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[Next Rule>>](#)**TITLE 40****SOCIAL SERVICES AND ASSISTANCE****PART 1****DEPARTMENT OF AGING AND DISABILITY SERVICES****CHAPTER 19****NURSING FACILITY REQUIREMENTS FOR LICENSURE  
AND MEDICAID CERTIFICATION****SUBCHAPTER AA****VENDOR PAYMENT****RULE §19.2601****Vendor Payment (Items and Services Included)**

(a) A facility provides, under the terms of the contract, for the total medical, nursing, and psychosocial needs of each recipient.

(b) The daily rate is compatible with reasonable charges consistent with efficiency, economy, and quality of total care. The facility must ensure that care meets the health needs and promotes the maximum well-being of recipients. The following items and services are included in the payment rate made to the facility by the Department of Aging and Disability Services (DADS) and, therefore, the facility must provide:

- (1) nursing care;
- (2) social services;
- (3) regular, special, and supplemental diets, including tube feedings;
- (4) nonlegend drugs, with the exception of insulin, and alcoholic beverages unless prescribed for medicinal purposes. Alcoholic beverages:
  - (A) prescribed for medicinal purposes must include the dosage and frequency of the alcohol; and
  - (B) not prescribed for medicinal purposes are at the expense of the recipient or family;
- (5) for a recipient who is not eligible for Medicare Part D benefits, legend drugs that are not covered by the Medicaid Vendor Drug Program;
- (6) for a recipient who is eligible for Medicare Part D benefits, legend drugs in a category that is not covered by Medicare Part D and that are not covered by the Medicaid Vendor Drug Program;
- (7) regular laundry services, except dry cleaning;
- (8) medical accessories, such as canulas, tubes, masks, catheters, ostomy bags and supplies, IV fluids, IV equipment, and equipment that can be used by more than one person, such as wheelchairs, adjustable chairs, crutches, canes, mattresses, hospital-type beds, enteral pumps, trapeze bars, walkers, and oxygen equipment, such as tanks, concentrators, tubing, masks, valves, and regulators.
  - (A) Facilities are required to maintain, in good repair, equipment necessary to meet the needs of the recipient.
  - (B) If a recipient desires equipment for exclusive use, its purchase is the responsibility of the recipient:

(i) Only the recipient can use the equipment, and it must be identified as the personal property of the recipient.

(ii) Upon discharge from the facility, the recipient retains the equipment he purchased. If the recipient dies, the purchased equipment must be transferred to the estate. If it is donated or sold to the facility by the recipient or the estate, the transaction must be documented. (See §19.416 of this title (relating to Personal Property)).

(C) If a recipient owns a piece of equipment that is medically necessary, the facility must maintain and repair the equipment.

(D) When Part B Medicare benefits are accessed to pay for equipment and accessories, the recipient or family may not be charged by the facility or supply company for any portion of these items;

(9) medical supplies, including, but not limited to tongue depressors, swabs, bandaids, cotton balls, and alcohol; and

(10) basic personal hygiene items and services to meet the needs of the residents (See §19.405(h) of this title (relating to Additional Requirements for Trust Funds in Medicaid-Certified Facilities) for a list of such items and services). The specific type or brand of personal hygiene items used by the facility must be disclosed to the recipient; then, if a recipient prefers to use a specific type or brand of a personal hygiene item(s) rather than the item(s) furnished by the facility, he may use his personal funds to purchase the item(s).

(A) Before purchasing or charging for the preferred item(s), the facility must secure written authorization from the recipient or family indicating his desired preference, the date, and signature of the person requesting the preferred item(s). The signature may not be that of an employee of the facility.

(B) If the recipient's personal funds are used to purchase an item(s), the item(s) is for his sole use.

(C) When the facility purchases personal hygiene item(s) with the recipient's personal funds, the facility must ensure that the item(s) is in an individual container or package that is labeled with the recipient's name. The facility is not held responsible for labeling personal hygiene items brought into the facility and not reported to the management.

(c) Facilities are not required to provide any particular brand of non-legend drug, medical accessory, equipment, or supply, but only those items necessary to ensure appropriate recipient care.

(1) Unless the physician orders a specific type or brand, the facility may choose the type or brand.

(2) If the recipient or family prefers a specific type or brand of item rather than the one furnished by the facility, the recipient, responsible party, or family may be billed for the item, or the recipient's personal funds may be used to purchase the item, or both.

(3) Before purchasing or charging for the preferred item, the facility must secure written authorization from the recipient or family indicating his desired preference, the date, and signature of the person requesting the preferred item. The signature may not be that of an employee of the facility.

(d) If a resident has requested and freely chosen to participate in an activity, or to have an item or service provided that is not included, or is different than that provided, in the daily vendor rate, then the resident may be

charged for the activity, item, or service.

(1) When documentation is present that supports the above criteria, and that is required by §19.405(d)(5) of this title, the amount may be paid from the resident's trust fund.

(2) When the facility acts as a collection agent for any item, service, or activity not included in the daily rate, the facility must be able to provide documentation that clearly indicates that any charges made to the recipient or his trust fund are pass-through costs only. The facility may not charge any fees, including handling fees, for these types of transactions.

(e) Except as described in paragraphs (1) and (2) of this subsection, DADS makes vendor payments to Nursing Facilities for the day a recipient enters a nursing facility, but not for the day a recipient leaves a facility. The two exceptions are as follows.

(1) If entrance and departure are on the same day, and the recipient does not enter another Title XIX facility on that day, DADS pays for the entire day.

(2) If departure is because of the recipient's death and the deceased recipient is not sent to another Title XIX facility for legal procedures necessary upon the death of the recipient, DADS pays for the entire day.

(f) Vendor payments are made to Medicaid Nursing Facilities that comply with the PASARR requirements.

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**Source Note:** The provisions of this §19.2601 adopted to be effective May 1, 1995, 20 TexReg 2393; amended to be effective August 1, 2000, 25 TexReg 6779; amended to be effective December 1, 2000, 25 TexReg 11665; amended to be effective January 1, 2006, 30 TexReg 7890

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Vendor Payment)**

(a) The Texas Department of Human Services (DHS) does not make vendor payments when a Title XIX recipient is absent from the facility because of:

- (1) therapeutic home visits that extend beyond three days; or
- (2) hospital inpatient services. However, DHS makes vendor payments for periods when a recipient is a hospital outpatient subject to the following limitations.

(A) DHS makes vendor payments when a Title XIX recipient is absent from the nursing facility past midnight for outpatient hospital services, including services resulting from hospital outpatient observation. In these cases the facility must document in the clinical record that the recipient was not admitted as an inpatient in the hospital.

(B) If the recipient is admitted to the hospital for inpatient services anytime during a hospital outpatient observation period, a patient transaction notice showing discharge must be submitted effective the date the recipient left the nursing facility.

(b) The facility may enter into a written agreement with the recipient or responsible party to reserve a bed, according to the specifications of §19.503 of this title (relating to Notice of Bed-hold Policy and Readmission in Medicaid-Certified Facilities).

(c) The facility may charge for transportation beyond normal transportation as defined in §19.2320 of this title (relating to Medical Transportation).

(d) The billing of flu shots to recipients by the nursing facility is not allowed.

(e) A facility must bill for charges not covered by Medicaid at least once a month. Each bill must itemize all extra charges by general category.

**Source Note:** The provisions of this §19.2602 adopted to be effective May 1, 1995, 20 TexReg 2393.

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(a) The facility must have written policies and procedures governing recipient therapeutic home visits away from the facility for the purpose of visiting with relatives and friends.

(b) The following conditions must be met for the facility to receive vendor payment:

(1) the recipient's plan of care provides for physician-authorized therapeutic visits;

(2) the facility must provide equipment and supplies necessary to meet the needs of the recipient, including, but not limited to, medication and oxygen and supplies for its administration;

(3) if a visit exceeds three days, the facility submits a discharge form effective the first day. Days are defined as 24-hour periods extending from midnight to midnight. In determining days of absence from a facility, the first day is the first 24-hour period beginning at midnight after the recipient's departure. Situations that require a discharge form effective the first day include:

(A) alternate care living arrangements, including at home;

(B) transfer or discharge to other medical care or living arrangements covered under Title XIX; and

(C) therapeutic visits that are over three days (one night must be spent in the facility between therapeutic home visits if vendor payment is to be made);

(4) the facility must maintain a record of each therapeutic visit away from the facility. Verification that therapeutic visits took place and were documented is a part of the audit procedures during the DHS audit of the facility. DHS does not pay for therapeutic visits which were not documented.

(c) Before a resident goes on therapeutic leave, the facility must provide written notification to the recipient, and, if known, a responsible party, or family or legal representative, regarding the three-day time limit for a home visit, as specified in subsection (b)(3) of this section.

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**Source Note:** The provisions of this §19.2603 adopted to be effective May 1, 1995, 20 TexReg 2393.

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(a) Vendor payment will be made based upon the nursing facility administrator's or the administrative designee's approval of the Nursing Care Statement.

(b) Vendor payment will be made at periodic intervals but not less than once per month for services rendered during the previous billing period.

(c) The vendor payment for an entire month will be in accordance with the number of calendar days in the month.

(d) Vendor payment for time periods of less than an entire calendar month shall be made in accordance with the number of days care was provided beginning with the effective date on the Notification of Recipient Medical Necessity Determination and/or Vendor Payment Plan.

(e) Days are defined as 24-hour periods extending from midnight to midnight. Payment is computed in terms of whole days, even though the recipient may have been in a nursing facility only a fractional part of the day of entrance. (See §19.2601(e) of this title (relating to Vendor Payment (Items and Services Included))).

(f) Vendor payment will be made in terms of daily rates.

(g) The recipient must have the status of a certified recipient, must have been determined to be in need of nursing facility care, and must be physically located in a Medicaid-certified bed of a facility at the time the service is rendered in order for the facility to receive payment for the service.

(h) The Texas Department of Human Services (DHS) will owe the facility no interest on payments not made within the time limits provided in these rules, the provider contract, or Chapter 2251 of the Government Code when the delay is the result of a bona fide dispute between DHS and the facility over compliance with the terms and conditions of the Medicaid program or is the result of other rules, laws or contract terms authorizing the withholding or nonpayment.

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**Source Note:** The provisions of this §19.2604 adopted to be effective May 1, 1995, 20 TexReg 2393; amended to be effective August 1, 2000, 25 TexReg 6779

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**RULE §19.2605****Effective Date of Vendor Coverage**

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If an applicant is determined to be eligible and in need of nursing facility care, the effective date of vendor coverage is either the date the individual entered the facility, the date of application, or the date the need for nursing facility care was established, whichever date is the latest.

(1) Once the effective date is established, the Texas Department of Human Services (DHS), through the contract agreement with the facility, sets the acceptable rates for services.

(2) If the facility charges the applicant an amount over the recognized monthly rate set by DHS, the difference must be refunded to the recipient or the responsible party.

(3) Private pay individuals living in Medicaid certified nursing facilities, or distinct parts, who do not receive SSI cash benefits may be eligible for "Three months prior" vendor payments. (See §19.2408 of this title (relating to Retroactive Medical Necessity Determinations)).

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**Source Note:** The provisions of this §19.2605 adopted to be effective May 1, 1995, 20 TexReg 2393.

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(a) Facilities must abide by Public Law 95-142 related to Medicare/Medicaid antifraud and abuse amendments.

(b) Participation will be limited to providers of services who accept, as payment in full, the amounts paid in accordance with the fee structure approved by the Texas Department of Human Services (DHS).

(c) Providers who have a contract with DHS and who solicit contributions, donations, or gifts from Medicaid recipients or family members will be in noncompliance with federal requirements.

(d) The facility must inform Medicaid recipients and their families that their right to nursing facility services is not contingent upon contributions. The facility must give copies of this notice to the recipient, and either the responsible party or family representative.

(e) If a recipient, family member, guardian, or other interested party does make a free-will contribution, the nursing facility administrator executes a statement for signature by both the contributor and the administrator. It will state that the services provided to any Medicaid recipient in the nursing facility are not predicated upon contributions and that the gifts are free-will contributions.

(f) When a provider accepts federal and/or state funds for items or services delivered which are not reimbursed within the per diem, the facility must document:

- (1) that the type of item or service is ordered by the physician;
- (2) that the item or service has not been billed to more than one payor source; and
- (3) that the recipient actually received the item or service.

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**Source Note:** The provisions of this §19.2606 adopted to be effective May 1, 1995, 20 TexReg 2393.

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**RULE §19.2607****Penalties for Supplementation**

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A felony conviction with a fine of not more than \$25,000 or imprisonment for not more than five years or both can be imposed on anyone in the facility who knowingly and willfully:

- (1) accepts, from the recipient, money or other considerations in excess of rates established by the state for services provided under a state plan approved under Title XIX;
- (2) charges, solicits, accepts, or receives any gifts, money, donation, or other consideration in addition to amounts required to be paid under a state plan approved under Title XIX (other than charitable donations from an organization or a person unrelated to the recipient) as a precondition for admitting or keeping a recipient in the nursing facility; or
- (3) accepts reimbursement from more than one source (including per diem reimbursement) for the same item or service.

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**Source Note:** The provisions of this §19.2607 adopted to be effective May 1, 1995, 20 TexReg 2393.

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**RULE §19.2608**

**Limitations on Provider Charges**

A provider of Medicaid (Title XIX) services may neither charge nor take other recourse against Medicaid applicants or recipients, their family members, or their representatives for any claim denied or reduced by the Texas Department of Human Services (DHS) because of the provider's failure to comply with any DHS rule, regulation, or procedure.

**Source Note:** The provisions of this §19.2608 adopted to be effective May 1, 1995, 20 TexReg 2393.

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To receive payment for a service, a nursing facility must submit a complete and accurate claim to the state Medicaid claims administrator so that it is received within 12 months after the date of service. In this section, the date of service is the last day of the month in which the service was provided.

- (1) All payments are subject to availability of funds as provided by law.
- (2) A nursing facility must submit claims and adjustments rejected or denied to the state Medicaid claims administrator within 12 months after the date of service. DADS may pay for claims and adjustments rejected or denied during the 12-month period through no fault of the nursing facility.
- (3) If a recipient's Medicaid eligibility is established after services are provided to the recipient, the nursing facility must submit the claim for service to the state Medicaid claims administrator within 12 months after the date eligibility is established.
- (4) A nursing facility may resubmit a claim after the 12-month period in the case of state-generated retroactive payments.
- (5) The provisions of §19.2413 of this chapter (relating to Determination of Payment Rate Based on the MDS Assessment Submission) apply to this section.
- (6) DADS recoups any inadvertent payments made to a facility.

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**Source Note:** The provisions of this §19.2609 adopted to be effective July 1, 1999, 24 TexReg 4833; amended to be effective November 1, 2002, 27 TexReg 9387; amended to be effective September 3, 2008, 33 TexReg 7264

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**RULE §19.2610****Medicare Part A Skilled Nursing Facility Deductible and  
Coinsurance Payment**

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When the Texas Department of Human Services (DHS) receives valid Medicare claims, DHS pays a portion of the Medicare Part A skilled nursing facility (SNF) deductible and coinsurance. When Medicare changes its daily interim payment, DHS adjusts the Medicaid payment on the Part A SNF coinsurance amount if necessary. The adjustment is effective on the first day of the month following the Medicare change.

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**Source Note:** The provisions of this §19.2610 adopted to be effective May 1, 1995, 20 TexReg 2393.

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(a) In this section, retroactive vendor payment is payment DADS makes retroactively to a nursing facility for services the nursing facility provided to an individual who was eligible for, but had not yet applied for, Medicaid. A nursing facility is eligible for up to three months retroactive vendor payment for services it provided, if:

- (1) the individual resided in a Medicaid-certified nursing facility, or a distinct part, during the time services were provided;
- (2) the individual did not receive Supplemental Security Income cash benefits;
- (3) the individual met Medicaid financial eligibility requirements;
- (4) the state Medicaid claims administrator has a current MDS assessment for the individual that the facility submitted in compliance with the federal MDS submission requirements; and
- (5) the nursing facility met physician certification and plan of care requirements during the time services were provided.

(b) After receipt of an application for Medicaid, Texas Health and Human Services Commission (HHSC) Medicaid eligibility staff notify the applicant whether the applicant meets financial eligibility. The state Medicaid claims administrator uses the applicant's current MDS assessment to make the MN determination and determine the effective date of the MN determination. For the purpose of establishing three months prior eligibility, the effective date of the MN determination for a new recipient is the first day of the month in which the recipient qualified for MN.

(c) If the requirements in subsection (a) of this section are met, DADS makes a retroactive vendor payment based on the recipient's calculated RUG rate for the period covered by the retroactive vendor payment.

(d) DADS or HHSC may verify that the recipient's record includes the required physician's certification, recertification, and plans of care, and that the plans were reviewed as required during the applicable periods.

(e) If a recipient paid the nursing facility for services for which the facility later receives retroactive vendor payment, the facility must reimburse the recipient the full amount the recipient paid, beginning with the effective date of Medicaid eligibility, minus any applied income or co-payment as determined by HHSC Medicaid eligibility staff.

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**Source Note:** The provisions of this §19.2611 adopted to be September 3, 2008, 33 TexReg 7264



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**RULE §19.2612****Quality Incentive Payment**

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For services delivered after September 1, 1999, the Texas Department of Human Services (DHS) may make Quality Incentive payments to facilities according to reimbursement rules developed by the Health and Human Services Commission. DHS will determine the qualifying facilities.

(1) The Texas Board of Human Services will review the adopted plan at least biennially.

(2) Incentive payments will be based on:

(A) specific resident care domains selected from the Center for Health Systems Research and Analysis (CHSRA) Quality Indicators; and

(B) regulatory compliance.

(3) The incentive payment is in addition to the daily vendor rate paid to the provider.

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**Source Note:** The provisions of this §19.2612 adopted to be effective January 1, 2000, 24 TexReg 10578

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(a) A specialized augmentative communication device system (ACD), also referred to as a speech-generating device system, is reimbursable if purchased by a facility for a Medicaid recipient and all criteria defined in this section are met. A physician and a licensed speech therapist must determine a recipient needs the ACD, and the facility must obtain DADS' approval of the request for reimbursement.

(b) A facility must request and receive prior authorization from DADS before purchasing the ACD. The request for prior authorization must include:

- (1) an evaluation and recommendation from a licensed speech therapist to purchase the ACD;
- (2) an attestation from the recipient's attending physician that the ACD is medically necessary for the recipient to maximize his functional communication within the facility's environment; and
- (3) a minimum of two bids for the ACD or a request for an exception to the two-bid minimum if the recommended ACD is only available through one vendor.

(c) The evaluation from the licensed speech therapist must include:

- (1) a description of how the ACD will specifically meet the need of the recipient;
- (2) detailed instructions for training on the use of the ACD for the recipient, facility staff, and family (if applicable);
- (3) a diagnosis relevant to the need for the ACD; and
- (4) the specific ACD being recommended.

(d) If an ACD costs more than \$10,000, DADS will facilitate an independent speech language review, at DADS' expense, to determine necessity for the ACD.

(e) After receiving prior authorization from DADS, the facility must purchase the ACD.

(f) To obtain reimbursement from DADS, a facility must submit to DADS the receipt for payment for the ACD and a copy of the approved prior authorization.

(1) A facility must fully explore and use other funding sources to pay for an ACD before submitting the request for reimbursement to DADS. If another funding source will pay for part of the ACD expense, the facility may request reimbursement for the balance if the requirements in subsections (b) and (c) of this section are met. If

another funding source is available, DADS reimburses only up to the remaining balance after other sources are fully utilized.

(2) A facility must submit the request for reimbursement within one year after the date of purchase.

(3) DADS reimburses the amount of the authorized bid or the remaining balance after all other sources are fully utilized.

(g) If DADS denies a request for reimbursement because the facility failed to obtain prior authorization or submit the necessary documentation for the ACD, the facility is responsible for the cost of the ACD.

(h) If DADS denies a prior authorization request, the recipient may request a Medicaid fair hearing in accordance with 1 TAC Chapter 357, Subchapter A.

(i) Only the recipient can use the ACD, and it must be identified as the personal property of the recipient.

(1) Upon discharge from the facility, the recipient retains the ACD. If the recipient dies, the ACD must be transferred to the recipient's estate. If it is donated or sold to the facility by the recipient or the recipient's estate, the transaction must be documented. (See §19.416 of this title (relating to Personal Property)).

(2) The facility is responsible for the repair and maintenance of the ACD while the recipient resides in the facility.

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**Source Note:** The provisions of this §19.2613 adopted to be effective July 1, 2007, 32 TexReg 3857

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(a) Customized power wheelchairs (CPWCs) are a service in the nursing facility Medicaid program for Medicaid-eligible nursing facility residents when medically necessary and prior authorized by the Health and Human Services Commission (HHSC) or its designee.

(b) A CPWC is a wheelchair that consists of a power mobility base and customized seating system.

(1) The power mobility base may include programmable electronics and may utilize alternate input devices.

(2) The wheelchair must be medically necessary, adapted, and fabricated to meet the individualized needs of the resident, and intended for the exclusive and ongoing use of the resident.

(3) Components of the customized seating system must be in part or entirely usable only by the resident for whom the power wheelchair is adapted and fabricated.

(c) When requested by a resident or the resident's legal representative, the nursing facility must procure an evaluation for a CPWC from a licensed physical or occupational therapist. If the evaluation recommends a CPWC, the nursing facility must submit all required forms to HHSC or its designee for prior authorization.

(d) After receiving prior authorization from HHSC or its designee, the facility must purchase the CPWC.

(e) To be eligible for reimbursement, the nursing facility must request and receive prior authorization from HHSC or its designee before purchasing a CPWC. The prior authorization request must include:

(1) a completed CPWC order form;

(2) an occupational or physical therapy evaluation of the resident;

(3) a statement signed by the resident's attending physician that the CPWC is medically necessary; and

(4) a detailed breakdown of proposed CPWC specifications from the customized power wheelchair supplier.

(f) To be eligible for reimbursement for a CPWC, the nursing facility must obtain an evaluation of the resident by an occupational or physical therapist licensed in the state of Texas prior to purchase of the CPWC. The occupational or physical therapy evaluation must include:

(1) a diagnosis relevant to the need for a CPWC;

(2) the specific CPWC and adaptations being recommended;

- (3) a description of how the CPWC will meet the specific needs of the resident;
- (4) a description of specific training needs for use of this device including training needs of the resident, nursing facility staff, and family (when applicable); and
- (5) written documentation from the therapist indicating that the resident is physically and cognitively capable of independently managing a power wheelchair.
- (g) Payment for physical or occupational therapy evaluations may be obtained for eligible residents in the same manner as payment for physical or occupational therapy evaluations is obtained in the Specialized and Rehabilitative Services programs, as described in §19.1306 of this chapter (relating to Payment for Specialized and Rehabilitative Services).
- (h) Following a review of the prior authorization request by HHSC or its designee, the nursing facility and resident will receive a written approval or denial of the request. If the request is approved, the nursing facility will promptly make arrangements to purchase the CPWC. If the request is denied, HHSC or its designee will send a notice of denial to the nursing facility resident informing the resident of the right to request a Medicaid fair hearing in accordance with 1 TAC Chapter 357, Subchapter A.
- (i) A facility must submit the request for reimbursement to DADS within one year after the date of purchase of the CPWC. If DADS denies a request for reimbursement because the facility failed to obtain prior authorization or submit the necessary documentation for the CPWC to HHSC or its designee, the facility is responsible for the cost of the CPWC and may not charge the cost to the resident or family.
- (j) A facility must fully explore and use other funding sources to pay for a CPWC before submitting the request for reimbursement to DADS. If another funding source will pay for part of the CPWC expense, the facility may request reimbursement for the balance if the requirements in subsections (d) - (f) of this section are met. If another funding source is available, DADS reimburses only up to the remaining balance after other sources are fully utilized.
- (k) Only the resident can use the CPWC, and it must be identified as the personal property of the resident.
- (l) The resident's comprehensive care plan must document that the CPWC is medically necessary.
- (m) Upon discharge from the facility, the resident retains the CPWC. If the resident dies, the CPWC becomes property of the resident's estate. As part of the estate, the CPWC is subject to all applicable Medicaid Estate Recovery Program (MERP) requirements, as detailed in 1 TAC Chapter 373. If the CPWC is donated or sold to the facility by the resident or executor of the resident's estate, the transaction must be documented in accordance with §19.416 of this chapter (relating to Personal Property).
- (n) As required by §19.2601(b)(8)(C) of this chapter (relating to Vendor Payment (Items and Services Included)), the nursing facility is required to maintain and repair all medically necessary equipment for its residents, including CPWCs obtained under this section.
- (o) Requests for replacement of a CPWC must be submitted in the same manner as the original prior authorization of the CPWC outlined in this section. A replacement CPWC may be requested no earlier than five years after the original date of purchase, unless the request includes an order from the prescribing physician familiar with the resident and an assessment by a physician or a licensed occupational or physical therapist with

documentation supporting why the current CPWC no longer meets the resident's needs. DADS does not authorize replacement in situations where the CPWC has been abused or neglected.

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**Source Note:** The provisions of this §19.2614 adopted to be effective May 1, 2008, 33 TexReg 3301

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# Texas Administrative Code

**TITLE 40**

## SOCIAL SERVICES AND ASSISTANCE

**PART 1**

## DEPARTMENT OF AGING AND DISABILITY SERVICES

**CHAPTER 19**NURSING FACILITY REQUIREMENTS FOR LICENSURE  
AND MEDICAID CERTIFICATION**SUBCHAPTER AA**

## VENDOR PAYMENT

**RULE §19.2615****Resident Transaction Notices**

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A nursing facility must electronically submit to the state Medicaid claims administrator a resident transaction notice within 72 hours after a recipient's admission or discharge from the Medicaid nursing facility vendor payment system. The nursing facility administrator must sign the resident transaction notice.

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**Source Note:** The provisions of this §19.2615 adopted to be September 3, 2008, 33 TexReg 7264

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