

# MEMORANDUM

**SUBJECT:** Community Care Policy Clarification CCAD 04012, PHC 04004

**TO:** Regional Administrators  
Regional Directors  
Long Term Care Services

**FROM:** Bettye M. Mitchell  
Deputy Commissioner  
Long Term Care  
State Office W-515

**DATE:** August 10, 2004

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The following clarifications pertain to the Contracting to Provide Primary Home Care (PHC) rules that became effective June 1, 2004.

**Policy Question 1:**

Is the Texas Department of Human Services (DHS) requiring that the Form 3052 be used as the practitioner's statement?

**Policy Clarification 1:**

DHS's Form 3052, Primary Home Care Practitioner's Statement of Medical Need, is provided for agencies that choose to use this form to document a practitioner's statement. Obtaining a practitioner's statement is a necessary component of finalizing eligibility for PHC or Community Attendant Care. The definition of the required statement is found in §47.3 and states:

(14) Practitioner's statement--A document such as the DHS Practitioner's Statement of Medical Need form that includes:

(A) a statement signed by a practitioner that the 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.

Agencies may use other forms of a practitioner's statement, and documentation of the certification that the practitioner is not excluded if these two required elements are included.

The exception is for requests for retroactive reimbursement for PHC. The provider's written request for retroactive payment must include a signed copy of DHS's Form 3052, Practitioner's Statement of Medical Need.

**Policy Question 2:**

Is the provider agency required to provide additional orientation to an attendant when the attendant will be providing services to a client he previously cared for, or when there is a service plan change, or when the attendant meets licensure requirements as a Home Health Aide, or has six months continuous experience in delivering attendant care?

**Policy Clarification 2:**

Yes. The provider agency must orient the attendant so he is aware of the client's current condition and tasks to be performed. In these circumstances the orientation may be done by telephone, rather than in person, at the discretion of the supervisor.

**Policy Question 3:**

§47.45 Pre-Initiation Activities subsection (d)(2)] "The provider agency must orally notify the case manager of any failure to complete the pre-initiation activities for negotiated referrals before the negotiated service initiation date." If the provider agency attempts to meet with the client on the negotiated start date to complete pre-initiation activities and the client is not home, agency staff cannot meet the timeframe for notifying the case manager. How is "before the negotiated service initiation date" measured in monitoring?

**Policy Clarification 3:**

The provider agency is considered to be in compliance with the notification timeframe if the oral notification of the inability to complete pre-initiation activities occurs prior to the:

- close of business on the negotiated service initiation date; or
- next workday if the negotiated start date falls on a weekend.

**Policy Question 4:**

When a delay occurs in completing pre-initiation activities or initiating services, the provider agency is to document the date it anticipates completion or initiation, or the reason the date cannot be anticipated. Is 'as soon as possible' (ASAP) acceptable documentation?

**Policy Clarification 4:**

No, ASAP is not acceptable. This conveys no real information. If circumstances are such that a date cannot be anticipated, the agency should provide the reason.

**Policy Question 5:**

Will a case manager be able to issue authorization for Community Attendant (CA) cases that transfer from one agency to another when the written notice of service initiation is received or will this information need to go to the regional nurse?

**Policy Clarification 5:**

§47.69 Transfer requires that inter-agency transfers be coordinated with the case manager to negotiate the transfer date. The receiving agency must initiate services on the begin date (Item 4) on DHS's Form 2101, Authorization for Community Care Services form.

The regional nurse does initial authorizations and annual re-authorizations of CA services. Interim plan changes, including transfers are negotiated with the case manager.

**Policy Question 6:**

The rules require that notification of service plan changes involving an increase in hours or loss of personal care tasks include the "type of change (including the number of service hours)". Why is this required, as provider agencies do not authorize hours?

**Policy Clarification 6:**

If the provider agency is communicating the need for an increase in hours to the case manager, there is a presumption that the agency has been notified of the change in client circumstances supporting the need for a change. The "number of service hours" to be included in the notification of the need would be a statement of the hours requested to meet the new service plan negotiated with the client. The provider agency must request an increase in the authorized hours from the case manager using the written notification described in §47.67(a)(2).

**Policy Question 7:**

How is the start of a service interruption calculated for someone on a variable schedule?

**Policy Clarification 7:**

For a **priority client** on a variable schedule, the service interruption occurs on the Sunday of the week following the week in which the client received no service or less than the weekly hours shown on the service plan. The service plan must include [§47.45(a)(2)(C)(ii)] the total weekly hours of service DHS authorizes the client to receive.

For example: looking at a 2004 calendar: the first full week of the month of July begins on Sunday, July 4<sup>th</sup> and ends on Saturday July 10<sup>th</sup>.

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31

If a priority client on a variable schedule, authorized for twenty (20) hours per week, receives only 14 hours during the July 4<sup>th</sup> to July 10<sup>th</sup> period, the service interruption begins on July 11<sup>th</sup>, 2004 (the Sunday following the week in which the client received less than authorized services).

If a **non-priority** client on a variable schedule, authorized for twenty (20) hours per week, receives only 14 hours during the July 4<sup>th</sup> to July 10<sup>th</sup> period, the service interruption begins on July 11<sup>th</sup>, 2004 and the 14<sup>th</sup> day of service interruption is July 24, 2004.

**Policy Question 8:**

Are provider agencies required to use specific forms to document supervisory visits, attendant orientation, client evaluations, service plans, or other program activities? Will DHS provide a form for use?

**Policy Clarification 8:**

Provider agencies are responsible for documenting all required elements necessary to substantiate rule compliance. Each agency can develop a form or format for doing required documentation. Monitoring will review for required documentation, including all requisite elements, rather than specific forms. Because a specific form is not required for supervisory visits, attendant orientation and client evaluations and service plans, DHS will not develop forms to document these actions.

Provider response to referrals or service plan changes are best documented on DHS's Form 2101, Authorization for Community Care Services, as this form will have the correct identifying client information.

**Policy Question 9:**

§47.67 states: "The provider agency must implement the service plan change on the following date, whichever is later:

- 1) the authorization date (Item 4) on 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 DHS' 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. “

Does item 2 require that the provider wait five days to implement if the authorization date is earlier than the date of receipt?

**Policy Clarification 9:**

No, the intent is that the provider implements the change **within** five days of the receipt date, if receipt is later than the authorization date.

**Policy Question 10:**

Will Monitoring Standard 1 be applicable for any pre-initiation activities completed before the review period? Example: The authorization receipt date is June 10, the review period is July, August and September and all pre-initiation activities are completed on June 30.

**Policy Clarification 10:**

Standard 1 will be applicable to cases in which the pre-initiation activities were due or completed during the review period.

**Policy Question 11:**

Will Monitoring Standard 2 be applicable for any services initiated before the review period? Example: The referral date is June 17, agency receipt date is June 20, the review period is July, August, and September and service initiation is June 30.

**Policy Clarification 11:**

Standard 2 will be applicable to cases in which services were due to be initiated during the review period or were initiated during the review period.

**Policy Question 12:**

What records will be used to determine implementation date on service plan changes?

**Policy Clarification 12:**

The authorization from DHS (Form 2101) and service delivery records are reviewed.

**Policy Question 13:**

Can licensure references or licensure timeframes be added to complaints standard?

**Policy Clarification 13:**

Contract monitoring is based on the contracting rules for providers. Long Term Care Regulatory staff is responsible for ensuring compliance with licensure requirements. Providers must ensure adherence to all relevant rules.

*The following questions were received in response to a review of the financial monitoring instrument. The explanation of financial errors on DHS's Form 3059, Primary Home Care Program Fiscal Monitoring Guide, utilizes the same wording as the §47 rules.*

**Policy Question 14:**

The first two descriptions of financial errors indicate the error is applied to the total number of units reimbursed for the pay period. Errors 3-7 do not include wording regarding the pay period. Why is the error not based on a pay period?

**Policy Clarification 14:**

The review period for financial errors is one month. The number of units reimbursed for a specific client is determined from claims payment data. During financial monitoring, DHS contract staff review all available documentation of service delivery to clients in the sample for the service month under review.

The first two errors indicate service delivery documentation or the number of units delivered is missing. Because there is no support for units claimed and reimbursed for the pay period, the error is applied to the total number of units not supported.

- Item 3. If the documented hours for a client are less than those reimbursed, DHS applies the error to the units reimbursed in excess of the units recorded on the service delivery documentation. Those units that are properly recorded are not used in calculating the units in error.

- Item 4. If client information indicates the client did not receive services on a day or days during the review month, and reimbursement exceeded the services correctly and appropriately documented, the error is applied to the units reimbursed for the days during the review period on which the client did not receive services.
- Items 6 and 7. Provider agencies are required to have a valid Practitioner's Statement of Medical Need prior to delivery of Title XIX PHC or Community Attendant Services. If the agency did not secure the Practitioner's Statement prior to any of the units claimed during the review period, or the statement is missing, the error is applied to the non-covered units reimbursed for the review period. Providers are subject to recoupment of ineligible units reimbursed outside the review month.

Please note that the provider agency is not required to obtain a practitioner's statement (either a new one or a copy of the practitioner's statement obtained by the previous provider agency) for transfer cases. Contract Managers should not apply §47.83(6) and (7) to transfer cases.

**Policy Question 15:**

When services are reimbursed without or before a valid practitioner's statement date, does this affect the overall compliance percentage?

**Policy Clarification 15:**

Fiscal errors do not figure into the overall compliance percentages. Compliance monitoring does include a review to ensure the practitioner's statement was obtained as a requisite step in pre-initiation activities and a determination if all pre-initiation activities and documentation were done within the required timeframes. Failure to perform all pre-initiation activities or meet timeframes will affect the compliance percentage.

Please contact Janice Wallace at (512) 438-2188 if you have questions regarding the provider rules. Questions regarding PHC monitoring forms or processes may be directed to Lettie Ojeda at (512) 438-4768.

*Signature on file*

BMM:ck

c: PMs  
SO Staff