times

Revision 12-2; Effective October 1, 2012

A program provider may accumulate service times, as described in Section 3610(b), 15-Minute Unit of Service, for specialized registered nursing provided to one individual during a single calendar month. The service times of more than one specialized registered nurse may be accumulated on the last day of the month.

Example:

A nurse provides specialized registered nursing services to one individual three times during a single calendar month: July 1, 2012, 8:30-8:55 a.m. (25 minutes); July 6, 2012, 4:15-4:20 p.m. (5 minutes); and July 28, 2012, 8:00-8:05 p.m. (5 minutes).

Without accumulating service times, **two units of service for specialized registered nursing are billable** for the service time of 25 minutes. The service times of five minutes are not billable because they are less than eight minutes each.

If all three service times are accumulated into one service time of 35 minutes (25 + 5 + 5), **two units of service for specialized registered nursing are billable**.

If the first service time of 25 minutes is billed as two units of service on the day it was provided, and the second and third service times are accumulated into one service time of 10 minutes (5 + 5), which is billable as one unit of service on the last day of the month, July 31, 2012, **three units of service for specialized registered nursing are billable** (2 + 1).

Example:

Nurse A provides 20 minutes of specialized registered nursing to an individual. On the same calendar day, Nurse B provides 20 minutes of specialized licensed vocational nursing to the same individual. You could not accumulate the time and neither service would meet the minimum requirements for billing a unit of their respective nursing component.

4472.7 Written Documentation

Revision 11-1; Effective September 1, 2011

A program provider must have written documentation to support a service claim for specialized registered nursing. The written documentation must meet the requirements set forth in [Section 3800](#), Written Documentation.

4473 Specialized Licensed Vocational Nursing

Revision 10-1; Effective June 1, 2010

4473.1 General Description of Service Component

Revision 10-0; Effective October 1, 2009

The specialized licensed vocational nursing service component is the provision of licensed vocational nursing, as defined in Texas Occupations Code, [Chapter 301 \(link is external\)](#), to an individual who has a tracheostomy or is dependent on a ventilator

4473.2 Billable Activity

Revision 21-1; Effective January 1, 2021

The only billable activities for the specialized licensed vocational nursing service component are:

- (1) interacting face-to-face with an individual who has a tracheostomy or is dependent on a ventilator and who has a medical need for licensed vocational nursing, including:
 - (A) preparing and administering medication or treatment ordered by a physician, podiatrist or dentist;
 - (B) assisting or observing administration of medication; and
 - (C) conducting a focused assessment of the individual's health status;
- (2) interacting by video conference, within the scope of practice of the licensed vocational nurse, with an individual who has a tracheostomy or is dependent on a ventilator and who has a medical need for licensed vocational nursing, including:
 - (A) observing administration of medication; and
 - (B) conducting a focused assessment of the individual's health status;
- (3) at the time an individual receives medication from a pharmacy, ensuring the accuracy of:

- (A) the type and amount of medication;
 - (B) the dosage instructions; and
 - (C) checking medications at the time they are received from the pharmacy for matching labels with the doctor's order and medication administration record sheet (MARS) for correct type and amount of medication;
- (4) if an error regarding an individual's medication has been documented or a lab result shows that an individual's therapeutic levels are abnormal:
- (A) storing medication;
 - (B) counting medication;
 - (C) reordering medication; or
 - (D) refilling medication;
- (5) researching medical information for an individual who has a tracheostomy or is dependent on a ventilator and who has a medical need for licensed vocational nursing, including:
- (A) reviewing documents to evaluate the quality and effectiveness of the medical treatment the individual is receiving; and
 - (B) completing a focused assessment;
- (6) preparing, documenting, or transmitting medical information to a physician or a licensed healthcare professional regarding an appointment the individual will have or had with the physician or licensed healthcare professional;
- (7) training a service provider of CFC PAS/HAB, transportation as a supported home living activity, residential assistance, day habilitation, in-home day habilitation, respite, in-home respite, employment assistance or supported employment, or a person other than a service provider who is involved in serving an individual on how to perform nursing tasks for an individual who has a tracheostomy or is dependent on a ventilator;
- (8) reviewing documents in preparation for the training described in paragraph (7) of this section;
- (9) interacting face-to-face or by video conference or speaking by telephone with a person regarding the health status of an individual who has a tracheostomy or is dependent on a ventilator, but not with:
- (A) a staff person who is not a service provider;
 - (B) a service provider of professional therapies; or
 - (C) a service provider of registered nursing, licensed vocational nursing, specialized registered nursing, or specialized licensed vocational nursing, unless interacting during:

- (i) an emergency involving the individual, including:
 - a medical emergency;
 - a behavioral emergency;
 - a natural disaster; and
 - a pandemic;
- (ii) a change in the individual's medical or behavioral condition; or
- (iii) a transition of nursing duties including:
 - a shift change;
 - a debriefing of on-call duties; and
 - a reassignment of caseloads;
- (10) interacting face-to-face or speaking by telephone with a pharmacist or representative of a health insurance provider, including the Social Security Administration, about an individual's insurance benefits for medication if the licensed vocational nurse justifies, in writing, the need for the licensed vocational nurse to perform the activity;
- (11) instructing a service provider, except a service provider of registered nursing or specialized registered nursing, on a topic specific to an individual such as choking risks for an individual who has cerebral palsy;
- (12) participating in a service planning team meeting;
- (13) participating in the development of an implementation plan;
- (14) participating in the development of an IPC; and
- (15) developing one annual nursing report.

4473.3 Activity Not Billable

Revision 20-1; Effective September 1, 2020

(a) Activities in Section 3300

The activities listed in [Section 3300](#), Activity Not Billable, are not billable for the specialized licensed vocational nursing service component.

(b) Activities Not Listed in Section 4420

Any activity not described in [Section 4420](#), Billable Activity, is not billable for the specialized licensed vocational nursing service component.

(c) Examples of Non-billable Activities

The following are examples of activities that are not billable for the specialized licensed vocational nursing service component, regardless of whether they constitute the practice of licensed vocational nursing:

- (1) performing or supervising an activity that does not constitute the practice of licensed vocational nursing, including:
 - (A) performing an activity that constitutes the practice of professional nursing and must be performed by a registered nurse;
 - (B) transporting an individual;
 - (C) waiting to perform a billable activity; and
 - (D) waiting with an individual at a medical appointment;
- (2) making a medical appointment;
- (3) instructing on general topics unrelated to a specific individual, such as cardiopulmonary resuscitation or infection control;
- (4) preparing a treatment or medication for administration and not interacting face-to-face with an individual;
- (5) storing, counting, reordering, refilling or delivering medication except as allowed in [Section 4473.2\(4\) and \(5\)](#), Billable Activity;
- (6) creating written documentation as described in [Section 4473.7](#), Written Documentation;
- (7) reviewing a written service log or written summary log of a service component as described in [Section 3820](#), Written Service Log and Written Summary Log, except as allowed in [Section 4473.2\(6\)\(A\)](#), Billable Activity;
- (8) interacting with a staff person who is not a service provider or a provider of professional therapies and the interaction is not during a service planning team meeting or during the development of an IPC or an implementation plan; and
- (9) performing an activity for which there is no medical need.

4473.4 Qualified Service Provider

Revision 10-0; Effective October 1, 2009

In addition to meeting the requirements in [Section 3400](#), Qualified Service Provider, a qualified service provider of the specialized licensed vocational nursing service component must be a licensed vocational nurse.

4473.5 Unit of Service

Revision 11-1; Effective September 1, 2011

(a) 15 Minutes

A unit of service for the specialized licensed vocational nursing service component is 15 minutes.

(b) Fraction of a Unit of Service

A service claim for specialized licensed vocational nursing may not include a fraction of a unit of service.

(c) Service Time

Service time is calculated in accordance with [Section 3610\(b\)](#), 15-Minute Unit of Service, including when multiple persons are being served.

4473.6 Accumulation of Service Times

Revision 12-2; Effective October 1, 2012

A program provider may accumulate service times, as described in [Section 3610\(b\)](#), 15-Minute Unit of Service, for specialized licensed vocational nursing provided to one individual during a single calendar month. The service times of more than one specialized licensed vocational nurse may be accumulated on the last day of the month.

Example:

A nurse provides specialized licensed vocational nursing services to one individual three times during a single calendar month: July 1, 2012, 8:30-8:55 a.m. (25 minutes); July 6, 2012, 4:15-4:20 p.m. (5 minutes); and July 28, 2012, 8:00-8:05 p.m. (5 minutes).

Without accumulating service times, **two units of service for specialized licensed vocational nursing are billable** for the service time of 25 minutes. The service times of five minutes are not billable because they are less than eight minutes each.

If all three service times are accumulated into one service time of 35 minutes (25 + 5 + 5), **two units of service for specialized licensed vocational nursing are billable.**

If the first service time of 25 minutes is billed as two units of service on the day it was provided, and the second and third service times are accumulated into one service time of 10 minutes (5 + 5), which is billable as one unit of service on the last day of the month, July 31, 2012, **three units of service for specialized licensed vocational nursing are billable (2 + 1).**

Example:

Nurse A provides 20 minutes of specialized licensed vocational nursing to an individual. On the same calendar day, Nurse B provides 20 minutes of specialized registered nursing to the same individual. You could not accumulate the time and neither service would meet the minimum requirements for billing a unit of their respective nursing component.

4473.7 Written Documentation

Revision 11-1; Effective September 1, 2011

A program provider must have written documentation to support a service claim for specialized licensed vocational nursing. The written documentation must meet the requirements set forth in [Section 3800](#), Written Documentation.

4500 Residential Assistance

Revision 10-1; Effective June 1, 2010

4510 General Description of Service Component

Revision 19-1; Effective November 15, 2019

The residential assistance service component is the provision of assistance and support necessary for an individual to perform personal care, health maintenance and independent living tasks, participate in community activities, and develop, retain and improve community living skills.

The residential assistance service component consists of the following subcomponents:

- (1) supported home living (transportation);
- (2) host home/companion care;
- (3) residential support; and
- (4) supervised living.

4520 Restrictions Regarding Submission of Claims for Residential Assistance

Revision 10-0; Effective October 1, 2009

A program provider may not submit a service claim for multiple residential assistance subcomponents provided to the same individual on the same day.

4530 Residential Location

Revision 19-1; Effective November 15, 2019

(a) "Own/Family Home"

A program provider must document a residential location of "own/family home" on an individual's IPC if no service provider provides host home/companion care, residential support or supervised living to the individual.

Example:

A minor is living with a parent or a person contracting with DFPS to provide residential child care to the minor and no service provider is paid to provide host home/companion care, residential support or supervised living to the minor. The minor must have a residential location of "own/family home" on her IPC.

Example:

An adult individual is living alone or with parents and no service provider is paid to provide host home/companion care, residential support or supervised living to the individual. The individual must have a residential location of "own/family home" on his IPC.

(b) "Host Home/Companion Care"

A program provider must document a residential location of "host home/companion care" on an individual's IPC if:

- (1) the program provider does not lease or own the individual's residence;
- (2) a service provider provides host home/companion care to the individual; and
- (3) the individual and the host home/companion care provider have the same residence.

Example:

The residence of one individual and the host home/companion care provider is leased by the individual but the program provider does not lease or own the residence. The individual must have a residential location of "host home/companion care" on his IPC.

Example:

The residence of three individuals and the host home/companion care provider is owned by the host home/companion care provider, but the program provider does not lease or own the residence. The three individuals must have a residential location of "host home/companion care" on their IPCs.

(c) "3-Person Home"

A program provider must document a residential location of "3-Person Home" on an individual's IPC if:

- (1) the individual's residence is a three-person residence; and
- (2) a service provider provides residential support or supervised living to the individual.

(d) "4-Person Home"

A program provider must document a residential location of "4-Person Home" on an individual's IPC if:

- (1) the individual's residence is a four-person residence; and
- (2) a service provider provides residential support or supervised living to the individual.

4540 Supported Home Living Billing Requirements

Revision 21-1; Effective January 1, 2021

(a) Billable Activity

The only billable activity for the supported home living subcomponent is transporting the individual, except from one day habilitation, employment assistance or supported employment site to another.

(b) Residential Location

A program provider may provide transportation as a supported home living activity to an individual only if the program provider has documented a residential location of "own/family home" on the individual's IPC, as described in [Section 4530\(a\)](#), Residential Location.

(c) Activity Not Billable

(1) Activities in Section 3300

The activities listed in [Section 3300](#), Activity Not Billable, are not billable for transportation as a supported home living activity.

(2) Activities Not Listed in Subsection (a)

Any activity not described in subsection (a) of this section is not billable for transportation as a supported home living activity.

(d) Restrictions Regarding Submission of Claims for Transportation as a Supported Home Living Activity

A program provider may not submit a service claim for:

- (1) transportation as a supported home living activity provided to an individual whose IPC does not have a residential location of own/family home; or
- (2) transporting an individual from one day habilitation, employment assistance or supported employment site to another.

(e) Qualified Service Provider

In addition to meeting the requirements in [Section 3400](#), Qualified Service Provider, a qualified service provider of transportation as a supported home living activity:

- (1) may not have the same residence as the individual; and
- (2) must have one of the following:
 - (A) a high school diploma;
 - (B) a high school equivalency certificate issued in accordance with the law of the issuing state; or
 - (C) both of the following:
 - (i) a successfully completed written competency-based assessment demonstrating the ability to provide transportation as a supported home living activity and the ability to document the provision of transportation as a supported home living activity in accordance with [Section 3800](#), Written Documentation, and subsection (j) of this section; and
 - (ii) written personal references which evidence the service provider's ability to provide a safe and healthy environment for the individual from at least three persons who are not relatives of the service provider ([Appendix II](#), Degree of Consanguinity or Affinity, explains who is considered a relative for purposes of these billing guidelines).

(f) Unit of Service

- (1) **15 Minutes**

A unit of service for transportation as a supported home living activity is 15 minutes.

(2) Fraction of a Unit of Service

A service claim for transportation as a supported home living activity may not include a fraction of a unit of service.

(3) Service Time

Service time is calculated in accordance with [Section 3610\(b\)](#), 15-Minute Unit of Service, including when multiple persons are being served.

(g) Determining Unit of Service for Transportation as a Supported Home Living Activity

The unit of service for a service claim for transportation as a supported home living activity is determined by:

- (1) calculating transportation time, number of passengers and number of service providers using Method A or Method B, as described in subsection (h) of this section;
- (2) determining service time using the formula set forth in subsection (i) of this section; and
- (3) converting service time to units of service for a service claim using [Appendix III](#), Conversion Table, as described in subsection (i)(3) of this section.

(h) Calculating Transportation Time, Passengers, Service Providers

(1) How to Calculate

Transportation time, number of passengers and number of service providers must be calculated using Method A or Method B as described below.

(2) Use of Only One Method on a Single Calendar Day

A program provider may not use Method A and Method B on the same calendar day.

(3) Definitions Applicable for Method A and Method B

The following definitions apply to Method A and Method B:

- (A) A "passenger" is a person who receives a service funded by HHSC, including a person enrolled in the ICF/IID program or a waiver program other than HCS.
- (B) A "trip" is a discrete period of continuous time during which one or more individuals are being transported in the same vehicle.

(4) Method A

Using Method A, the transportation time, number of passengers and number of service providers are the same for all individuals transported in a single trip:

- (A) Transportation time begins when the first individual gets on the vehicle and ends when the last individual gets off the vehicle.
- (B) The number of passengers is the total number of passengers transported during the trip.
- (C) The number of service providers is the total number of service providers who provide services during the trip, including the driver of the vehicle.

(5) Method B

Using Method B, the transportation time, number of passengers and number of service providers are determined separately for each individual transported in a single trip in segments that begin and end when the number of passengers or the number of service providers changes during the trip.

(i) Determining Service Time

(1) How to Determine

Service time must be determined using the transportation time, number of passengers and number of service providers for an entire trip (if using Method A) or for each segment of a trip (if using Method B).

(2) Formula

The formula for calculating the service time is:

Service Time = [Number of Service Providers times Transportation Time] ÷ Number of Passengers

(3) Converting Service Time to Units of Service

Service time must be converted to units of service for a service claim as set forth on [Appendix III](#), Conversion Table.

(4) Examples of Determining Unit of Service for Transportation as a Supported Home Living Activity

See [Appendix V](#), Determining Units of Service for the Supported Home Living Activity of Transporting an Individual, for examples of determining the units of service for a service claim for transportation as a supported home living activity.

(5) Accumulation of Service Times

(A) For Single Calendar Day

A program provider may accumulate service times, as described in [Section 3610\(b\)](#), 15-Minute Unit of Service, for transporting one individual on a single calendar day. The service times of more than one service provider may be accumulated.

(B) Example of Accumulating Service Time

See [Appendix V](#), Determining Units of Service for the Supported Home Living Activity of Transporting an Individual, for an example of accumulating service time for transportation as a supported home living activity.

(j) Written Documentation

A program provider must have written documentation to support a service claim for the supported home living activity of transporting an individual. The written documentation must include:

- (1) the name of the individual who was being transported;
- (2) the day, month and year the transportation was provided;
- (3) the place of departure and destination for the individual being transported;
- (4) a notation of whether the program provider is using Method A or Method B to calculate transportation time, as required by subsection(g)(1) of this section;
- (5) a begin and end time for each transportation time, as described in subsection (h) of this section;
- (6) the total minutes of each transportation time;
- (7) for each "trip" if using Method A (subsection (h)(3) and (4) of this section) or, for each "segment" if using Method B (subsection (h)(5) of this section).
- (8) the number of passengers;
- (9) the number of service providers;
- (10) the resulting service time; and
- (11) the signature of the service provider transporting the individual;
- (12) the unit of service for a service claim resulting from each service time; and

- (13) any service times accumulated to make a unit of service for a service claim.

Example Form

[Form 2124](#), Supported Home Living (SHL)/Community Support (CS) Transportation Log, may be used to document transportation as a supported home living activity. This log is only an example, however. A program provider may document such activity in any way that meets requirements.

4550 Host Home/Companion Care Subcomponent

Revision 19-1; Effective November 15, 2019

(a) Requirements of Setting

(1) Residence of Individual

An individual receiving host home/companion care must:

- (A) have a residence that the program provider does not lease or own; and
- (B) have a residence in which no more than three persons receive:
 - (i) host home/companion care; or
 - (ii) a non-HCS Program service similar to host home/companion care (for example, Community Living Assistance and Support Services or services funded by HHSC or by a person's own resources); and
- (C) if the individual is a minor, not have the same residence as a parent of the minor or the spouse of a parent of the minor.

(2) Service Provider's Residence and Availability

The service provider must:

- (A) have the same residence as the individual; and
- (B) ensure that host home/companion care is provided to an individual when needed.

(b) Billable Activity

The only billable activities for the host home/companion care subcomponent are:

- (1) assisting the individual with activities of daily living, including:
 - (A) bathing, dressing and personal hygiene;
 - (B) eating;

- (C) meal planning and preparation; and
- (D) housekeeping;
- (2) assisting the individual with ambulation and mobility;
- (3) reinforcing any professional therapies subcomponent provided to the individual;
- (4) assisting with the administration of the individual'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 Human Resources Code, §§161.091-.093, as applicable;
- (5) conducting habilitation activities that teach the individual to:
 - (A) develop or improve skills that allow the individual to live more independently;
 - (B) develop socially valued behaviors;
 - (C) integrate into community activities;
 - (D) use natural supports and typical community services available to the public; and
 - (E) participate in leisure activities;
- (6) securing transportation for or transporting the individual;
- (7) supervising the individual's safety and security; and
- (8) performing a billable activity listed above by a person, on behalf of the host home companion care provider, if the person meets the requirements of a qualified service provider in subsection (f) of this section and in [Section 3400](#), Qualified Service Provider, except [Section 3410 \(2\) and \(3\)](#), General Requirements.

(c) Residential Location

A program provider may provide host home/companion care to an individual only if the program provider has documented a residential location of "host home/companion care" on the individual's IPC, as described in [Section 4530\(b\)](#), Residential Location.

(d) Activity Not Billable

(1) Activities in Section 3300

The activities listed in [Section 3300](#), Activity Not Billable, are not billable for the host home/companion care subcomponent.

(2) Activities Not Listed in Subsection (b)

Any activity not described in subsection (b) of this section is not billable for the host home/companion care subcomponent.

(e) Restrictions Regarding Submission of Claims for Host Home/Companion Care

A program provider may not submit a service claim for host home/companion care:

- (1) provided to an individual whose IPC does not have a residential location of "host home/companion care;"
- (2) provided to an individual who has a residence:
 - (A) that is not the same as the service provider's residence;
 - (B) that the program provider leases or owns; or
 - (C) in which more than three persons receive:
 - (i) host home/companion care; or
 - (ii) a non-HCS Program service similar to host home/companion care (for example, Community Living Assistance and Support Services or services funded by HHSC or by a person's own resources);
- (3) provided to a minor if a parent of the minor or the spouse of a parent of the minor has the same residence as the minor;
- (4) if, during any part of the day for which the service claim was submitted, host home/companion care was not provided to an individual when needed; and
- (5) provided on the effective dates of the following events, as determined by the dates entered into the HHSC enrollment and billing system for the HCS Program:
 - (A) termination of an individual's HCS Program services;
 - (B) suspension of an individual's HCS Program services; or
 - (C) an individual's transfer to another program provider.

(f) Qualified Service Provider

In addition to meeting the requirements in [Section 3400](#), Qualified Service Provider, a qualified service provider of the host home/companion care subcomponent must have one of the following:

- (1) a high school diploma;

- (2) a high school equivalency certificate issued in accordance with the law of the issuing state; or
- (3) both of the following:
 - (A) a successfully completed written competency-based assessment demonstrating the ability to provide host home/companion care and the ability to document the provision of host home/companion care in accordance with [Section 3800](#), Written Documentation, and subsection (h) of this section, Written Documentation, below; and
 - (B) written personal references which evidence the service provider's ability to provide a safe and healthy environment for the individual from at least three persons who are not relatives of the service provider ([Appendix II](#), Degree of Consanguinity or Affinity, explains who is considered a relative for purposes of these billing guidelines).

(g) Unit of Service

(1) One Day

A unit of service for the host home/companion care subcomponent is one day.

(2) Maximum Number and Fraction of a Unit of Service

A service claim for host home/companion care may not:

- (A) be for more than one unit of service; or
- (B) include a fraction of a unit of service.

(h) Written Documentation

Except as provided in subsection (i)(3) of this section, a program provider must have written documentation to support a service claim for host home/companion care. The written documentation must:

- (1) meet the requirements set forth in [Section 3800](#), Written Documentation;
- (2) include a description of the location of the individual's residence (by address or residential location as described in Section 4530); and
- (3) include:
 - (A) a written service log, as described in [Section 3820](#), Written Service Log and Written Summary Log, of the calendar day for which the service claim is submitted; or
 - (B) a written summary log as described in Section 3820.

(i) Submitting a Service Claim for an Individual on a Visit with Family or Friend

(1) Length of Visit

A program provider may submit a service claim for host home/companion care for an individual who is on a visit with a family member or friend away from the individual's residence if the visit is for at least a calendar day. If the visit is for more than 14 consecutive calendar days, the program provider may submit a service claim for only 14 calendar days of the visit.

(2) Only Requirements of this Subsection Apply

This is the only subsection of this section that applies to a service claim submitted for host home/companion care for an individual on a visit with a family member or friend.

(3) Written Documentation

A program provider must have written documentation to support a service claim for host home/companion care for an individual on a visit with a family member or friend. The written documentation must include:

- (A) the name of the individual;
- (B) the dates the individual was visiting the family member or friend;
and
- (C) the date and signature of the individual's host home/companion care service provider.

4560 Residential Support Subcomponent

Revision 19-1; Effective November 15, 2019

(a) Requirements of Setting

(1) Residence of Individual

The residence of an individual receiving residential support must be a three-person residence or a four-person residence.

A program provider:

- (A) may not have the same residence as the individual; and
- (B) must lease or own the residence.

(2) Availability and Presence of Service Provider

A service provider must be:

- (A) available to provide residential support to an individual, as needed;
- (B) present and awake in the residence when the individual is present in the residence; and
- (C) available to provide services for at least two shifts in one calendar day (one shift during the day and one shift at night during sleeping hours).

(b) Requirement Regarding Extended Shifts and Prohibition of a Shift more than 24 Consecutive Hours

(1) Off Duty Requirement

If a service provider works an extended shift, the service provider must be off duty for at least eight hours before working another shift of any length.

(2) No Shifts of More than 24 Hours

A program provider may not have a service provider work more than 24 consecutive hours.

(c) Billable Activity

The only billable activities for the residential support subcomponent are:

- (1) assisting the individual with activities of daily living, including:
 - (A) bathing, dressing and personal hygiene;
 - (B) eating;
 - (C) meal planning and preparation; and
 - (D) housekeeping;
- (2) assisting the individual with ambulation and mobility;
- (3) reinforcing any professional therapies subcomponent provided to the individual;
- (4) assisting with the administration of the individual'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 Human Resources Code, §161.091-.093, as applicable;
- (5) conducting habilitation activities that train the individual to:
 - (A) develop or improve skills that allow the individual to live more independently;
 - (B) develop socially valued behaviors;

- (C) integrate into community activities;
- (D) use natural supports and typical community services available to the public; and
- (E) participate in leisure activities;
- (6) securing transportation for or transporting the individual; and
- (7) supervising the individual's safety and security.

(d) Residential Location

A program provider may provide residential support to an individual only if the program provider has documented a residential location of "3-Person Home" or "4-Person Home" on the individual's IPC, as described in [Section 4530 \(c\) and \(d\)](#), Residential Location.

(e) Activity Not Billable

(1) Activities in Section 3300

The activities listed in [Section 3300](#), Activity Not Billable, are not billable for the residential support subcomponent.

(2) Activities Not Listed in Subsection (c)

Any activity not described in subsection (c) of this section, Billable Activity, is not billable for the residential support subcomponent.

(f) Restrictions Regarding Submission of Claims for Residential Support

A program provider may not submit a service claim for residential support:

- (1) provided to an individual whose IPC does not have a residential location of "3-Person Home" or "4-Person Home;"
- (2) provided to an individual whose residence is not a three-person residence or a four-person residence;
- (3) when no service provider is present and awake in the residence when an individual is present in the residence;
- (4) if a service provider is not available to provide residential support to an individual during any part of a day;
- (5) provided during a period in which a service provider of residential support worked any part of a shift that was more than 24 consecutive hours; or
- (6) provided on the effective dates of the following events, as determined by the dates entered into the HHSC automated system for the HCS Program:

- (A) termination of an individual's HCS Program services;
- (B) suspension of an individual's HCS Program services; or
- (C) an individual's transfer to another program provider.

(g) Qualified Service Provider

In addition to meeting the requirements in [Section 3400](#), Qualified Service Provider, a qualified service provider of the residential support subcomponent:

- (1) may not lease or own the individual's residence;
- (2) must have one of the following:
 - (A) high school diploma;
 - (B) a high school equivalency certificate issued in accordance with the law of the issuing state; or
 - (C) both of the following:
 - (i) a successfully completed written competency-based assessment demonstrating the ability to provide residential support and the ability to document the provision of residential support in accordance with [Section 3800](#), Written Documentation, and subsection (i) of this section, Written Documentation, below; and
 - (ii) written personal references which evidence the service provider's ability to provide a safe and healthy environment for the individual from at least three persons who are not relatives of the service provider ([Appendix II](#), Degree of Consanguinity or Affinity, explains who is considered a relative for purposes of these billing guidelines); and
- (3) may reside in the residence with a spouse or person with whom the service provider has a spousal relationship.

(h) Unit of Service

(1) One Day

A unit of service for the residential support subcomponent is one day.

(2) Maximum Number and Fraction of a Unit of Service

A service claim for residential support may not:

- (A) be for more than one unit of service per calendar day; or
- (B) include a fraction of a unit of service.

(i) Written Documentation

Except as provided in subsection (j)(3) of this section, a program provider must have written documentation supporting a service claim for residential support. The written documentation must:

- (1) meet the requirements set forth in [Section 3800](#), Written Documentation;
- (2) include a description of the location of the individual's residence (by address or location code); and
- (3) demonstrate that a service provider is present and awake in the residence during the time an individual is present in the residence or is available to provide services when the individual is away from the residence for at least two shifts in one calendar day (one shift during the day and one shift at night during sleeping hours)

(j) Submitting a Service Claim for an Individual on a Visit with Family or Friend

(1) Length of Visit

A program provider may submit a service claim for residential support for an individual who is on a visit with a family member or friend away from the individual's residence if the visit is for at least a calendar day. If the visit is for more than 14 consecutive calendar days, the program provider may submit a service claim for only 14 calendar days of the visit.

(2) Only Requirements of this Subsection Apply

Subsection (j) is the only portion of Section 4560 that applies to a service claim submitted for residential support for an individual on a visit with a family member or friend.

(3) Written Documentation

A program provider must have written documentation to support a service claim for residential support for an individual on a visit with a family member or friend. The written documentation must include:

- (A) the name of the individual;
- (B) the dates the individual was visiting the family member or friend;
and
- (C) the date and signature of the individual's residential support service provider.

4570 Supervised Living Subcomponent

Revision 19-1; Effective November 15, 2019

(a) Requirements of Setting

(1) Residence of Individual

The residence of an individual receiving supervised living must be a three-person residence or a four-person residence.

A program provider:

- (A) may not have the same residence as the individual; and
- (B) must lease or own the residence.

(2) Availability and Presence of Service Provider

A service provider must be:

- (A) available to provide supervised living to the individual as needed; and
- (B) present in the residence during normal sleeping hours.

(b) Billable Activity

The only billable activities for the supervised living subcomponent are:

- (1) assisting the individual with activities of daily living, including:
 - (A) bathing, dressing and personal hygiene;
 - (B) eating;
 - (C) meal planning and preparation; and
 - (D) housekeeping;
- (2) assisting the individual with ambulation and mobility;
- (3) reinforcing any professional therapies subcomponent provided to the individual;
- (4) assisting with the administration of the individual'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 Human Resources Code, §161.091-.093, as applicable;
- (5) conducting habilitation activities that train the individual to:
 - (A) develop or improve skills that allow the individual to live more independently;
 - (B) develop socially valued behaviors;
 - (C) integrate into community activities;

- (D) use natural supports and typical community services available to the public; and
- (E) participate in leisure activities;
- (6) securing transportation for or transporting the individual; and
- (7) supervising the individual's safety and security.

(c) Residential Location

A program provider may provide supervised living to an individual only if the program provider has documented a residential location of "3-Person Home" or "4-Person Home" on the individual's IPC, as described in [Section 4530 \(c\) and \(d\)](#), Residential Location.

(d) Activity Not Billable

(1) Activities in Section 3300

The activities listed in Section 3300, Activity Not Billable, are not billable for the supervised living subcomponent.

(2) Activities Not Listed in Subsection (b)

Any activity not described in subsection (b) of this section is not billable for the supervised living subcomponent.

(e) Restrictions Regarding Submission of Claims for Supervised Living

A program provider may not submit a service claim for supervised living:

- (1) provided to an individual whose IPC does not have a residential location of "3-Person Home" or "4-Person Home;"
- (2) provided to an individual whose residence is not a three-person residence or a four-person residence;
- (3) when the service provider is absent from the residence during normal sleeping hours;
- (4) if a service provider is not available to provide supervised living to an individual during any part of a day; and
- (5) provided on the effective dates of the following events, as determined by the dates entered into the HHSC automated system for the HCS Program:
 - (A) termination of an individual's HCS Program services;
 - (B) suspension of an individual's HCS Program services; or
 - (C) an individual's transfer to another program provider.

(f) Qualified Service Provider

In addition to meeting the requirements in [Section 3400](#), Qualified Service Provider, a qualified service provider of the supervised living subcomponent:

- (1) may not lease or own the individual's residence;
- (2) must have one of the following:
 - (A) a high school diploma;
 - (B) a high school equivalency certificate issued in accordance with the law of the issuing state;
 - (C) both of the following:
 - (i) a successfully completed written competency-based assessment demonstrating the ability to provide supervised living and the ability to document the provision of supervised living in accordance with [Section 3800](#), Written Documentation, and No. 8, Written Notification, below; and
 - (ii) written personal references which evidence the service provider's ability to provide a safe and healthy environment for the individual from at least three persons who are not relatives of the service provider ([Appendix II](#), Degree of Consanguinity or Affinity, explains who is considered a relative for purposes of these billing guidelines); and
- (3) may reside in the residence with a spouse or person with whom the service provider has a spousal relationship.

(g) Unit of Service

(1) One Day

A unit of service for the supervised living subcomponent is one day.

(2) Maximum Number and Fraction of a Unit of Service

A service claim for supervised living may not:

- (A) be for more than one unit of service per calendar day; or
- (B) include a fraction of a unit of service.

(h) Written Documentation

Except as provided in subsection (i)(3) of this section, a program provider must have written documentation to support a service claim for supervised living. The written documentation must:

- (1) meet the requirements set forth in [Section 3800](#), Written Documentation;
- (2) include a description of the location of the individual's residence (by address or residential location as described in Section 4530); and
- (3) demonstrate that a service provider is present in the residence during normal sleeping hours.

(i) Submitting a Service Claim for an Individual on a Visit with Family or Friend

(1) Length of Visit

A program provider may submit a service claim for supervised living for an individual who is on a visit with a family member or friend away from the individual's residence if the visit is for at least a calendar day. If the visit is for more than 14 consecutive calendar days, the program provider may submit a service claim for only 14 calendar days of the visit.

(2) Only Requirements of this Subsection Apply

Subsection (i) is the only portion of Section 4570 that applies to a service claim submitted for supervised living for an individual on a visit with a family member or friend.

(3) Written Documentation

A program provider must have written documentation to support a service claim for supervised living for an individual on a visit with a family member or friend. The written documentation must include:

- (A) the name of the individual;
- (B) the dates the individual was visiting the family member or friend;
and
- (C) the date and signature of the individual's supervised living service provider.

4580 Submitting a Service Claim for Residential Assistance During a Preselection Visit

Revision 19-1; Effective November 15, 2019

A program provider may submit a service claim for residential assistance while an individual is on a preselection visit only if:

- (1) the preselection visit is justified in the individual's implementation plan;

- (2) host home companion care, residential support or supervised living is authorized by the individual's IPC;
- (3) the day for which the service claim is submitted is not beyond the 30th consecutive day of a preselection visit;
- (4) the service claim:
 - (A) is for the residential assistance subcomponent authorized by the individual's IPC;
 - (B) is based on billable activity, as described in [Section 4500](#), Residential Assistance, for the residential assistance subcomponent being provided to the individual during the preselection visit;
 - (C) must be based on activity performed by a qualified service provider as described in [Section 3400](#), Qualified Service Provider, and as described in Section 4500 for the residential assistance subcomponent being provided to the individual during the preselection visit;
 - (D) must be for the date the residential assistance subcomponent being provided to the individual during the preselection visit was actually provided;
 - (E) must be for units of service determined in accordance with [Section 3620](#), Daily Unit of Service, and in accordance with Section 4500 for the residential assistance subcomponent being provided to the individual during the preselection visit; and
 - (F) must be supported by written documentation, as required by [Section 3800](#), Written Documentation, and as required by Section 4500 for the residential assistance subcomponent being provided to the individual during the preselection visit.

4600 Respite

Revision 11-1; Effective September 1, 2011

4610 General Description of Service Component

Revision 21-1; Effective January 1, 2021

(a) Temporary Provision of Assistance

The respite service component:

- (1) is the temporary provision of assistance and support necessary for an individual to perform personal care, health maintenance and independent living tasks, participate in community activities, and develop, retain and improve community living skills;

- (2) provides relief for a caregiver of the individual who:
- (A) has the same residence as the individual;
 - (B) routinely provides assistance and support necessary for an individual to perform personal care, health maintenance and independent living tasks, participate in community activities, and develop, retain and improve community living skills;
 - (C) is temporarily unavailable to provide such assistance and support; and
 - (D) is not a service provider of host home/companion care, residential support, or supervised living; and
 - (E) is not a service provider of CFC PAS/HAB unless:
 - (i) the service provider of CFC PAS/HAB routinely provides unpaid assistance and support to the individual; and
 - (ii) is used to provide temporary support to the primary caregiver.

(b) Room and Board

The program provider must provide room and board to the individual free of charge.

4620 Requirement of Setting

Revision 21-1; Effective January 1, 2021

Respite must be provided to an individual in a setting that is not the residence of the individual. The settings in which respite may be provided are as follows:

- (1) a site at which day habilitation is provided;
- (2) a camp accredited by the American Camp Association;
- (3) a respite facility;
- (4) the residence of another person:
 - (A) a three-person residence;
 - (B) a four-person residence;
 - (C) a residence in which host home/companion care is provided; and
- (5) a setting in the community other than those described in paragraphs (1) through (4) of this section.

4630 Billable Activity

Revision 21-1; Effective January 1, 2021

The only billable activities for the respite service component are:

- (1) interacting face-to-face with an individual to:
 - (A) assist the individual with activities of daily living, including:
 - (i) bathing, dressing and personal hygiene;
 - (ii) eating;
 - (iii) meal planning and preparation; and
 - (iv) housekeeping;
 - (B) assist the individual with ambulation and mobility;
 - (C) reinforce any professional therapies subcomponent provided to the individual;
 - (D) assist with the administration of the individual'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 Human Resources Code, §161.091-.093, as applicable;
 - (E) conduct habilitation activities that teach the individual to:
 - (i) develop or improve skills that allow the individual to live more independently;
 - (ii) develop socially valued behaviors;
 - (iii) integrate into community activities;
 - (iv) use natural supports and typical community services available to the public; and
 - (v) participate in leisure activities;
 - (F) secure transportation for the individual;
 - (G) supervise the individual's safety and security; and
 - (H) transport the individual, except from one day habilitation site to another;
- (2) interacting face-to-face or by telephone with an individual or an involved person regarding an incident that directly affects the individual's health or safety;
- (3) performing one of the following activities that does not involve interacting face-to-face with an individual:
 - (A) shopping for the individual;
 - (B) planning or preparing meals for the individual;
 - (C) housekeeping for the individual;
 - (D) procuring or preparing the individual's medication; or

- (E) securing transportation for the individual;
- (4) participating in a service planning team meeting;
- (5) participating in the development of an implementation plan; and
- (6) participating in the development of an IPC.

4640 Respite in Residence or During Overnight Stay in Non-residence

Revision 21-1; Effective January 1, 2021

(a) Residence

If an individual receives respite in a residence, the residence must be:

- (1) a three-person residence;
- (2) a four-person residence;
- (3) a residence in which host home/companion care is provided; or
- (4) the residence of another person (other than a three-person residence, four-person residence or a residence in which host home/companion care is provided) in which no more than three persons are receiving HCS Program services or a non-HCS program service similar to HCS Program services.

(b) Non-residence

- (1) Except as provided in paragraph (2) of this subsection, if an individual is receiving respite during an overnight stay in a setting that is not the residence of any person, no more than six persons receiving HCS Program services or a non-HCS Program service similar to HCS Program services may be in the setting.
- (2) An individual may receive respite in a camp setting if the camp is accredited by the American Camp Association.

4641 Residential Location

Revision 21-1; Effective January 1, 2021

A program provider may provide respite to an individual only if the program provider has documented a residential location of "own/family home" on the individual's IPC, as described in [Section 4530\(a\)](#), Residential Location.

4650 Activity Not Billable

Revision 21-1; Effective January 1, 2021

(a) Activities in Section 3300

The activities listed in [Section 3300](#), Activity Not Billable, are not billable for the respite service component.

(b) Activities Not Listed in Section 4620

Any activity not described in [Section 4620](#), Billable Activity, is not billable for the respite service component.

4651 Submitting a Service Claim for Respite

Revision 21-1; Effective January 1, 2021

If a program provider provides 10 hours or more of respite to an individual in one calendar day, the program provider may submit a service claim for no more than 40 units of service.

4652 Restrictions Regarding Submission of Claims for Respite

Revision 21-1; Effective January 1, 2021

A program provider may not submit a service claim for:

- (1) respite provided to an individual whose IPC does not have a residential location of "own/family home;"
- (2) respite provided to an individual who does not have the same residence as a caregiver who routinely provides assistance and support necessary for the individual to perform personal care, health maintenance and independent living tasks, participate in community activities, and develop, retain and improve community living skills;
- (3) respite provided to an individual that is not for relief of a caregiver who routinely provides assistance and support described in the bullet directly above;
- (4) respite provided to an individual that is relief of a caregiver who is a service provider of host home/companion care, residential support or supervised living to the individual;
- (5) respite provided to an individual who lives independently (that is, does not have a caregiver who routinely provides the assistance and support described in the second bullet above);
- (6) respite provided in a location that does not meet the requirements of [Section 4620 Requirements of Setting](#); or
- (7) 40 units of service or more of respite provided on a day for which a service claim for CFC PAS/HAB is also submitted.

4660 Qualified Service Provider

Revision 19-1; Effective November 15, 2019

In addition to meeting the requirements in [Section 3400](#), Qualified Service Provider, a qualified service provider of the respite service component:

- (1) may not have the same residence as the individual; and
- (2) must have one of the following:
 - (A) a high school diploma;
 - (B) a high school equivalency certificate issued in accordance with the law of the issuing state; or
 - (C) both of the following:
 - (i) a successfully completed written competency-based assessment demonstrating the ability to provide respite and the ability to document the provision of respite in accordance with [Section 3800](#), Written Documentation, and [Section 4690](#), Written Documentation; and
 - (ii) written personal references which evidence the service provider's ability to provide a safe and healthy environment for the individual from at least three persons who are not relatives of the service provider ([Appendix II](#), Degree of Consanguinity or Affinity, explains who is considered a relative for purposes of these billing guidelines).

4670 Unit of Service

Revision 19-1; Effective November 15, 2019

(a) 15 Minutes

A unit of service for the respite service component is 15 minutes.

(b) Fraction of a Unit of Service

A service claim for respite may not include a fraction of a unit of service.

4680 Payment Limit

Revision 21-1; Effective January 1, 2021

The maximum amount HHSC will pay a program provider for respite, in-home respite, or a combination of both provided to an individual is 1200 units of service (300 hours) per IPC year. Respite and in-home respite is the same program service on the IPC.

4690 Written Documentation

Revision 19-1; Effective November 15, 2019

A program provider must have written documentation to support a service claim for respite. The written documentation must:

- (1) meet the requirements set forth in Section 3800, Written Service Log and Written Summary Log;
- (2) include the exact time the service event began and the exact time the service event ended documented by the service provider making the written service log; and
- (3) include a written justification in the individual's PDP for the use of more than one service provider for any activity simultaneously performed by more than one service provider.

4691 In-Home Respite

4691.1 General Description of Service Component

Revision 21-1; Effective January 1, 2021

Temporary Provision of Assistance

The in-home respite service component:

- (1) is the temporary provision of assistance and support necessary for an individual to perform personal care, health maintenance and independent living tasks, and develop, retain and improve community living skills;
- (2) provides relief for a caregiver of the individual who:
 - (A) has the same residence as the individual;
 - (B) routinely provides assistance and support necessary for an individual to perform personal care, health maintenance and independent living tasks, and develop, retain and improve community living skills;
 - (C) is temporarily unavailable to provide such assistance and support;
 - (D) is not a service provider of host home/companion care, residential support, or supervised living; and
 - (E) is not a service provider of CFC PAS/HAB unless:
 - (i) the service provider of CFC PAS/HAB routinely provides unpaid assistance and support to the individual; and

(ii) is used to provide temporary support to the primary caregiver.

4691.2 Requirement of Setting

Revision 21-1; Effective January 1, 2021

In-home respite must be provided in the individual's residence.

4691.3 Billable Activity

Revision 21-1; Effective January 1, 2021

The only billable activities for the in-home respite service component are:

- (1) interacting face-to-face with an individual to:
 - (A) assist the individual with activities of daily living, including:
 - (i) bathing, dressing and personal hygiene;
 - (ii) eating;
 - (iii) meal planning and preparation; and
 - (iv) housekeeping;
 - (B) assist the individual with ambulation and mobility;
 - (C) reinforce any professional therapies subcomponent provided to the individual;
 - (D) assist with the administration of the individual'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 Human Resources Code, §161.091-.093, as applicable;
 - (E) conduct habilitation activities that teach the individual to:
 - (i) develop or improve skills that allow the individual to live more independently;
 - (ii) develop socially valued behaviors;
 - (iii) integrate into community activities;
 - (iv) use natural supports and typical community services available to the public; and
 - (v) participate in leisure activities;
 - (F) secure transportation for the individual; and
 - (G) supervise the individual's safety and security;

- (2) interacting face-to-face or by telephone with an involved person regarding an incident that directly affects the individual's health or safety;
- (3) performing one of the following activities that does not involve interacting face-to-face with an individual:
 - (A) shopping for the individual by phone or online;
 - (B) planning or preparing meals for the individual;
 - (C) housekeeping for the individual;
 - (D) procuring the individual's medication by phone or online;
 - (E) preparing the individual's medication; or
 - (F) securing transportation for the individual;
- (4) participating in a service planning team meeting;
- (5) participating in the development of an implementation plan; and
- (6) participating in the development of an IPC.

4691.4 Activity Not Billable

Revision 21-1; Effective January 1, 2021

(a) Activities in Section 3300

The activities listed in [Section 3300](#), Activity Not Billable, are not billable for the in-home respite service component.

(b) Activities Not Listed in Section 4691.3

Any activity not described in [Section 4691.3](#), Billable Activity, is not billable for the in-home respite service component.

4691.5 Residential Location

Revision 21-1; Effective January 1, 2021

A program provider may provide in-home respite to an individual only if the program provider has documented a residential location of "own/family home" on the individual's IPC, as described in [Section 4530\(a\)](#), Residential Location.

4691.6 Restrictions Regarding Submission of Claims for In-Home Respite

Revision 21-1; Effective January 1, 2021

A program provider may not submit a service claim for:

- (1) in-home respite provided to an individual whose IPC does not have a residential location of "own/family home;"
- (2) in-home respite provided to an individual who does not have the same residence as a caregiver who routinely provides assistance and support necessary for the individual to perform personal care, health maintenance and independent living tasks, participate in community activities, and develop, retain and improve community living skills;
- (3) in-home respite provided to an individual that is not for relief of a caregiver who routinely provides assistance and support described in the bullet directly above;
- (4) in-home respite provided to an individual that is relief of a caregiver who is a service provider of host home/companion care, residential support or supervised living to the individual;
- (5) in-home respite provided to an individual who lives independently (that is, does not have a caregiver who routinely provides the assistance and support described in the second bullet above);
- (6) in-home respite provided in a location that is not the individual's residence; or
- (7) 40 units of service or more of in-home respite provided on a day for which a service claim for CFC PAS/HAB is also submitted.

4691.7 Qualified Service Provider

Revision 21-1; Effective January 1, 2021

In addition to meeting the requirements in [Section 3400](#), Qualified Service Provider, a qualified service provider of the in-home respite service component:

- (1) may not have the same residence as the individual; and
- (2) must have one of the following:
 - (A) a high school diploma;
 - (B) a high school equivalency certificate issued in accordance with the law of the issuing state; or
 - (C) both of the following:
 - (i) a successfully completed written competency-based assessment demonstrating the ability to provide in-home respite and the ability to document the provision of in-home respite in accordance with [Section 3800](#), Written Documentation, and [Section 4690.10](#), Written Documentation; and
 - (ii) written personal references which evidence the service provider's ability to provide a safe and healthy environment for the individual from at least three persons who are not

relatives of the service provider ([Appendix II](#), Degree of Consanguinity or Affinity, explains who is considered a relative for purposes of these billing guidelines).

4691.8 Unit of Service

Revision 21-1; Effective January 1, 2021

(a) 15 Minutes

A unit of service for the in-home respite service component is 15 minutes.

(b) Fraction of a Unit of Service

A service claim for in-home respite may not include a fraction of a unit of service.

4691.9 Payment Limit

Revision 21-1; Effective January 1, 2021

The maximum amount HHSC will pay a program provider for respite, in-home respite, or a combination of both provided to an individual is 1200 units of service (300 hours) per IPC year. Respite and in-home respite is the same program service on the IPC.

4691.10 Written Documentation

Revision 21-1; Effective January 1, 2021

A program provider must have written documentation to support a service claim for in-home respite. The written documentation must:

- (1) meet the requirements set forth in Section 3800, Written Service Log and Written Summary Log;
- (2) include the exact time the service event began and the exact time the service event ended documented by the service provider making the written service log; and
- (3) include a written justification in the individual's PDP for the use of more than one service provider for any activity simultaneously performed by more than one service provider.

4700 Supported Employment

Revision 14-2; Effective April 10, 2014

4710 General Description of Service Component

Revision 14-3; Effective September 1, 2014

Supported employment means assistance provided in order to sustain competitive employment or self-employment to an individual 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 employment adaptations, supervision, training related to an individual's assessed needs, and earning at least a minimum wage (if not self-employed).

4720 Billable Activity

Revision 19-1; Effective November 15, 2019

The only billable activities for the supported employment service component are:

- (1) employment adaptations, supervision and training related to an individual's disability;
- (2) assisting the individual with transportation needs which include:
 - (A) determining how the individual will travel to and from a job;
 - (B) training the individual on how to travel to and from the job; and
 - (C) securing transportation for or transporting an individual, as necessary, to assist self-employment, work from home or perform in a work setting;
- (3) participating in a service planning team meeting;
- (4) orienting and training the individual in work-related tasks;
- (5) training or consulting with employers, coworkers or advocates to maximize natural supports;
- (6) monitoring job performance;
- (7) communicating with managers and supervisors to gather input and plan training;
- (8) communicating with company personnel or support systems to ensure job retention;
- (9) training in work-related tasks or behaviors to ensure job retention (for example, grooming or behavior management);
- (10) setting up compensatory strategies;
- (11) assisting the individual to report earned income to the Social Security Administration and HHSC;

- (12) assisting the individual to develop a method for ongoing income reporting and for staying informed about the impact of the individual's earnings on cash, Medicaid and other benefits;
- (13) assisting the individual to utilize work incentives to maintain needed benefits and continue to access needed supports and services;
- (14) assisting the individual with career advancement;
- (15) assisting the individual to develop assets and obtain self-sufficiency through work;
- (16) training or consulting in work-related tasks or behaviors, such as support for advertising, marketing and sales;
- (17) training or consulting with paid or natural supports (accountants, employees, etc.) who are supporting the individual either short-term or long-term in managing the business;
- (18) problem-solving related to company personnel or support systems necessary to run the business effectively and efficiently; and
- (19) assistance with bookkeeping, marketing and managing data or inventories.

4730 Activity Not Billable

Revision 21-1; Effective January 1, 2021

(a) Activities in Section 3300

The activities listed in [Section 3300](#), Activity Not Billable, are not billable for the supported employment service component.

(b) Activities Not Listed in Section 4720

Any activity not described in [Section 4720](#), Billable Activity, is not billable for the supported employment service component.

(c) Examples of Non-billable Activities

The following are examples of activities that are not billable for the supported employment service component:

- (1) interacting with an individual prior to the individual's employment;
- (2) face-to-face contact with an individual to provide supported employment services simultaneously with day habilitation, in-home day habilitation, employment assistance, CFC PAS/HAB, respite, or in-home respite is being provided face-face;
- (3) habilitation activities provided and billed as part of day habilitation, in-home day habilitation, or CFC PAS/HAB;

- (4) time spent waiting to provide a service;
- (5) 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 HHSC to the provider for incentive payments, subsidies or unrelated vocational training expenses;
- (6) any activity that occurs before or after employment which is gained as a result of paying an employer to encourage the employer to hire an individual;
- (7) 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 an individual that the employer typically makes available to other workers without disabilities filling similar positions in the business;
- (8) paying the individual as an incentive to participate in Supported Employment activities; and
- (9) paying the individual for expenses associated with the start-up costs or operating expenses of an individual's business.

4740 Qualified Service Provider

Revision 19-1; Effective November 15, 2019

In addition to meeting the requirements in Section 3400, Qualified Service Provider, a qualified service provider of the supported employment service component:

- (1) is at least 18 years of age, is not the individual's legally responsible person and must have one of the following:
 - (A) a bachelor's degree in rehabilitation, business, marketing or a related human services field, and at least six months of paid or unpaid experience providing services to people with disabilities;
 - (B) an associate's degree in rehabilitation, business, marketing or a related human services field, and at least one year of paid or unpaid experience providing services to people with disabilities; or
 - (C) a high school diploma or a certificate recognized by a state as the equivalent of a high school diploma, and at least two years of paid or unpaid experience providing services to people with disabilities, and
- (2) has experience evidenced by:
 - (A) for paid experience, a written statement from a person who paid for the service or supervised the provision of the service; and
 - (B) for unpaid experience, a written statement from a person who has personal knowledge of the experience.

4750 Restrictions Regarding Submission of Claims for Supported Employment

Revision 14-2; Effective April 10, 2014

A program provider may not submit a service claim for supported employment provided to an individual if supported employment is available to the individual through the public school system.

4760 Unit of Service

Revision 19-1; Effective November 15, 2019

(a) 15 Minutes

A unit of service for the supported employment service component is 15 minutes.

(b) Fraction of a Unit of Service

A service claim for supported employment may not include a fraction of a unit of service.

(c) Service Time

Service time is calculated in accordance with [Section 3610\(b\)](#), 15-Minute Unit of Service, including when multiple persons are being served.

4770 Written Documentation

Revision 19-1; Effective November 15, 2019

A program provider must have written documentation to support a service claim for supported employment. The written documentation must:

- (1) meet the requirements set forth in [Section 3800](#), Written Documentation;
- (2) include the exact time the service event began and the exact time each service event ended documented by the service provider making the written service log;
- (3) include evidence that supported employment services are not available to the individual through a program funded under the Individuals with Disabilities Education Act (20 U.S.C. §1401 et seq.); and
- (4) for any activity simultaneously performed by more than one service provider, include a written justification in the individual's PDP for the use of more than one service provider.

4800 Employment Assistance

Revision 14-2; Effective April 10, 2014

4810 General Description of Service Component

Revision 19-1; Effective November 15, 2019

Employment assistance means assistance provided to an individual to help the individual locate paid competitive employment in the community or self-employment and consists of individualized, person-directed activities to develop and implement strategies for achieving the individual's desired employment outcome, including more suitable employment for individuals who are employed.

4820 Employment Assistance Billable Time/Activities

Revision 19-1; Effective November 15, 2019

The only billable activities for employment assistance service component are:

- (1) identifying an individual's employment preferences, job skills and requirements for a work setting and work conditions;
- (2) locating prospective employers offering employment compatible with an individual's identified preferences, skills and requirements;
- (3) contacting a prospective employer on behalf of an individual and negotiating the individual's employment;
- (4) assisting the individual with transportation needs, which includes:
 - (A) determining how the individual will travel to and from a job;
 - (B) training the individual on how to travel to and from a job;
 - (C) securing transportation for or transporting an individual, as necessary, to assist the individual to obtain a job; and
 - (D) transporting the individual to help the individual locate paid employment in the community;
- (5) participating in service planning team meetings, including those with the Texas Workforce Commission or, for individuals under age 22, with the individual's school district;
- (6) exploring options related to wages and employment outcomes (including self-employment outcomes);
- (7) exploring the individual'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 individual's work skills and behaviors at home and in the community;
- (10) touring current or potential work environments with the individual;
- (11) assisting the individual to understand the impact of work activity on his/her services and financial supports;
- (12) assisting the individual to utilize work incentives to maintain needed benefits;
- (13) collecting personal and professional reference information;
- (14) assessing the individual's learning style and needs for adaptive technology, accommodations and on-site supports;
- (15) assessing the individual's strengths, challenges and transferable skills from previous job placements;
- (16) identifying the individual's assets, strengths and abilities;
- (17) identifying negotiable and non-negotiable employment conditions;
- (18) identifying targeted job tasks the individual can perform or potentially perform;
- (19) identifying potential employers or self-employment options;
- (20) training related to an individual'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 individual jobs;
- (23) performing a job analysis to determine if a potential job meets the individual's interests, capabilities, preferences and ongoing support needs;
- (24) assisting the individual with job applications, pre-employment forms, practice interviews, and pre-employment testing or physicals;
- (25) accompanying the individual to interviews;
- (26) negotiating aspects of the individual's employment with prospective employers;
- (27) educating the employer about the Work Opportunity Tax Credit and other employer benefits; and
- (28) if the individual is seeking self-employment:
 - (A) supporting the individual in work-related tasks or behaviors, such as advertising, marketing, sales, accounting, and obtaining licenses and registrations;

- (B) training or consulting with paid or natural supports (accountants, employees, etc.) who will be supporting the individual either short-term or long-term in managing the business; and
- (C) setting up services to address long-term supports that will be necessary to sustain the business.

4830 Employment Assistance Non-billable Time/Activities

Revision 21-1; Effective January 1, 2021

(a) Activities in Section 3300

The activities listed in [Section 3300](#), Activity Not Billable, are not billable for the employment assistance service component.

(b) Activities Not Listed in Section 4820

Any activity not described in [Section 4820](#), Billable Activity, is not billable for the employment assistance service component.

(c) Examples of Non-billable Activities

The following are examples of activities that are not billable for the employment assistance service component:

- (1) employment assistance provided when an individual is independently employed in the community, unless the PDP has identified outcomes for the individual to find additional or more suitable employment;
- (2) habilitation activities provided and billed as part of the day habilitation, in-home day habilitation or CFC PAS/HAB service component;
- (3) time spent waiting to provide a billable activity for employment assistance;
- (4) interacting face-to-face with an individual to provide employment assistance at the same time that day habilitation, in-home day habilitation, supported employment, CFC PAS/HAB, respite or in-home respite is being provided;
- (5) services similar to employment assistance accessed or funded through other sources such as the Texas Workforce Commission, the public school system, Medicaid Rehabilitative Services for Persons with Chronic Mental Illness, senior citizen centers, volunteer programs, or other community-based sources;
- (6) any activity using Medicaid funds paid by HHSC to the program provider for incentive payments, subsidies or unrelated vocational training expenses, such as paying an employer:

- (A) to encourage the employer to hire an individual; or
 - (B) for supervision, training, support and adaptations for an individual that the employer typically makes available to other workers without disabilities filling similar positions in the business; and
- (7) any activity using Medicaid funds paid by HHSC to the program provider for incentive payments, subsidies or unrelated vocational training expenses, such as paying an individual:
- (A) as an incentive to participate in employment assistance activities; or
 - (B) for expenses associated with the start-up costs or operating expenses of the individual's business.

4840 Employment Assistance Qualified Service Provider

Revision 19-1; Effective November 15, 2019

In addition to meeting the requirements in [Section 3400](#), Qualified Service Provider, a qualified service provider of the employment services component:

- (1) is at least 18 years of age, is not the individual's legally responsible person and must have one of the following:
 - (A) a bachelor's degree in rehabilitation, business, marketing or a related human services field, and at least six months of paid or unpaid experience providing services to people with disabilities;
 - (B) an associate's degree in rehabilitation, business, marketing or a related human services field, and at least one year of paid or unpaid experience providing services to people with disabilities; or
 - (C) a high school diploma or a certificate recognized by a state as the equivalent of a high school diploma, and at least two years of paid or unpaid experience providing services to people with disabilities; and
- (2) has experience evidenced by:
 - (A) for paid experience, a written statement from a person who paid for the service or supervised the provision of the service; and
 - (B) for unpaid experience, a written statement from a person who has personal knowledge of the experience.

4850 Unit of Service.

Revision 19-1; Effective November 15, 2019

(a) 15 Minutes

A unit of service for the supported employment service component is 15 minutes.

(b) Fraction of a Unit of Service

A service claim for supported employment may not include a fraction of a unit of service.

(c) Service Time

Service time is calculated in accordance with [Section 3610\(b\)](#), 15-Minute Unit of Service, including when multiple persons are being served.

4860 Written Documentation

Revision 19-1; Effective November 15, 2019

A program provider must have written documentation to support a service claim for employment assistance. The written documentation must:

- (1) meet the requirements set forth in Section 3800, Written Documentation;
- (2) include the exact time the service event began and the exact time each service event ended documented by the service provider making the written service log;
- (3) include evidence that employment assistance services are not available to the individual through a program funded under §110 of the Rehabilitation Act of 1973 or a program funded under the Individuals with Disabilities Education Act (20 U.S.C. §1401 et seq.); and
- (4) for any activity simultaneously performed by more than one service provider, include a written justification in the individual's PDP for the use of more than one service provider.

Section 5000, General Requirements for Service Components Not Based on Billable Activity

Revision 20-1; Effective September 1, 2020

5100 Applicable Service Components

Revision 20-1; Effective September 1, 2020

Section 5000 applies only to the following service components:

- (1) adaptive aids;
- (2) minor home modifications;
- (3) dental treatment; and
- (4) transition assistance services.

5200 Service Claim Requirements

Revision 19-1; Effective November 15, 2019

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

- (1) the claim must be for a service component that is authorized by an IPC that meets the requirements of 40 TAC, [§9.159](#);
- (2) the claim must be for a service component or subcomponent provided during a period of time for which the individual has a LOC;
- (3) the claim must be for a service component provided to only one individual;
- (4) the claim must be for the date the individual received the service component;
- (5) the claim must be supported by written documentation as described in [Section 5300](#), Written Documentation, and [Section 6000](#), Adaptive Aids, Minor Home Modifications and Dental Treatment, for the particular service component being claimed; and
- (6) the claim must 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:
 - (A) the individual received the adaptive aid;
 - (B) the minor home modification was completed; or
 - (C) the individual received the dental treatment.

5300 Written Documentation

Revision 19-1; Effective November 15, 2019

(a) Legible

A program provider must have written, legible documentation as described by this section and [Section 6000](#) to support a service claim.

(b) Proof of Licensed Professional Qualifications

A program provider must have a written document from the appropriate state licensing agency or board to prove that a licensed professional, as required by [Section 6160\(a\)\(1\)](#), Required Documentation for an Adaptive Aid, and a provider of dental treatment, as described in [Section 6350](#), Provider of Dental Treatment, is properly licensed.

Section 6000, Adaptive Aids, Minor Home Modifications, Dental Treatment, and Transition Assistance Services

Revision 20-1; Effective September 1, 2020

6100 Adaptive Aids

Revision 10-1; Effective June 1, 2010

6110 General Description of Service Component

Revision 10-0; Effective October 1, 2009

An adaptive aid is an item or service that enables an individual to retain or increase the ability to perform activities of daily living or to control the individual's environment.

6120 Billable Adaptive Aids

Revision 10-0; Effective October 1, 2009

The only billable items and services for the adaptive aids service component are listed in [Appendix VII](#), Billable Adaptive Aids. The repair and maintenance of a billable item not covered by warranty is also billable for the adaptive aids service component.

6130 Items and Services Not Billable

Revision 19-1; Effective November 15, 2019

(a) Items and Services Not Listed in Appendix VII

Any item or service not listed in [Appendix VII](#), Billable Adaptive Aids, is not billable under the adaptive aids service component.

(b) Examples of Non-Billable Items and Services

The following are examples of items and services that are not billable for the adaptive aids service component:

- (1) an appliance (for example, washer, dryer, stove, dishwasher or vacuum cleaner);
- (2) swimming pool;
- (3) hot tub;
- (4) eye exam;
- (5) shoes not specifically designed for the individual;
- (6) automobile;
- (7) lift for a vehicle other than one owned or leased by the individual's host home/companion care provider, the individual or the individual's relative ([Appendix II](#), Degree of Consanguinity or Affinity, explains who is considered a relative for purposes of these guidelines);
- (8) toy, game or puzzle;
- (9) recreational equipment (for example, swing set or slide);
- (10) personal computer or software for purposes other than to augment expressive and receptive communication (for example, educational purposes);
- (11) medication, including a co-payment for a medication;
- (12) daily hygiene products (for example, deodorant, lotions, soap, toothbrush, toothpaste, feminine products, band-aids or cotton swabs);
- (13) rent;
- (14) utilities (for example, gas, electric, cable or water);
- (15) food;
- (16) ordinary bedding supplies (for example, bedspread, pillow or sheet);
- (17) exercise equipment;
- (18) pager, including a monthly service fee;
- (19) conventional telephone, including a cellular phone or a monthly service fee;
- (20) home security system, including a monthly service fee;

- (21) non-sterile gloves for use by paid service providers;
- (22) iPads, iPods or tablets; and
- (23) iPad, iPod or tablet accessories or applications.

6140 Property of Individual

Revision 10-0; Effective October 1, 2009

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

6150 Payment Limit

Revision 10-0; Effective October 1, 2009

The maximum amount HHSC pays a program provider for all adaptive aids provided to an individual is \$10,000 per IPC year.

6160 Required Documentation for an Adaptive Aid

Revision 20-1; Effective September 1, 2020

(a) Adaptive Aid Costing \$500 or More

For an adaptive aid costing \$500 or more, a program provider must obtain the documentation described below before purchasing the adaptive aid.

(1) Written Assessment

A program provider must obtain a written, legible assessment by one of the licensed professionals noted for the specific adaptive aid, as shown in [Appendix VII](#), Billable Adaptive Aids. The written assessment must:

- (A) be based on a face-to-face evaluation of the individual by the licensed professional conducted not more than one year before the date of purchase of the adaptive aid;
- (B) include a description of and a recommendation for a specific adaptive aid listed on [Appendix VII](#) and any associated items or modifications necessary to make the adaptive aid functional;
- (C) include a diagnosis that is related to the individual's need for the adaptive aid (for example, cerebral palsy, quadriplegia or deafness);
- (D) include a description of the condition related to the diagnosis (for example, unable to ambulate without assistance); and
- (E) include a description of the specific needs of the individual, including information justifying medical necessity, if required,

and how the adaptive aid will meet those needs (for example, the individual needs to ambulate safely and independently from room to room and the use of a walker will allow him to do so).

(2) Individual and Program Provider Agreement

An individual or legally authorized representative and program provider must:

- (A) meet and consider the written assessment required by paragraph (1) of this subsection;
- (B) document any discussion about the recommended adaptive aid;
- (C) agree that the recommended adaptive aid is necessary and should be purchased; and
- (D) document their agreement in writing and sign the agreement.

(3) Proof of Non-coverage by Medicaid and Medicare

(A) Obtaining Proof of Non-Coverage from the Durable Medical Equipment Provider that Contracts with the Individual's Managed Care Organization

A program provider must obtain proof of non-coverage as described in subparagraph (B) of this paragraph from a durable medical equipment provider that contracts with the individual's managed care organization.

(B) Adaptive Aids Noted with a (1) or (2) on Appendix VII, Billable Adaptive Aids

(i) Documentation Required

Except as provided in subparagraph (C) of this paragraph, Nutritional Supplements, for an adaptive aid noted on [Appendix VII, Billable Adaptive Aids](#), with a (1) or, for an adaptive aid noted with a (2) for an individual who is under 21 years of age. The program provider must obtain one of the following as proof of non-coverage by Medicaid:

- a letter from Texas Medicaid Healthcare Partnership (TMHP) or from the individual's managed care organization that includes:
 - a statement that the requested adaptive aid is denied under the Texas Medicaid or the Texas Health Steps Comprehensive Care Program; and
 - the reason for the denial, which must not be one of the following:

- Medicare is the primary source of coverage;
- information submitted to Texas Medicaid to make payment was incomplete, missing, insufficient or incorrect;
- the requested adaptive aid is not medically necessary;
- the request was not made in a timely manner; or
- the requested adaptive aid must be leased;
- a letter from Texas Medicaid Healthcare Partnership (TMHP) or the individual's managed care organization 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
- a provision from the current Texas Medicaid Providers Procedure Manual stating that the requested adaptive aid is not covered by Texas Medicaid or the Texas Health Steps Comprehensive Care Program.

(ii) Additional Documentation Required for Individuals Who are Eligible for Medicare

In addition to the documentation required by clause (i) of this subparagraph, for an individual eligible for Medicare, a program provider must obtain one of the following for an adaptive aid noted with a (1) or (2) on [Appendix VII](#):

- a copy of a Medicare Remittance Advice Notice that includes:
 - a statement that the requested adaptive aid is denied under Medicare; and
 - the reason for the denial, which must not be one of the following:
 - information submitted to Medicare 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;
- a copy of a Medicare Remittance Advice Notice 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

- a 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.

(iii) Unacceptable Documentation

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

- a 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
- a statement from a Medicare DME provider that the adaptive aid requested is not covered by Medicare.

(C) Nutritional Supplements

For a nutritional supplement (service code 121), the program provider must obtain one of the following as proof of non-coverage by Medicaid:

- (i) the documentation described under subparagraph (B)(i) of this paragraph; or
- (ii) a written statement from the individual's program provider that the individual:
 - is 21 years of age or older;
 - is not fed through a G-tube; and
 - is not dependent on the nutritional supplement as the individual's sole source of nutrition.

(4) Bids

(A) Required Number of Bids

A program provider must obtain comparable bids for the requested adaptive aid from three vendors, except as provided in subparagraph (C) of this paragraph. Comparable bids describe the adaptive aid and any associated items or modifications identified in the assessment required by paragraph (1) of this subsection.

(B) Required Content and Time Frame

A bid must:

- (i) 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;
- (ii) state the total cost of the requested adaptive aid;
- (iii) include the name, address and telephone number of the vendor, who may not be a relative of the individual ([Appendix II](#), Degree of Consanguinity or Affinity, explains who is considered a relative for purposes of these guidelines);
- (iv) for an adaptive aid other than interpreter service (service code 126) and specialized training for augmentative communication programs (service code 259), include a complete description of the adaptive aid and any associated items or modifications as identified in the written assessment required by paragraph (1) of this subsection, which may include pictures or other descriptive information from a catalog, web-site or brochure;
- (v) for interpreter service (service code 126) and specialized training for augmentative communication programs (service code 259), include the number of hours of direct service to be provided and the hourly rate of the service; and
- (vi) be obtained within one year after the written assessment required by paragraph (1) of this subsection is obtained.

(C) Program Provider Not Required to Obtain Three Bids

(i) One Bid

A program provider may obtain only one bid for the following adaptive aids:

- eyeglasses (service code 220);
- hearing aids, batteries and repairs (service code 260); and
- orthotic devices, orthopedic shoes and braces (service code 107).

(ii) One or Two Bids

A program provider may obtain only one bid or two comparable bids for an adaptive aid, other than one listed in clause (i) of this subparagraph, if the program provider has written justification for obtaining less than three bids because the adaptive aid is available from a limited number of vendors.

(D) Request for Payment of Higher Bid

(i) Documentation Required

If a program provider will request authorization for payment, as described by [Section 6170](#), Authorization for Payment, that is not based on the lowest bid, the program provider must have written justification for payment of a higher bid.

(ii) Examples of Justification That May Be Acceptable

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

- the higher bid is based on the inclusion of a longer warranty for the adaptive aid; and
- the higher bid is from a vendor that is more accessible to the individual than another vendor.

(E) Proof of Ownership

If applicable, a program provider must obtain proof that the individual, individual's family member or host home/companion care provider owns the vehicle for which a vehicle lift (service code 101) is requested.

(b) Adaptive Aids Costing Less Than \$500

For an adaptive aid costing less than \$500, a program provider must obtain the documentation described in paragraph (1) of this subsection before purchasing the adaptive aid.

(1) Individual and Program Provider Agreement, Proof of Non-Coverage, Bids and Proof of Ownership

For an adaptive aid costing less than \$500, a program provider must obtain:

- (A) a recommendation for the adaptive aid listed in [Appendix VII, Billable Adaptive Aids that:](#)
 - (i) is from one of the licensed professionals noted for the specific adaptive aid, as shown in Appendix VII; and
 - (ii) includes a description of the adaptive aid;
- (B) an individual and program provider agreement, as described in subsection (a)(2) of this section (except that there may not be a written assessment to consider), made not more than one year before the date of purchase of the adaptive aid;
- (C) if applicable, proof of non-coverage by Medicaid and Medicare, as described in subsection (a)(3) of this section;

- (D) bids, as described subsection (a)(4) of this section, unless the program provider has obtained HHSC approval of an annual vendor in accordance with paragraph (2) of this subsection;
- (E) if applicable, written justification for less than three bids and payment of a higher bid as described in subsection (a)(4)(C) and (D) of this section;
- (F) if applicable, proof of ownership as described in subsection (a)(4)(E) of this section; and
- (G) documentation justifying the medical necessity of the adaptive aid if required by the Medicaid State Plan.

(2) Approval of Annual Vendor

In lieu of obtaining bids in accordance with subsection (a)(4) of this section for an adaptive aid costing less than \$500 monthly, a program provider must, in accordance with this paragraph, obtain HHSC approval of an annual vendor.

(A) Documentation Required

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

- (i) a list of the adaptive aids to be provided by an annual vendor;
- (ii) 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 individual ([Appendix II](#), Degree of Consanguinity or Affinity, explains who is considered a relative for purposes of these guidelines);
- (iii) documentation identifying the vendor for whom the program provider seeks HHSC approval; and
- (iv) 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.

(B) Approval Period and Time Frame for Submission

(i) Approval Period

An approval of an annual vendor by HHSC is only valid for a calendar year.

(ii) Time Frame for Submission

To obtain approval of an annual vendor, a program provider must submit documentation required by subparagraph (A) of this paragraph:

- 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.

(C) Approval of Multiple Vendors

HHSC may approve more than one annual vendor for a program provider per calendar year.

6170 Authorization for Reimbursement

Revision 19-1; Effective November 15, 2019

(a) Requesting Authorization for Reimbursement

(1) Adaptive Aids Costing \$500 or More

To obtain authorization for reimbursement for an adaptive aid costing \$500 or more, a program provider must:

- (A) submit a completed [Form 4116-MHM-AA](#), Minor Home Modification/Adaptive Aids Summary Sheet, to HHSC in accordance with the form instructions; and
- (B) keep in the individual's record the documentation required by [Section 6160\(a\)](#), Required Documentation for an Adaptive Aid.

(2) Adaptive Aid Costing Less than \$500

To obtain authorization for reimbursement for an adaptive aid costing less than \$500, a program provider must:

- (A) submit a completed Form 4116-MHM-AA to DADS in accordance with the form instructions; and
- (B) keep in the individual's record the documentation required by [Section 6160\(b\)](#).

(3) Requisition Fee

A program provider may request authorization for payment of a requisition fee for an adaptive aid in accordance with the instructions on [Appendix IX](#), Minor Home Modifications, Adaptive Aids or Dental Summary Sheet.

(4) Time Frame for the Request for Authorization for Reimbursement

A program provider must request authorization for reimbursement for an adaptive aid no later than 12 months after the last day of the month in which the individual received the adaptive aid.

(b) Notification for Authorization for Reimbursement

(1) Authorization for Reimbursement Given or Denied

HHSC notifies a program provider on the CARE Reimbursement Authorization Inquiry (C77):

- (A) that authorization for reimbursement is given or denied;
- (B) if given, the amount which HHSC has authorized; and
- (C) if denied, the reason for denial.

(2) Corrected Requests

If a request for authorization for reimbursement is denied, a program provider must submit a corrected request no more than 12 months after the last day of the month in which the individual received the adaptive aid.

6200 Minor Home Modifications

Revision 10-1; Effective June 1, 2010

6210 General Description of Service Component

Revision 15-3; Effective December 8, 2015

A minor home modification is a physical adaptation to an individual's residence that is necessary to address the individual's specific needs and that enables the individual to function with greater independence in the individual's residence or to control his or her environment.

A minor home modification includes a pre-enrollment minor home modification.

6220 Billable Minor Home Modifications

Revision 10-0; Effective October 1, 2009

The only billable adaptations for the minor home modification service component are listed in [Appendix X](#), Billable Minor Home Modifications. The repair and maintenance of a billable adaptation not covered by warranty is also billable for the minor home modifications service component.

6230 Adaptations Not Billable

Revision 19-1; Effective November 15, 2019

(a) Adaptations Not Listed in Appendix X

Any adaptation not listed in [Appendix X](#), Billable Minor Home Modifications, is not billable under the minor home modification service component.

(b) Examples of Non-Billable Adaptations

The following are examples of adaptations that are not billable for the minor home modification service component:

- (1) general repair of a residence (for example, repairing a leaking roof or rotten porch, controlling termite damage or leveling a floor);
- (2) general remodeling of a residence that does not address an individual's specific needs;
- (3) an adaptation that adds square footage to a residence;
- (4) construction of new room, including installation of plumbing and electricity;
- (5) a septic tank;
- (6) general plumbing or electrical work;
- (7) hot water heater;
- (8) central heating or cooling system;
- (9) heater;
- (10) fire sprinkler system;
- (11) fire alarm system;
- (12) appliance (for example, washer, dryer, stove, dishwasher or refrigerator);
- (13) fence;
- (14) carport;
- (15) driveway;
- (16) deck; and
- (17) hot tub.

6240 Payment Limit

Revision 20-1; Effective September 1, 2020

Payment by HHSC to a program provider for minor home modifications is subject to the following limitations:

- (1) a program provider may be paid a maximum of \$7,500 during the time the individual is enrolled in the HCS program and such payment may be made in one or more IPC years; and
- (2) beginning the first full IPC year after the \$7,500 amount is paid, the maximum amount HHSC pays a program provider is \$300 per individual for repair and maintenance per IPC year.

6250 Required Documentation for a Minor Home Modification

Revision 20-1; Effective September 1, 2020

(a) Pre-enrollment Minor Home Modifications Costing Any Amount and Other Minor Home Modifications Costing \$1,000 or More

For a pre-enrollment minor home modification costing any amount and for a minor home modification (other than a pre-enrollment minor home modification) costing \$1,000 or more, a program provider must obtain the documentation described in this subsection before purchasing the minor home modification.

(1) Written Assessment

A program provider must obtain a written, legible assessment by one of the licensed professionals noted for the specific minor home modification on [Appendix X](#), Billable Minor Home Modifications. The written assessment must:

- (A) be based on a face-to-face evaluation of the individual by the licensed professional conducted in the individual's residence not more than one year before the date of purchase of the minor home modification;
- (B) include a description of and a recommendation for a minor home modification listed in [Appendix X](#) and any associated installation specifications necessary to make the minor home modification functional;
- (C) include a diagnosis that is related to the individual's need for the minor home modification (for example, cerebral palsy, quadriplegia or deafness);
- (D) include a description of the condition related to the diagnosis (for example, unable to ambulate without assistance); and
- (E) include a description of the specific needs of the individual and how the minor home modification will meet those needs (for

example, the individual needs to enter and exit the home safely and the addition of a wheelchair ramp will allow him to do so).

(2) Individual and Program Provider Agreement

An individual or legally authorized representative and program provider must:

- (A) meet and consider the written assessment required by paragraph (1) of this subsection;
- (B) document any discussion about the recommended minor home modification;
- (C) agree that the recommended minor home modification is necessary and should be purchased; and
- (D) document their agreement in writing and sign the agreement.

(3) Bids

(A) Required Number of Bids

A program provider must obtain comparable bids for the requested minor home modification from three vendors, except as provided in subparagraph (C) of this paragraph. Comparable bids describe the minor home modification and any associated installation specifications identified in the written assessment required by paragraph (1) of this subsection.

(B) Required Content and Time Frame

A bid must:

- (i) be cost effective according to current market prices (materials and labor) and be the lowest cost unless contraindicated by specific written justification for using a higher bid;
- (ii) state the total cost of the requested minor home modification and, if it includes more than one modification, state the cost of each modification by service code;
- (iii) include the name, address and telephone number of the vendor;
- (iv) include a complete description of the minor home modification and any associated installation specifications, as identified in the written assessment required by paragraph (1) of this subsection;
- (v) include a drawing or picture of both the existing and proposed floor plans;

- (vi) include a statement that the minor home modification will be made in accordance with all applicable state and local building codes; and
- (vii) be obtained within one year after the written assessment required by paragraph (1) of this subsection is obtained.

(C) Program Provider Not Required to Obtain Three Bids

A program provider may obtain only two comparable bids for the requested minor home modification if the program provider has written justification for obtaining less than three bids because the minor home modification is available from a limited number of vendors.

(D) Request for Reimbursement of Higher Bid

(i) Documentation Required

If a program provider will request authorization for reimbursement, as described by [Section 6270](#), Authorization for Reimbursement, that is not based on the lowest bid, the program provider must have written justification for the reimbursement of a higher bid.

(ii) Examples of Justification That May be Acceptable

An example of justification that supports payment of a higher bid is the inclusion of a longer warranty for the minor home modification.

(b) Minor Home Modifications (Other Than Pre-enrollment Minor Home Modifications) Costing Less Than \$1,000

For a minor home modification (other than a pre-enrollment minor home modification) costing less than \$1,000, a program provider must obtain the following documentation before purchasing the minor home modification:

- (1) a recommendation for the minor home modification listed in [Appendix X, Billable Minor Home Modifications that:](#)
 - (A) is from one of the licensed professionals noted for the specific minor home modification, as shown in Appendix X; and
 - (B) includes a description of the Minor Home Modification;
- (2) an individual and program provider agreement, as described in subsection (a)(2) of this section (except that there may be no written assessment to consider), made not more than one year before the date of purchase of the minor home modification;
- (3) bids, as described in subsection (a)(3) of this section; and

- (4) if applicable, written justification for less than three bids or payment of a higher bid as described in subsection (a)(3)(C) and (D) of this section.

6260 Pre-enrollment Minor Home Modification Prior Authorization Process

Revision 19-1; Effective November 15, 2019

(a) Requirement for Prior Authorization from HHSC

HHSC requires a program provider to obtain prior authorization from HHSC for a pre-enrollment minor home modification before HHSC will pay for the minor home modification. A program provider must request prior authorization in accordance with this section.

(b) Documentation Required

- (1) To obtain prior authorization for a pre-enrollment minor home modification, the program provider must:
- (A) complete, with the applicant or legally authorized representative and service coordinator, [Form 8611](#), Pre-enrollment MHM Authorization Request; and
 - (B) obtain and give the following documentation to the service coordinator:
 - (i) a pre-enrollment minor home modifications assessment, as described in [Section 6250\(a\)\(1\)](#), Required Documentation for a Minor Home Modification;
 - (ii) service planning team meeting documentation evidencing agreement with the recommendation(s) of the applicant's need for the pre-enrollment minor home modification, as described in Section 6250(a)(2);
 - (iii) three bids, as described in Section 6250(a)(3) and;
 - (iv) if applicable, and subject to approval by HHSC, written justification for less than three bids or payment of a higher bid, as described in Section 6250(a)(3)(C) and (D).
- (2) The service coordinator submits completed Form 8611 and the above described documentation to HHSC.

(c) HHSC Review of Form 8611

HHSC reviews completed Form 8611 and the documentation submitted by the service coordinator and indicates on the form whether it authorizes or denies a requested pre-enrollment minor home modification. HHSC sends a copy of

signed Form 8611 to the service coordinator who then sends a copy of the form to the program provider.

6270 Authorization for Reimbursement

Revision 19-1; Effective November 15, 2019

(a) Requesting Authorization for Reimbursement

(1) Pre-Enrollment Minor Home Modifications

To obtain authorization for reimbursement for a pre-enrollment minor home modification:

- (A) for an individual who enrolls with a program provider, the program provider must:
 - (i) submit a completed [Form 4116-MHM-AA](#), Minor Home Modification/Adaptive Aids Summary Sheet, to HHSC in accordance with the form instructions; and
 - (ii) keep in the individual's record the documentation required by [Section 6260\(b\)](#), Pre-Enrollment Minor Home Modification Prior Authorization Process; and
- (B) for an individual who does not enroll with a program provider, the program provider must:
 - (i) complete [Form 8612](#), TAS/MHM Payment Exception Request, based on the pre-enrollment minor home modifications and pre-enrollment minor home modification assessments authorized by HHSC on [Form 8611](#), Pre-Enrollment MHM Authorization Request; and
 - (ii) submit completed Form 8612 to HHSC no sooner than 30 days after the individual's proposed enrollment date but within 12 months after the last day of the month in which the pre-enrollment minor home modification was completed.

(2) Minor Home Modifications (Other Than Pre-enrollment Minor Home Modifications) Costing \$1,000 or More

To obtain authorization for reimbursement for a minor home modification (other than a pre-enrollment minor home modification) costing \$1,000 or more, a program provider must:

- (A) submit a completed Form 4116-MHM-AA to HHSC in accordance with the form instructions; and
- (B) keep the documentation required by [Section 6250\(a\)](#), Required Documentation for a Minor Home Modification in the individual's record.

(3) Minor Home Modifications (Other Than Pre-enrollment Minor Home Modifications) Costing Less Than \$1,000

To obtain authorization of reimbursement for a minor home modification (other than a pre-enrollment minor home modification) costing less than \$1,000, a program provider must:

- (A) submit a completed Form 4116-MHM-AA to HHSC in accordance with the form instructions; and
- (B) keep the documentation required by Section 6250(b) in the individual's record.

(4) Requisition Fee

A program provider may request authorization for payment of a requisition fee for a minor home modification (including a pre-enrollment minor home modification) in accordance with the instructions in [Appendix IX](#), Minor Home Modifications, Adaptive Aids or Dental Summary Sheet.

(b) Time Frame for the Request for Authorization for Reimbursement

A program provider must request authorization for reimbursement for a minor home modification no later than 12 months after the last day of the month in which the minor home modification was completed.

(c) Notification for Authorization for Reimbursement

(1) Authorization for Payment Given or Denied

HHSC notifies a program provider on the Client Assignment and Registration (CARE) System Reimbursement Authorization Inquiry (C77):

- (A) that authorization for reimbursement is given or denied;
- (B) if given, the amount which HHSC has authorized; and
- (C) if denied, the reason for denial.

(2) Corrected Requests

If a request for authorization for payment is denied, a program provider must submit a corrected request no later than 12 months after the last day of the month in which the minor home modification was completed.

6300 Dental Treatment

Revision 19-1; Effective November 15, 2019

6310 General Description of Service Component

Revision 10-0; Effective October 1, 2009

The dental treatment service component includes emergency dental treatment, preventive dental treatment, therapeutic dental treatment and orthodontic dental treatment.

6320 Age Requirement

Revision 10-0; Effective October 1, 2009

Dental treatment may be provided only to an individual 21 years of age or older.

6330 Billable Dental Treatment

Revision 19-1; Effective November 15, 2019

The only billable services for the dental treatment service component are:

- (1) dental treatment necessary to control bleeding, relieve pain or eliminate acute infection;
- (2) an operative procedure required to prevent the imminent loss of teeth;
- (3) treatment of an injury to a tooth or supporting structure;
- (4) a dental examination, an oral prophylaxis or a topical fluoride application;
- (5) pulp therapy for permanent or primary teeth;
- (6) restoration of carious permanent or primary teeth;
- (7) dental treatment related to maintenance of space;
- (8) the limited provision of a removable prosthesis (for example, dentures) when masticatory function is impaired, an existing prosthesis is unserviceable, or employment or social development is impaired due to aesthetic considerations;
- (9) treatment of retained deciduous teeth;
- (10) cross bite therapy;
- (11) treatment of a facial accident involving a severe traumatic deviation;
- (12) treatment of a cleft palate with a gross malocclusion that will benefit from early treatment;
- (13) treatment of a severe, handicapping malocclusion affecting permanent dentition with a minimum score of 26 as measured on the Handicapping Labio-lingual Deviation Index; and

(14) anesthesiology if needed to perform a billable service listed in this section.

6340 Services Not Billable

Revision 19-1; Effective November 15, 2019

(a) Items and Services Not Listed in Subsection 6330

Any service not listed in [Section 6330](#), Billable Dental Treatment, is not billable under the dental treatment service component.

(b) Examples of Non-Billable Services

The following are examples of services that are not billable for the dental treatment service component:

- (1) cosmetic orthodontia; and
- (2) teeth whitening.

6350 Provider of Dental Treatment

Revision 10-0; Effective October 1, 2009

A provider of the dental treatment service component must be a person licensed to practice dentistry in accordance with Texas Occupations Code, [Chapter 256](#).

6360 Payment Limit

Revision 19-1; Effective November 15, 2019

The maximum amount HHSC pays a program provider for all dental treatment provided to an individual is \$2,000 per individual plan of care (IPC) year.

6370 Authorization for Reimbursement

Revision 19-1; Effective November 15, 2019

(a) Requesting Authorization for Reimbursement

(1) Dental Treatment

To obtain authorization for reimbursement for dental treatment, a program provider must:

- (A) submit a completed [Form 4116-Dental](#), Dental Summary Sheet, to HHSC in accordance with the form instructions; and
- (B) keep in the individual's record:

- (i) a statement from the provider of dental treatment that includes:
- (ii) the individual's name; and
- (iii) a description of each dental service provided to the individual, itemized by cost;
- (C) proof that the program provider purchased the dental treatment, and the date of purchase; and
- (D) a completed Form 4116-Dental, in accordance with the form instructions.

(2) Requisition Fee

A program provider may request authorization for payment of a requisition fee for dental treatment in accordance with the instructions in [Appendix IX](#). The requisition fee is not counted toward the payment limit that HHSC pays a program provider for dental treatment, as described in [Section 6360](#), Payment Limit.

(b) Time Frame for Request for Authorization for Reimbursement

A program provider must request authorization for reimbursement for dental treatment no later than 12 months after the last day of the month in which the individual received the dental treatment.

(c) Notification for Authorization for Reimbursement

(1) Authorization for Payment Given or Denied

HHSC notifies a program provider on the CARE Reimbursement Authorization Inquiry (C77):

- (i) that authorization for reimbursement is given or denied;
- (ii) if given, the amount which DADS has authorized; and
- (iii) if denied, the reason for denial.

(2) Corrected Request

If a request for authorization for reimbursement is denied, a program provider must submit a corrected request no later than 12 months after the last day of the month in which the individual received the dental treatment.

6400 Transition Assistance Services (TAS)

Revision 15-3; Effective December 8, 2015

6410 General Description of Service Component

Revision 15-3; Effective December 8, 2015

Services provided to assist an applicant in setting up a household in the community before being discharged from a nursing facility, an intermediate care facility for individuals with an intellectual disability or related conditions (ICF/IID) or a general residential operation (GRO) and before enrolling in the HCS Program.

6420 Billable Transition Assistance Services (TAS)

Revision 19-1; Effective November 15, 2019

TAS consists of:

- (1) for an applicant whose proposed IPC does not include residential support, supervised living or host home/companion care:
 - (A) paying security deposits required to lease a home, including an apartment, or to establish utility services for a home;
 - (B) purchasing essential furnishings for a home, such as a table, a bed, chairs, window blinds, eating utensils and food preparation items;
 - (C) paying for expenses required to move personal items, such as furniture and clothing, into a home;
 - (D) paying for services to ensure the health and safety of the applicant in a home, such as pest eradication, allergen control or a one-time cleaning before occupancy; and
 - (E) purchasing essential supplies for a home, such as toilet paper, towels and bed linens; and
- (2) for an applicant whose proposed initial IPC includes residential support, supervised living or host home/companion care:
 - (A) purchasing bedroom furniture;
 - (B) purchasing personal linens for the bedroom and bathroom; and
 - (C) paying for allergen control.

6430 Reserved for Future Use

Revision 115-3; Effective December 8, 2015

6440 Property of Individual

Revision 15-3; Effective December 8, 2015

A billable item must be the exclusive property of the individual for whom it is purchased.

6450 Payment Limit

Revision 19-1; Effective November 15, 2019

(a) HHSC Payment to Program Provider

Payment by HHSC to a program provider for TAS is limited to:

- (1) \$2,500, if the applicant's proposed initial individual plan of care (IPC) does not include residential support, supervised living or host home/companion care; or
- (2) \$1,000, if the applicant's proposed initial IPC includes residential support, supervised living or host home/companion care.

(b) Lifetime Limit

An individual may receive TAS only once in the individual's lifetime.

6460 TAS Prior Authorization Process

Revision 19-1; Effective November 15, 2019

(a) Requirement for Prior Authorization from HHSC

HHSC requires a program provider to obtain prior authorization from HHSC for TAS before HHSC will pay for TAS. A program provider must request prior authorization in accordance with this section.

(b) Documentation Required

- (1) **Form 8604, Transition Assistance Services (TAS) Assessment and Authorization**

To obtain prior authorization for TAS, the program provider must complete Form 8604 with the applicant or legally authorized representative and service coordinator.

- (2) **Submission of Form 8604 to HHSC**

The service coordinator submits the completed Form 8604 to HHSC.

(c) HHSC Review of Form 8604

HHSC reviews completed Form 8604 and indicates on the form whether it authorizes or denies the requested TAS. HHSC sends a copy of signed Form

8604 to the service coordinator, who then sends a copy of the form to the program provider.

6470 Authorization for Payment for TAS

Revision 19-1; Effective November 15, 2019

(a) Requesting Authorization for Payment

To obtain authorization for payment for TAS:

- (1) for an individual who enrolls with a program provider, the program provider must keep in the individual's record:
 - (A) completed [Form 8604](#), Transition Assistance Services (TAS) Assessment and Authorization, authorized by HHSC; and
 - (B) itemized receipts from vendors evidencing the purchase of TAS authorized by Form 8604 that includes:
 - (i) the name of the vendor;
 - (ii) a description of each item or service;
 - (iii) the cost of each item or service; and
 - (iv) the date of purchase of each item or service; or
- (2) for an individual who does not enroll with a program provider, the program provider must:
 - (A) complete [Form 8612](#), TAS/MHM Payment Exception Request, based on the TAS authorized by HHSC on Form 8604; and
 - (B) submit completed Form 8612 to HHSC no sooner than 30 days after the individual's proposed enrollment date, but within 12 months after the last day of the month in which TAS is purchased.

(b) TAS Service Fee

A program provider may request authorization for payment of a service fee (a flat fee) for TAS authorized by HHSC on Form 8604.

(1) Time Frame for the Request for Authorization for Payment

A program provider must request authorization for payment for TAS no later than 12 months after the last day of the month in which TAS was purchased.

(2) Corrected Request

If a request for authorization for payment is denied, a program provider must submit a corrected request no later than 12 months after the last day of the month in which TAS was purchased.

6480 Qualified Service Provider

Revision 20-1; Effective September 1, 2020

A qualified service provider of transition assistance services must:

- (1) have a residence with a different address than the individual's residence;
- (2) be an adult;
- (3) not be a relative or legally authorized representative of the individual receiving services;
- (4) have:
 - (A) a high school diploma or a certificate recognized by a state as the equivalent of a high school diploma; or
 - (B) documentation of a proficiency evaluation of experience and competence to perform the job tasks that includes:
 - (i) a written competency-based assessment; and
 - (ii) at least three written personal references from persons not related by blood to the service provider that indicate the ability to provide a safe, healthy environment for the individuals being served;
- (5) be a staff member or contractor of the program provider;
- (6) not have been convicted of an offense listed under §250.006 of the Texas Health and Safety Code;
- (7) not be designated in either the *Employee Misconduct Registry* or the *Nurse Aid Registry*;
- (8) maintained by HHSC as having abused, neglected or exploited a person or misappropriated a person's property; and
- (9) not be listed on the LEIE maintained by the United States Department of Health and Human Services, Office of Inspector General or the LEIE maintained by the Texas Health and Human Services Commission, Office of Inspector General.

Appendices

Appendix I Billing and Payment Review Protocol

Revision 19-1; Effective November 15, 2019

(a) Introduction

This protocol is used to conduct a billing and payment review of a Home and Community-based Services (HCS) Program provider. A billing and payment review is a review conducted by HHSC staff of written documentation maintained by a program provider and submitted to HHSC upon request. The purpose of a review is to determine whether the program provider is in compliance with the *HCS Program Billing Guidelines*. HHSC recoups from a program provider for a service claim that HHSC cannot verify is supported by written documentation in accordance with the *Billing Guidelines* and may require corrective action by the program provider.

(b) Types of Reviews

(1) Routine reviews

A routine review is a billing and payment review conducted by HHSC for an HCS program provider at least once every four years per program provider. During a routine review, HHSC reviews documentation required by the *Billing Guidelines* for:

- (A) services provided during a three-month period of time; and
- (B) the following number of individuals:
 - (i) for an HCS provider for which a routine review resulted in a recoupment amount that is 10% or less of the total amount of the claims reviewed, five individuals plus 5% of the total number of individuals provided services during the review period;
 - (ii) for an HCS provider for which a routine review has not been conducted:
 - if the program provider provided HCS Program services to 10 or fewer individuals during the review period, the number of individuals provided services during the review period, but in no case more than five individuals; or

- if the program provider provided HCS Program services to more than 10 individuals during the review period, five individuals plus 10% of the total number of individuals provided services during the review period; or
- (iii) for an HCS provider for which a routine review resulted in a recoupment amount that is more than 10% of the total amount of the claims reviewed:
- if the program provider provided HCS Program services to 10 or fewer individuals during the review period, all of the individuals; or
 - if the program provider provided HCS Program services to more than 10 individuals during the review period, 10 individuals plus 10 % of the total number of individuals provided services during the review period.

(2) Special reviews

A special review is a billing and payment review conducted by HHSC for one or more HCS provider agreements as a result of a billing anomaly identified by HHSC staff or as a result of information related to billing issues received from a source other than HHSC staff. During a special review, HHSC reviews documentation for:

- (A) any length of time as determined by HHSC;
- (B) any number of individuals as determined by HHSC; and
- (C) any type of service as determined by HHSC.

(c) Methods of Review

(1) On-site review

An on-site review is a billing and payment review conducted at a program provider's place of business.

(2) Desk review

A desk review is a billing and payment review conducted at a HHSC office.

(d) Routine Review Process

(1) On-site review

- (A) HHSC notifies a program provider of an on-site review by telephone at least 14 days before and by facsimile at least one day before the date the on-site review is scheduled to begin. The telephonic and written notices include a statement that all written documentation required by the *Billing Guidelines* related

to a specified program provider agreement must be made available to the HHSC review team at a specified time and place.

- (B) At least two business days before the on-site review, HHSC faxes to the program provider the list of individuals for whom records will be reviewed.
- (C) Upon arrival at the program provider's place of business, the HHSC review team informs the program provider of the sample of individuals and time period for which written documentation will be reviewed. During the review, the review team may expand the time period under review and may request documentation related to individuals who were not initially included in the review.
- (D) The review team reviews the documentation submitted by the program provider. The review team does not accept any documentation created by the program provider during the review.
- (E) When the review team completes the initial review of the documentation submitted by the program provider, the review team gives the program provider a list of all unverified claims and explains why the claims are unverified. The review team allows the program provider to provide additional documentation and refute the unverified claims.
- (F) The review team conducts an exit conference with the program provider. During the exit conference the review team summarizes the findings of the review, provides technical assistance to improve documentation practices, and answers questions from the program provider. The review team also gives an estimate of the amount of claims to be recouped. HHSC does not allow the program provider to submit additional documentation or refute any unverified claims after the exit conference.
- (G) HHSC sends a letter by certified mail to the program provider. Generally, HHSC sends this letter within 30 days after the exit conference. If HHSC did not identify any unverified claims, the letter notifies the program provider of such. If HHSC identified unverified claims, the letter includes a detailed report of the unverified claims, the reason the claims were not verified, the amount to be recouped by HHSC, any required corrective action and notice of the right to request an administrative hearing. Examples of corrective actions that HHSC may require a program provider to take are submitting a plan to improve the program provider's billing practices and reviewing documentation beyond the scope of the billing and payment review.

- (H) If HHSC requires a program provider to take a corrective action and the program provider does not request an administrative hearing for the recoupment, HHSC includes in the letter described in subparagraph (G) of this paragraph a date by which the program provider must take the corrective action. If the program provider does not take the required corrective action by the date required by HHSC, HHSC may:
 - (i) impose a vendor hold on payments due to the program provider under the HCS provider agreement until the program provider takes the corrective action; and
 - (ii) terminate the provider agreement.

(2) Desk review

- (A) HHSC notifies a program provider of a desk review by telephone and certified mail. The written notice specifies the individuals and time period to be reviewed, as well as the documentation the program provider must submit to HHSC for the desk review. The notice states that the documentation must be received by HHSC within 14 calendar days after the program provider receives the notice. The date the notice is received by the program provider is the date of the signature appearing on the "green card" – Postal Service form 1138. If the signature is not dated, the received date will be the date the "green card" is postmarked.
- (B) HHSC will accept one of the following as proof of its receipt of the documentation submitted by the program provider:
 - (i) the dated signature of a HHSC employee on a "green card" – Postal Service form 1138;
 - (ii) a dated signature of an agent of HHSC evidencing receipt of the documentation; or
 - (iii) a dated, traceable receipt from a commercial courier service or the U.S. Postal Service.
- (C) HHSC does not accept documentation submitted via facsimile or documentation received by HHSC after the 14-day time period described in the notice.
- (D) The review team reviews the documentation submitted by the program provider. During the review, the review team may expand the time period under review and may request documentation related to individuals who were not initially included in the review.
- (E) HHSC sends a letter by certified mail to the program provider. If HHSC did not identify any unverified claims, the letter notifies the program provider of such. If HHSC identified unverified claims, the letter includes a detailed report of the unverified

claims, the reason the claims were not verified and the amount to be recouped by HHSC. The letter also gives the program provider an opportunity to submit additional documentation for certain unverified claims and a written argument to refute any unverified claim. Further, the letter states that the additional documentation and written argument must be received by HHSC within 14 calendar days after the program provider receives the letter. The date the letter is received by the program provider is the date of the signature appearing on the "green card" – Postal Service form 1138. If the signature is not dated, the received date will be the date the "green card" is postmarked.

- (F) Proof of receipt by HHSC of any additional documentation and written argument submitted by the program provider is the same as the proof of receipt of documentation described in subparagraph (B) of this paragraph.
- (G) HHSC does not accept additional documentation or a written argument submitted via facsimile or received by HHSC after the 14-day time period described in the letter.
- (H) The review team reviews any additional documentation and argument submitted by the program provider. HHSC sends a letter by certified mail to the program provider that either upholds the unverified claims listed in the previous letter or revises the unverified claims and adjusts the amount to be recouped by HHSC. The letter also gives the program provider notice of the right to request an administrative hearing.

(e) Special Review Process

A special review is generally conducted in accordance with the process for a routine review except:

- (1) HHSC may not always give a program provider prior notice of an on-site review;
- (2) during an on-site review, HHSC may interview an individual or program provider staff and may visit an individual's residence or any other location where an individual receives HCS Program services; and
- (3) in addition to documentation required by the *Billing Guidelines*, HHSC may request the program provider to submit documentation required by state or federal law, rule or regulation for HHSC review.

(f) Payment of Unverified Claims

Payment to HHSC by a program provider of an unverified claim is accomplished by HHSC recouping the program provider's HCS Medicaid payments for the amount of the unverified claim. Such recoupment is done electronically through

the automated billing system. A program provider may determine the unverified claim upon which recoupment was based by referring to the applicable electronic billing report. If unverified claims cannot be recouped electronically through the automated billing system, HHSC will create an accounts receivable number for repayment to be processed.

Appendix II Degree of Consanguinity or Affinity

02-2012

For the purposes of these billing guidelines, a person is considered to be a relative if the person is related within the fourth degree of consanguinity or within the second degree of affinity.

Relationships of Consanguinity

Two people are related to each other by consanguinity if one is a descendant of the other or if they share a common ancestor. An adopted child is considered to be a child of the adoptive parent for this purpose.

Example: Person A is related by the third degree of consanguinity to person B if person B is person A's uncle (brother of person A's father) because they share a common ancestor. However, person A is not related by consanguinity to person C if person C is the uncle's spouse, because person A and person C share no common ancestor.

Relationships of Affinity

Two people are related by affinity if they are married to each other, or if one person is related by consanguinity to the other person's spouse.

Example: Person A is related within the second degree of affinity to the brother of person A's spouse because the brother and the spouse are related by consanguinity.

The ending of a marriage between two people by divorce or the death of a spouse ends relationships by affinity created by that marriage, unless a child of that marriage is living, in which case the marriage is considered to continue as long as a child of that marriage lives.

The chart below lists relationships within the fourth degree of consanguinity and within the second degree of affinity.

Relationship of Consanguinity

	1st Degree	2nd Degree	3rd Degree*	4th Degree*
Person	child or parent	grandchild, sister, brother or grand-parent	great-grandchild, niece, nephew, aunt,* uncle* or great-grandparent	great-great-grandchild, grandniece, grandnephew, first cousin, great aunt,* great uncle* or great-great-grandparent

*An aunt, uncle, great aunt or great uncle is related to a person by consanguinity only if he or she is the sibling of the person's parent or grandparent.

Relationship of Affinity

	1st Degree	2nd Degree
Person	spouse, mother-in-law, father-in-law, son-in-law, daughter-in-law, stepson, stepdaughter, stepmother or stepfather	brother-in-law, sister-in-law, spouse's grandparent, spouse's grandchild, grandchild's spouse or spouse of grandparent

Shared Appendix 29

This appendix appears in the following handbooks:

- Home and Community-based Services Program Billing Guidelines (HCSBG): Appendix II
- Texas Home Living Program Billing Guidelines (TxHmLbg): Appendix VI

- Transition Assistance Services Orientation Handbook (TAS): Appendix III

Appendix III Conversion Table

02-2012

Service Time	Unit(s) of Service for Service Claim
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
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

Service Time	Unit(s) of Service for Service Claim
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

Service Time	Unit(s) of Service for Service Claim
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
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

Service Time	Unit(s) of Service for Service Claim
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

Service Time	Unit(s) of Service for Service Claim
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
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

Service Time	Unit(s) of Service for Service Claim
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

Service Time	Unit(s) of Service for Service Claim
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

Shared Appendix 27

This appendix appears in the following handbooks:

- Home and Community-based Services Program Billing Guidelines (HCSBG): Appendix III
- Texas Home Living Program Billing Guidelines (TxHmLBG): Appendix III

Appendix IV Retainer Payment Review Protocol

Revision 21-2; Effective April 5, 2021

(a) PURPOSE

This protocol is used to conduct a retainer payment review of an HCS program provider to determine if:

- (1) the program provider is in compliance with the HHSC rule at 40 TAC §9.193; and
- (2) the attestations made by the program provider in the retainer payment attestation form required by §9.193(g) are accurate.

(b) OVERVIEW

This protocol includes:

- (1) the background of retainer payments;
- (2) types of retainer payment reviews,
- (3) duration of a review;
- (4) sample size;
- (5) review period;
- (6) review expansion;
- (7) desk review process; and
- (8) required documents.

(c) BACKGROUND

HHSC rule at 40 §9.193 allows HCS program providers to submit a service claim and receive payment from HHSC for supervised living and residential support when an individual, whose residence is a program provider's three-person residence or four-person residence, is not receiving the service because the individual is living away from the residence during the COVID-19 public health emergency. A payment made by HHSC in this circumstance is a "retainer payment" authorized by the Centers for Medicare and Medicaid Services.

HHSC may make retainer payments for no more than 90 days per individual and allows the 90 days to not be consecutive. Section 9.193 describes the conditions that must exist for an HCS program provider to submit a service claim for a retainer payment, including completion of an HHSC retainer payment attestation form.

A retainer payment review is different from a provider fiscal compliance review because a provider fiscal compliance review determines a program provider's compliance with the HCS Program Billing Requirements, CFC service guidelines, the provider agreement for the HCS Program and HHSC rules at 40 TAC §§49.301-49.313 and 40 TAC Chapter 9, Subchapter D. A retainer payment review does not affect the sample size for a provider fiscal compliance review (refer to Appendix I, Provider Fiscal Compliance Review Protocol).

(d) REVIEW TEAM(S)

HHSC Provider Fiscal Compliance staff conduct retainer payment reviews.

(e) TYPES OF REVIEWS FOR RETAINER PAYMENTS

(1) Routine Retainer Payment Review

(A) Description

HHSC staff will conduct a routine retainer payment review of each HCS program provider that receives a retainer payment from HHSC. HHSC will complete the review within three years after June 2021. A

routine retainer payment review may be conducted at the same time as another HHSC review, survey, or audit.

(B) Duration of Review

- (i) A routine retainer payment review is generally completed within the same calendar week it is initiated but may be extended into the following week(s) because of the number of contracts being reviewed and the sample size.
- (ii) The length of the review depends on several factors such as:
 - number of contracts reviewed;
 - sample size;
 - number of program providers being reviewed; and
 - any unforeseen issues that arise during the review.

(C) Sample Size

HHSC staff reviews each HCS contract of the program provider for which a retainer payment was received.

- (i) The sample size for each contract is five plus five percent (5+5%).
- (ii) The sample is randomly selected based on the number of individuals for whom a retainer payment was received.

(D) Review Period

The review period is March 20, 2020 through October 23, 2020.

(E) Review Expansion

During a routine retainer payment review, HHSC staff may determine that a program provider's retainer payment service claim resulted in the program provider receiving an overpayment. If HHSC staff suspect that a service claim resulted in an overpayment because of a systemic issue, HHSC staff may expand the sample size of the review after obtaining written approval from the HHSC Provider Fiscal Compliance manager.

Examples of systemic issues are:

- (i) a retainer payment attestation is inaccurate;
- (ii) an inappropriate billing code was used for multiple retainer payment service claims; and
- (iii) a retainer payment attestation form was not submitted to HHSC.

(2) Special Retainer Payment Reviews

(A) Description

HHSC staff will conduct a special retainer payment review of one or more HCS contracts of the program provider for which a retainer payment was received as a result of a billing anomaly identified by HHSC staff or a source other than HHSC, such as another state agency, a program provider, or an individual. The review period and sample list for a special retainer payment review may overlap with the review period and sample list for a provider fiscal compliance review. HHSC staff may conduct more than one special retainer payment review of a program provider.

(B) Duration of Review

(i) A special retainer payment review is generally completed within the same calendar week it is initiated but may be extended into the following week(s) because of the number of contracts being reviewed and the sample size.

(ii) The length of the review depends on several factors such as:

- number of contracts reviewed;
- sample size;
- number of program providers being reviewed; and
- any unforeseen issues that arise during the review.

(C) Sample Size

HHSC determines the number of individuals to be reviewed.

(D) Review Period

HHSC determines the review period. The review period is a number of days during March 20, 2020 through October 23, 2020.

(E) Review Expansion

During a special retainer payment review, HHSC staff may determine that a program provider's retainer payment service claim resulted in the program provider receiving an overpayment. If HHSC staff suspect that a service claim resulted in an overpayment because of a systemic issue, HHSC staff may expand the sample size and review period of the review after obtaining written approval from the HHSC Provider Fiscal Compliance manager.

Examples of systemic issues are:

- (i) a retainer payment attestation is inaccurate;

- (ii) an inappropriate billing code was used for multiple retainer payment service claims; and
- (iii) a retainer payment attestation form was not submitted to HHSC.

(f) DESK REVIEW PROCESS

HHSC conducts retainer payment reviews by desk review. A desk review is conducted at an HHSC office and not at the program provider's location.

(1) Routine Retainer Payment Desk Review

- (A) At least 14 calendar days before the date a routine desk review is scheduled to begin, HHSC staff will notify a program provider by telephone:
 - (i) that a routine retainer payment review will be conducted;
 - (ii) the date the review will begin; and
 - (iii) the time of the entrance conference on the begin date of the review.
- (B) HHSC staff will, within two business days after the telephone contact in (A) above, email or fax the program provider confirmation of the information described in (A) above.
- (C) HHSC will, at least seven calendar days before the routine desk review is scheduled to begin, fax or email the program provider a letter notifying the program provider that HHSC will be conducting a routine retainer payment review. The letter includes:
 - (i) the date and time of the entrance conference;
 - (ii) the names of the individuals included in the review sample;
 - (iii) the review period;
 - (iv) a list of required documentation;
 - (v) the deadline to submit the required documentation; and
 - (vi) method to submit the requested documentation.
- (D) On the scheduled date and time of the entrance conference, HHSC staff will contact the program provider by telephone and conduct the entrance conference. HHSC staff will complete an Entrance Conference Checklist Form at the entrance conference, which includes a roster of all attendee names. HHSC staff will send the form to the program provider, by fax or email, requesting that the program provider add the names of their attendees to the form and send the completed form to HHSC staff.

- (E) HHSC staff will accept the required documentation submitted by the program provider during the entrance conference. HHSC staff will notify the program provider each day during the review of any missing documentation that is necessary to justify the retainer payment claims. Such notification will be made by sending the program provider, by email or fax, a Requested Documents List Form. The sent email or fax confirmation will serve as verification that the program provider was requested to provide missing documentation.
 - (F) HHSC staff will notify the program provider of the date of the exit conference at least one business day before the exit conference date. HHSC staff will not accept documentation from the program provider at the exit conference.
 - (G) HHSC will conduct the exit conference by telephone. HHSC staff will complete an Exit Conference Form, which includes a roster of all attendee names. HHSC staff will send the form to the program provider, by fax or email, requesting that the program provider add the names of their attendees to the form and send the completed form to HHSC staff.
 - (H) During the exit conference, HHSC staff will explain the findings of the routine retainer payment review, including any overpayment made by HHSC, to the program provider. If HHSC staff determine no overpayment was made, HHSC will, at the exit conference, fax or email a letter to the program provider notifying the program provider of this determination. If HHSC determines that overpayments were made to the program provider, HHSC will fax or email a demand for payment letter to the program provider within 30 days after the exit conference.
 - (I) The demand for payment letter will inform the program provider of:
 - (i) the amount the program provider must refund to HHSC;
 - (ii) the process on how to obtain information from HHSC about payment options; and
 - (iii) the process to request an appeal of the demand for payment.
- (2) Special Retainer Payment Desk Review
- (A) At least seven calendar days before the date a special desk review is scheduled to begin, HHSC staff will notify a program provider by telephone:
 - (i) that a special retainer payment review will be conducted;
 - (ii) the date the review will begin; and

- (iii) the time of the entrance conference on the begin date of the review.
- (B) HHSC staff will, within two business days after the telephone contact in (A) above, fax or email the program provider confirmation of the information described in (A) above.
- (C) On the scheduled date and time of the entrance for the special desk review, HHSC staff will contact the program provider by telephone and conduct an entrance conference. HHSC staff will complete an Entrance Conference Checklist Form at the entrance conference, which includes a roster of all attendee names. HHSC staff will send the form to the program provider, by fax or email, requesting that the program provider add the names of their attendees to the form and send the completed form to HHSC staff.
- (D) During the entrance conference, HHSC staff will fax or email the program provider a letter notifying the program provider that HHSC will be conducting a special retainer payment review. The letter includes
 - (i) the names of the individuals included in the review sample;
 - (ii) the review period;
 - (iii) a list of required documentation;
 - (iv) the deadline to submit the required documentation; and
 - (v) method to submit the requested documentation.
- (E) HHSC staff will accept the required documentation submitted by the program provider no later than one business day after the date of the entrance conference.
- (F) HHSC staff will notify the program provider each day during the review of any missing documentation that is necessary to justify the retainer payment claims. Such notification will be made by sending the program provider, by email or fax, a Requested Documents List Form. The sent email or fax confirmation will serve as verification that the program provider was requested to provide missing documentation.
- (G) HHSC staff will notify the program provider of the date of the exit conference at least one business day before the exit conference date. HHSC staff will not accept documentation from the program provider at the exit conference.
- (H) HHSC will conduct the exit conference by telephone. HHSC staff will complete an Exit Conference Form, which includes a roster of all attendee names. HHSC staff will send the form to the program provider, by fax or email, requesting that the program

provider add the names of their attendees to the form and send the completed form to HHSC staff.

- (I) During the exit conference, HHSC staff will explain the findings of the special retainer payment review, including any overpayment made by HHSC, to the program provider. If HHSC staff determine no overpayment was made, HHSC will, at the exit conference, fax or email a letter to the program provider notifying the program provider of this determination. If HHSC determines that overpayments were made to the program provider, HHSC will fax or email a demand for payment letter to the program provider within 30 days after the exit conference.
- (J) The demand for payment letter will inform the program provider of:
 - (i) the amount the program provider must refund to HHSC;
 - (ii) the process on how to obtain information from HHSC about payment options; and
 - (iii) the process to request an appeal of the demand for payment.

(g) REQUIRED DOCUMENTS

HHSC will request that the program provider submit to HHSC the following documentation for each individual included in the sample for a retainer payment review:

- (1) copies of signed and dated Person Directed Plans (PDPs);
- (2) copies of signed and dated Implementation Plans (IPs);
- (3) copies of signed and dated Intellectual Disability/Related Condition Assessments (ID/RCs);
- (4) copies of signed and dated Individual Plans of Care (IPCs);
- (5) copies of all progress notes relating to the specified service(s) and dates listed in the notification letter;
- (6) copies of all progress notes relating to specifies service(s) provided 14 calendar days prior to the date for which a retainer payment(s) was made.

Examples:

- (A) If a program provider was paid retainer payment claims for April 7, 2020 through May 23, 2020, the program provider must submit the progress notes or service delivery logs for the RSS and/or SL service component provided beginning March 24, 2020 through April 6, 2020.
- (B) If a program provider submitted retainer payment claims for May 1, 2020 through June 30, 2020 and July 15, 2020 through August 13, 2020, the documentation requested would include progress notes or service delivery logs for the RSS and/or SL service component from April 17, 2020 through April 30, 2020 and July 1, 2020 through July 14, 2020;
- (7) copies of personnel records for all service providers identified in the documentation described in (6) above;
- (8) copies of payroll records including timesheets for the service providers described in (6) above;
- (9) copies of all attestation forms submitted to HHSC and evidence of submission;
- (10) copies of documentation used to support the revenue comparison described in 40 TAC §9.193(g)(1)(C);
- (11) copies of the program provider's financial statements, such as:
 - (A) general ledger;
 - (B) bank statements;
 - (C) expenses;
 - (D) balance sheets; and
 - (E) income statement; and
- (12) copies of any other documentation that support retainer payment attestations and claims.

Appendix V Determining Units of Service for the Supported Home Living Activity of Transporting an Individual

Revision 10-0; Effective October 1, 2009

Determining Units of Service for a Single Trip (Examples 1 and 2)

Example 1

Example 1: Facts

- A program provider transports Individuals A, B and C, who are individuals receiving HCS supported home living, and Passenger D, a person enrolled in the program provider's ICF/IID program, in the same vehicle, using one service provider.
- Individual A departs at 8:15 a.m., Individual B departs at 8:25 a.m., and Individual C and Passenger D depart at 9:00 a.m.
- Individuals A and B arrive at 9:15 a.m. Individual C and Passenger D arrive at 10:00 a.m.

Individual	Departure Time	Arrival Time
A	8:15	9:15
B	8:25	9:15
C	9:00	10:00
D	9:00	10:00

Example 1: Method A

Transportation time for Individuals A, B, and C is 105 minutes, with **four passengers** (A, B, C and D) and **one service provider**: The first individual (A) departed at 8:15 a.m. and the last individual (C) arrived at 10:00 a.m. The time between 8:15 and 10:00 is 105 minutes.

Passenger D does not need units of service determined because he is not enrolled in the HCS program. However, he is counted when determining the number of passengers.

The service time for individuals A, B, and C is 26.25 minutes:

Service Time = [# of Service Providers x Transportation Time] ÷ # of Passengers

- Service Time = $(1 \times 105) \div 4$
Service Time = $105 \div 4$
Service Time = 26.25 minutes<

Using [Appendix III](#), Conversion Table, the service time of 26.25 minutes is converted to 2 units of service.

Using Method A, Individuals A, B and C all have 2 units of service.

Example 1: Method B

Individual A's transportation time has three segments:

- transportation time of 10 minutes (8:15-8:25) with one passenger (A only) and one service provider;
- transportation time of 35 minutes (8:25-9:00) with two passengers (A and B) and one service provider; and
- transportation time of 15 minutes (9:00-9:15) with four passengers (A, B, C and D) and one service provider.

Individual B's transportation time has two segments:

- transportation time of 35 minutes (8:25-9:00) with two passengers (A and B) and one service provider; and
- transportation time of 15 minutes (9:00-9:15) with four passengers (A, B, C and D) and one service provider.

Individual C's transportation time has two segments:

- transportation time of 15 minutes (9:00-9:15) with four passengers (A, B, C and D) and one service provider; and
- transportation time of 45 minutes (9:15-10:00) with two passengers (C and D) and one service provider.

Passenger D does not need units of service determined because he is not enrolled in the HCS program. However, he is counted when determining the number of passengers.

Service Time = [# of Service Providers x Transportation Time] ÷ # of Passengers

Individual A's service time for each segment:

- Service Time = $(1 \times 10) \div 1$
Service Time = $10 \div 1$
Service Time = 10 minutes
- Service Time = $(1 \times 35) \div 2$
Service Time = $35 \div 2$
Service Time = 17.5 minutes
- Service Time = $(1 \times 15) \div 4$
Service Time = $15 \div 4$
Service Time = 3.75 minutes

Individual B's service time for each segment:

- Service Time = $(1 \times 35) \div 2$
Service Time = $35 \div 2$
Service Time = 17.5 minutes
- Service Time = $(1 \times 15) \div 4$
Service Time = $15 \div 4$
Service Time = 3.75 minutes

Individual C's service time for each segment:

- Service Time = $(1 \times 15) \div 4$
Service Time = $15 \div 4$
Service Time = 3.75 minutes
- Service Time = $(1 \times 45) \div 2$
Service Time = $45 \div 2$
Service Time = 22.5 minutes

Total service time for each individual is determined by adding the service time of each segment:

- **Individual A:** 10 minutes + 17.5 minutes + 3.75 minutes = 31.25 minutes
- **Individual B:** 17.5 minutes + 3.75 minutes = 21.25 minutes
- **Individual C:** 3.75 minutes + 22.5 minutes = 26.25 minutes

Using [Appendix III](#), Conversion Table, service time is converted to units of service:

- **Individual A:** 31.25 minutes = 2 units of service
- **Individual B:** 21.25 minutes = 1 unit of service
- **Individual C:** 26.25 minutes = 2 units of service

Using Method B, Individual B has 1 unit of service, and Individuals A and C each have 2 units of service.

Example 2

Example 2: Facts

- A program provider transports two individuals, Individuals E and F, in the same vehicle using two service providers.
- Individual E departs with a service provider at 2:00 p.m. Individual F departs with another service provider at 2:10 p.m.
- Individuals E and F arrive at 2:40 p.m.

Individual	Departure Time	Arrival Time
E	2:00	2:40
F	2:10	2:40

Example 2: Method A

The transportation time for Individuals E and F is 40 minutes, with two passengers (E and F) and two service providers. The first individual (E) departed at 2:00 and the last individuals (E and F) arrived at 2:40. The time between 2:00 and 2:40 is 40 minutes.

The service time for individuals E and F is 40 minutes:

Service Time = [# of Service Providers x Transportation Time] ÷ # of Passengers

- Service Time = $(2 \times 40) \div 2$
Service Time = $80 \div 2$
Service Time = 40 minutes

Using [Appendix III](#), Conversion Table, the service time of 40 minutes is converted to 3 units of service.

Using Method A, Individuals E and F each have 3 units of service of supported home living for the transportation provided.

Example 2: Method B

Individual E’s transportation time has two segments:

- transportation time of 10 minutes (2:00-2:10) with one passengers (E only) and one service provider; and
- transportation time is 30 minutes (2:10-2:40) with two passengers (E and F) and two service providers.

Individual F's transportation time has one segment:

- Transportation time is 30 minutes (2:10-2:40) with two passengers (E and F) and two service providers.

Service Time = [# of Service Providers x Transportation Time] ÷ # of Passengers

Individual E's service time for each segment:

- Service Time = $(1 \times 10) \div 1$
Service Time = $10 \div 1$
Service time = 10 minutes
- Service Time = $(2 \times 30) \div 2$
Service Time = $60 \div 2$
Service Time = 30 minutes

Individual F's service time:

- Service Time = $(2 \times 30) \div 2$
Service Time = $60 \div 2$
Service Time = 30 minutes

Total service time for Individual E is determined by adding the service time of each segment:

- Individual E: 10 minutes + 30 minutes = 40 minutes

Using [Appendix III](#), Conversion Table, service time is converted to units of service:

- **Individual E:** 40 minutes = 3 units of service
- **Individual F:** 30 minutes = 2 units of service

Using Method B, Individual E has 3 units of service and Individual F has 2 units of service.

Determining Units of Service for Multiple Trips (Example 3)

Example 3

Example 3: Facts

- A program provider transports Individuals A, B and C and Passenger D, as described in Example 1 (this will be referred to as the "outgoing trip").
- The program provider transports Individuals A, B and C and Passenger D back to their original locations later the same day (the "return trip").

- Service times for the return trip for Individuals A, B and C are the same as the service times for the outgoing trip.

Example 3: Method A - Service Times (see Example 1: Method A)

Individual	Outgoing Trip Service Time	Return Trip Service Time
A	26.25	26.25
B	26.25	26.25
C	26.25	26.25

Example 3: Method A – Without Accumulation of Service Times

Service times for the outgoing and return trips for Individuals A, B and C are **not** accumulated; units of service from the outgoing trip (see Example 1: Method A) are combined with the units of service of the return trip: 2 units of service + 2 units of service = 4 units of service.

Using Method A without accumulating service times for the outgoing and return trips, Individuals A, B and C each have 4 units of service.

Example 3: Method A – With Accumulation of Service Times

Service times of the outgoing and the return trips for Individuals A, B and C are accumulated for a total service time of 52.5 minutes: 26.25 minutes + 26.25 minutes = 52.5 minutes.

Using [Appendix III](#), Conversion Table, the total service time of 52.5 minutes is converted to 3 units of service.

Using Method A and accumulating service times for the outgoing and return trips, Individuals A, B and C each have 3 units of service.

Example 3: Method B - Service Times (see Example 1: Method B)

Individual	Outgoing Trip Service Time	Return Trip Service Time
A	31.25	31.25
B	21.25	21.25
C	26.25	26.25

Example 3: Method B – Without Accumulation of Service Times

Service times for the two trips are not accumulated; units of service from the outgoing trip (see Example 1: Method B) are combined with the units of service of the return trip:

- **Individual A:** 2 units of service + 2 units of service = 4 units of service
- **Individual B:** 1 unit of service + 1 unit of service = 2 units of service
- **Individual C:** 2 units of service + 2 units of service = 4 units of service

Using Method B without accumulating service times for the outgoing and return trips, Individuals A and C each have 4 units of service; Individual B has 2 units of service.

Example 3: Method B – With Accumulation of Service Times

Service times of the outgoing and the return trips for Individuals A, B and C are accumulated for a total service time:

- **Individual A:** 31.25 minutes + 31.25 minutes = 1 hour, 2.5 minutes
- **Individual B:** 21.25 minutes + 21.25 minutes = 42.5 minutes
- **Individual C:** 26.25 minutes + 26.25 minutes = 52.5 minutes

Using [Appendix III](#), Conversion Table, the total service time is converted to units of service:

- **Individual A:** 1 hour, 2.5 minutes = 4 units of service
- **Individual B:** 42.5 minutes = 3 units of service
- **Individual C:** 52.5 minutes = 3 units of service

Using Method B and accumulating service times for the outgoing and return trips, Individual A has 4 units of service, and Individuals B and C each have 3 units of service.

Appendix VI Example of Supported Home Living Transportation Log

Revision 10-0; Effective October 1, 2009

[Example of Supported Home Living Transportation Log \(https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-2124-supported-home-livingcommunity-support-transportation-log\)](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-2124-supported-home-livingcommunity-support-transportation-log)

Appendix VII Billable Adaptive Aids

Revision 20-1; Effective September 1, 2020

(1) Abbreviations and Numbers

The following abbreviations and numbers, as used in this attachment, have the following meanings:

(A) Licensed Professionals

- **(AU)** – A person licensed as an audiologist in accordance with Chapter 401 of the Texas Occupations Code.
- **(DI)** – A person licensed as a dietitian in accordance with Chapter 701 of the Texas Occupations Code.
- **(NU)** – A person licensed to practice professional or vocational nursing by the Board of Nurse Examiners in accordance with Chapter 301 of the Texas Occupations Code.
- **(MD)** – A person licensed as a physician in accordance with Texas Occupations Code, Chapter 155.
- **(OT)** – A person licensed as an occupational therapist in accordance with Chapter 454 of the Texas Occupations Code.
- **(OPH)** – A person licensed as a physician in accordance with Texas Occupations Code, Chapter 155, and certified by the American Board of Ophthalmology.
- **(OPT)** – A person licensed as an optometrist or therapeutic optometrist in accordance with Texas Occupations Code, Chapter 351.
- **(PT)** – A person licensed as a physical therapist in accordance with Chapter 453 of the Texas Occupations Code.
- **(PS/BS)** – A person licensed as a psychologist, provisional license holder or psychological associate in accordance with Chapter 501 of the Texas Occupations Code; a person certified by HHSC as described in 40 TAC §5.161; or a behavior analyst certified by the Behavior Analyst Certification Board, Inc.
- **(SP)** – A person licensed as a speech-language pathologist in accordance with Chapter 401 of the Texas Occupations Code.

(B) Other Abbreviations and Numbers

- (1) – The item is available through Texas Medicaid Home Health Services and Medicare for individuals of all ages.*

(2) – The item is available through Texas Health Steps Comprehensive Care Program for individuals under the age of 21.*

* Texas Medicaid covers items marked with a (1) or (2) through the Home Health Durable Medical Equipment Prosthetics, Orthotics, and Supplies (DMEPOS) policy.

(2) List of Billable Adaptive Aids

The following items and services, listed by category, including repair and maintenance not covered by warranty, are billable adaptive aids:

Lifts

101	<p>a vehicle lift adaptation for a vehicle owned by an individual, an individual’s family member or host home/companion care provider if it is the primary mode of transportation for the individual, but not to exceed one lift every five years. Repairs and maintenance not covered by warranty are not limited to the five-year requirement.</p> <ul style="list-style-type: none"> • A vehicle that is expected to be modified or adapted must meet one of the following criteria: <ul style="list-style-type: none"> ▸ vehicle is less than 5 years old and mileage is less than 50,000 miles; or ▸ vehicle passed an independent inspection performed by a certified automotive technician. <p>(OT, PT, MD)</p>
104	<ul style="list-style-type: none"> • a hydraulic, manual or electronic lift (1) (OT, PT, MD); • replacement sling (1) (OT, PT, MD); • a barrier-free (ceiling or wall mounted) lift system including installation of the lift (2) (OT,PT,MD); • a porch lift or stair lift (OT,PT,MD)
128	<p>a transfer bench (1) (OT, PT, MD)</p>

Mobility Aids

106	<p>a crutch, walker or cane (1) (OT, PT, MD)</p>
107	<p>an orthotic device, orthopedic shoes or a brace which is custom fabricated specifically for an individual (2) (OT, PT, MD)</p>

157	a manual or electric wheelchair or a necessary accessory (1) (OT, PT, MD)
158	a forearm platform attachment for a walker (1) (OT, PT, MD)
159	a portable wheelchair ramp (1) (OT, PT, MD)
160	a battery or charger for an electric wheelchair (1) (OT, PT, MD, NU)
161	a gait trainer or gait belt (1) (OT, PT, MD, NU)
163	a adaptive stroller or travel seat (OT, PT, MD)

Positioning Devices

151	a hospital bed (1) or crib (2) (OT, PT, MD)
154	a standing board or frame, positioning chair, or wedge (1) (OT, PT, MD)
155	a trapeze bar (1) (OT, PT, MD)
156	a lift chair, but not the lift mechanism if it is reimbursable through Medicare (OT, PT, MD)
162	a bath or shower chair (1) (OT, PT, MD, NU)
164	a toileting chair (1) (OT, PT, MD, NU)
165	a portable bathtub rail (1) (OT, PT, MD)

Controls and Switches

109	a sip and puff control (1) (OT, PT)
110	an adaptive switch used to operate items necessary for daily functioning (OT, PT)

Environmental Control Units

111	an adaptive lock (OT, PT)
112	an electronic control unit or automatic door opener (OT, PT)
114	a voice, light, smoke or motion activated device (OT, PT, AU)

Rental and Repair

210	temporary rental of a billable adaptive aid to allow for the repair, purchase or replacement of the adaptive aid (1) (OT, PT, MD, NU) *Texas Medicaid will consider repairs only to individual-owned equipment that is considered a benefit of Texas Medicaid
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Medical Supplies

120	diapers, briefs, pull-ons, liners, diaper wipes, disposable underpads, reusable underpads (1) (MD, NU)
121	a multivitamin product with a prescription, a nutritional supplement listed in the <i>Texas Medicaid Provider Procedures Manual</i> (for example, Ensure, Boost, Glucerna) or Thick-It (2) (MD)
122	an enteral feeding formula and supplies (1) (MD)
201	medically necessary supplies for tracheotomy care, decubitus care, ostomy care, respirator/ventilator care or catheterization (1) (MD, NU)
206	<ul style="list-style-type: none"> • a glucose monitor (MD, NU) • other supplies for an individual's use in self-monitoring blood sugar (1) (MD, NU)
207	an adapted medication dispenser or pill crusher (MD, NU)
208	an air humidifier, purifier or specialized air filter, or a medically necessary portable heating and/or cooling device to manage the symptoms of a seizure disorder, respiratory or cardiac condition, or inability to regulate body temperature (MD)
209	a muscle stimulator (1) (OT, PT, MD)
211	a urinal (1) (MD, NU)
212	a specialized thermometer (MD, NU)
213	a specialized scale (MD, NU, DI)
214	medical support hose (1) (MD, NU)
215	specialized clothing (for example, a weighted vest), a dressing aid or bib (OT, PT, MD, NU)
216	a specialized or treated mattress or mattress cover (2) (MD, NU)
217	an egg-crate, sheepskin or other medically necessary mattress pad (1) (MD, NU)
218	a cleft palate feeder (1) (MD, OT, PT, DI)
219	a blood pressure or pulse monitor for an individual's use in self-monitoring (1) (MD, NU)
220	<p>prescription eyeglasses beyond Medicaid limit (1) (OPH, OPT)</p> <p>(Texas Medicaid covers prescription eye glasses annually for individuals under 21 years of age with no limit on repair or replacement for damaged or lost glasses. Texas Medicaid covers glasses every 2 years for individuals 21 years of age or older.)</p>

221	non-sterile disposable gloves for individuals who require catheterization, have skin breakdown or require wound care, or have a documented disease that may be transmitted through urine or stool and the care of the individual is provided by a non-paid caregiver (1) (MD, NU)
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Communication Aids (including batteries)

124	a direct selection, alphanumeric, scanning or encoding communicator (1) (SP)
125	a speech amplifier or augmentative communication device (1) (SP)
126	sign language interpreter service for non-routine communications, such as IDT meetings, or medical/professional appointments (SP, AU)
251	an emergency response system or service, monitoring device (MD, NU) or medical alert bracelet (MD, NU)
254	a communication board or book (SP, AU)
255	a closed-captioning device for an individual with a hearing impairment (AU, SP, MD)
256	a signature stamp for an individual with a visual or physical impairment, muscular weakness or limited range of motion (OPH, OT, PT)
257	a signature guide for an individual with a visual or physical impairment, muscular weakness or limited range of motion (OPH, OT, PT)
258	a personal computer or accessory necessary for the individual to communicate independently (SP)
259	specialized training for augmentative communication software, not to exceed \$1,000 per individual, per IPC year (1) (SP) (If Texas Medicaid purchases an augmentative communication device, training is included in the cost of the device.)
260	a hearing aid (1) (AU) or battery (1) (AU, MD, NU)

Adapted Equipment for Activities of Daily Living

324	a lever door handle (OT, PT)
401	a device or item used to enable an individual to independently pick up or grasp an object (for example, a reacher) (OT, PT)
402	a device or item used to enable an object to be firmly positioned and secure (for example, a dycem mat) (OT, PT)
403	a device or item used to enable an individual to independently hold and sustain control of an object (for example, a hand strap) (OT, PT)

404	adapted dinnerware, an eating utensil or meal preparation device (OT, PT)
405	a specialized clock or wristwatch for an individual with a visual or hearing impairment (OT, PT)
406	an electric razor or electric toothbrush for an individual with a muscular weakness or limited range of motion who shaves self or brushes own teeth (OT, PT)
407	a speaker, large button or braille telephone for an individual who is verbal but cannot use a conventional telephone (OT, PT)
408	a microwave oven, if use of a conventional oven presents a safety hazard to the individual (OT, PT)
409	a hand-held shower device (1) (OT, PT)

Safety Restraints and Safety Devices

113	a safety restraint (1) (PS, MD) or wheelchair tie down (1) (OT, PT, MD, NU)
450	a bed rail (1) (OT, PT, MD, NU)
451	safety padding (1) (PS/BS, OT, PT, MD)
452	a helmet used due to a seizure disorder or other medical condition (2) (PS/BS, MD, NU)
453	an adaptation to furniture (PS/BS) (OT, PT)

Appendix VIII Reserved for Future Use

Appendix IX Minor Home Modifications, Adaptive Aids or Dental Summary Sheet

Providers must submit [Form 4116-MHM-AA](https://hhs.texas.gov/laws-regulations/forms/4000-4999/form-4116-mhm-aa-minor-home-modificationadaptive-aids-summary-sheet) (<https://hhs.texas.gov/laws-regulations/forms/4000-4999/form-4116-mhm-aa-minor-home-modificationadaptive-aids-summary-sheet>), Minor Home Modification/Adaptive Aids Summary Sheet, or [Form 4116-Dental](https://hhs.texas.gov/laws-regulations/forms/4000-4999/form-4116-dental-dental-summary-sheet) (<https://hhs.texas.gov/laws-regulations/forms/4000-4999/form-4116-dental-dental-summary-sheet>), Dental Summary Sheet, to the Health and Human Services Commission to request reimbursement authorizations for payments for minor home modifications, adaptive aids and dental services.

Shared Appendix 30

This appendix appears in the following handbooks:

- Home and Community-based Services Program Billing Guidelines (HCSBG): Appendix IX
- Texas Home Living Program Billing Guidelines (TxHmLBG): Appendix VII

Appendix X Billable Minor Home Modifications

Revision 20-1; Effective September 1, 2020

Abbreviations

The following abbreviations, as used in this attachment, have the following meanings:

Licensed Professionals

- **(MD)** – A person licensed as a physician in accordance with Texas Occupations Code, Chapter 155.
- **(OT)** – A person licensed as an occupational therapist in accordance with Chapter 454 of the Texas Occupations Code.
- **(PT)** – A person licensed as a physical therapist in accordance with Chapter 453 of the Texas Occupations Code.
- **(PS/BS)** – A person licensed as a psychologist, provisionally licensed psychologist, board certified behavioral specialist or psychological associate in accordance with Chapter 501 of the Texas Occupations Code.
- **(SP)** – A person licensed as a speech-language pathologist in accordance with Chapter 401 of the Texas Occupations Code.

List of Billable Minor Home Modifications

The following adaptations, listed by category, including repair and maintenance not covered by warranty, are billable minor home modifications:

Wheelchair Ramp

301	a wheelchair ramp or landing that meets the requirements in §4.8 of the Americans with Disabilities Act Accessibility Guidelines (ADAAG) found at www.ada.gov (OT, PT)
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Modification to a Bathroom

302	a shower adaptation (OT, PT)
303	a sink adaptation (OT, PT)
304	a bathtub adaptation (OT, PT)
305	a toilet adaptation (OT, PT)
306	a water faucet control adaptation (OT, PT)
307	a floor urinal or bidet adaptation (OT, PT)
308	a plumbing adaptation (OT, PT)
309	a turnaround space adaptation (OT, PT)

Modifications to Kitchen Facilities

310	a sink adaptation (OT, PT)
311	a sink cut-out (OT, PT)
312	a turnaround space adaptation (OT, PT)
313	a water faucet control adaptation (OT, PT)
314	a plumbing adaptation (OT, PT)
315	a worktable or work surface adjustment (OT, PT)
316	a cabinetry adjustment (OT, PT)

Specialized Accessibility and Safety Adaptations

317	a door widening or emergency exit adaptation (OT, PT)
318	a flooring adaptation for wheelchair accessibility (OT, PT)
319	a handrail or safety bar permanently attached to a wall, floor and/or ceiling (for example, a grab bar, a toilet frame, a super pole) (OT, PT)
320	an adapted wall switch or outlet, a specialized doorbell or door scope (OT, PT)
321	a voice, light, motion activated or electronic device hard wired in the individual's residence (OT, PT)
322	a fire alarm adaptation made to an existing system (OT, PT)
324	a lever door handle (OT, PT)
325	a safety glass, film or padding adaptation (PS/BS, MD)

Shared Appendix 28

This appendix appears in the following handbooks:

- Home and Community-based Services Program Billing Guidelines (HCSBG): Appendix X
- Texas Home Living Program Billing Guidelines (TxHmLBG): Appendix V

Revisions

Revision 21-2, Retainer Payment Review Protocol

Revision 21-2; Effective April 5, 2021

Revised	Title	Change
Appendix IV	Retainer Payment Review Protocol	Added Retainer Payment Review Protocol

HCSBG, Revision 21-1, EVV Updates, In-Home Day Habilitation and In-Home Respite

HCSBG, Revision 21-1; Effective January 1, 2021

Revised	Title	Change
Entire Billing Guidelines	Various Sections	Updated references to day habilitation and respite to include in-home day habilitation and in-home respite

Revised	Title	Change
<u>Section 3210</u>	(Service Claim Requirements) General Requirements	Added requirement that a service claim for in-home day habilitation and in-home respite match the EVV visit transaction
<u>Section 3510</u>	15-Minute Unit of Service	Added in-home respite as 15-minute unit of service
<u>Section 3520</u>	Daily Unit of Service	Added in-home day habilitation as daily unit of service
<u>Section 4220</u>	(Professional Therapies) Billable Activity	Deleted the requirement that a service provider of professional therapies cannot review written service log or written summary log as a billable activity
<u>Section 4230</u>	(Professional Therapies) Activity Not Billable	Added the service provider of professional therapies can review a written service log or written summary log as described in Section 4220(4)
<u>Section 4320</u>	(Day Habilitation) Requirement of Setting	Revised Section 4320 to require that Day habilitation must be provided to an individual in a setting that is not the residence of the individual.
<u>Section 4350</u>	(Day Habilitation) Restrictions Regarding Submission of Claims for Day Habilitation	Added a restriction for Day Habilitation provided that contravenes a physicians order, a behavioral support provider or for an individual who is 55 years of age or older and chooses to receive in-home Day Habilitation
<u>Section 4360</u>	(Day Habilitation) Qualified Service Provider	Deleted requirement that a qualified service provider must not be the host home/companion care service provider unless the day habilitation services are provided at a location that has a different address from the individual's residence.

Revised	Title	Change
<u>Section 4360</u>	(Day Habilitation) Qualified Service Provider	Deleted requirement that a qualified service provider must not be the host home/companion care service provider unless the day habilitation services are provided at a location that has a different address from the individual's residence.
<u>Section 4381</u>	In-Home Day Habilitation	Added New Section In-Home Day Habilitation
<u>Section 4381.3</u>	(In-Home Day Habilitation) Requirement for Justification by a Licensed Professional or to be 55 years of age or Older	Added new section
<u>Section 4381.4</u>	(In-Home Day Habilitation) EVV Requirements for In-Home Day Habilitation	Added that for individuals who have a residential location of "own home/family home" must comply with 1 TAC Chapter 354, Subchapter O, Electronic Visit Verification
<u>Section 4620</u>	(Respite) Requirement of Setting	Revised Section 4620 that respite can only be provided in a location that is not the individuals residence and the locations where respite can be provided
<u>Section 4630</u>	(Respite) Billable Activity	Added billable activities, participating in a service planning team meeting, participating in the development of an implementation plan; and participating in the development of an IPC

Revised	Title	Change
<u>Section 4651</u>	(Respite) Restrictions Regarding Submissions of Claims for Respite	Deleted Restriction that limits respite to 10 hrs per calendar day when provided in a location other than the individuals residence
<u>Section 4680</u>	(Respite) Payment Limit	Added that the payment limit for respite, in-home respite or a combination of both is 1200 units (300 hrs) and respite and in-home respite is the same program service on the IPC.
<u>Section 4691</u>	In-Home Respite	Added New Section In-Home Respite
<u>Section 4691.2</u>	(In-Home Respite) Requirement of Setting	Added that in-home respite can only be provided in a location that is the individuals residence.
<u>Section 4691.3</u>	(In-Home Respite) Billable Activity	Added billable activities, participating in a service planning team meeting, participating in the development of an implementation plan; and participating in the development of an IPC
<u>Section 4691.9</u>	(In-Home Respite) Payment Limit	Added that the payment limit for respite, in-home respite or a combination of both is 1200 units (300 hrs) and respite and in-home respite is the same program service on the IPC.

HCSBG, Revision 20-1, Miscellaneous Changes

Revision 20-1; Effective September 1, 2020

Revised	Title	Change
<u>Section 1200</u>	Service Components	Added Transition Assistance Services to the list of HCS services

Revised	Title	Change
<u>Section 3410</u>	Qualified Service Provider: General Requirements	Revised requirements that a staff member or contractor of a program not be listed on the employee misconduct registry as unemployable or on the nursing misconduct registry as suspended or revoked.
<u>Section 3440</u>	Qualified Service Provider: Requirement for Service Provider Who Becomes Spouse of Individual To Inform Program Provider	Added new section 3440 Requirement for Service Provider Who Becomes Spouse of Individual To Inform Program Provider
<u>Section 3710</u>	Billing Service Components at the same time and billing day habilitation at the same time as service coordination: One Service Provider	Added exception to one service provider, providing different services to the same individual at the same time
<u>Section 3720</u>	Billing Service Components at the same time and billing day habilitation at the same time as service coordination: Multiple Service Providers	Added requirements for multiple service providers allowance when an individual is an LON 9 and added examples for multiple service providers
<u>Section 3810</u>	Written Documentation: General Requirements	Deleted requirements for co-payments for professional therapies and added requirement that prohibits a statement or other information photocopied from another service log
<u>Section 3820</u>	Written Documentation: Written Service Log and Written Summary Log	Added requirements for written summary log to add location of service event
<u>Section 4260</u>	Professional Therapies: Written Documentation	Delete all references to co-payment

Revised	Title	Change
Section 4270	Professional Therapies: Insurance Co-Payment and Deductible	Delete Section 4270 Regarding Insurance Copayment and Deductible
<u>Section 4350</u>	Day Habilitation: Restrictions Regarding Submission of Claims for Day Habilitation	Added restriction for day habilitation setting provided by host home companion care provider in the individuals home.
<u>Section 4360</u>	Day Habilitation: Qualified Service Provider	Added requirement that Day Habilitation cannot be provided by an individual Host Home/Companion Care service provider unless day habilitation is provided at a location that is different than the individuals residence.
<u>Section 4370</u>	Day Habilitation: Unit of Service	Delete requirements for DH to have consecutive hours to be billed
<u>Section 4420</u>	Registered Nursing: Billable Activities	Added more billable activities to registered nursing including: <ul style="list-style-type: none"> • Increase in billable activities for checking medications • Allowance for nursing to review service logs or summaries • Allowance of preparing, documenting and transmitted information with healthcare providers • Allowance of increased nurse to nurse communication
<u>Section 4430</u>	Registered Nursing: Activity Not Billable	Deleted prohibition of nurse reviewing services logs and nurse to nurse communication

Revised	Title	Change
<u>Section 4471.2</u>	Licensed Vocational Nursing: Billable Activity	<p>Deleted requirements related to the LVN pilot project that allowed LVN triage and added more billable activities to licensed vocational nursing including:</p> <ul style="list-style-type: none"> • Increase in billable activities for checking medications • Allowance for nursing to review service logs or summaries • Allowance of preparing, documenting and transmitted information with healthcare providers • Allowance of increased nurse to nurse communication
<u>Section 4471.3</u>	Licensed Vocational Nursing: Activity Not Billable	Deleted prohibition of nurse reviewing services logs and nurse to nurse communication
<u>Section 4472.2</u>	Specialized Registered Nursing: Billable Activity	<p>Added more billable activities to specialized registered nursing including:</p> <ul style="list-style-type: none"> • Increase in billable activities for checking medications • Allowance for nursing to review service logs or summaries • Allowance of preparing, documenting and transmitted information with healthcare providers • Allowance of increased nurse to nurse communication
<u>Section 4472.3</u>	Specialized Registered Nursing: Activity Not Billable	Deleted prohibition of nurse reviewing services logs and nurse to nurse communication

Revised	Title	Change
<u>Section 4473.2</u>	Specialized Licensed Vocational Nursing: Billable Activity	Deleted requirements related to the LVN pilot project that allowed LVN triage and added more billable activities to specialized vocational nursing: <ul style="list-style-type: none"> • Increase in billable activities for checking medications • Allowance for nursing to review service logs or summaries • Allowance of preparing, documenting and transmitted information with healthcare providers • Allowance of increased nurse to nurse communication
<u>Section 4473.3</u>	Specialized Licensed Vocational Nursing: Activity Not Billable	Deleted prohibition of nurse reviewing services logs and nurse to nurse communication
<u>Section 5000</u>	General Requirements for Service Components Not Based on Billable Activity	Added Transition Assistance Services to titles
<u>Section 6000</u>	Adaptive Aids, Minor Home Modifications, Dental Treatment and Transition Assistance Services	Added Transition Assistance Services to titles
<u>Section 6160</u>	Adaptive Aids: Required Documentation for an Adaptive Aid	Added requirements for a recommendation from a licensed professional that includes a description for Adaptive Aids costing less than \$500
<u>Section 6240</u>	Minor Home Modifications: Payment Limit	Revised wording to clarify requirements regarding the MHM lifetime limit

Revised	Title	Change
Section 6250	Minor Home Modifications: Required Documentation for a Minor Home Modification	Deleted reference that requires program provider to obtain the documentation described in paragraph (1). New requirements include the program provider must obtain documentation described in subsection.
Section 6250	Minor Home Modifications: Required Documentation for a Minor Home Modification	Added requirements for a recommendation from a licensed professional that includes a description of Minor Home Modification costing less than \$500
Section 6480	Transition Assistance Services: Qualified Service Provider	Added Qualified Service Provider Section for TAS
Appendix X	Billable Minor Home Modifications	Revised website for American with Disabilities Act

HCSBG, Revision 19-1, Miscellaneous Changes

Revision 19-1; Effective November 15, 2019

The following changes were made:

Revised	Title	Change
Entire Handbook	Various Sections	Changes Department of Aging and Disability Services (DADS) to Texas Health and Human Services Commission (HHSC) and makes formatting changes.
2000	Definitions	Adds additional language to the definition for "clean claim," adds "HHSC," deletes "prior approval," and revises "residence."
3840	Determining Location of Residence of Service Provider	Changes the title.

Revised	Title	Change
4380	Written Documentation	Adds a requirement for the service provider of day habilitation to provide all or a portion of services.
4560	Residential Support Subcomponent	Adds a requirement that staff cannot work a shift exceeding 24 hours and deletes the requirement that location of a visit be included in written documentation when an individual is on visit with a family member or friend.
4570	Supervised Living Subcomponent	Deletes the requirement that location of a visit be included in written documentation when an individual is on visit with a family member or friend.
4630	Respite in Residence or During Overnight Stay in Non-residence	Adds an individual can receive respite in a camp setting if the camp is accredited by the American Camp Association.
4810	General Description of Service Component (Employment Assistance)	Adds a description of employment assistance, including an emphasis on individualized, person-directed activities.
5200	Service Claim Requirements	Adds a requirement that claims be entered into the Medicaid system no later than 12 months after the service was delivered for an adaptive aid, minor home modification and dental treatment.
6160	Required Documentation for an Adaptive Aid	Adds requirements for how program providers obtain proof of non-coverage by Medicaid and Medicare through the individual's managed care organization and deletes the requirement that program providers use one annual vendor.

Revised	Title	Change
6330	Billable Dental Treatment	Adds anesthesiology to billable dental treatment.
Appendix I	Billing and Payment Review Protocol	Revises the frequency of routine review from every two years to every four years and adds an additional method HHSC can recoup funds from a program provider if funds cannot be recouped through the automated billing system.
Appendix VII	Billable Adaptive Aids	Revises other abbreviations and numbers to indicate Medicaid coverage for individuals of all ages and individuals under 21, updates the list to indicate items currently covered by Medicaid, adds licensed professionals that can recommend the adaptive aids for some items, and adds clarification of Medicaid coverage for some items.

HCSBG, Revision 15-3, Miscellaneous Changes

Revision 15-3; Effective December 8, 2015

The following changes were made:

Revised	Title	Change
2000	Definitions	Adds GRO or General Residential Operation, ICF/IID or intermediate care facility for individuals with an intellectual disability or related conditions, pre-enrollment minor home modifications and pre-enrollment minor home modifications assessment.
6210	General Description of Service Component	Adds a minor home modification includes a pre-enrollment minor home modification.
6240	Payment Limit	Adds "for repair and maintenance per individual plan of care (IPC) year."

Revised	Title	Change
6250	Required Documentation for a Minor Home Modification	Adds pre-enrollment minor home modifications costing any amount and other minor home modifications costing \$1,000 or more, and adds minor home modifications other than pre-enrollment minor home modifications costing less than \$1,000.
6260	Pre-enrollment Minor Home Modification Prior Authorization Process	Adds a new section.
6270	Authorization for Payment	Moves and revises the content previously in Section 6260.
6400	Transition Assistance Services (TAS)	Adds new Sections 6400 through 6470.
Forms	Forms Table of Contents	Adds Form 8604, Transition Assistance Services (TAS) Assessment and Authorization, Form 8611, Pre-Enrollment MHM Authorization Request, and Form 8612, TAS/MHM Payment Exception Request.

HCSBG, Revision 15-2, Miscellaneous Changes

Revision 15-2; Effective October 30, 2015

The following changes were made:

Revised	Title	Change
1200	Service Components	Adds supported home living (transportation).
2000	Definitions	Adds ADLs or activities of daily living, CFC PAS/HAB or Community First Choice Personal Assistance Services/Habilitation, health-related tasks, IADLs or instrumental activities of daily living, and transportation plan.
3100	Applicable Service Components	Adds supported home living (transportation).
3300	Activity Not Billable	Deletes a reference to Section 4540.

Revised	Title	Change
3430	Relative, Guardian or Managing Conservator Qualified as Service Provider	Adds transportation as a supported home living activity.
3510	15-Minute Unit of Service	Adds transportation as a supported home living activity.
3610	15-Minute Unit of Service	Changes terminology to supported employment and employment assistance. Adds transportation as a supported home living activity.
3720	Multiple Service Providers	Adds transportation as a supported home living activity and adds CFC PAS/HAB. Deletes information regarding performance as a different activity.
3810	General Requirements	Adds transportation as a supported home living activity.
3840	Proof of Location of Residence of Service Provider	Adds transportation as a supported home living activity.
3850	Example Forms	Adds transportation as a supported home living activity.
4220	Billable Activity	Adds CFC PAS/HAB and transportation as a supported home living activity.
4420	Billable Activity	Adds CFC PAS/HAB and transportation as a supported home living activity.
4471.2	Billable Activity	Adds CFC PAS/HAB and transportation as a supported home living activity.
4472.2	Billable Activity	Adds CFC PAS/HAB and transportation as a supported home living activity.
4473.2	Billable Activity	Adds CFC PAS/HAB and transportation as a supported home living activity.

Revised	Title	Change
4510	General Description of Service Component	Adds supported home living (transportation).
4540	Support Home Living Billing Requirements	Changes the title and updates the first paragraph to the only billable activity for the supported home living subcomponent is transporting the individual, except from one day habilitation, employment assistance or supported employment site to another. Adds transportation as a supported home living activity.
4610	General Description of Service Component	Adds the respite service component is not a service provider of CFC PAS/HAB unless the service provider of CFC PAS/HAB routinely provides unpaid assistance and support to the individual and is used to provide temporary support to the primary caregiver.
4651	Restrictions Regarding Submission of Claims for Respite	Adds CFC PAS/HAB.
4720	Billable Activity	Adds determining how the individual will travel to and from a job.
4730	Activity Not Billable	Adds CFC PAS/HAB.
4820	Employment Assistance Billable Time/Activities	Adds determining how the individual will travel to and from a job.
4830	Employment Assistance Non-billable Time/Activities	Adds CFC PAS/HAB.

HCSBG, Revision 15-1, Dental Limit Increase

Revision Notice 15-1; Effective September 1, 2015

The following changes were made:

Revised	Title	Change
6360	Payment Limit	Increases the maximum amount for all dental treatment provided to an individual to \$2,000 per individual plan of care (IPC) year.

HCSBG, Revision 14-3, Miscellaneous Changes

Revision 14-3; Effective September 1, 2014

The following changes were made:

Revised	Title	Change
2000	Definitions	Revises the definitions for competitive employment, four-person residence, integrated employment, and adds self-employment.
4240	Qualified Service Provider	Adds a licensed clinical social worker and a licensed professional counselor.
4330	Billable Activity	Removes to develop opportunities for employment in the community.
4350	Restrictions Regarding Submission of Claims for Day Habilitation	Adds day habilitation that is being provided by one service provider who is also the same service provider of a different component or subcomponent to the same individual at the same time, and adds day habilitation in the individual's residence without prior justification.
4420	Billable Activity	Moves the placement of information about checking medications.
4471.2	Billable Activity	Moves the placement of information about checking medications.
4472.2	Billable Activity	Moves the placement of information about checking medications.

Revised	Title	Change
4473.2	Billable Activity	Moves the placement of information about checking medications.
4540	Supported Home Living Subcomponent	Adds a link to Section 3720, Multiple Service Providers.
4560	Residential Support Subcomponent	Adds a program provider may not have the same residence as the individual and must lease or own the residence. Adds a service provider must be available to provide services for at least two shifts in one calendar day (one shift during the day and one shift at night during sleeping hours).
4570	Supervised Living Subcomponent	Adds a program provider may not have the same residence as the individual and must lease or own the residence. Adds a qualified service provider may reside in the residence with a spouse or parent with whom the service provider has a spousal relationship.
4610	General Description of Service Component	Adds the respite service component is used to provide temporary support to the primary caregiver in non-routine circumstances.
4620	Billable Activity	Adds any billable activity referenced in this section that occurs at a camp that is accredited by the American Camp Association.
4651	Restrictions Regarding Submission of Claims for Respite	Adds respite provided to an individual on a routine basis.
4710	General Description of Service Component	Adds self-employment to the first sentence.
4720	Billable Activity	Adds several billable activities for the supported employment service component.
4730	Activity Not Billable	Adds several activities that re not billable for the supported employment service component.

Revised	Title	Change
4780	Supported Employment Documentation Requirements	Adds a new section regarding written documentation for supported employment.
4810	General Description of Service Component	Adds competitive employment in the community or self-employment.
4820	Employment Assistance Billable Time/Activities	Describes Employment Assistance services and adds several individualized, person-directed services.
4830	Employment Assistance Non-billable Time/Activities	Adds using Medicaid funds paid by the Department of Aging and Disability Services.

HCSBG, Forms

Form	Title
<u>2122</u>	Service Delivery Log with Written Narrative/Written Summary
<u>2123</u>	Adaptive Aid/Minor Home Modification Request for Prior Approval
<u>2124</u>	Community Support Transportation Log
<u>4116-Dental</u>	Dental Summary Sheet
<u>4116-MHM-AA</u>	Minor Home Modification/Adaptive Aids Summary Sheet
<u>4117</u>	Supported Employment/Employment Assistance Service Delivery Log
<u>4118</u>	Respite Service Delivery Log
<u>4119</u>	Residential Support Services (RSS) and Supervised Living (SL) Service Delivery Log
<u>4120</u>	Day Habilitation Service Delivery Log
<u>4121</u>	Supported Home Living/Community Support/Community First Choice Personal Assistance Services/Habilitation
<u>4122(es)</u>	Host/Companion Service Delivery Log
<u>4123</u>	Nurse Services Delivery Log - Billable Activities
<u>8580</u>	Request for Variance of Supported Employment - Employer Requirements
<u>8604</u>	Transition Assistance Services (TAS) Assessment and Authorization
<u>8611</u>	Pre-Enrollment MHM Authorization Request
<u>8612</u>	TAS/MHM Payment Exception Request

(es) = form also available in Spanish.

HCSBG, Contact Us

For accessibility issues with this handbook, please email:

accessibility@hhsc.state.tx.us

For questions about the Home and Community-based Services Program Billing Guidelines, email: hcsolicy@hhsc.state.tx.us