6EPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE AND MEDICAID SERVICES

1. TRANSMITTAL NUMBER: **07-018**

2. STATE: **TEXAS**

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
CENTER FOR MEDICARE AND MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: **September 1, 2007**

5. TYPE OF PLAN MATERIAL *(Circle One)*:

☐ ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
Section 1905(a)(6), Social Security Act, relating to medical care or any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State Law.

7. FEDERAL BUDGET IMPACT: SEE ATTACHMENT
a. FFY **2007** **$ 2,721**
b. FFY **2008** **$34,467**
c. FFY **2009** **$36,999**

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
See Attachment

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
See Attachment

10. SUBJECT OF AMENDMENT:
The amendment eliminates the 2.5 percent Medicaid payment reduction for Medicaid services delivered by providers of in-home total parenteral hyperalimentation services that was implemented September 1, 2003 and removes other language inapplicable to this section. The proposed amendment is effective September 1, 2007.

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Sent to Governor's Office this date. Comments, if any, will be forwarded upon receipt.

12. SIGN [redacted]

13. TYPED NAME:
Chris Traylor

14. TITLE:
State Medicaid Director

15. DATE SUBMITTED: 8/15/07

16. RETURN TO:
Chris Traylor
State Medicaid Director
Post Office Box 85200
Austin, Texas 78708

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 15 August, 2007

18. DATE APPROVED: 2 October, 2009

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 1 September, 2007

20. SIGNATURE OF REGIONAL OFFICIAL: [redacted]

21. TYPED NAME: Bill Brooks

22. TITLE: Associate Regional Administrator Div of Medicaid & Children's Health

23. REMARKS:

FORM CMS – 179 (07-92)

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
1301 Young Street, Room 833
Dallas, Texas 75202

CENTERS for MEDICARE & MEDICAID SERVICES

Division of Medicaid & Children's Health, Region VI

October 2, 2009

Our Reference: SPA TX 07-018

Mr. Chris Traylor
Associate Commissioner for Medicaid & CHIP
Health and Human Services Commission
Post Office Box 13247
Mail Code: H100
Austin, Texas 78711

Dear Mr. Traylor:

We have reviewed the State's proposed amendment to the Texas State Plan submitted under Transmittal Number 07-018, dated August 15, 2007. The purpose of this plan amendment is to clarify coverage and reimbursement for in-home total parenteral hyperalimentation by moving this service to the home health coverage pages. The amendment also eliminates the 2.5 Percent Medicaid payment reduction for Medicaid services delivered by providers of in-home total parenteral hyperalimentation services that was implemented September 1, 2003.

Based on the information submitted, we have approved the amendment for incorporation into the official Texas State Plan with an effective date change of September 1, 2007. A copy of the CMS-179 and the approved plan pages are enclosed with this letter.

If you have any questions, please contact Ford J. Blunt at (214) 767-6381.

Sincerely,

[redacted]

Bill Brooks
Associate Regional Administrator

Enclosures
cc: Tamela Griffin, Policy Development Support

7. **Home Health Services (continued).**

In-Home Services for Total Parenteral Nutrition (TPN)

a) Definition: In-home Total Parenteral Nutrition (TPN)/Hyperalimentation activities outlined in this section of the State plan are available to Medicaid eligible recipients for the treatment of conditions which require long-term nutritional support. TPN/Hyperalimentation is not available when oral/enteral intake will maintain adequate nutrition.

b) Services: Home health services, including in-home Total Parenteral Nutrition (TPN)/hyperalimentation activities, are provided to a recipient on his or her physician's orders as part of a written plan of care that the physician reviews every 60 days.

Medically necessary TPN/hyperalimentation services include:

i) Medical Supplies in accordance with 42 C.F.R. § 440.70(b)(3) including:

(A) TPN/Hyperalimentation solutions and additives as ordered by the client's physician.
(B) Supplies and equipment that are required for the administration of prescribed solutions and additives.
(C) Enteral supplies, nutritional products, and equipment, if medically necessary, in *conjunction* with TPN/hyperalimentation.

ii) Nursing Services in accordance with 42 C.F.R. § 440.70(b)(1):

(A) Visits by a registered nurse appropriately trained in the administration of TPN/Hyperalimentation.
(B) Education of the client and/or caregivers regarding the administration of in-home TPN/Hyperalimentation before the service begins. Education also must include the use and maintenance of required supplies and equipment.

c) Providers: In-home TPN/hyperalimentation equipment and supplies must be provided by an enrolled Medicaid durable medical equipment supplier or a medical supply provider who meets the requirements of, and provides the services in accordance with, 42 C.F.R. § 440.70 and other applicable state and federal laws and regulations.

Nursing services are delivered by Home Health Agencies meeting requirements for participation in Medicare and requirements at 42 CFR §440.70(d).

d) Place of Service: In home TPN/hyperalimentation services must be delivered in the recipient's place of residence as defined in 42 C.F.R. § 440.70.

7. **Home Health Services (continued).**

In-Home Services for Total Parenteral Nutrition (TPN)

a) Definition: In-home Total Parenteral Nutrition (TPN)/Hyperalimentation activities outlined in this section of the State plan are available to Medicaid eligible recipients for the treatment of conditions which require long-term nutritional support. TPN/Hyperalimentation is not available when oral/enteral intake will maintain adequate nutrition.

b) Services: Home health services, including in-home Total Parenteral Nutrition (TPN)/hyperalimentation activities, are provided to a recipient on his or her physician's orders as part of a written plan of care that the physician reviews every 60 days.

Medically necessary TPN/hyperalimentation services include:

i) Medical Supplies in accordance with 42 C.F.R. § 440.70(b)(3) including:

(A) TPN/Hyperalimentation solutions and additives as ordered by the client's physician.
(B) Supplies and equipment that are required for the administration of prescribed solutions and additives.
(C) Enteral supplies, nutritional products, and equipment, if medically necessary, in *conjunction* with TPN/hyperalimentation.

ii) Nursing Services in accordance with 42 C.F.R. § 440.70(b)(1):

(A) Visits by a registered nurse appropriately trained in the administration of TPN/Hyperalimentation.
(B) Education of the client and/or caregivers regarding the administration of in-home TPN/Hyperalimentation before the service begins. Education also must include the use and maintenance of required supplies and equipment.

c) Providers: In-home TPN/hyperalimentation equipment and supplies must be provided by an enrolled Medicaid durable medical equipment supplier or a medical supply provider who meets the requirements of, and provides the services in accordance with, 42 C.F.R. § 440.70 and other applicable state and federal laws and regulations.

Nursing services are delivered by Home Health Agencies meeting requirements for participation in Medicare and requirements at 42 CFR §440.70(d).

d) Place of Service: In home TPN/hyperalimentation services must be delivered in the recipient's place of residence as defined in 42 C.F.R. § 440.70.

25. In-home Services for Total Parenteral Hyperalimentation

The single state agency or its designee reimburses each provider on a monthly basis. Reimbursement is based on one-twelfth of the maximum yearly fee established by the single state agency or its designee. Effective January 1, 1993, the maximum yearly fee is $53,000 or $145 per day. The single state agency or its designee does not reimburse more than a one-week supply of solutions and additives if the solutions and additives are shipped and not used because of the recipient's loss of eligibility, change in treatment, or inpatient hospitalization. The provider must exclude from its monthly billing any days that the recipient is an inpatient in a hospital or other medical facility or institution. Payment for partial months will be prorated based upon actual days of administration. Hospital outpatient departments furnishing in-home total parenteral nutrition must be separately enrolled as a provider of in-home parenteral hyperalimentation.

STATE Texas
DATE REC'D 3-15-07
DATE APPV'D 10-2-09
DATE EFF 9-1-07
HCFA 179 07-18

A

SUPERSEDES: TN- 03-19

Attachment to Blocks 8 & 9 of CMS Form 179

Transmittal No. TX 07-018, Amendment 777

Number of the Plan Section or Attachment	Number of the Superseded Plan Section or Attachment
Appendix 1 to Attachment 3.1-A	Appendix 1 to Attachment 3.1-A
Page 15a	Page 15a (TN 92-15)
Delete Page	Page 26a (TN 89-019)
Delete Page	Page 26b (TN 89-019)
Appendix 1 to Attachment 3.1-B	Appendix 1 to Attachment 3.1-B
Page 15a	Page 15a (TN 92-15)
Delete Page	Page 26a (TN 89-019)
Delete Page	Page 26b (TN 89-019)
Attachment 4-19-B	Attachment 4-19-B
Page 18	Page 18 (TN 03-19)

Marks, Marsha L. (CMS/SC)

From: CMS SPA_Waivers_Dallas_R06
Sent: Wednesday, August 15, 2007 10:07 AM
To: Davenport,Barbara
Cc: Marks, Marsha L. (CMS/SC); Hall, Sandra D. (CMS/SC)
Subject: Confirmation

Importance: High

THIS MAILBOX IS FOR THE SUBMITTAL OF STATE PLAN AMENDMENTS AND SECTION 1915(b) AND 1915(c) NON-WEB BASED WAIVERS AND RESPONSES TO REQUESTS FOR ADDITIONAL INFORMATION ON SUBMITTED SPAs/WAIVERS ONLY. ANY OTHER CORRESPONDENCE WILL BE DISREGARDED.

This response confirms the receipt of your State Plan Amendment (SPA)/Waiver request or your response to a SPA/Waiver Request for Additional Information (RAI). You can expect a formal response to your submittal to be issued within 90 days. To calculate the 90th day, please count the date of this receipt as day zero. The 90th day will be 90 calendar days from that date.