Subchapter A, Introduction

§47.1. Purpose.

This chapter establishes the requirements for provider agencies contracting to provide in-home attendant services to eligible individuals through the Texas Department of Aging and Disability Services (DHS) Primary Home Care Program. The requirements in this chapter apply to primary home care services, family care services, and community attendant services, unless otherwise specified in the text.

§47.3. Definitions.

The following words, terms, and phrases have the following meanings when used in this chapter, unless the context clearly indicates otherwise:

(1) Activities of daily living (ADLs)--Activities that are essential to daily self care, including bathing, dressing, grooming, routine hair and skin care, meal preparation, feeding, exercising, toileting, transferring and ambulation. For the purposes of this chapter, ADLs do not include services that must be provided or supervised by licensed personnel.

(2) Attendant—A person who provides the authorized tasks to an individual.

(3) Case manager--A DADS employee who is responsible for case management activities. Activities include eligibility determination, individual registration, assessment and reassessment of an individual's need, service plan development, and intercession on the individual's behalf.

(3) Client--A Community Care for Aged and Disabled (CCAD) client, as defined in Chapter 48 of this title (relating to Community Care for Aged and Disabled), who is eligible to receive services under this chapter. References in this chapter to “client” include the client’s representative, unless the context indicates otherwise.

(4) Community attendant (CA) services--A service under the Primary Home Care Program providing in-home attendant services to individuals with a medical need for assistance with specific tasks. CA services (formerly known as §1929(b) or frail elderly) are provided under Title XIX of the federal Social Security Act (relating to Grants to States for Medical Assistance Programs) at 42 U.S.C. §1396t (relating to Home and community care for functionally disabled elderly individuals) and may be provided through the agency, service responsibility option (SRO) or consumer directed services (CDS) option of service delivery as described in Chapter 41 of this title.

(5) Contract--The formal, written agreement between DADS and a provider agency to provide services to individuals under this chapter in exchange
for reimbursement.

(6) Contract manager--A DADS [DHS] employee who is responsible for the overall management of the contract with the provider agency.

(7) Days--Any reference to days means calendar days, unless otherwise specified in the text. Calendar days include weekends and holidays.

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

(9) Family care (FC) services--A service under the Primary Home Care Program providing in-home attendant services to eligible adults. FC services are provided under Title XX of the federal Social Security Act (relating to Block Grants to States for Social Services) at 42 U.S.C. §1397 et seq. and may be provided through the agency, CDS or SRO models of service delivery as described in Chapter 41 of this title.

(10) Functional Limitation—An individual’s requirement for assistance with activities of daily living caused by a physical limitation or disability.

(11) Imminent danger--An immediate, real threat to a person’s safety.

(12) Individual—A person who is enrolled in the Primary Home Care program. References in this chapter to “individual” include the individual’s representative unless the context indicates otherwise.

(13) Medical need--A medical diagnosis that results in a functional limitation and need for assistance with activities of daily living. [For purposes of this chapter, activities of daily living do not include services that must be provided or supervised by licensed personnel.]

(14) Negotiated referral—A request from the case manager to a provider agency to evaluate a person for service delivery, in which the case manager determines that the person’s needs require that services begin on a particular date.

(15) Non-priority—The [one of two types of] eligibility status for service delivery as determined by the case manager for an individual who does not meet the criteria described in §48.2918(d) of this title (relating to Eligibility for Primary Home Care or Community Attendant Services). Services delivered to such an individual may be referred to as non-priority services, and an attendant who serves such an individual may be referred to as a non-priority attendant.

(16) Practitioner—A person holds a doctor of medicine or doctor of osteopathy degree and is currently licensed in Texas, Louisiana, Arkansas, Oklahoma or New Mexico, a physician assistant currently licensed in Texas, or a registered nurse approved by the Texas State Board of Nursing to practice as an advanced practice nurse.

(17) Practitioner's statement--[A document such as the DADS']
Practitioner’s statement of medical need form, that includes:

(A) a statement signed by a practitioner that the individual [client] has a current medical need for assistance with personal care tasks and other activities of daily living; and

(B) certification that the provider agency verified with the United States’ Centers for Medicare and Medicaid Services that the practitioner is not excluded from participation in Medicare or Medicaid.

(15) Practitioner’s statement date—The practitioner’s statement date is:

(A) the later of the following:

(i) the practitioner’s signature date on the practitioner’s statement; or

(ii) the date the provider agency receives the practitioner’s statement. If the provider agency fails to stamp the receipt date on the form, the date of the practitioner’s signature will be used to determine the practitioner’s statement date; or

(B) the date of the practitioner’s oral statement obtained for a negotiated referral. The provider agency must document the practitioner’s oral statement date on the practitioner’s written statement required in §47.47(c)(2) of this chapter (relating to Medical Need Determination).

(17 [6]) Primary Home Care Program--A DADS [DHS] attendant care services program. Community attendant (CA), primary home care (PHC), and family care (FC) are the three types of services available under the Primary Home Care Program.

(18 [7]) Primary home care (PHC) services--A service under the Primary Home Care program providing in-home attendant services to individuals [clients] with an approved medical need for assistance with specific tasks. PHC services are provided under Title XIX of the federal Social Security Act, at 42 U.S.C. §1396a (relating to State plans for medical assistance) [and may be provided through the agency, SRO, or CDS option models of service delivery as defined in Chapter 41 of this title].

(19 [8]) Priority--The eligibility status for service delivery as determined by the case manager for an individual [client] who meets the criteria described in §48.2918(d 4) of this title. Services delivered to such an individual [a client] may be referred to as priority services, and an attendant who serves such an individual [a client] may be referred to as a priority attendant.

(20 [19]) Provider agency--A licensed home and community support services agency that contracts with DADS [DHS] to provide services to clients in exchange for reimbursement.

(21 [9]) Reckless behavior--Acting with conscious indifference to the consequences.
(22) Regional nurse—A DADS [DHS] employee who is responsible for authorizing an individual [a client] to receive CA services.

(23) Representative—An individual's [The client's] spouse, other responsible party, designated representative or legally authorized representative (LAR).

(24) Routine referral—A written request from the case manager to a provider agency to evaluate an individual [person] for service delivery when [in which] the case manager determines that the individual’s [person’s] needs do not require a verbal [negotiated] referral.

(25) Service Plan—A single document that is agreed upon and signed by an individual and the provider agency containing the elements described in §47.45(a)(2) of this chapter.

(26) Service schedule—A schedule for delivering attendant services that is agreed upon and signed by the individual [client]. A fixed service schedule specifies certain days, times of day, or time periods for delivery of the services. A variable service schedule states the number of hours of services to be delivered per day or per week, not to exceed the authorized hours per week, and does not otherwise specify any certain days, times of day, or time periods for delivery of the services.

(27) Signature—A person's name written in longhand or a mark representing his or her name on a document to certify it is correct. Initials are not an acceptable substitute for a signature, unless initials have been established as the person's official signature.

(28) Supervisor—A provider agency employee who:

(A) coordinates the delivery of services in the individual’s [the client’s] service plan;

(B) supervises attendants; and

(C) meets the requirements for a supervisor found in §97.404 of this title (relating to Standards Specific to Agencies Licensed to Provide Personal Assistance Services).

(29) Unit of service—One hour of service delivered to an individual [a client].


(31) Written—Information recorded on paper or other legible document. [Written information may be sent by mail or fax, or hand delivered.]

(32) Utilization Review—a planned, systematic review of service utilization to evaluate, efficiency, quality, and appropriateness of services and service plans. Utilization review may include routinely scheduled review of services or providers, or may be focused on an identified issue.

(33) Verbal referral—An oral request from the case manager to a provider agency to evaluate an individual for service delivery, in which case the case manager determines
that the individual’s needs require that services begin on a particular date.

§47.5. Overview of Process.

The provider agency must:

(1) provide the tasks described in §47.41 of this chapter (relating to Allowable Tasks);

(2) accept all referrals as described in §47.43 of this chapter (relating to Referrals);

(3) conduct pre-initiation activities as described in §47.45 of this chapter (relating to Pre-Initiation Activities);

(4) resolve any service delivery issues as described in §47.49 of this chapter (relating to Interdisciplinary Team);

(5) ensure attendants are qualified and oriented to the individual and service plan as described in §47.23 of this chapter (relating to Attendant Qualifications) and §47.25 of this chapter (relating to Attendant Orientation);

(6) start services for the individual as described in §47.61 of this chapter (relating to Service Initiation);

(7) provide services to the individual as described in §47.63 of this chapter (relating to Service Delivery);

(8) process any need for service plan changes as described in §47.67 of this chapter (relating to Service Plan Changes);

(9) coordinate transfers to or from another provider agency as described in §47.69 of this chapter (relating to Transfers);

(10) suspend services only as described in §47.71 of this chapter (relating to Suspensions); and

(11) process special requirements for annual reauthorizations for community attendant services as described in §47.73 of this chapter (relating to Annual Reauthorization for Community Attendant Services).

(12) submit information to DADS as required for utilization review as described in subsection G of this chapter.

(13) provide services to individuals eligible for Primary Home Care services in the Integrated Care Management (ICM) program as described in subsection H of this chapter (relating to Integrated Care Management)

Subchapter B, Provider Agency Contracts
§47.11. Contracting Requirements.

(a) General contracting requirements. The provider agency must meet all provisions described in this chapter and Chapter 49 of this title (relating to Contracting for Community Care Services).

(b) Licensure. The provider agency in the Primary Home Care Program must deliver only personal assistance services, as defined in §97.2 of this title (relating to Definitions) and must provide services in accordance with all licensure requirements pursuant to Chapter 97 of this title (relating to Licensing Standards for Home and Community Support Services Agencies [only under the Personal Assistance Services (PAS) category of Home and Community Support Services Agency licensure].

Subchapter C, Staff Requirements

§47.21. Supervisor Training Requirements.

(a) General training. The provider agency must train all supervisors as described in §97.245 of this title (relating to Staffing Policies).

(b) Program-specific training. The provider agency must ensure the supervisor understands the applicable rules and procedures of the Primary Home Care Program.

§47.23. Attendant Qualifications.

In addition to the requirements described in §97.404 of this title (relating to Standards Specific to Agencies Licensed to Provide Personal Assistance Services), attendants must:

[(1) be an employee of the provider agency;]

[(2) be 18 years of age or older;]

[(3) not be a legal or foster parent of a minor who receives the service; and]

[(4) not be the spouse of an individual (a client) who receives the service. This paragraph is not applicable to family care services.]

§47.25. Attendant Orientation.

(a) Orientation. In addition to the requirements described in this section, the provider agency must ensure each attendant is oriented as described in Chapter 97, Subchapter C, of this title (relating to Minimum Standards for All Home and Community Support Services Agencies) and §97.404 of this title (relating to Standards Specific to Agencies Licensed to Provide Personal Assistance Services). Orientation is not required for supervisors acting as attendants.

(b) Method of orientation.
(1) The method of [An attendant must receive] orientation must be determined by the supervisor and may be conducted

(A) in person, with the participation of the individual, in the individual's [the client's] home or other location where services are delivered,

(B) by telephone, or

(C) in the provider agency office at the discretion of the supervisor.

(2) The individual [client] must be present when the attendant receives orientation in person.

(2 [3]) An attendant may receive orientation by telephone or in the provider agency office without the participation of the individual, at the discretion of the supervisor, only if the attendant:

(A) meets the requirements described in §97.701 of this title (relating to Home Health Aides); [or]

(B) has six continuous months of experience in delivering attendant care; []

(4) An attendant may receive orientation by telephone, at the discretion of the supervisor, when:

(C [A]) the attendant has been oriented and the service plan changes; or

(B) the attendant previously worked for the individual [client].

(c) [5]) The provider agency supervisor may use discretion to determine if the attendant needs to be oriented if:

(1 [A]) the attendant previously worked for the individual [client]; and

(2 [B]) the service plan has not changed since the attendant worked for the individual [client].

(d [e]) Due dates. The supervisor must orient each attendant on or before the time the attendant begins to provide attendant services.

(e [d]) Documentation of attendant orientation.

(1) The attendant orientation must be recorded on a single document that includes:

(A) the individual [client] name and DADS individual [DHS-client] number;

(B) the attendant name;

(C) the date of the attendant orientation;

(D) whether the orientation was conducted in person with the individual
by telephone, or in the provider agency office;

(E) information about how the individual's condition affects the performance of tasks;

(F) the tasks to be performed;

(G) the service schedule;

(H) the number of hours the attendant is to provide;

(I) the total number of hours the individual is authorized to receive;

(J) safety and emergency procedures, including universal precautions;

(K) specific situations about which the attendant should notify the provider agency, including:

(i) changes in the individual's needs;

(ii) incidents that affect the individual's condition;

(iii) hospitalization of the individual;

(iv) the absence or relocation from home; and

(v) the attendant’s inability to work; and

(L) the signature of the:

(i) supervisor who conducts the orientation;

(ii) the attendant who is oriented, if present; and

(iii) the individual, if present.

(2) The provider agency must maintain documentation of the attendant orientation in the individual file.

Subchapter D, Service Plan Development

§47.41. Allowable Tasks.

The Primary Home Care Program includes the following tasks:

(1) Personal care tasks related to the care of the individual's physical health. These tasks are:

(A) bathing, which is:

(i) drawing water in sink, basin, or tub;
(ii) hauling or heating water;
(iii) laying out supplies;
(iv) assisting in or out of tub or shower;
(v) sponge bathing and drying;
(vi) bed bathing and drying;
(vii) tub bathing and drying; and
(viii) providing standby assistance for safety;

(B) dressing, which is:
   (i) dressing the individual [client];
   (ii) undressing the individual [client]; and
   (iii) laying out clothes;

(C) meal preparation, which is:
   (i) cooking a full meal;
   (ii) warming up prepared food;
   (iii) planning meals;
   (iv) helping prepare meals; and
   (v) cutting client's food for eating;

(D) feeding/eating, which is:
   (i) spoon-feeding;
   (ii) bottle-feeding;
   (iii) assisting with using eating and drinking utensils and adaptive devices. This does not include tube feeding; and
   (iv) providing standby assistance or encouragement;

(E) exercise, which is walking with the individual [client];

(F) grooming/shaving/oral care, which is:
   (i) shaving;
   (ii) brushing teeth;
(iii) shaving underarms and legs, when requested;
(iv) caring for nails; and
(v) laying out supplies;

(G) routine hair/skin care, which is:
(i) washing hair;
(ii) drying hair;
(iii) assisting with setting, rolling, or braiding hair. This does not include styling, cutting, or chemical processing of hair;
(iv) combing or brushing hair;
(v) applying nonprescription lotion to skin;
(vi) washing hands and face;
(vii) applying makeup; and
(viii) laying out supplies;

(H) assistance with self-administered medications. This means assistance with medication as defined in §97.2(11[θ]) of this title (relating to Definitions);

(I) toileting, which is:
(i) changing diapers;
(ii) changing colostomy bag or emptying catheter bag;
(iii) assisting on or off bedpan;
(iv) assisting with the use of a urinal;
(v) assisting with feminine hygiene needs;
(vi) assisting with clothing during toileting;
(vii) assisting with toilet hygiene, including the use of toilet paper and washing hands;
(viii) changing external catheter;
(ix) preparing toileting supplies and equipment. This does not include preparing catheter equipment; and
(x) providing standby assistance; and

(J) transfer/ambulation, which is:
(i) non-ambulatory movement from one stationary position to another (transfer). This does not include carrying;

(ii) adjusting or changing the individual's [the client's] position in a bed or chair (positioning);

(iii) assisting in rising from a sitting to a standing position;

(iv) assisting in positioning for use of a walking apparatus;

(v) assisting with putting on and removing leg braces and prostheses for ambulation;

(vi) assisting with ambulation or using steps;

(vii) assisting with wheelchair ambulation; and

(viii) providing standby assistance.

(2) Home management tasks that support the individual's [the client's] health and safety. These tasks include:

(A) cleaning, which is:

(i) cleaning up after the individual's [the client's] personal care tasks;

(ii) emptying and cleaning the individual's [the client's] bedside commode;

(iii) cleaning the individual's [the client's] bathroom;

(iv) changing the individual's [the client's] bed linens and making the individual's [the client's] bed;

(v) cleaning floor of living areas used by individual [client];

(vi) dusting areas used by individual [client];

(vii) carrying out the trash and setting out garbage for pick up;

(viii) cleaning stovetop and counters;

(ix) washing the individual's [the client's] dishes; and

(x) cleaning refrigerator and stove;

(B) laundry, which is:

(i) doing hand wash;

(ii) gathering and sorting;

(iii) loading and unloading machines in residence;
(iv) using Laundromat machines;
(v) hanging clothes to dry;
(vi) folding and putting away clothes; and

(C) shopping, which is:

(i) preparing a shopping list;
(ii) going to the store and purchasing or picking up items;
(iii) picking up medication; and
(iv) storing the individual's purchased items.

(3) Escort. Escort includes the following:

(A) accompanying the individual outside the home to support the individual in living in the community;

(B) arranging for transportation. The provider agency may also choose to directly provide transportation; however, direct individual transportation is not reimbursed under the Primary Home Care program;

(C) accompanying the individual to a clinic, doctor's office, or location for medical diagnosis or treatment; and

(D) waiting in the doctor's office or clinic with an individual necessary due to client's condition or distance from home.

§47.43. Referrals.

(a) The provider agency must:

(1) accept all DADS referrals for services under the Primary Home Care program; and

(2) conduct the pre-initiation activities as described in §47.45 of this chapter (relating to Pre-Initiation Activities).

(b) There are two methods of referral:

(1) For verbal referrals, the case manager makes the referral by phone and on DADS Authorization for Community Care Services form.

(2) For routine referrals, the case manager makes the referral on DABS Authorization for Community Care Services form.

§47.45. Pre-Initiation Activities.

(a) Pre-initiation activities. The supervisor must complete the following activities for
each referral:

(1) Conduct an evaluation.

(A) The evaluation must be a single document that includes the person’s self-report of:

(i) the dates and reasons for any hospitalization within the last three months; and

(ii) the assistance needed for the person to achieve activities of daily living, including any assistive devices or medical equipment used by the person.

(B) If the provider agency determines during the evaluation that the individual exhibits reckless behavior that results in imminent danger to the health and safety of the individual, or the attendant the provider agency must convene an Interdisciplinary Team meeting as described in §47.49 of this chapter (relating to Interdisciplinary Team) to discuss the barriers to service delivery.

(2) Develop a service plan on [... The service plan must be] a single document that:

(A) is agreed upon and signed by the individual and the provider agency;

(B) indicates the location of service delivery. The provider agency must:

(i) make a reasonable effort to deliver services at a location outside the client’s home, if requested by the client; and

(ii) maintain written justification if the client's request was not granted; and

(C) records the following:

(i) the tasks the individual will receive,

II. The provider agency must ensure that at least one personal care task is authorized by the Texas Department of Human Services (DHS), scheduled, and provided.

II. Recipients of family care services are not required to receive any personal care tasks; and

III. The provider agency must ensure the tasks the client will receive do not duplicate any services received from any other source;

(ii) the total weekly hours of service DADS [DHS] authorizes the individual to receive;

(iii) the service schedule;
(iv) frequency of supervisory visits; and

(v) a statement that:

(I) the Primary Home Care Program only provides the tasks allowable in the program as described in §47.41 of this chapter (relating to Allowable Tasks) and agreed to on the service plan; and

(II) the provider agency is not responsible for meeting the applicant's needs other than tasks allowed under the Primary Home Care Program.

(3) Obtain a practitioner’s statement and submit for DADS review and approval as described in §47.47 of this chapter (relating to Medical Need Determination). This paragraph does not apply to family care services.

(b) Service plan deviations [differences].

(1) The provider agency must orally notify the case manager when the initial service plan developed by the provider agency:

(A) has more hours than authorized on DADS' [DHS’s] Authorization for Community Care Services form; [or]

(B) has no personal care tasks. This subparagraph does not apply to family care services, or;

(C) is temporarily changed as described in subsection (b)(3) of this section.

(2) The provider agency must discuss the difference in the service plan with the case manager.

(3) The provider agency must provide services according to the existing service plan, until the provider agency receives a new DADS [DHS] Authorization for Community Care Services form, unless:

(A) the individual requests and requires temporary assistance with allowable tasks not identified on the service plan due to a change in circumstances or available supports; and

(B) the change in tasks does not increase the total approved hours of service or continue for more than 30 days.

(4) The provider agency must request and obtain a new DADS Authorization for Community Care Services when a temporary deviation from the service plan is to continue for more than 30 days or would result in more hours of service provided than were approved.

(5) [44] The provider agency must maintain the following documentation regarding the temporary service plan deviation [difference] in the individual [client] file:
(A) the specific deviation [difference] in the service plan; [and]

(B) the duration of the temporary deviation; and

(C) the reason for the temporary deviation as described at subsection (b)(3) of this section [decision regarding the difference].

(c) Pre-initiation activities due date. The provider agency must complete the pre-initiation activities as follows:

(1) for routine referrals, within 14 days after one of the following dates, whichever is later:

(A) the referral date (Item 1) on DADS' [DHS's] Authorization for Community Care Services form; or

(B) the date the provider agency receives DADS' [DHS's] Authorization for Community Care Services form. If the provider agency fails to stamp the receipt date on the form, the referral date (Item 1) will be used to determine timeliness; and

(2) for verbal [negotiated] referrals, by the service initiation date negotiated with the case manager.

(d) Delay in pre-initiation activities.

(1) The provider agency may delay meeting the due dates only for reasons beyond its control. The provider agency must continue pre-initiation activities and set a date, if possible, for completion. The provider agency must document any failure to complete the pre-initiation activities for routine referrals by the due date, including:

(A) the reason for the delay [which must be beyond the control of the provider agency;]

(B) either the date the provider agency anticipates it will complete the pre-initiation activities or specific reasons why the provider agency cannot anticipate a completion date; and

(C) a description of the provider agency's ongoing efforts to complete pre-initiation activities.

(2) The provider agency must orally notify the case manager of any failure to complete the pre-initiation activities for verbal [negotiated] referrals before the negotiated service initiation date. Oral notice means directly speaking with the case manager and does not include a message left by voice mail. The case manager may refer the individual [client] to another provider agency.

(e) Documentation of pre-initiation activities.

(1) The provider agency may combine the evaluation and service plan into a single document, but each item must be clearly identifiable.
The provider agency must maintain documentation of the pre-initiation activities in the individual file.

§47.47. Medical Need Determination.

(a) Applicability. This section does not apply to family care services.

(b) Determining medical need. The provider agency must ensure medical need determination by obtaining and submitting a complete DADS practitioner’s statement to DADS for review and approval by the applicable due date, as described in §47.45(c) of this chapter, (relating to Pre-Initiation Activities) for:

1. Individuals whom DADS refers to the provider agency, unless the person requests and is to receive family care services;

2. Individuals currently receiving services who are receiving family care services and whom DADS refers to the provider agency for primary home care or community attendant services; and

3. Individuals currently receiving services whom DADS refers to the provider agency to have medical need reassessed, as requested by the case manager, such as when the initial medical need was established for a limited time.

(c) Reinstatement of Services. If services are terminated, all pre-initiation activities including medical need determination must be completed before services are reinstated.

(d) Mental illness and mental retardation. Persons diagnosed with mental illness, mental retardation, or both are not considered to have established medical need based solely on such diagnoses, but may establish medical need through a related diagnosis that results in a functional limitation.

(e) Documentation of medical need determination. The provider agency must maintain a copy of the DADS practitioner’s statement in the individual file.

§47.49. Interdisciplinary Team.

(a) Interdisciplinary Team (IDT). The IDT is a designated group that includes the following people who meet when the provider agency identifies the need to
discuss service delivery issues or barriers to service delivery:

(1) the individual [client] or the individual's [the client's] representative, or both;

(2) a provider agency representative; and

(3) a DADS [Texas Department of Human Services (DHS)] representative. A DADS [DHS] representative may be:

(A) the case manager (or designee);

(B) the contract manager (or designee); or

(C) the regional nurse (or designee).

(b) Convening an IDT meeting.

(1) The provider agency must convene an IDT meeting within three working days of the date the provider agency:

(A) suspends services to an individual [a client] under §47.71(a)(7) or (b) of this chapter (relating to Suspensions); or

(B) identifies an issue that prevents the provider agency from carrying out a requirement of the Primary Home Care Program.

(2) If the provider agency is unable to convene an IDT meeting with all the members described in subsection (a) of this section, the provider agency must convene the IDT meeting with the available members and send the documentation of the IDT meeting described in subsection (e) of this section to the Regional Director [Administrator] for the DADS [DHS] region in which the individual [client] resides.

(A) The documentation must be sent within five working days of the date of the IDT meeting.

(B) Further action by the provider agency may be required, based on a DADS [DHS] review of the IDT meeting documentation.

(c) IDT meeting.

(1) The IDT meeting may be conducted by telephone conference call or in person.

(2) The IDT must:

(A) evaluate the issue;

(B) identify any solutions to resolve the issue; and

(C) make recommendations to the provider agency.

(d) IDT meeting outcome. The provider agency must do one of the following within two working days after the IDT meeting:
(1) implement the recommendations of the IDT; or

(2) discharge the individual [client] from the provider agency and refer the case back to the case manager for referral to another provider agency.

(e) Documentation of the IDT meeting. The provider agency must document the IDT meeting in the individual [client] file, including the:

(1) specific reasons for calling the IDT meeting. [If the specific reasons include staffing issues, the provider agency must document good faith efforts to find staffing for the individual [client]. Examples of good faith efforts may include:

(A) placement of newspaper, television, or radio ads;
(B) outreach through churches and other nonprofits;
(C) use of employment agencies;
(D) use of state agency administered programs; and
(E) efforts to encourage clients to locate and refer to the provider agency potential attendants in the community;]

(2) participants in the IDT meeting. If all members described in subsection (a) of this section are unable to participate, the provider agency must document all efforts made to convene an IDT meeting with all the members;

(3) recommendations of the IDT;

(4) provider agency’s action as a result of the IDT recommendations; and

(5) reasons for the provider agency's actions.

Subchapter E, Service Requirements

§47.57. Service Delivery Options.

Individuals receiving primary home care and community attendant services have a choice of one of the following three service delivery options as defined in Chapter 41 of this title.

(1) Agency option--In the agency option:

(A) the agency is responsible for personnel decisions, such as selecting, supervising, and dismissing the attendant who provides services to the consumer, with input from the consumer;

(B) the provider agency is responsible for:
(i) recruitment of attendants and substitute attendants (a responsibility the individual may share);

(ii) payroll for attendants and substitute attendants; and

(iii) filing tax-related reports of attendants and substitute attendants;

(C) the provider agency is the employer of record of attendants and substitute attendants; and

(D) the provider agency is responsible for providing substitute attendants.

(2) Consumer directed services (CDS) option--In the CDS option:

(A) the individual recruits, hires, manages, and dismisses attendants;

(B) the individual is the employer of record of his or her attendant and substitute attendant;

(C) the individual is responsible for providing substitute attendants; and

(D) the Consumer Directed Services Agency (CDSA) is responsible for financial management services including:

(i) registering as the individual’s employer agent with the Internal revenue Services and the Texas Workforce Commission;

(ii) payroll for attendants and substitute attendants;

(iii) filing tax-related reports of attendants and substitute attendants;

(iv) tracking expenditures; and

(v) submitting quarterly expenditure reports to the employer and case manager.

(E) the provider agency is not required to be licensed under Chapter 97 of this title when performing the functions described in subparagraph (D) of this paragraph.

(3) Service Responsibility Option (SRO)— In the SRO option

(A) the consumer selects, manages, supervises and dismisses attendants;

(B) the provider is the employer of record for the attendant and substitute attendant;
(C) the provider agency is responsible for:

(i) providing substitute attendants;

(ii) payroll for attendants and substitute attendants; and

(iii) filing tax-related reports of attendants and substitute attendants;

(D) the individual and supervisor must negotiate the frequency of supervisory visits; and

(E) the individual is responsible for the new attendant orientation. At the individual’s discretion the agency supervisor may be present.

§47.59. Support Consultation.

(1) Support consultation is an optional service available when CDS or the SRO is chosen by an individual receiving primary home care or community attendant services.

(2) Support consultation in CDS:

(a) is provided by a support advisor and provides a level of assistance and training beyond that provided by the CDSA through financial management services.

(b) helps an employer to meet the required employer responsibilities of the CDS option to successfully deliver program services.

(3) Support consultation in the SRO provides the required SRO Orientation and additional support when needed by the individual to effectively carry out consumer responsibilities under the SRO.

§47.61. Service Initiation.

(a) Medical need requirement. The provider agency must not initiate services to an individual identified in §47.47(b) of this chapter (relating to Medical Need Determination) until the provider agency receives notice of DADS review and approval of the completed DADS practitioner’s statement. This section does not apply to family care services.

(b) Service initiation. The provider agency must initiate services:

(1) for routine referrals described in §47.43 of this chapter (relating to Referrals):

(A) for family care services, within 14 days after the following, whichever is later:

(i) the referral date (Item 1) on DADS Authorization for
Community Care Services form; or

(ii) the date the provider agency receives DADS' [DHS'] Authorization for Community Care Services form. If the provider agency fails to stamp the receipt date on the form, the referral date (Item 1) is used to determine timeliness; or

(B) for primary home care and community attendant services, by the initiation date determined by the provider agency. The service initiation date must be within seven days after [of] DADS approval of the completed DADS [the] practitioner’s statement date; and

(2) for verbal [negotiated] referrals described in §47.43 of this chapter, on the date negotiated.

(c) Notification of service initiation [and practitioner’s statement date]. Within 14 days after initiating services the

[(1) The] provider agency must send

[(A written notice of service initiation to the case manager for family care, primary home care, and community attendant services, [and]

[(B) the practitioner’s statement date:]

[(i) to the case manager, for primary home care; or]

[(ii) to the regional nurse, for community attendant services.]

[(2) The provider agency must send the written notice within 14 days after initiating services.]

(d) Delay in service initiation. The provider agency may delay service initiation only for reasons beyond its control that are not directly caused by the provider agency. The provider agency must continue efforts to initiate services and set a date, if possible, for service initiation. The provider agency must document any failure to initiate services by the applicable due date in subsection (b) of this section, including:

(1) the reason for the delay; [— which must be:

——— (A) beyond the control of the provider agency; and

——— (B) not caused directly by the provider agency;]

(2) either the date the provider agency anticipates it will initiate services, or specific reasons why the provider agency cannot anticipate a service initiation date; and

(3) a description of the provider agency's ongoing efforts to initiate services.

(e) Documentation of service initiation. The provider agency must maintain documentation of service initiation in the individual client file.
§47.63. Service Delivery.

(a) Delivery of services.

(1) The provider agency must:

(A) ensure services are delivered according to the service plan described in §47.45 of this chapter (relating to Pre-Initiation Activities);

(B) ensure all authorized and scheduled services are provided to an individual, except in the case of a service interruption, as defined in subsection (b) of this section;

(C) ensure an individual does not receive, during a calendar month, more than five times the weekly authorized hours on DADS' Authorization for Community Care Services form; and

(D) ensure each individual determined eligible for primary home care or community attendant services is given the opportunity to choose from the three service delivery options described at §47.57 of this chapter (relating to Service Delivery Options);

(E) make a reasonable effort to deliver services at a location outside the individual’s home, if requested by the individual; and

(F) maintain written justification if an individual’s request for services to be delivered at a location outside the individual’s home was not granted.

(G) except for recipients of family care services, that at least one personal care task is authorized by DADS, scheduled and delivered.

(H) ensure the services the individual will receive do not duplicate any services received from any other source;

[(a) Service interruptions. A service interruption occurs when [on a particular day or time when services are scheduled. DHS will not hold the provider agency responsible if:

(1) the client requests that:

(A) no hours of service be provided; or

(B) fewer hours of service than reflected in the service schedule be provided; or

(C) a specific attendant not provide services to the client;

(2) the client is not at home when services are scheduled;

(3) services are suspended as described in §47.71 of this chapter (relating to Suspensions); or

(4) services are not delivered for other reasons beyond the control of the provider agency, such as acts of nature and other disasters.]
(b) Service interruptions.

(1) A service interruption occurs when fixed schedule services are not delivered as scheduled or variable schedule services are not all delivered within one week.

(A) For a fixed service schedule, the service interruption begins on the first day services are scheduled but not delivered.

(B) For a variable service schedule, the service interruption begins the Sunday following the week the individual did not receive all the weekly hours on a service plan approved by the individual.

(2) DADS will not hold the provider agency responsible if:

(A) the individual requests that:

(i) no hours of service be provided; or

(ii) fewer hours of service than reflected in the service schedule be provided; or

(iii) a specific attendant not provide services to the individual;

(B) the individual is not at home when services are scheduled;

(C) services are suspended as described in §47.71 of this chapter (relating to Suspensions); or

(D) services are not delivered for other reasons beyond the control of the provider agency, such as acts of nature and other disasters.

[(b) Delivery of services.

(1) The provider agency must ensure:

(A) services are delivered according to the service plan described in §47.45 of this chapter (relating to Pre-Initiation Activities);

(B) all authorized and scheduled services are provided to a client, except in the case of a service interruption, as defined in subsection (a) of this section, and

(C) a client does not receive, during a calendar month, more than five times the weekly authorized hours on the Texas Department of Human Services’ (DHS’s) Authorization for Community Care Services form;

(2) The provider agency must not exceed the weekly authorized hours except in the case of a temporary increase

(A) due to unusual circumstances and client need; and

(B) requested by the client.
(c) Service interruption documentation.

(1) In the case of a priority individual [client], the provider agency must document all service interruptions by the 30th day after the beginning of the service interruption.

(2) In the case of a non-priority individual [client], the provider agency must document all service interruptions that exceed 14 consecutive days by the 30th day after the day service interruption exceeds 14 consecutive days.

(A) For a fixed service schedule, the service interruption begins on the first day services are scheduled but not delivered.

(B) For a variable service schedule, the service interruption begins the Sunday following the week the client did not receive all the weekly hours on a service plan approved by the client.

(3) The reason documented must be a reason listed in subsection (a) of this section.

(4) If the provider agency learns of a service interruption after the deadlines listed in paragraphs (1) and (2) of this subsection, the provider agency must document the following as soon as the provider agency learns of the service interruption:

(A) the reason for the service interruption[. The reason documented must be a reason listed in subsection (a) of this section];

(B) the reason for the delay in documenting the service interruption; and

(C) the date the provider agency learned of the service interruption.

(d) Service delivery outside the individual's [the client's] home.

(1) The provider agency may develop a service plan that includes services regularly delivered at a location other than the individual's [the client's] home. The service plan must not exceed the weekly hours authorized on DADS' [DHS's] Authorization for Community Care Services form.

(2) The provider agency may deliver services outside the individual's [the client's] home when the service plan does not include the regular delivery of such services.

(3) The provider agency:

(A) may deliver services outside the individual's [the client's] home only if the individual [client] requests such services.

(B) is not required to pay for expenses incurred by attendants to deliver[ing]
services outside the individual's [the client's] home.

(C) must:

(i) make a reasonable effort to deliver services at a location other than the individual's [the client's] home when requested by the individual [client];

(ii) maintain written justification if the individual's [the client's] request was not granted; and

(iii) document in the individual's [the client's] file:

(I) each instance when an individual [a client] requested services at a location other than the home;

(II) whether the individual's [the client's] request was granted;

(III) what services were provided; and

(IV) where the services were delivered.

(e) Service delivery documentation.

(1) The provider agency must document the delivery of services, including:

(A) the provider agency name;

(B) the provider agency vendor number;

(C) the attendant name;

(D) the individual [client] name;

(E) the DADS [DHS] individual [client] number;

(F) the specific service delivery period, including month, day, and year, as applicable;

(G) the tasks assigned;

(H) the units of service delivered;

(I) the dates services were delivered;

(J) certification that the attendant delivered the documented tasks.

(i) For electronic service delivery documentation systems, each person delivering services inputs a unique identifier to certify the services delivered.

(ii) For paper service delivery documentation systems, each person delivering services signs the timesheet to certify the services delivered.
(I) The attendant must sign his or her name or a mark representing his or her name on the timesheet to certify that it is correct. Initials are not an acceptable substitute for a signature.

(II) An attendant who is unable to sign the timesheet may designate another person to sign the timesheet. The provider agency must maintain written documentation of the:

(-a-) reason the attendant is unable to sign the timesheet; and

(-b-) identity of the person authorized to sign the timesheet on behalf of the attendant.

(2) Paper service delivery documentation must be a single document with a specific service delivery period not exceeding one calendar month.

(f) Documentation of service delivery. The provider agency must maintain documentation of service delivery in the individual [client] file[-] including documentation that identifies [The provider agency must be able to identify] all attendants delivering services [tasks] to the individual [client].

(g) If an IDT is conducted due to provider agency staffing issues, the provider agency must make and document good faith efforts to find staffing for the individual [client]. Examples of good faith efforts may include:

________ (A) placement of newspaper, television, or radio ads;

________ (B) outreach through churches and other nonprofits;

________ (C) use of employment agencies;

________ (D) use of state agency administered programs; and

________ (E) efforts to encourage clients to locate and refer to the provider agency potential attendants in the community;

§47.65. Supervisory Visits.

(a) Supervisory visits. A supervisor must conduct in-person supervisory visits with the individual to assess and document on a single form whether the:

(1) service plan is adequate;

(2) individual [client] continues to need the services;

(3) individual [client] needs a service plan change;

(4) attendant continues to be competent to provide the authorized tasks; and

(5) attendant is delivering the authorized tasks.
(b) Frequency. The supervisor must establish the frequency of in-person supervisory visits, based on the specific needs of the individual, the attendant, or both. The frequency of in-person supervisory visits must be at least annually.

(c) Documentation of supervisory visits. The provider agency must maintain documentation of each supervisory visit in the individual’s file.

(d) Combining a supervisory visit and new attendant orientation. The supervisor may conduct a scheduled supervisory visit and a new attendant orientation jointly. When orienting the new attendant, while also conducting the supervisory visit, the supervisor must mark items (a)(4) and (a)(5) of this subsection as not applicable.

§47.67. Service Plan Changes.

(a) Increase in hours or terminations.

(1) The provider agency must send notice to the case manager in writing within seven days of learning of any change that may:

(A) require an increase in hours in the individual's service plan; or

(B) result in termination of services due to the individual receiving no personal care tasks. This subparagraph does not apply to family care services.

(2) The notification must include the:

(A) date the provider agency learned of the need for the change;

(B) reason for the change;

(C) type of change (including the number of service hours); and

(D) signature and date of the provider agency representative.

(b) Decrease in hours. The provider agency must develop a new service plan, as described in §47.45(a)(2) of this chapter (relating to Pre-Initiation Activities), within 21 days of the provider agency identifying the need for an ongoing decrease in hours from the service plan currently approved by the individual.

(c) Immediate increase in hours.

(1) The provider agency must discuss with the case manager the reason an individual requires an immediate increase in service hours, and must obtain approval from the case manager of both the number of additional service hours to be provided the individual and the effective date of the change.

(2) The provider agency must implement the immediate increase in hours on the date negotiated with the case manager.

(3) The provider agency must document the immediate increase in hours.
Documentation must include:

(A) the date the provider agency received approval for the change;
(B) the name of the case manager who approved the change;
(C) the effective date of the change; and
(D) the number of hours authorized.

(4) The provider agency must maintain documentation of service plan changes:

(A) in the individual [client] file; and

(B) according to the terms of the contract.

(d) Implementation of service plan changes. The provider agency must implement the service plan change on the following date, whichever is later:

(1) the authorization date (Item 4) on DADS' [the Texas Department of Human Services’ (DHS’s) Authorization for Community Care Services form; or

(2) five days after the date the provider agency receives DADS' [DHS’s] Authorization for Community Care Services form. If the provider agency fails to stamp the receipt date on the form, the authorization date (Item 4) will be used to determine timeliness.

(e) Delay in service implementation. If the provider agency does not implement a service plan change on the effective date of the change, the provider must set a new implementation date. The provider agency must document by the next working day any failure to implement a service plan change on the effective date of the change. The documentation must include:

(1) the reason for the failure to timely implement the service plan change; and

(2) the new implementation date.

§47.69. Transfers.

(a) Negotiation of individual [client] transfer from one provider agency to another. The provider agencies involved in an individual [a client] transfer must coordinate with the case manager to negotiate the transfer date.

(b) Initiation of services. The receiving provider agency must initiate services on the negotiated date. The negotiated date is the begin date (Item 4) on DADS' [the Texas Department of Human Services’ (DHS’s)] Authorization for Community Care Services form.

(c) Evaluation and service plan. On or before the begin date (Item 4), the receiving provider agency must:
(1) conduct an assessment, as described in §47.45 of this chapter (relating to Pre-Initiation Activities); and

(2) develop a service plan, as described in §47.45 of this chapter.

§47.71. Suspensions.

(a) Required suspensions. The provider agency must suspend services if:

(1) the individual [client] permanently leaves the state or moves to a county where the provider agency does not contract with DADS [the Texas Department of Human Services (DHS)] to provide services under the Primary Home Care Program;

(2) the individual [client] moves to a location where services cannot be provided under the Primary Home Care Program;

(3) the individual [client] dies;

(4) the individual [client] is admitted to an institution. An institution is defined as a:

(A) hospital;

(B) nursing facility;

(C) state school;

(D) state hospital; or

(E) intermediate care facility serving persons with mental retardation or a related condition;

(5) the individual [client] requests that services or specific tasks end;

(6) The Texas Health and Human Services Commission [DHS] denies the individual's [the client's] Medicaid eligibility (not applicable to family care services); or

(7) the individual [client] or someone in the individual's [the client's] home exhibits reckless behavior, which may result in imminent danger to the health and safety of the individual [client], the attendant, or another person. If this occurs, the provider agency must make an immediate referral to:

(A) the Texas Department of Family and Protective [and Regulatory] Services or other appropriate protective services agency;

(B) local law enforcement, if appropriate; and

(C) the individual's [the client's] case manager.

(b) Optional suspensions. The provider agency may suspend services if:

(1) the individual [client] or someone in the individual's [the client's] home
engages in discrimination against a provider agency or DADS [DHS] employee in violation of applicable law; or

(2) the individual [client] refuses services for more than 30 consecutive days.

(c) Notification of service suspension. The provider agency must notify the case manager by fax of any suspension by the next working day. The faxed notice of a suspension must include:

(1) the date of service suspension;
(2) the reason(s) for the suspension;
(3) the duration of the suspension, if known; and
(4) an explanation of the provider agency’s attempts to resolve the problem that caused the suspension, including the reasons why the problem was not resolved. This paragraph only applies to suspensions under subsection (a)(7) and (b) of this section.

(d) Interdisciplinary Team (IDT) meeting. The provider agency must convene an IDT meeting, as described in §47.49 of this chapter (relating to Interdisciplinary Team), if services are suspended under subsection (a)(7) or (b) of this section.

(e) Resuming services after suspension.

(1) The provider agency must resume services after suspension:

(A) upon the individual's [the client's] return home, or the date the provider agency becomes aware of the individual's [the client's] return home, if applicable;

(B) on the date specified in writing by the case manager;

(C) as a result of a recommendation by the IDT; or

(D) upon the provider agency’s receipt of notification from the case manager that the provider agency must resume services pending the outcome of the appeal.

(2) The provider agency must notify the case manager in writing of the date services resume and must send the notice within seven days of that date.

§47.72. Compliance with Program Requirements.

(a) Termination of services. DADS must terminate services to an individual who has had services suspended on more than three occasions as described in §47.71(a)(7) or §47.71(b)(1) of this title.

(b) Right of appeal. An individual for whom services have been terminated may appeal this decision by requesting a Fair Hearing as described at 1 TAC, Chapter 357

(c) Notification. Instances of failure to comply with program requirements or suspensions within the past 12 months must be communicated to the gaining provider at
§47.73. Annual Reauthorization for Community Attendant Services.

(a) Reauthorization request.

(1) The provider agency must request annual reauthorization for all community attendant services clients.

(2) The provider agency must send the following to the regional nurse to obtain annual reauthorization:

(A) DADS' [the Texas Department of Human Services’ (DHS’s)] Authorization for Community Care Services form received from the case manager; [and]

(B) a signed statement indicating whether the supervisor agrees or disagrees with the tasks and hours indicated on DADS' [DHS’s] Authorization for Community Care Services form. If the supervisor disagrees, the statement must provide the specific reasons for disagreeing with the hours and tasks on this form; and[–]

(C) the DADS practitioner’s statement documenting a medical diagnosis that results in a functional limitation and need for assistance with activities of daily living.

(b) Reauthorization request due date. The provider agency must submit the information described in subsection (a)(2) of this section to the regional nurse within 14 days after one of the following dates, whichever is later:

(1) the referral date (Item 1) on DADS' [DHS’s] Authorization for Community Care Services form; or

(2) the date the provider agency receives DADS' [DHS’s] Authorization for Community Care Services form. If the provider agency fails to stamp the receipt date on the form, the referral date (Item 1) will be used to determine timeliness.

(c) DADS makes the authorization determination and notifies the provider

(d [e]) Documentation of annual reauthorization. The provider agency must maintain documentation of the written request for reauthorization for community attendant services in the individual [client] file.

§47.75. Complaints.

The provider agency must comply with the complaint procedures described in:

(1) §49.18 of this title (relating to Consumer/individual Rights and Responsibilities);

(2) §49.17 of this title (relating to Complaint Procedures); and

(3) §97.250 of this title (relating to Investigations).
Subchapter F, Claims Payment and Documentation

§47.81. Monitoring Medicaid Eligibility.

(a) Applicability. This section does not apply to clients who are receiving family care services.

(b) Verification of Medicaid eligibility. The provider agency must verify each month that an individual [a client] remains Medicaid eligible. The provider agency may verify the individual's [the client's] current Medicaid eligibility by:

1. viewing the individual's DADS [the client's Texas Department of Human Services (DHS)] Medicaid Identification form; or

2. using the current systems available to verify individual [client] registration.

(c) Reimbursement. The provider agency is not entitled to payment from DADS [DHS] for services delivered if the provider agency fails to verify the individual [client] has current Medicaid eligibility.

§47.83. Monitoring Reviews.

(a) Monitoring reviews. DADS [The Texas Department of Human Services (DHS)] conducts monitoring reviews in the Primary Home Care Program as described in Chapter 49 of this title (relating to Contracting for Community Care Services) and in this chapter.

(b) Fiscal monitoring. Fiscal monitoring in the Primary Home Care Program includes monitoring financial errors, which are applied to the entire unit of service. Financial errors include the following instances:

1. DADS [DHS] reimburses the provider agency for services, but the service delivery documentation is missing for the period for which services are reimbursed. DADS [DHS] applies the error to the total number of units reimbursed for the pay period.

2. DADS [DHS] reimburses the provider agency for services, but the attendant fails to complete the units of service delivered portion of the service delivery documentation. DADS [DHS] applies the error to the total number of units reimbursed for the pay period.

3. DADS [DHS] reimburses the provider agency for hours that exceed the total number of hours recorded on the service delivery documentation. DADS [DHS] applies the error to the total number of units reimbursed in excess of the units recorded on the service delivery documentation. The lesser of the two totals is used to calculate the total number of hours recorded on the service delivery documentation if the following occurs:

   A) the time in and time out are recorded on the service delivery documentation, and the sum of the time in and time out does not equal the total time recorded for the pay period; or
(B) the sum of the daily totals of time does not equal the total time recorded for the pay period.

(4) DADS [DHS] reimburses the provider agency for units of service for days on which the individual [client] did not receive services. DADS [DHS] applies the error to the total number of units reimbursed for the day on which the individual [client] did not receive services.

(5) DADS [DHS] reimburses the provider agency for units of service for days on which the individual [client] was Medicaid ineligible. DADS [DHS] applies the error to the total number of units reimbursed for the days on which the individual [client] was Medicaid ineligible. This paragraph does not apply to family care services.

(6) The provider agency makes a claim for services, but a valid practitioner’s statement is missing. DADS [DHS] applies the error to the total number of units claimed and not covered by a valid practitioner’s statement. This paragraph does not apply to family care services.

(7) The provider agency makes a claim for services, but the date of DADS approval of the practitioner’s statement [date] is after the first day services were delivered. DADS [DHS] applies the error to the total number of units claimed before the practitioner’s statement date. This paragraph does not apply to family care services.

§47.85. Retroactive Payment Procedures.

(a) Applicability.

(1) This section does not apply to family care services.

(2) A provider agency that chooses to request retroactive payment must comply with the requirements of this section.

(b) Definition of retroactive payment. A retroactive payment is payment by the Texas Department of Human Services (DHS) to a provider agency for services under the Primary Home Care Program that are provided before the date the case manager determines the person’s eligibility for the services.

(c) Reimbursement.

(1) The provider agency may be reimbursed for services provided before the date a completed, signed, and dated copy of DHS’s Application for Assistance—Aged and Disabled form is received:

(A) for up to three months for a person who does not have Medicaid eligibility at the time of the request for retroactive payment; and

(B) for an indefinite period for a person who is Medicaid eligible at the time of the request for retroactive payment.

(2) DHS only reimburses the provider agency for the:
(A) services described in §47.41 of this chapter (relating to Allowable Tasks);

(B) number of hours of services allowed to be provided the person, calculated as described in §48.2918(c) of this title (relating to Eligibility for Primary Home Care); and

(C) allowable costs of the Primary Home Care Program, as described in 1 TAC, Chapter 355 (relating to Medicaid Reimbursement Rates).

(3) DHS will not reimburse the provider agency for the retroactive period if:

(A) the provider agency fails to submit the required documentation within the required time frames; or

(B) the person provided services does not meet the requirements described in subsection (d) of this section.

(d) Requirements before requesting retroactive payment. The provider agency may not request retroactive payment unless:

(1) the person appears to be Medicaid eligible as defined in §48.1201 of this title (relating to Definition of Program Terms);

(2) the provider agency obtains a practitioner’s written statement as described in §47.47 of this chapter (relating to Medical Need Determination);

(3) the person requires at least one personal care task as described in §47.41 of this chapter; and

(4) the provider agency has verified and documented that the person is not already receiving services under the Primary Home Care Program from another provider agency.

(e) Pre-initiation activities. The provider agency must complete the pre-initiation activities described in §47.45(a) of this chapter (relating to Pre-Initiation Activities).

(f) Intake referral. On the day that the provider agency completes the pre-initiation activities, the provider agency must contact the local DHS office by telephone and make an intake referral by providing DHS information on the person to start the eligibility process.

(g) Service initiation. The provider agency must not begin to provide services to the person before the date the provider agency completes the pre-initiation activities and processes the intake referral as described in subsections (e) and (f) of this section.

(h) Requesting retroactive payment.

(1) A provider agency’s written request for retroactive payment must include:

(A) a copy of the service plan required by subsection (e) of this section;

(B) a copy of DHS’s Practitioner’s Statement of Medical Need form; and
(C) the retroactive payment information, including the:

(i) name of the provider agency;

(ii) contact information for the person;

(iii) date services were started;

(iv) tasks provided to the person. This includes both tasks allowed and not allowed by the Primary Home Care Program;

(v) weekly hours of service provided to the person. This includes hours allotted to tasks allowed and not allowed by the Primary Home Care Program; and

(vi) cost per hour of service charged to the person.

(2) The provider agency must submit the written request for retroactive payment:

(A) to the case manager or, if no case manager has been assigned, to DHS intake staff; and

(B) within seven days after the date the provider agency processes the intake referral.

(i) Charges to persons who receive services.

(1) The provider agency may charge a person for services for which the provider agency intends to request retroactive payment, unless the person is Medicaid eligible.

(2) The provider agency must reimburse the entire amount of all payments made by the person to the provider agency for eligible services, even if those payments exceed the amount DHS will reimburse for the services, if DHS determines that the person is eligible for the Primary Home Care Program.

(j) Documentation of retroactive payment requests. The provider agency must maintain documentation of retroactive payment requests in the person’s file.

§47.87. Record Keeping.

(a) General record keeping requirements. The provider agency must maintain records according to:

(1) Chapter 49 of this title (relating to Contracting for Community Care Services);

(2) Chapter 69 of this title (relating to Contracted Services); [and]

(3) the terms of the contract.

(4) this chapter; and

(5) the provider agency’s company policies.
(b) Program specific records. The provider agency must maintain records of compliance with the requirements of this chapter.

(c) Financial records. The provider agency must maintain financial records:

(1) to support its billings to DADS [the Texas Department of Human Services (DHS)] for payment under §47.89 of this chapter (relating to Reimbursement);

(2) to document reimbursements made by DADS [DHS]. The documentation must include:

(A) amount of reimbursement;
(B) voucher number;
(C) warrant number;
(D) date of receipt; and
(E) any other information necessary to trace deposits of reimbursements and payments made from the reimbursements in the provider agency’s accounting system; and

(3) in accordance with generally accepted accounting principles (GAAP) and DADS [DHS] procedures. A provider agency’s financial records must include the following:

(A) deposit slips, bank statements, cancelled checks, and receipts;
(B) purchase orders;
(C) invoices;
(D) journals and ledgers;
(E) payroll and tax records;
(F) service delivery documentation;
(G) Internal Revenue Service, Department of Labor, and other government records and forms;
(H) records of insurance coverage, claims, and payments (for example, medical, liability, fire and casualty, and workers' compensation);
(I) equipment inventory records;
(J) records of the provider agency's internal accounting procedures;
(K) chart of accounts, as defined by GAAP; and
[(L) records of the provider agency’s company policies.]
(d) Subcontractor records. If a provider agency utilizes a subcontractor, the provider agency must maintain records of the subcontractor’s activities. Maintaining all records to support subcontractor claims is the responsibility of the provider agency.

(e) Failure to maintain records. Failure to maintain records as specified in this section may result in:

1. corrective action plans;
2. monetary exceptions; or
3. other actions deemed necessary or appropriate by DADS [DHS].

§47.89. Reimbursement.

(a) Billing requirements.

1. The provider agency must bill for services provided as described in §49.41 of this title (relating to Billings and Claims Payment).

2. The provider agency must not bill DADS [Texas Department of Human Services (DHS)] for:

   (A) more hours than the individual's [the client's] weekly authorization, except when services are delivered as described in §47.63(a [b]) of this chapter (relating to Service Delivery);

   (B) services delivered in a licensed facility, if the facility is required by the license to provide those services; and

   (C) services or tasks that duplicate any services or tasks provided to the individual [client] by another source.

(b) Unit rate. The provider agency must agree to accept the unit rate authorized by DADS [DHS].

(c) Documentation. The provider must maintain the documentation described in this chapter to be eligible for reimbursement.

(d) Rounding. The provider agency must bill DADS [DHS] for services in quarter-hour increments, rounding up to the next quarter-hour if the actual time worked is eight minutes or more, and rounding down to the previous quarter hour if the actual time worked is seven minutes or less.

(e) Allowable Tasks. The provider agency must bill DADS [DHS] only for the tasks described in §47.41 of this chapter (relating to Allowable Tasks).

Subchapter G, Utilization Review
§47.91. Utilization Review.

(a) DADS conducts a utilization review of a service plan and supporting documentation at any time to:

(1) determine appropriateness of services;

(2) validate service provision; or

(3) evaluate quality of services.

(b) Providers must submit to DADS documentation supporting the service plan as requested by DADS.

(c) If DADS determines that one or more of the services specified in a service plan do not meet the requirements described in Subchapters D and E of this rule, DADS denies or reduces the service, modifies the service plan, and sends written notification to the individual and provider.

(d) DADS may conduct utilization reviews of providers and services based on utilization patterns and trends.

Subchapter H, Integrated Care Management

§47.101. Definitions.

The majority of words, terms, and phrases associated with the Primary Home Care program, as defined in §47.43, apply to the Integrated Care Management program; however, there are words, terms, and phrases specific to the ICM program that have the following meanings when used in this subchapter, unless the context clearly indicates otherwise:

(1) ICM--Integrated Care Management

(2) ICM Contractor-- An entity under contract with the Texas Health and Human Services Commission (HHSC) and responsible for managing and coordinating acute care services and long term services and supports (LTSS) for applicants and individuals for the ICM Program.

(3) ICM Program -- A combined waiver program HHSC and DADS operate as authorized by the Centers for Medicare and Medicaid Services (CMS) in accordance with §1915(b) and §1915(c) of the Social Security Act, where an ICM contractor manages and coordinates acute care services and LTSS services for eligible individuals.

(4) Primary Home Care Program—An ICM attendant care services program. In the ICM program, the Primary Home Care (PHC) Program consists of only PHC services. The ICM contractor is responsible for managing PHC services for ICM members.
case managers are responsible for managing CA and FC services for ICM members.

(5) Provider agency—A licensed home and community support services agency that contracts with DADS and the ICM contractor to provide services to ICM members in exchange for reimbursement.

(6) Service Plan—A single document that is agreed upon and signed by an individual and the ICM contractor. The service plan must include the elements described in §47.45(a)(2) of this chapter.

§47.103. ICM Service Coordination

(a) Title XIX Primary Home Care (PHC) services for ICM members are coordinated through the ICM Contractor. Title XX services are coordinated through DADS case managers.

(b) The ICM Contractor is responsible for administrative services related to service coordination and utilization review, including the authorization and management of Medicaid services.

(c) The ICM Contractor is not responsible for monitoring the provider agency’s contract with DADS or for paying claims.

(d) DADS is responsible for service plan approval, contract monitoring, and claims payment tasks.

§47.105. Overview of the Process.

The provider agency must comply with §47.5 of this chapter, except as noted in the following sections of this sub-chapter.

§47.107. Contracting Requirements.

(a) The provider agency must:

(1) comply with contracting requirements as described in §47.11 of this chapter; and

(2) contract with the ICM contractor to provide services.

§47.109. Staff Requirements.

The provider agency must comply with staff requirements as described in §47.21, §47.23, and §47.25 of this chapter.

§47.111. Allowable Tasks

The ICM Primary Home Care program includes the tasks as described in §47.41.

§47.111. Referrals
The provider agency must comply with referral requirements as described §47.43 except as follows.

(a) The provider agency must accept all ICM Contractor referrals for services under the ICM Primary Home Care program.

(b) There are two methods of referral:

(1) For verbal referrals, the ICM Contractor makes the referral by phone and on DADS' Authorization for Community Care Services form.

(2) For routine referrals, the ICM Contractor makes the referral on DADS' Authorization for Community Care Services form.

§47.113. Pre-Initiation Activities.

(a) The provider agency must comply with pre-initiation requirements as described §47.45 with the following exceptions:

(1) the ICM contractor is responsible for developing a service plan in coordination with the provider;

(2) the ICM contractor is responsible for obtaining the practitioner’s statement; and,

(b) the provider agency must orally notify the ICM Contractor with respect to:

(1) service plan deviations; and

(2) pre-initiation activities.

§47.115. Medical Need Determination.

In addition to complying with the medical need determination requirements as described §47.47 of this chapter, the ICM Contractor must coordinate with DADS to complete the tasks required to determining the individual’s medical need.

§47.117. Interdisciplinary Team.

(a) The provider agency must comply with interdisciplinary team (IDT) requirements as described §47.49, except that:

(1) instead of a DADS representative, the IDT must include an ICM Contractor representative; and

(2) any actions requiring notification, review, or documentation by a DADS case manager are the responsibility of the ICM Contractor.

§47.119. Service Delivery Options.

The provider agency must comply with service delivery option requirements described in §47.57 of this chapter.
§47.121. Support Consultation.

The provider agency must comply with support consultation requirements described in §47.59 of this chapter.

§47.123. Service Initiation.

The provider agency must comply with service initiation requirements in described in §47.61 of this chapter.

§47.125. Service Delivery.

The provider agency must comply with service initiation requirements in described in §47.63 of this chapter.

§47.127. Supervisory Visits.

The provider agency must comply with supervisory visit requirements described in §47.65 of this chapter.

§47.129. Service Plan Changes.

(a) The provider agency must comply with service plan change requirements described in §47.67 of this chapter, with the following exceptions:

   (1) Increase in hours or terminations. The provider agency must send notice to the ICM Contractor in writing within seven days of learning of any changes described in §47.67(1) and §47.67(2) of this chapter.

   (2) Decrease in hours. The ICM Contractor must develop a new service plan, as described in §47.45(a)(2) of this chapter (relating to Pre-Initiation Activities), within 21 days of the provider agency identifying the need for an ongoing decrease in hours from the service plan currently approved by the individual.

   (3) Immediate increase in hours. The provider agency must:

       (A) discuss with the ICM Contractor the reason an individual requires an immediate increase in service hours; and

       (B) must obtain approval from the ICM Contractor for both:

       (i) the number of additional service hours to be provided the individual; and

       (ii) the effective date of the change.

       (C) implement the immediate increase in hours on the date negotiated with the ICM Contractor.

       (D) document the immediate increase in hours as required in §47.67(c)(3), except that documentation must include the name of the ICM Contractor representative
who approved the change.

§47.131. Transfers.

The provider agency must comply with transfer requirements described in §47.69 of this chapter except that provider agencies involved in an individual transfer must coordinate with the ICM Contractor to negotiate the transfer date.

§47.133. Suspensions.

The provider agency must comply with suspension requirements in §47.71 of this chapter with the following exceptions described at §47.71(a)(1) and §47.71(a)(7):

(a) Required suspensions. The provider agency must suspend services if:

(1) the individual permanently leaves the state or moves to a county where the provider agency does not contract with DADS and the ICM Contractor to provide services under the Primary Home Care Program; or

(2) the individual or someone in the individual's home exhibits reckless behavior, which may result in imminent danger to the health and safety of the individual, the attendant, or another person. If this occurs, the provider agency must make an immediate referral to:

(A) the Texas Department of Family and Protective Services or other appropriate protective services agency;

(B) local law enforcement, if appropriate; and

(C) the individual's ICM Contractor representative.

(b) Optional suspensions. The provider agency may suspend services if:

(1) the individual or someone in the individual's home engages in discrimination against a provider agency or ICM Contractor employee in violation of applicable law; or

(2) the individual refuses services for more than 30 consecutive days.

(c) Notification of service suspension. The provider agency must notify the ICM Contractor by fax of any suspension by the next working day. The faxed notice of a suspension must include those elements described in §47.71(c)(1)-(4) of this chapter.

(e) Resuming services after suspension.

(1) The provider agency must resume services after suspension in compliance with §47.71(e) of this chapter, with the following exceptions:

(B) on the date specified in writing by the ICM Contractor;

(D) upon the provider agency’s receipt of notification from the ICM Contractor that the provider agency must resume services pending the outcome of the
appeal.

(2) The provider agency must notify the ICM Contractor in writing of the date services resume and must send the notice within seven days of that date.

§47.135. Compliance with Program Requirements.

(a) Termination of services. The ICM Contractor must request that DADS terminate services to an individual who has had services suspended on more than three occasions as described in §47.71(a)(7) or §47.71(b)(1) of this title.

(b) If DADS approves a request to terminate services, the rights of appeal and notification requirements described at §47.72(b-c) of this chapter apply.

§47.137. Complaints.

In addition to the complaint requirements in described in §47.75 of this chapter, ICM providers must comply with complaint procedures described in the ICM Contractor’s Provider Administrative Manual.

§47.139. Monitoring Medicaid Eligibility.

The provider agency must comply with requirements to monitor Medicaid eligibility as described in §47.81 of this chapter.

§47.141. Monitoring Reviews.

(a) All provisions described in §47.83 of this chapter apply to the ICM program with the following exceptions related to financial errors:

(1) Fiscal monitoring. Fiscal monitoring in the ICM program includes monitoring financial errors, which are applied to the entire unit of service.

(2) Financial errors include when the provider agency makes a claim for services, but the date of the ICM Contractor’s approval of the practitioner’s statement is after the first day services were delivered. DADS applies the error to the total number of units claimed before the practitioner’s statement date.

§47.143. Record Keeping.

The provider agency must comply with record keeping requirements described in §47.87 of this chapter.

§47.145. Reimbursement.

The provider agency must comply with reimbursement requirements described in §47.89 of this chapter.

§47.147. Utilization Review.

All provisions described in §47.91 of this chapter apply to the ICM program with the
following exceptions:

(a) In the ICM program the ICM Contractor, instead of DADS, is responsible for conducting all utilization review tasks.

(b) If the ICM Contractor determines that one or more of the services specified in a service plan do not meet the requirements described in Subchapters D and E of this chapter, the ICM Contractor will request DADS approval to deny or reduce the service.

(c) If DADS approves a request to deny or reduce a service, the ICM Contractor will modify the service plan and send written notification to the provider.

(d) If DADS approves a request to deny or reduce a service, DADS will send written notification to the individual.