

MEMORANDUM

SUBJECT: Community Care Policy Clarification CCAD 03006, CBA 03002, CBA/AFC 03002, CBA AL/RC 03002, CDS 03001, MDCP 03001

TO: Regional Administrators
Regional Directors
Long Term Care Services

FROM: Becky Beechinor
Assistant Deputy Commissioner
Long Term Care
State Office W-511

DATE: August 15, 2003

Policy Question 1:

Is there a time limit to how often dentures can be authorized on the Individual Service Profile (ISP) for Community Based Alternatives (CBA) clients?

Policy Clarification 1:

No.

Policy Question 2:

Does CBA pay for gloves for incontinent care if the client lives in an Adult Foster Care (AFC) Home?

Policy Clarification 2:

The rate set for CBA AFC providers take into account the higher level of care provided and thus gloves would not be covered as a separate supply.

Policy Question 3:

Does CBA pay for gloves for incontinent care or universal precautions for family members?

Policy Clarification 3:

No. Universal precautions are guidelines to protect health care workers, as well as patients, from exposure to HIV, hepatitis B, hepatitis C, and other blood borne germs. Following these guidelines, health care workers treat blood, certain body fluids (including semen, vaginal fluid, and synovial fluid), and tissue from all patients as if they were infectious. The guidelines do not apply to body fluids such as sweat, tears, saliva, urine, and feces **unless they contain visible blood.**

Universal precautions do not apply to family members or clients providing care. They should be taught good hand washing techniques, as good hand washing is the most important technique for stopping the spread of microorganisms.

Exception #1: The CBA program will pay for gloves for family use in the care of the incontinent client, if the client has an **active** infectious disease that is transmitted through urine (if incontinent of urine) or stool (if incontinent of stool). Examples of active infectious diseases that would qualify are MRSA and Hepatitis.

Exception #2: The CBA program will provide gloves for family members to use to provide wound care to protect the client.

Policy Question 4:

On October 9, 2002, an approval was given for a wheelchair trailer for a client. The Home and Community Support Services (HCSS) obtained the trailer. Now additional money is being requested because the trailer was not considered Tax Exempt. The 3671-E reflects \$230.00 is required to pay for the taxes. Do we approve payment for taxes or is this considered an added expense for the wheelchair trailer?

Policy Clarification 4:

Yes, we can approve payment of taxes as part of the cost of the trailer. Trailers are not tax-exempt items.

Policy Question 5:

Can CBA pay for an electric hospital bed for a client in an Assisted Living (AL) facility?

Policy Clarification 5:

CBA is the payer of last resort. CBA will pay for a partial electric hospital bed only if the bed is medically necessary and related to the client's diagnosis or disability. Medicare, Medicaid, and other third party resources should be pursued prior to submitting the request for payment to the CBA program. CBA will not pay for an electric hospital bed that is requested solely for staff convenience.

Policy Question 6:

Can CBA pay for a hooyer lift for a client in an AL facility?

Policy Clarification 6:

CBA is the payer of last resort. CBA will pay for a hooyer lift only if the lift is medically necessary and related to the individual client's diagnosis or disability. Medicare, Medicaid, and other third party resources should be pursued prior to submitting the request for payment to the CBA program. CBA will not pay for a hooyer lift that is solely for staff convenience or used for other clients.

Policy Question 7:

Can CBA pay for Geri-chairs?

Policy Clarification 7:

CBA will pay for a Geri-chair only if the client is alert, oriented, and able to remove the tray table **without** assistance and as desired. Otherwise, a Geri-chair would be considered a restraint. The CBA program does not pay for restraints. Evidence-based best practice research has shown that use of restraints have a detrimental effect on clients.

Policy Question 8:

CBA policy 4141 states "CBA funds can be used to purchase window air conditioners, etc., for a client's principal living area, such as a bedroom. CBA does not pay for multiple air conditioners to cover a client's residence. Does this mean clients are limited to one air condition unit per home?"

Policy Clarification 8:

The CBA program will only pay for one air conditioner unit for the client's principal living area.

Policy Question 9:

If client already has an air conditioner prior to CBA, can a second air conditioner be requested through CBA for the living room?

Policy Clarification 9:

The CBA program will only pay for one air conditioner unit for the client's principal living area. If the principal living area already has an air conditioner unit, CBA would not purchase another unit to cool another part of the house.

Policy Question 10:

Does CBA pay for dental implants?

Policy Clarification 10:

CBA does not pay for dental implants. The list of approved dental modalities found in the CBA Case Manager (CM) handbook does not include implants. The definition of an adaptive aid is "devices medically necessary to treat, rehabilitate, prevent or compensate for medical conditions resulting in disability or loss of function. Adaptive Aids (AA) enable persons with functional impairments to perform the activities of daily living or control the environment in which they live." AA "should be limited to the most cost effective items that can meet the client's needs, directly aid the participant to avoid premature nursing facility (NF) placement and provide NF residents an opportunity to return to the community." Dental implants do not meet the definition of an adaptive aid. The caseworker must forward requests for dental treatments other than those specifically listed in the handbook to the regional nurse for review and approval/denial.

Policy Question 11:

Can CBA pay for outpatient charges? We have a client that needs dentures and due to his medical history, the dentist is requesting that he go through outpatient surgery. Regional nurses need to know if they can approve this through CBA. If a waiver client goes to a hospital to get dental services as an outpatient, due to need

for anesthesia, is this a valid/allowable expense for dental service under a waiver program?

Policy Clarification 11:

It would be an allowable expense as long as the person was there only on an "outpatient" basis. If the waiver client were admitted, then it would not be allowable. Federal regulation 441.300 says to provide waiver services "ONLY TO RECIPIENTS WHO ARE NOT INPATIENTS OF A HOSPITAL, SNF, ICF ICF/MR."

Policy Question 12:

Who would be responsible for gloves in the Consumer Directed Services (CDS) option, when the Personal Care Attendant works for the client and the client is the employer?

Policy Clarification 12:

The CDS client should claim the gloves as an Administrative Employer-Related Expense. The client can claim any expense that is related to being the employer. The CDS (VFI) Agency Training Guide, page 39, includes a chart that lists allowable compensation and administrative expenses. Rate Analysis provided this chart, which lists the most common expenses.

Policy Question 13:

I received a request for aloe vera cream, moisture barrier, and lanolin wipes. The client is incontinent of bowel and bladder daily. I know, according to the policy manual that incontinent supplies are covered. I think the caseworkers should be able to approve these things. Are these medical supplies still considered approved? Can caseworkers approve these items?

Policy Clarification 13:

Incontinence supplies are not covered as a "grouped" item in the CBA CM handbook. Medicaid may pay for skin barrier wipes and moisture barriers. Lanolin wipes are a convenience item. Aloe Vera cream is an over the counter item and only one type of the cream is considered a moisture barrier. Caseworkers should not approve the items and should refer these requests to the regional nurse. The caseworker may not recognize that the items are similar and may be duplicative. That is where nursing knowledge and experience plays a vital role in ensuring that requested items are a medical necessity and not just convenience items.

Policy Question 14:

Should the CBA HCSS agency registered nurse not submit to the Texas Department of Human Services (DHS) case manager requests for adaptive aids, minor home modifications, or medical supplies, that she knows/thinks CBA doesn't pay for?

Policy Clarification 14:

The CBA HCSS agencies must submit such requests with the supporting documentation to DHS staff for a decision. It is outside the HCSS agency RN's role to make decisions about what DHS will/will not pay for. Decisions regarding such requests must be made by DHS staff and must be made under DHS procedures to ensure that the client's due process rights are observed. Clients have the right to appeal denial of services through the CBA program.

Policy Question 15:

Does the CBA program pay for safety needles and lancets for clients in an assisted living facility?

Policy Clarification 15:

No. Needles and syringes are available through the Vendor Drug Program (VDP) and diabetic testing supplies are available through Medicaid and Medicare. CBA does not pay for items paid through Medicaid, Medicare, or other third party resource.

The AL provider is required to use safe engineering devices and must have their own requirements concerning needle safety in their facility. If the provider uses needles or syringes other than that provided through the VDP, they should include the costs on their cost report.

Policy Question 16:

Can the CBA program pay for Aloe Vesta cream?

Policy Clarification 16:

The CBA program does not pay for over the counter creams or lotions except for skin barrier products. The item must be verified as being a skin barrier product prior

to approval being given. For instance, Aloe Vesta has numerous products. Only one is listed as a skin protective cream that is petroleum based.

Policy Question 17:

Does the CBA program pay for diabetic shoes, slippers, or socks?

Policy Clarification 17:

Diabetic shoes are paid for through Medicare if there is a physician order. If the client does not have Medicare, diabetic shoes could be approved if there is a documented medical need and a physician order for the shoes. The regional nurse should evaluate requests for diabetic slippers or socks on an individual basis.

Policy Question 18:

TED Hose are not listed on the list of allowable medical supplies/adaptive aids but is a frequently needed item by CBA clients. Any chance these can be approved without having to obtain regional nurse approval?

Policy Clarification 18:

The regional nurse should review all initial requests for TED hose. There are many variables that should be considered in the approval process that require the medical knowledge and expertise of the nurse to make the decision. A caseworker may approve a subsequent request for TED hose if a regional nurse approved the original request AND there has not been a change in the client's condition and ability to apply and remove the hose. The caseworker should consult with the regional nurse if he or she has a question whether the request should be approved.

Policy Question 19:

We need clarification regarding electrical wiring for air conditioning units. Back in 1998 we received clarification from state office, that CBA does not authorize wiring to accommodate air conditioners but have requested air conditioners be purchased that can be run in the current wiring system. In 2001, we received another clarification from state office that if the electrical wiring on the CBA manual does not apply to air conditioners, that caseworker should submit these request to the regional nurses as a special waiver. These two clarifications are contradictory; therefore we are requesting that you provide us with the correct procedure. We have some agencies that are requesting for a bigger air conditioning unit and then make a request for wiring, which would involve installing a dedicated electrical box

to accommodate the larger unit. Should regional nurses be approving these requests or should the CWs have agency submit a request for a smaller unit that will fit the wiring at client's home?

Policy Clarification 19:

The CBA program purchases air conditioning units for cooling the primary living space of the client. The program does not purchase the large units that cool the entire house or section of the house. Electrical wiring should be approved only if necessary for the approval of one air conditioning unit for the primary living space of the client if the air conditioning unit meets the medical necessity requirements listed in the CBA CM Handbook.

Policy Question 20:

I need a clarification for section 4443.2 of the CBA Handbook. The section in question states: Examples of legitimate licensure reasons for declining acceptance of care include:

- The lack of a specialty nurse(s) available for a medically complex case. Such a case could include an applicant who is ventilator dependent and the agency does not employ a licensed nurse or a sufficient number of licensed nurses with ventilator experience.
- A client who requests attendant services during the time the HCSS agency is not open for business.
 1. Does the section mean that an agency can refuse a client if their office hours are 8 to 5 and the client wants services at 6:00 p.m.?
 2. Another question is if the agency's hours are 8 to 5, and they have a client with Personal Attendant Services (PAS) hours after 5 does the agency have to offer a back-up if the attendant does not show?

Policy Clarification 20:

The HCSS agency who accepts a client is doing so with the understanding that they are able to meet the client's needs and plan of care. If service delivery is after hours and is part of the client's plan of care, then the agency should provide back up. If the agency determines that they cannot meet the client's needs, then they may either refuse to accept the client or discharge the client with reasonable notice.

Policy Question 21:

Does CBA pay for Oxygen?

Policy Clarification 21:

Yes. Per the CBA CM handbook 4424.9, Oxygen - Equipment necessary to provide oxygen, including but not limited to concentrators, tanks, and regulators, is considered medically necessary durable equipment not covered in the state plan for the Texas Medicaid Program and must be billed under adaptive aids. Tubing, masks, cylinder refills, and distilled water are examples of some medical supplies necessary for pulmonary and respirator or ventilator care and are to be billed under medical supplies. Paying the co-insurance for oxygen provided on a rental basis through Medicare or private insurance is a cost effective way of providing service to an individual when purchase is not considered or the oxygen can be rented with the option to buy. If this is the case, the oxygen co-insurance is billed under adaptive aids.

Policy Question 22:

Does the CBA program pay for Fleet's enemas?

Policy Clarification 22:

The Medicaid VDP pays for enemas with a physician order. Their website does not list the specific brand that is covered. The VDP should be accessed for enemas.

Policy Question 23:

Can there be an exception to the CBA rule that the spouse cannot be the paid provider?

Policy Clarification 23:

No. The caseworker should explore other non-waiver services that may provide assistance.

Policy Question 24:

We have received an HCSS agency request for a client for this specialized medication system at \$75.00/month. This system has built in monitoring capability. It plugs into the phone line and if medications are not dispensed after several reminders, client's family or friends are called automatically by phone. This system is tied into an IMD center that conducts nightly checks to insure system is working. They have trained staff to answer questions that provide support to clients over the

phone. The agency sent me a brochure explaining the system. A lot of our clients are not able to self medicate and some do need reminders. Personally, I think there are other alternatives to helping clients with their medications. Can CBA pay for such a system?

Policy Clarification 24:

State office staff has received information on this type of system and it appears to be appropriate in some situations. For instance if the individual lives alone and there is not a support system available this type of system may be appropriate. If someone has family members that can call to remind him or her to take their pills, it would not be appropriate to approve this system for convenience. Just like everything else, there should not be an automatic approval for this type of system and there should be sufficient documentation to support for this as opposed to the normal pill planners.

Policy Question 25:

Can the CBA program pay for hyperbaric chamber treatments?

Policy Clarification 25:

No. These treatments are not included under therapy services through the CBA program. Therapy services include physical therapy, occupational therapy, and speech pathology services.

Medicare, Medicaid, or third party resources should be used to pay for hyperbaric chamber treatments. The 2003 Texas Medicaid Providers Procedure Manual, section 24.3.3.21, lists the only FDA-approved indications for hyperbaric oxygen chamber (therapy) in accordance with the guidelines established by the Undersea and Hyperbaric Medical Society.

Policy Question 26:

Do children who move into the CBA program due to aging out of the Medically Dependent Program or the Comprehensive Care Program qualify for Rider 7?

Policy Clarification 26:

Yes.

Policy Question 27:

Does a HCSS agency nurse have to do an onsite assessment of a potential CBA client? (The HCSS agency received 3652, 2060 and 3671-C).

Policy Clarification 27:

The initial assessment of a potential CBA client must be completed on site because the CBA program pays for this assessment. If the initial HCSS agency that the client was referred to does not accept the potential client, other agencies that the client is referred to do not have to make onsite visits, unless the case worker has authorized the payment of a second pre-enrollment assessment.

Policy Question 28:

Do we pay for multiple assessments when a referral(s) are made to various HCSS agencies?

Policy Clarification 28:

A second on-site assessment may be authorized by the caseworker if the potential client was not accepted by the first HCSS agency he or she was referred to.

Policy Question 29:

Are concrete ramps covered as a waiver service?

Policy Clarification 29:

No. Waiver programs pay for treated lumber ramps. If the client requests an upgrade in materials (e.g. Redwood to match house or concrete), the client must absorb the additional cost above the cost of treated lumber.

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If you have any questions, please contact your regional contact person.

Signature on file

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