

Chapter 412, Local Authority Responsibilities
Amendments to: §§ 412.108, 412.303, and 412.322
DRAFT 12-29-15

Legend: (Proposed Amendments)

Bold and Underlined = Proposed new language

~~Strikethrough~~ = Current language proposed for deletion

Regular Print = Current language

(No change.) = No changes are being considered for the designated subdivision

[Brackets] = Language for information only

[Concerning 412-C, Charges for Community-based Services (add language missing from current rule)]

§412.108. Billing Procedures.

(a) – (c) (No change.)

(d) Billing the person (or parents).

(1) No third-party coverage. If the monthly account amount for services not covered by third-party coverage:

(A) exceeds the person's maximum monthly fee (MMF), then the amount is reduced to equal the MMF and the LMHA bills person (or parent) the MMF; or

(B) is less than the person's MMF, then the LMHA bills the person (or parent) the monthly account amount for services not covered by third-party coverage.

(2) Medicare third-party coverage. Nothing in this paragraph is intended to conflict with any applicable law, rule, or regulation with which a LMHA must comply.

(A) The following amounts are added to equal the total amount applied toward the person's MMF:

(i) the amount of all applicable co-payments and co-insurance for services listed in the monthly account as covered by Medicare third-party coverage;

(ii) the amount Medicare third-party coverage was billed but did not pay because the deductible hasn't been met; and

(iii) the monthly account amount for services not covered by third-party coverage.

(B) If the total amount applied toward the person's MMF as described in paragraph (2)(A) of this subsection:

(i) exceeds the person's MMF, then the amount is reduced to equal the MMF and the LMHA bills person (or parent) the MMF; or

(ii) is less than the person's MMF, then the LMHA bills the person (or parent) the total amount applied toward the MMF.

(3) Non-Medicare third-party coverage.

(A) Cost-sharing exceeds MMF. If the amount of all applicable co-payments, co-insurance, and deductibles for services listed in the monthly account as covered by non-Medicare third-party coverage exceeds the person's MMF, then the LMHA bills the person (or parent) all applicable co-payments, co-insurance, and deductibles.

(B) Cost-sharing does not exceed MMF.

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(i) If the amount of all applicable co-payments, co-insurance, and deductibles for services listed in the monthly account as covered by non-Medicare third-party coverage does not exceed the person's MMF, then the following amounts are added to equal the total amount applied toward the person's MMF, then the following amounts are added to equal the total amount applied toward the person's MMF:

- (I) the amount of all applicable co-payments, co-insurance, and deductibles; and
- (II) the monthly account amount for services not covered by third-party coverage.

(ii) If the total amount applied toward the person's MMF as described in paragraph (3)(B) of this subsection:

(I) exceeds the person's MMF, then the amount is reduced to equal the MMF and the LMHA bills person (or parent) the MMF; or

(II) is less than the person's MMF, then the LMHA bills the person (or parent) the total amount applied toward the MMF.

(C) Annual cost-sharing limit. If the person (or parent) has reached his/her annual cost-sharing limit (i.e., maximum out-of-pocket expense) as verified by the non-Medicare third-party coverage, then the LMHA will not bill the person (or parent) any co-payments, co-insurance, or deductibles, as applicable to the annual cost-sharing limit, for services covered by the non-Medicare third-party coverage for the remainder of the policy-year.

(4) Social Security work incentive provisions.

(A) If the person identified a payment amount for specific services in his/her approved plan utilizing Social Security work incentive provisions (i.e., *Plan to Achieve Self-Sufficiency; Impairment Related Work Expense*), then the LMHA bills the person the monthly account amount for the specific services up to the identified payment amount. If the monthly account amount for the specific services is greater than the identified payment amount, then the remaining balance is applied toward the person's MMF.

(B) The following amounts are added to equal the total amount applied toward the person's MMF:

(i) any remaining balance as described in paragraph (4)(A) of this subsection; and

(ii) the monthly account amount for services not covered by third-party coverage.

(C) If the total amount applied toward the person's MMF as described in paragraph (4)(B) of this subsection:

(i) exceeds the person's MMF, then the amount is reduced to equal the MMF and the LMHA bills person (or parent) the MMF; or

(ii) is less than the person's MMF, then the LMHA bills the person (or parent) the total amount applied toward the MMF.

(e) (No change.)

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[Concerning 412-G, Mental Health Community Services Standards (add PA to definition of LPHA and revise QMHP definition)]

§412.303. Definitions.

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

(1) – (18) (No change.)

(19) DSM--The current edition of the *Diagnostic Statistical Manual of Mental Disorders* published by the American Psychiatric Association **that is approved for use by the department.**

(20) – (34) (No change.)

(35) LPHA or licensed practitioner of the healing arts--A staff member who is:

- (A) a physician;
- (B) a licensed professional counselor (**LPC**);
- (C) a licensed clinical social worker (**LCSW**);
- (D) a licensed psychologist;
- (E) an advanced practice nurse; or
- (F) a **physician assistant (PA)**; or
- (G) a licensed marriage and family therapist (**LMFT**).

(36) – (44) (No change.)

(45) **PA or Physician assistant**--A staff member who **has specialized psychiatric/mental health training and who** is licensed as a physician assistant by the Texas State Board of Physician Assistant Examiners in accordance with Texas Occupations Code, Chapter 204.

(46) – (47) (No change.)

(48) QMHP-CS or qualified mental health professional-community services--A staff member who is credentialed as a QMHP-CS who has demonstrated and documented competency in the work to be performed and:

- (A) has a bachelor's degree from an accredited college or university with a minimum number of hours that is equivalent to a major (as determined by the LMHA or MCO in accordance with §412.316(d) of this title (relating to Competency and Credentialing)) in psychology, social work, medicine, nursing, rehabilitation, counseling, sociology, human growth and development, physician assistant, gerontology, special education, educational psychology, early childhood education, or early childhood intervention;
- (B) is a registered nurse; or

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(C) completes an alternative credentialing process as determined by the LMHA or MCO in accordance with § 412.316(c) and (d) of this title. ~~identified by the department.~~

(49) – (64) (No change.)

[Concerning 412-G, Mental Health Community Services Standards (revise reference to DSM)]

§ 412.322. Provider Responsibilities for Treatment Planning and Service Authorization.

(a) (No change.)

(b) Diagnostics. The diagnosis of a mental illness must be:

- (1) rendered by an LPHA, acting within the scope of his/her license, who has interviewed the individual, either face-to-face or via telemedicine;
- (2) based on the all five axes of the current DSM;
- (3) documented in writing, including the date, signature, and credentials of the person making the diagnosis; and
- (4) supported by and included in the assessment.

(c) – (g) (No change)

(h) Discharge Summary. Not later than 21 calendar days after an individual's discharge, whether planned or unplanned, the provider must document in the individual's medical record:

- (1) a summary, based upon input from all the disciplines of treatment involved in the individual's treatment plan, of all the services provided, the individual's response to treatment, and any other relevant information;
- (2) recommendations made to the individual or their LAR (if applicable) for follow up services, if any; and
- (3) the individual's last diagnosis, based on the ~~upon all five axes of the current~~ DSM.