Volume 2, Number 3, January 11, 1977
Pages 77 - 114

TEXAS REGISTER

In This Issue...

Office of the Secretary of State

NOTES ON THE ISSUE

Because of a change in the contract for purchased health services which became effective on January 1, 1977, the Department of Public Welfare has adopted emergency rules governing the Medicaid program. The new rules will not alter the services provided by the program. They are, rather, a set of rules generally applicable to the Medicaid program, without regard to the specific program. The Medicaid rules formerly consisted of the handbooks and manuals of the previous provider, Blue Cross of Texas, which were adopted by reference by the department. Blue Cross had held the contract since the inception of the Medicaid program. The new provider was awarded the contract in the fall of 1976. The department plans to propose the permanent adoption of these rules in a later issue.

A brief report from the *Energy Policy Monitor* of the Governor's Energy Advisory Council brings favorable news about the economic feasibility of solar energy as a heating source. The report appears in the In Addition section of this issue.

Cover illustration represents Elisabet Ney's statue of Stephen F. Austin, which stands in the foyer of the State Capitol.

Artwork: Gary Thornton

TEXAS REGISTER

The *Texas Register* is published twice weekly, 100 times a year by the Texas Register Division, Office of the Secretary of State; Box 819, Texas Commodore Building; Austin, Texas 78701. Telephone (512) 475-7886.

The *Register* contains executive orders of the Governor; summaries of Attorney General's opinions and summaries of requests for opinions; emergency rules, proposed rules, and adopted rules of state agencies; notices of open meetings; and miscellaneous notices of general interest to the public of Texas.

Subscriptions, payable in advance, are $25 (plus tax) for one year. Back issues, when available, are $1 each (plus tax).

Mark White
Secretary of State

Texas Register Division

William H. Lalla, Director

Tommy Denton	Linda Camp	Anne Lewis
Anne Fitzpatrick	Bobby Duncan	Deborah Jackson
Mary Barrow	Terry Foster	Emily Jones

CONTENTS

Opinions

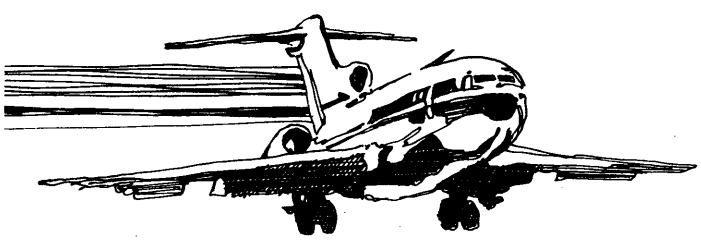
Summary of Opinion H-915

Request from General James Rose, Executive Director, Texas Water Quality Board, Austin, concerning the effect of 1975 legislation on the need for the Harris County Flood Control District to submit its plans to the Texas Water Development Board.

Summary of Opinion: The Harris County Flood Control District is not required to submit its plans for projects, other than levees and structures relating to levees, to the Texas Water Development Board.

Filed: January 3, 1977, 11:38 a.m.

Doc. No. 770009



Summary of Opinion H-916

Request from John E. Fitzgibbon, Webb County Attorney, Laredo, concerning whether a school district may contract with a company which employs a member of the school district's board of trustees.

Summary of Request: A school district should not contract with a company which employs a member of the district's board of trustees in a managerial capacity, even though the trustee derives no direct financial benefit from the contract.

Filed: January 3, 1977, 11:39 a.m.

Doc. No. 770010

Summary of Opinion H-917

Request from Dorman H. Winfrey, Director and Librarian, Texas State Library, Austin, concerning confidentiality of non-current personnel files transferred to the State Archives.

Summary of Opinion: Non-current personnel files transferred to the State Archives from permanent preservation retain the same status as they had before transfer under the Texas Open Records Act, Article 6252-17a, Vernon's Annotated Civil Statutes, and are public except insofar as disclosure would constitute a clearly unwarranted invasion of personal privacy. The right of privacy is personal to the individual and lapses upon his death, rendering his personnel file public except insofar as its disclosure would constitute a clearly unwarranted invasion of the personal privacy of living individuals.

Filed: January 3, 1977, 11:39 a.m.

Doc. No. 770011

Summary of Opinion H-918

Request from Joe Max Shelton, Grayson County Attorney, Sherman, concerning whether the Fire and Police Employee Relations Act, Article 5154c-1, Vernon's Annotated Civil Statutes, applies to sheriffs' departments.

Summary of Opinion: With the exception of those persons designated "county police officers" under Article 6869d, Vernon's Texas Civil Statutes, Article 5154c-1, the Fire and Police Employee Relations Act, is not applicable to law enforcement officers employed by a sheriff's department.

Issued in Austin, Texas, on December 31, 1976.

Doc. No. 770012

C. Robert Heath
Opinion Committee Chariman
Attorney General's Office

Filed: January 3, 1977, 11:40 a.m.

For further information, please call (512) 475-5445.

An agency may adopt emergency rules after determining what it considers to be an imminent peril to the public health, safety, or welfare. These rules are effective immediately on filing with the secretary of state for no more than 120 days, renewable once for no more than 60 days. An agency must submit written reasons, published in the *Register*, for the emergency adoption of rules.

Numbering System-- Each rule is designated by a unique 10-digit number which is divided into four units by decimal points. The first unit (three digits) indicates the agency which promulgates the rule. The second unit (two digits) indicates the category of rules to which the rule belongs. The third unit (two digits) indicates the subcategory of rules, if any, within the category. The fourth unit (three digits) indicates the individual rule.

Symbology-- Changes to existing material are indicated in ***bold italics***. [Brackets] indicate deletion of existing material.

Texas Department of Labor and Standards

Boiler Inspection Division

General Requirements 063.33.07

The Boiler Inspection Division of the Texas Department of Labor and Standards has for many years made special inspections, known as shop surveys, for the purpose of certifying manufacturers and installations of boiler and certain pressure vessels pursuant to the requirements of the American Society of Mechanical Engineers Boiler and Pressure Vessel Code. Attorney General Opinion H-897 now prevents this agency from making general shop surveys and charging a fee therefor for certain shops not actively engaged in the fabrication of boilers, pressure piping, and appurtenances to be used in the installation and operation of boilers but does not prevent an inspection more narrowly directed at the actual construction or construction process of boilers to be installed in this state. The current rules require all new boilers and certain pressure vessels to be constructed, inspected, and installed in accordance with the ASME Boiler and Pressure Vessel Code. To continue this safety requirement, the department is adopting this emergency rule, to protect public health, safety and welfare, which will provide for inspections without charge within the limited scope hereinafter described and not prohibited by the Attorney General Opinion H-897.

This rule is to become effective immediately and is promulgated under the authority of Article 5221c, Texas Civil Statutes, as amended.

.023. ASME Boiler and Pressure Vessel Code Certification. Qualified Inspectors of the Boiler Inspection Division of the Texas Department of Labor and Standards shall, upon written request of anyone currently or intending to manufacture, assemble, or install boilers and certain pressure vessels or their appurtenances coming within the scope of the Boiler Inspection Law, make an inspection of said manufacturer, assembler, or installer, inspecting the construction and construction process of said boilers to determine the qualification of said person or firm to be certified under the ASME Boiler and Pressure Vessel Code. This inspection without charge shall also apply to on-site construction.

Issued in Austin, Texas, on January 3, 1977.

Doc. No. 770028

Jackie W. St. Clair
Commissioner
Texas Department of Labor and Standards

Effective Date: January 4, 1977
Expiration Date: May 3, 1977

For further information, please call (512) 475-4799.

State Department of Public Welfare

The State Department of Public Welfare (DPW) provides Title XIX purchased health services for eligible recipients through a health insuring agent. Since the department's current contract for these services expired on December 31, 1976, it is necessary to repeal those department rules adopting by reference the provider manuals issued by Blue Cross of Texas and propose the rules in a new format.

Effective January 1, 1977, Title XIX purchased health services will be provided through a contract with Electronic Data Systems Federal (EDSF) Corporation. The rules filed in relation to the change in contractor do not alter the Title XIX Medicaid purchased health program but represent an effort by the department to make the rules generic to the program.

To protect the rights of providers and eligible recipients and to ensure uninterrupted continuance of the purchased health services program, the Department of Public Welfare adopts the following emergency repeals and new rules effective January 1, 1977.

Purchased Health Services

Medicaid Procedures for Providers 326.36.01.001

This rule is repealed under the authority of Articles 695c and 695j-1, Texas Civil Statutes.

.001. Blue Cross Medicaid Manual for Providers of Services. DPW adopts by reference the *Blue Cross Medicaid Manual for Providers of Services*, with the exception of item 12, Chiropractic Benefits, on page 8.

Doc. No. 766824

326.36.01.002-.006

These rules are promulgated under the authority of Articles 695c and 695j-1, Texas Civil Statutes.

.002. Claim Information Requirements. Eligible providers are required to provide separate claim information for each eligible recipient. Claims must be complete, accurate, and as specified by the health insuring agent with departmental approval. Required information includes, but is not limited to:

(a) name, address, and appropriate identification number of the provider of services and/or supplies;

(b) the date of the claim;

(c) the name, address, identification number, and eligibility status of the individual who received services and/or supplies;

(d) the type of such services and/or supplies provided;

(e) the date(s) each service and/or supplies were provided;

(f) the amounts of each charge for the various types of services and/or supplies;

(g) the total charge for services and/or supplies;

(h) credits for any payments made at the time of submission of the claim, including payments made by private health insurance and under Medicare;

(i) indication that the eligible recipient has health, accident, or other insurance policies, or is covered by private or governmental benefit systems, or other third party liability, when reported, known, or suspected;

(j) the date of the eligible recipient's death, if applicable; and

(k) a certification by the eligible provider or his or her designated representative which meets the requirements of 45 Code of Federal Regulations 250.80.

.003. Compliance with Civil Rights Act. DPW has assured compliance with the U.S. Department of Health, Education, and Welfare regulations promulgated under Title VI of the Civil Rights Act of 1964, which states: "No person in the U. S. shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subject to discrimination under any program or activity receiving federal assistance."

Under this policy, payment to eligible providers cannot be made for care and services under federally assisted programs conducted by DPW unless such care and service is provided without discrimination on the ground of race, color, or national origin. Written complaints of noncompliance should be made to the Commissioner of Public Welfare, John H. Reagan Building, Austin, Texas, or the Secretary of HEW, Washington, D.C., or both.

.004. Time Limits for Submitted Claims. Claims must be submitted by eligible providers to the health insuring agent on a timely basis. Inpatient hospital claims must be submitted within days from date of discharge. Outpatient hospital claims and claims from all other providers must be submitted within 90 days from the date service was provided. For claims on a new Medicaid applicant who has applied for coverage that has not been assigned a Medicaid recipient number on the date of service, the filing period will not commence until after the recipient has been assigned a number. With respect to items and services which are Medicare benefits provided to eligible recipients enrolled under Medicare, the billing requirements and procedures of Medicare apply.

.005. Retention of Records. The provider must maintain all records necessary to fully disclose the services provided. These records must be retained for a period of five years from the date of the service, or until all audit questions are resolved, whichever is longer. Records and supporting information must be made available upon request, regarding any payment claims for services or supplies by the provider, to DPW or its designated agent.

.006. Unauthorized Charges. Certification or agreement is required of each eligible provider to the effect that no charges beyond reimbursement paid under the Texas Medical Assistance Program for covered services have been, or will be, billed to the eligible recipient.

Doc. No. 766825

Medicaid Eyeglass Program 326.36.02.001

This rule is repealed under the authority of Articles 695c and 695j-1, Texas Civil Statutes.

.001. Blue Cross Medicaid Eye Glass Program Manual. **DPW adopts by reference the handbook for the Blue Cross Medicaid Eye Glass Program with the exception of page 5.**

Doc. No. 766826

326.36.02.002-.006

These rules are promulgated under the authority of Articles 695c and 695j-1, Texas Civil Statutes.

.002. Payment for Eyeglasses. The health insuring agent pays the amounts determined, as set forth in this category, for eyeglasses dispensed to eligible recipients by eyeglass suppliers in accordance with, but not in excess of, the maximum allowances determined by the department.

(a) If an eyeglass supplier is a physician or a Doctor of Optometry, payment is made in accordance with the Option (Option A or Option B, as specified herein) selected by such eyeglass supplier. The option selected by a physician or Doctor of Optometry may be changed by giving written notice to the health insuring agent 120 days in advance of the effective date of the change; such change will be applicable to supplies dispensed to eligible recipients on and after such effective date.

(b) An eyeglass supplier who is an optician is paid in accordance with Option A.

(c) Under Option A, reimbursement is the lesser of the material invoice cost or the maximum allowance under Option A plus a handling fee and a dispensing fee, where appropriate.

(d) Under Option B, reimbursement is the lesser of the supplier's usual price or the maximum allowance under Option B plus a handling fee.

(e) Payments are limited to basic serviceable types of lenses and styles of frames. A reasonable selection must be offered. Special tints, coatings, and types of lenses as well as certain styles of frames are beyond the program benefits. The provider must offer the recipient appropriate eyewear within the program benefits so there is no extra expense to the recipient. This does not preclude the recipient from selecting eyewear of his choice beyond the program limitations. This is an expense to the recipient. The department pays up to its benefit limit, but the extra expense for optional supplies is borne by the recipient. If the item of eyewear involved is not specified by the department for program eyeglasses and the item is selected by the recipient, the supplier may charge the recipient the supplier's usual price for such eyewear.

(f) No payment is made for material or supplies regardless of cost if they do not meet the program specifications. If the recipient desires lens types, tints, or frames beyond the scope of the program, he must sign a statement on the claim form which states he was offered serviceable glasses at no cost to himself but desired other types or styles beyond the program benefits and agrees to pay the difference between the department's benefits and dispenser's charges. The recipient must make arrangements to pay the balance (the balance must be itemized). The provider may make no extra charges to the recipient for professional services.

(g) Contact lenses. The benefit payable for covered contact lenses is the reasonable charge for the contact lenses, including the handling and dispensing services provided by the eyeglass supplier.

(h) Repairs. Major repairs are those repairs or adjustments to eyeglasses for which the actual cost of materials used exceeds the amount stipulated by the department. All other repairs and adjustments to eyeglasses under the eyeglasses program are classified as minor repairs. An eyeglass supplier may not bill the eligible recipient for any such minor repairs performed and an eyeglass supplier must perform minor repairs on eyeglasses dispensed by such supplier upon request. For major repairs, the health insuring agent pays the eyeglass supplier's actual cost for the supplies dispensed, plus the handling fee stipulated by the department. The benefit for supplies may not exceed the benefits which would have been payable if the damaged item of eyewear had been replaced rather than repaired. No benefit is provided for repair of eyeglasses which do not meet program specifications.

.003. Additional Claim Information Requirements. In addition to the general requirements in Rule 326.36.01.001, the following information is required on claims for optometric services:

(a) Description of lenses and frames provided.

(b) A certification by the eyeglass supplier that the supplies dispensed comply with specifications established for the eyeglasses program.

(c) Claims payable under Option A must include the prescription with a copy of the invoice for the supplies dispensed, either attached to the claim form or previously submitted to the health insuring agent and identified as such on the claim form and coded into the data file.

(d) Claims payable under Option B must include the prescription.

(e) Claims for major repairs must include a copy of the invoice for supplies dispensed.

(f) If the claim form for replacement of eyeglasses or the records of the health insuring agent indicate that eyeglasses have been dispensed to the eligible recipient involved within 24 months prior to the dispensing of the new eyeglasses, professionally adjudged necessity satisfactory to the health insuring agent must be attached to the claim form. The new eyeglasses required must be due to either a loss or

destruction of the previous eyeglasses or due to a change in the eligible recipient's needed visual correction sufficient to require new lenses.

(g) If an eyeglass supplier has been determined by the health insuring agent to have abused the eyeglasses program, claims submitted by such eyeglass supplier after the date of such determination are required to have attached justification, satisfactory to the health insuring agent, that the services and supplies for which claim is being made and/or the amount claimed are covered benefits under the eyeglasses program.

(h) Name, address, and appropriate identification number of ordering physician or Doctor of Optometry, as appropriate.

.004. Authorized Optometric Benefits. The following are authorized optometric services:

(a) Eye refraction services consisting of one examination of the eyes per eligible recipient by refraction done by either a Doctor of Optometry or a physician during each state fiscal year.

(b) Post surgical lenses, including frames prescribed by a physician or Doctor of Optometry, are authorized as required during convalescence from cataract surgery, or one set of other prosthetic lens, including frames required by an individual lacking the organic lens of the eye, is authorized. No benefits or payments are provided for subsequent cataract or prosthetic lenses or for other eyeglasses.

(c) Eyeglasses program.

(1) Benefits are available for eyeglasses, for necessary repairs to eyeglasses, and for replacement of lost or destroyed eyeglasses, provided that the supplies used comply with the specifications established by the department. The date of dispensing of services and supplies by an eyeglass supplier is the date on which the eyeglass supplier accepts the order by the eligible recipient for the eyewear involved.

(2) Benefits for contact lenses are available under the eyeglasses program only if:

(A) there is no other way to correct the visual defect;

(B) the dispensing eyeglass supplier submits written justification for the contact lenses to the health insuring agent; and

(C) the dispensing eyeglass supplier receives approval from the health insuring agent of such written justification prior to dispensing the contact lenses.

.005. Specifications for the Eyeglasses Program. Specifications for the eyeglasses program are as follows:

(a) All lenses must be clear glass. All lenses must be heat or chemically treated dress eyewear meeting all standards of the American Standard Prescription Requirements for first quality glass ophthalmic lenses (Z 80.1-1964).

(b) Frames must be either zylonite or combination metal and zylonite.

(c) An eyeglass supplier must show each eligible recipient a choice of:

(1) at least three styles of zylonite frames appropriate for male or female children or adults; and

(2) at least two styles of combination metal and zylonite frames appropriate for male or female;

(3) with a choice of three colors and be able to dispense standard sizes of the frames shown at no cost to the eligible recipient.

(d) Frames must be only those manufactured in the United States of America.

(e) A frame must be serviceable and meet statutory quality standards.

(f) All lens and frame materials must be new.

(g) Bifocal lens must be as a minimum Kryptoc of 22mm flat top lens or equivalent.

(h) Trifocal lens must be as a minimum flat top 7/25 lens or equivalent.

(i) All supplies must be at least equivalent in quality to program eyeglasses provided under this category at no cost to the eligible recipients.

(j) All repair materials for which a charge is made under the eyeglasses program must be new and at least equivalent to the original item.

.006. Eyeglasses Program Fees. The fees paid for benefits under the eyeglasses program are determined by DPW within appropriation limits and are approved by the Board of Public Welfare.

Doc. No. 766827

Medicaid Family Planning Program 326.36.03.001

This rule is repealed under the authority of Articles 695c and 695j-1, Texas Civil Statutes.

.001. Blue Cross Medicaid Family Planning Manual. DPW adopts by reference the *Blue Cross Medicaid Family Planning Manual for Providers of Services.*

Doc. No. 766828

326.36.03.002-.006

These rules are promulgated under the authority of Articles 695c and 695j-1, Texas Civil Statutes.

.002. Payment for Family Planning Services. The maximum amount paid by the health insuring agent for each family planning service provided by a family plan-

ning agency is the fee for such service stipulated by the department. The amounts paid by the health insuring agent for covered services provided by the other stipulated eligible providers are the amounts determined in accordance with applicable provisions of this category. Payment is made for medical care and services provided to eligible recipients by a Title XIX hospital, an out-of-state hospital, a physician, an approved laboratory, or a family planning agency, approved as an eligible provider, if such care and services are family planning services on the date rendered.

.003. Additional Claim Information Requirements. In addition to the general requirements in Rule 326.36.01.002, the following information is required on claims from family planning agencies:

(a) Place of service (e.g., inpatient hospital, outpatient hospital, family planning agency, physician's office, patient's home, independent laboratory).

(b) Diagnoses, to a maximum of two primary and three secondary, of the condition for which treatment and services were provided. With respect to diagnostic or other services furnished at the request of another physician, this requirement may be waived by the health insuring agent if the physician providing the service shows that such information is not available to him.

(c) Name, address, and appropriate identification number of ordering physician.

(d) All supplemental information, including clarification of the diagnoses in terms of the degree or extent of involvement necessary to substantiate the need for services provided and/or charges made.

.004. Authorized Family Planning Benefits. Subject to certain conditions and limitations, family planning services are those items detailed as follows:

(a) Health history and physical examination. The health insuring agent provides reimbursement for the following services and procedures when prescribed, provided, or directly supervised by a physician:

(1) Complete obstetrical history, including menarche, menstrual, gravidity, parity, pregnancy outcomes, and complications of pregnancy/delivery.

(2) Significant illness-morbidity, hospitalizations, and previous medical care, information about thromboembolic disease, breast and genital neoplasm, diabetic and prediabetic condition, cephalgia and migraine, hematologic phenomena, pelvic inflammatory disease.

(3) Problems relating to previous contraceptive use.

(4) Family social, health, and mental health history.

(5) Physical examination. Examination includes:

(A) thyroid palpation;

(B) examination of breasts and axillary glands;

(C) auscultation of heart and lungs;

(D) blood pressure;

(E) weight and height;

(F) abdominal examinations;

(G) pelvic examinations; and

(H) extremities.

(6) Patient consultation. Consultation includes:

(A) instruction on reproductive anatomy and physiology, and

(B) overview of available methods of contraception including consultation on the use of rhythm method if chosen by patient.

(7) Duration or frequency.

(A) There is a limit of one annual comprehensive examination and evaluation for each eligible recipient per state fiscal year.

(B) There may be follow-up visits or examinations when medically necessary. The physician must sign the individual service itemized on the claim form when follow-up visits or examinations are required.

(b) Laboratory services. Reimbursement is made by the health insuring agent for laboratory services and procedures.

(1) The following services are reimbursable as routine procedures covered under family planning services:

(A) hematocrit or hemoglobin;

(B) urinalysis (for sugar and protein);

(C) Papanicolaou smear;

(D) N. gonorrhea smear (if indicated); and

(E) syphillis serology (if indicated).

(2) The special laboratory services and procedures noted below are covered if needed as the result of positive history or if deemed medically necessary at the time of examination by the attending physician.

(A) tuberculosis skill test;

(B) vaginal smear for diagnosis of infection;

(C) microscopic analysis or culture of urine;

(D) sickle cell screening;

(E) rubella hemaggutination test;

(F) post-prandial blood glucose; and

(G) pregnancy testing.

(3) Duration or frequency.

(A) In connection with the annual examination and evaluation, the evaluation and the routine procedures listed above are immediately covered.

(B) Additional special laboratory procedures are covered if indicated as the result of positive history or if deemed medically necessary at the time of examination by the attending physician. The physician must sign the individual service itemized on the claim form when follow-up visits and examinations are required.

(C) In follow-up visits, subsequent laboratory procedures are covered when deemed necessary by the attending physician and if considered an integral part of family planning services. The physician must sign the individual service itemized on the claim form when follow-up visits and examinations are required.

(D) These services and procedures must be provided in the context of medical judgment, using policies and practices that constitute quality family planning services.

(c) Contraceptive methods and devices. Reimbursement is made by the health insuring agent for these services:

(1) The furnishing and insertion of intrauterine (IUD) and other mechanical devices. The professional charge for these services may include the cost of such devices when furnished by the eligible provider.

(2) The fitting and furnishing of diaphragms when furnished by the physician and not by prescription. The professional charge for these services may include the cost of such devices when furnished by the eligible provider.

(3) Voluntary sterilization. Vasectomy or tubal ligation within the context of applicable law.

(4) Abortion within the context of applicable law.

(d) Other treatment services. Treatment for vaginal infection, cervical cancer, and other treatment services are covered only when provided under other provisions of this category and are not covered as a family planning service.

(e) Benefits are paid for hospital services which are provided as a result of providing a family planning service, provided that any inpatient hospital care for family planning is considered as inpatient hospital care under Rule 326.36.07.003; and further provided that if a benefit is provided for a service under this rule, benefits are not available for the same service under any other rule of this category.

(f) Voluntary sterilization requires informed consent at least 72 hours prior to such sterilization. Any eligible recipient is legally incapable of giving informed consent who either is under 21 years of age or has been adjudicated incompetent by a court of competent jurisdiction. Informed consent means the voluntary, knowing assent from the eligible recipient on whom any sterilization is to be performed after having been given (as evidenced by a document executed by such eligible recipient):

(1) a fair explanation of the procedures to be followed;

(2) a description of the attendant discomforts and risks;

(3) a description of the benefits to be expected;

(4) counseling concerning appropriate alternative methods and the effect and impact of the proposed sterilization including the fact that it must be considered to be an irreversible procedure;

(5) an offer to answer any inquiries concerning the procedures; and

(6) an instruction that the eligible recipient is free to withdraw his or her consent to the procedure at any time prior to the sterilization without prejudicing his or her future care and without loss of other project or program benefits to which the eligible recipient might otherwise be entitled.

.005. Provider Certification for Family Planning Services. Certification and participation for family planning agencies in the family planning program require the completion, submission, and approval by the health insuring agent of the provider and physician agreement, Provider Certification for Family Planning Services. Certified providers obtaining the services of additional physicians must submit a physician's agreement for each new doctor added to the agency's staff. The physician's agreement states that the physician will not personally bill the program for the services he provides in the agency. Also, any reimbursement received by the physician directly, for his services in the agency, will be turned over to the agency. The agreement does not limit nor prevent the physician from receiving Title XIX payment for providing family planning services in the place of his practice (office, hospital, or clinic).

.006. Family Planning Fees. The fees paid to approved family planning agencies are determined by DPW within appropriation limits and are approved by the Board of Public Welfare.

Doc. No. 766829

Blue Cross Medicaid Home Health Program Manual 326.36.04.001

This rule is repealed under the authority of Articles 695c and 695j-1, Texas Civil Statutes.

.001. Blue Cross Medicaid Home Health Program Manual. **DPW adopts by reference the rules contained in *The Blue Cross Medicaid Home Health Care Program Manual for Providers of Services.***

Doc. No.766830

326.36.04.002-.012

These rules are promulgated under the authority of Articles 695c and 695j-1, Texas Civil Statutes.

.002. Provider Participation Requirements. The following conditions must be met to establish qualifications for participation as a Title XIX home health agency in the Medicaid Home Health Care Program:

(a) The provider must be certified for participation as a home health agency under Title XVIII Medicare.

(b) The provider must enter into a written provider agreement with DPW relating to the provision of services and making of payments.

.003. Authorized Home Health Services. Subject to certain conditions, limitations, and exclusions, payment will be made for home health services when provided to an eligible Medicaid recipient age 21 or over upon the written recommendations of the patient's attending physician as appropriately described in a written plan of care and when prior authorized by the health insuring agent.

.004. Benefits for Medicare/Medicaid Recipients. For eligible Medicare/Medicaid recipients, Medicare must be utilized as the primary resource for payment of home health benefits. Payment is made for the deductible portion of valid assigned Medicare claims for home health services. Eligible recipients who have exhausted their home health benefits under Medicare are not entitled to receive home health services under the Medical Assistance Program. However, prior authorization may be given for payment of home health aide services and certain medical supplies, equipment, or appliances suitable for use in the home when:

(a) an eligible Medicaid recipient enrolled in Medicare does not qualify for home health services under Medicare because skilled nursing care or physical therapy or speech therapy is not an essential element of the patient's treatment plan; and/or

(b) the medical supplies, equipment, or appliances for use in the eligible recipient's place of residence are not otherwise available as a Medicare Part B benefit.

.005. Limitations on Home Health Services. Home health services are limited to:

(a) Part-time or intermittent professional nursing services provided by a registered nurse or licensed vocational nurse furnished by a Title XIX home health agency. Part-time is defined as less than an eight-hour shift per day.

(1) Payment is considered for nursing visits required to teach the patient and/or a family member or neighbor how to safely and effectively implement a service or activity which is necessary to the care and treatment of a patient in a home setting.

(2) Visits for the purpose of skilled nursing observation and evaluation are covered, provided the physician specifically requests a nurse to visit the home for this purpose. In these instances, the doctor's orders must reflect adequate information to document the need for such visits. Nursing visits for the primary purpose of assessing a patient's nursing care needs are not reimbursable as a professional nursing visit.

(3) Visits for the purpose of providing general supervision to a home health aide are considered a professional nursing visit.

(4) The services of a male orderly requested for the purpose of inserting a urinary catheter in a male patient are considered a nursing service and billed as a nursing visit when prescribed by the treating physician.

(5) Nursing visits for the purpose of administering intramuscular and intravenous injections constitute professional nursing services. Visits for the purpose of giving medications are not covered if:

(A) the medication is not considered medically necessary to the treatment of the individual's illness;

(B) the administration of medication exceeds the therapeutic frequency or duration by accepted standards of medical practice;

(C) there is not a medical reason prohibiting the administration of the medication by mouth; or

(D) the patient or a member of his family has been taught to give the injection.

(b) Personal care services of a home health aide who is under the supervision of a professional registered nurse assigned by the home health agency. The primary objective of a home health aide visit and the majority of time spent in the home must be for the purpose of providing personal care services. Visits made primarily for the purpose of performing housekeeping services are not covered. Light housekeeping services are considered incidental and are not covered for payment if they substantially increase the amount of time the aide spends in the home.

(c) Visits by either a nurse or a home health aide may not exceed an aggregate of 50 visits per eligible recipient per benefit period as defined under this category. Benefit period for purposes of this rule means the 12 successive months beginning with the first date an eligible recipient receives an authorized home health visit. These visits are computed or counted on the same basis as such visits are computed or counted under Part B of Medicare.

(d) Purchase of certain medical supplies and the purchase, rental, and/or repair of durable medical equipment and appliances suitable for use in the eligible recipient's place of residence. Durable medical

equipment is defined as equipment which can withstand repeated use and is primarily and customarily used to serve a medical purpose.

(e) The covered medical supplies listed below are those items considered most essential in the physician-prescribed treatment of an ill or injured patient in his own home. All of these items are primarily designed for therapeutic purposes. Items which are not listed may in selected instances be required for a particular patient. Consideration may be given to prior authorization of such items when the need can be medically documented on an individual case basis. Medical supplies are available only when provided in conjunction with a current treatment plan. Compensable items include:

(1) colostomy and ileostomy care supplies;
(2) urinary appliances;
(3) sheepskin pads and incontinent pads;
(4) crutch and cane tips;
(5) other irrigation sets;
(6) supports and abdominal binders (not to include braces);
(7) medicine chest supplies;
(8) syringes and needles; and
(9) dressing supplies.

(f) Payment will be considered for purchase, rental, or repair of durable medical equipment prescribed by the physician and determined medically necessary in illness/injury or for treatment of a malformed body member when provided in conjunction with a current treatment plan. The health insuring agent reviews and approves the most appropriate plan and the most economical method (rental, purchase, or repair) of meeting the eligible recipient's needs on a planned basis. Periodic rental payment is made only for the period of time the equipment can be substantiated as medically necessary. Periodic rental payments will end when medical necessity for the equipment no longer exists or when the total monthly payments equal the reasonable purchase costs, whichever comes first. Equipment is purchased if it is determined that purchase is more practical or less costly than periodic payments. If the purchase or rental cost exceeds the lowest charge level at which such service is consistently available in the locality, the provider will be requested to obtain a second bid from another supplier. Compensable medical appliances and equipment (rental, purchase, or repairs) include:

(1) non-electric wheelchairs, including required special equipment;
(2) canes, crutches, walkers, and trapeze bars;
(3) bed pans and urinals;
(4) non-electric hospital beds and mattresses;
(5) air flotation or air pressure mattresses and cushions; and
(6) bedside rails and bed trays.

(g) Medical supplies, equipment, or appliances not listed may in exceptional circumstances be considered for payment when it can be medically substantiated as part of the treatment plan that such service would serve a specific medical purpose on an individual case basis.

.006. Repair of Durable Medical Equipment and Appliances.

(a) Requests for repairs of durable medical equipment or appliances must include:

(1) medical information from the attending physician substantiating that the medical appliance or equipment continues to serve a specific medical purpose; and

(2) an itemized estimated cost list of the repairs.

(b) Repairs will not be authorized in situations where the equipment has been abused or neglected by the patient and/or his family.

.007. Program Exclusions. Program benefits do not include payment for:

(a) bath home whirlpools, home exercisors, hemodialysis equipment, respirators, and mechanical lifts;
(b) oxygen and related equipment, including IPPB machines;
(c) speech and physical therapy;
(d) medical social services;
(e) nutritional services;
(f) occupational services and therapy;
(g) drugs or biologicals (except as provided for in this category);
(h) chore services;
(i) electric beds or electric wheelchairs;
(j) a visit by a licensed nurse to perform a service that could be self-administered or provided by a non-medical person without the direct supervision of a nurse. In determining whether or not a visit requires the skill of a nurse, consideration is given to the type of service being provided and the condition of the patient identified in the plan of care; or
(k) any services or supplies furnished a recipient who is a resident or patient in a hospital, skilled nursing facility, or intermediate care facility.

.008. Patient Supervision.

(a) Patients must be seen by their physician within 30 days prior to the start of home health care services. This physician visit may be waived when a diagnosis has already been established by the attending physician and the patient is currently undergoing active medical care and treatment. Such a waiver is based on the physician's statement that an additional evaluation visit is not medically necessary.

(b) Patients receiving home health care services must remain under the care and supervision of a physi-

cian who reviews and revises the plan of care as often as he determines necessary.

.009. Written Plan of Care. Home health care services are available only when provided upon recommendation of the attending physician in accordance with the physician's detailed plan of care which includes:

(a) all pertinent diagnoses;

(b) specific description of types of required services, including amount, duration, and frequency of such services;

(c) functional limitations and permitted activities;

(d) anticipated time of care and instructions for discharge;

(e) nutritional requirements;

(f) prescribed medications and/or treatments;

(g) mental status;

(h) any safety or precautionary measures;

(i) prognosis and rehabilitation potential; and

(j) date patient was last seen.

.010. Time Limited Authorizations.

(a) Prior authorizations for payment of home health benefits may be issued for a service period not to exceed 60 days on any given authorization. This does not mean specific authorization cannot be limited to a time period less than the established maximum. When treatment exceeds 60 days, the home health agency is required to submit an extension notice.

(b) When there is a payment request for continuation of services under the same plan of treatment, information from the provider must include a signed and dated progress report from the physician as to the need for continued care and services. When there is a change in the service plan, the provider must submit the physician's signed and dated revised plan of care.

(c) Each home health care plan is evaluated on an individual case basis. The provider is notified in writing of the authorization (or denial) of payment for requested services.

(d) All requests submitted for prior authorization of covered Medicaid home health benefits must include:

(1) patient identification information (as it appears on the Medical Care ID Card):

(A) full name, age, and address;

(B) medical assistance program case number; and

(C) health insurance claim number (where applicable);

(2) physician's plan of care. The plan must be in writing and signed and dated by the attending physician;

(3) clinical record date (completed by provider);

(A) home or living environment;

(B) family composition;

(C) any nursing observations pertinent to the overall plan of care in the home; and

(D) type of service the patient is receiving from other community or state agencies. When the patient is receiving chore or homemaking services from DPW, indicate date of contact with agency social worker to coordinate in-home services;

(4) in instances where inadequate or incomplete information is submitted, the provider will be requested to furnish additional documentation as required to make a decision on the request.

.011. Payment for Home Health Services.

(a) The amount payable for services rendered to eligible recipients by Title XIX home health agencies which are covered, the manner of payment, and the method of settlement of underpayments and overpayments are determined under the same methods and procedures as are used for determining reimbursable amounts for comparable services under such Title XIX home health agency's agreement to be a provider of services under Medicare and covering the same period to the extent permitted by applicable federal regulations. Such payments by the health insuring agent to such Title XIX home health agencies are subject to the same requirements and penalties of said Medicare agreement.

(b) The same annual reports covering a 12-month period of operation (based on a provider's reporting year) as are required in Medicare are used to ensure payment of reasonable cost for Medicaid home health care benefits as provided in this program category.

(c) Providers participating in the program must accept payment from the health insuring agent as payment in full for the covered services. Charges may not be imposed on the patient/recipient, or others on their behalf, for covered services.

.012. Additional Claim Information Requirements. In addition to the general requirements in Rule 326.36.01.002, the following information is required on claims for home health services:

(a) type of services or supplies furnished for each date given;

(b) diagnosis or diagnoses;

(c) date of each service;

(d) charge for each home health unit of service;

(e) written prior authorization obtained from the health insuring agent;

(f) certification by the Title XIX home health agency that services were provided in accordance with this category; and

(g) name, address, and appropriate identification number of the referring physician.

Medicaid Chiropractic Program 326.36.05

These amendments are promulgated under the authority of Articles 695c and 695j-1, Texas Civil Statutes.

*.001 **Additional Claim Information Requirements** [Claims Documentation]. **In addition to the general requirements in Rule 326.36.01.002, the following information is required on chiropractic claims*** [Before a claim filed for reimbursement of chiropractic services can be considered for payment, the claim form must contain the following information]:

(a) [A diagnosis.] The [primary] diagnosis of [must be] subluxation ***which specifies the level and condition (acute or chronic).*** [either so stated or identified by a term descriptive of subluxation. The descriptive term should refer either to the condition of the spinal joint involved or to the direction of the position assumed by the bone names.]

(b) ***Place of service.*** [Location of subluxation. The precise level of the subluxation must be specified to substantiate a claim for manipulation of the spine. This designation is made in relation to the part of the spine in which the subluxation is identified. The level of subluxation may be specified in the following ways:

[(1) The exact bones may be listed (C5, Tl, etc.).

[(2) The location may be used if it implies several bones (lumbosacral, occiput and C1, etc.).]

(c) ***The type of each treatment procedure.*** [The symptoms. A description of the symptoms associated with subluxation must be shown on the claim form. They must bear a direct relationship to the level of subluxation.]

(d) ***Certification*** [Documentation of X-ray. The claim form must indicate] that an x-ray film is available demonstrating the existence of a subluxation at the specified level of the spine.

(e) [The] Date of the x-ray. [is also required on the claim form. In the case of an acute condition, the x-ray must be taken no more than three months prior to the initial date of treatment. For a chronic condition the x-ray must not have been taken more than 12 months prior to the initial course of treatment. The claim form must also specify the condition as acute or chronic.]

(f) ***The number of miles for which a travel charge is made.*** [If all of the above requested information is not shown on the claim form, the missing information will be requested from the chiropractor, resulting in delay of processing for Medicaid payment.]

(g) ***The individual charge for each authorized service related to a major diagnosis.***

(h) [Treatment phase. The] Number of manual manipulations that have been performed. [(e.g., second, fifth, tenth treatment, etc.) must be stated.]

.004. Authorized Chiropractic Services.

(a) Chiropractic services include those services provided by a Doctor of Chiropractic and which are within the scope of practice of his profession as defined by state law. Benefits are limited to services which consist of necessary treatment or correction by means of manual manipulation of the spine, by use of hands only, to correct a subluxation demonstrated by x-ray to the same extent that such benefits are provided under Part B of Medicare. Benefits are available under this rule only for services which are provided during the first 24 visits to any one eligible recipient by a Doctor of Chiropractic during any one benefit period. Benefit period for purposes of this rule means the 12 consecutive monthly periods beginning September 1 and ending August 31 each year.

(b) Coverage does not extend to the diagnostic, therapeutic services, or adjunctive therapies furnished by a chiropractor or by others under his or her orders of direction. This exclusion applies to the x-ray taken for the purpose of determining the existence of a subluxation of the spine. Additionally, braces or supports, even though ordered by an M.D. or D.O. and supplied by a chiropractor, are not reimbursable items.

Doc. No. 766832

Physician Services 326.36.06

These rules are promulgated under the authority of Articles 695c and 695j-1, Texas Civil Statutes.

.001. Additional Claim Information Requirements. In addition to the general requirements in Rule 326.36.01.002, the following information is required on claims for physician services:

(a) The appropriate identification number of each physician providing a specific service (except pathologists or radiologists in group practices).

(b) Place of service (inpatient hospital, outpatient hospital, skilled nursing facility, intermediate care facility, physician's office, patient's home, independent laboratory, etc.).

(c) The type of each diagnostic, treatment, or surgical procedure (type or kind of each diagnostic x-ray, laboratory procedure, and each surgical procedure performed).

(d) The number of miles for which a travel charge is made.

(e) The date on which each service was provided.

(f) The individual charge for each service related to the major diagnosis.

(g) Diagnosis(es) to a maximum of two primary and three secondary diagnoses of the condition(s) for which treatment and services were provided. With respect to diagnostic or other services furnished at the request of another physician, this requirement may be waived by the health insuring agent if the physician rendering the service shows that such information is not available to him.

(h) The name, address, and appropriate identification number of the ordering physician or doctor if services were provided by another physician or doctor.

(i) All pertinent supplemental information, including clarification of the diagnoses in terms of the degree or extent of involvement necessary to substantiate the need for the services provided and/or charges made.

.002. Authorized Physician Services. The term "physician services" includes those reasonable and medically necessary services provided by or under the personal supervision of a physician and which are within the scope of practice of his profession as defined by state law. These services include oral surgery as defined in Rule 326.36.11.018 and rendered by a Doctor of Dentistry.

Doc. No. 766833

Hospital Services 326.36.07

These rules are promulgated under the authority of Articles 695c and 695j-1, Texas Civil Statutes.

.001. Payment for Hospital Services. The amount payable for services delivered to eligible recipients by hospitals, the manner of payment, and the method of settlement of underpayments and overpayments are determined under similar methods and procedures as are used for determining reimbursable amounts under such institution's agreement to be a provider of services under Medicare and covering the same period, to the extent permitted by applicable federal requirements. Variances are accounted for in the *State Title XIX Plan for the Texas Medical Assistance Program.* Such payments by the health insuring agent to such institutions are subject to similar requirements and penalties of said Medicare agreement.

.002. Additional Claim Information Requirements. In addition to the general requirements in Rule 326.36.01.002, the following information is required on or must accompany hospital claims:

(a) Inpatient hospital care:

(1) copy of the patient's itemized daily charges, including data elements and format as specified by the department;

(2) date and hour of admission and discharge, including inclusive dates during which services were provided if claims are made for a period other than that beginning on the date of admission and ending with the date of discharge;

(3) number of days of care;

(4) charges for bed, meals, and nursing care;

(5) admitting diagnoses or symptoms;

(6) discharge diagnoses (or diagnoses at end of period for which a claim is made if discharge has not occurred) up to a maximum of two primary diagnoses and three secondary diagnoses;

(7) surgical procedures, if any;

(8) individual charges for ancillary services identified by code in accordance with the *Hospital Billing Guide* established by the health insuring agent and approved by the department;

(9) dates on which the various types of services were provided. The posting date is satisfactory except when a portion of the period of care precedes or succeeds the certified period of eligibility. In such cases, record the actual date that each of the above types of services were provided;

(10) certification by the hospital that the hospital has on file a record that services provided were upon order of a physician or doctor, a record of admission, continued stay certification, extension recertification, and 60-day recertification;

(11) the hospital's medical record number;

(12) the name, address, and appropriate identification number of the attending physician and, if appropriate, consulting physician(s) or doctor(s);

(13) the certification portion of the Texas Admissions and Review Program (TARP) abstract.

(b) Hospital outpatient services:

(1) surgical procedure(s) related to each specific diagnosis(es), where possible;

(2) medical treatment(s) related to each specific diagnosis(es), where possible;

(3) diagnosis(es) to a maximum of two primary and three secondary diagnoses;

(4) charges for each service;

(5) date of each service;

(6) name, address, and appropriate identification number of the attending physician and (if known) of ordering and consulting physician(s).

.003. Authorized Inpatient Hospital Services. Inpatient hospital services include those items and services ordinarily furnished by the hospital for the care and treatment of inpatients which are provided under the direction of a physician in a Title XIX hospital or a Titles XVIII and XIX approved out-of-state hospital. Except as otherwise specified, and subject to the qualification limitations and exclusions set forth, benefits are provided for hospital services set forth below when provided to eligible recipients:

(a) Duration of care. When an eligible recipient is confined to a Title XIX hospital or a Titles XVIII and XIX approved out-of-state hospital as a bed-patient, the health insuring agent provides benefits for hospital services actually furnished to him during the first 30 days of such confinement during each Title XIX spell of illness, if medically necessary. Such services are subject to the utilization review requirements of the Texas Medical Assistance Program.

(b) Benefits for bed-patient hospital care. The hopital services for which benefits are provided under (a) above consist of the following:

(1) bed and board in semi-private accommodations or in an intensive or coronary care unit, including meals, special diets, and general nursing services; or an allownce for bed and board in private accommodations, including meals, special diets, and general nursing services, to the extent of the hospital's charge for its most prevalent semi-private accommodations, except that bed and board in private accommodations are provided in full if required for medical reasons;

(2) either the first three pints of whole blood or the first three units of packed red cells, provided that such is not available without cost;

(3) all other care in the nature of usual hospital services, except occupational therapy;

(4) maternity care (includes the usual and customary care for female recipients).

.004 Authorized Outpatient Hospital Services.

(a) Outpatient hospital services include those diagnostic, therapeutic, rehabilitative, or palliative items or services furnished by or under the direction of a physician to an outpatient by a Title XIX hospital or an out-of-state hospital. This does not include occupational therapy or drugs and biologicals which can be self-administered.

(b) If any eligible recipient receives outpatient services for which benefits are provided from a Title XIX hospital which would provide such services without charge upon payment of a registration fee, payment is made for such registration fee in lieu of any other benefits for such services.

.005 Hospitalization (Dental Care Only) for Individuals Under Age 21 Years. Hospitalization is authorized under the EPSDT program for individuals under the age of 21 years for dental care that requires in-hospital services. Prior approval must be obtained from the Texas Department of Health Resources before admission and treatment. Claims from the hospital and physician are processed in the usual manner through the health insuring agent, and claims from the dentist will be processed through the Texas Department of Health Resources.

Doc. No. 766834

Laboratory, X-Ray, and Radiation Therapy 326.36.08

These rules are promulgated under the authority of Articles 695c and 695j-1, Texas Civil Statutes.

.001. Additional Claim Information Requirements. In addition to the general requirements in Rule 326.36.01.002, the following information is required on claims for laboratory and x-ray services and radiation therapy: the name, address, and appropriate identification number (if known) of ordering physician.

.002. Authorized Services. Laboratory and x-ray services and radiation therapy include professional and technical laboratory and radiological services ordered by a physician and provided to a patient by or under the direction of a physician in either:

(a) an office or similar facility other than a hospital outpatient department or clinic, or

(b) an approved laboratory (but only with respect to those services which the laboratory is certified to provide under Medicare).

Doc. No. 766835

Podiatry Services 326.36.09

These rules are promulgated under the authority of Articles 695c and 695j-1, Texas Civil Statutes.

.001. Additional Claim Information Requirements. In addition to the general requirements in Rule 326.36.01.002, the following information is required on claims for podiatry services:

(a) place of service;

(b) the type of each diagnostic, treatment, or surgical procedure;

(c) the number of miles for which a travel charge is made;

(d) the individual charge for each service related to the major diagnosis;

(e) diagnosis(es) to a maximum of two primary and three secondary diagnoses of the condition(s) for which treatment and services were provided. With respect to diagnostic or other services furnished at the request of a physician or another podiatrist, this requirement may be waived by the health insuring agent if the podiatrist providing the services shows that such information is not available to him;

(f) name, address, and appropriate identification number of the ordering physician or podiatrist if services were provided by a non-ordering podiatrist;

(g) all supplemental information, including clarification of the diagnoses in terms of the degree or extent of involvement necessary to substantiate the need for the services provided and/or changes made.

.002. Authorized Podiatry Services. The term "podiatry services" includes those services provided by or under the personal supervision of a Doctor of Podiatry which are within the scope of practice of his profession as defined by state law and for which benefits are provided under Medicare.

Doc. No. 766836

Ambulance Services 326.36.10

These rules are promulgated under the authority of Articles 695c and 695j-1, Texas Civil Statutes.

.001. Additional Claim Information Requirements. In addition to the general requirements in Rule 326.36.01.002, the following information is required on claims for ambulance services:

(a) type of ambulance service provided (air, ground, or boat);

(b) origin and destination of each separate trip;

(c) charges for ambulance services provided with justification, including flat-rate charged or number of miles traveled at a specified rate for air, ground, or boat ambulance.

.002. Authorized Ambulance Services. Payment is made for ambulance services when such services are provided in accordance with the laws, regulations, and guidelines governing ambulance services under Part B of Medicare and when conditions below are met. Certain distinctions exist for those recipients defined as severely disabled. The term "severely disabled" is used to denote any individual whose severe physical handicap limits his mobility to the extent that he must be transported by litter or while remaining in a wheelchair and an ambulance is the appropriate means of transport.

(a) To be covered, ambulance service must be medically necessary and reasonable. Medical necessity is established when the eligible recipient's condition is such that use of any other method of transportation is contraindicated and, in the case of an eligible recipient who is severely disabled, no other suitable transportation is available. For an eligible recipient who is not severely disabled, if other suitable transportation other than ambulance could be utilized without endangering such eligible recipient's health, no payment may be made for ambulance service.

(b) Any eligible recipient who is severely disabled as that term is defined above will be transported to and from the eligible provider of his choice who is generally available and used by other residents of the community for any appropriate medical care included under the Medical Assistance Program. If no eligible provider of the appropriate care is available within the community, transportation will be to and from the nearest eligible provider who can provide approriate medical care included under the Medical Assistance Program.

(c) Any eligible recipient who is not severely disabled will be transported to the nearest hospital or skilled nursing facility which would ordinarily be expected to have the appropriate facilities for the treatment of the injury or illness involved. Ambulance service from a hospital or skilled nursing facility to this type of eligible recipient's home is covered when the home is within the locality of the hospital or skilled nursing facility or where such eligible recipient's home is outside of the locality of such hospital or skilled nursing facility but such hospital or skilled nursing facility is the nearest one with appropriate facilities.

(d) The term "locality," with respect to ambulance service for eligible recipients who are not severely disabled, means the service area surrounding the hospital or skilled nursing facility from which individuals normally come or are expected to come for hospital or skilled nursing services. The term "appropriate facility," with respect to ambulance service for eligible recipients who are not severely disabled, means that the facility is generally equipped to provide the needed hospital or skilled nursing care for the illness or injury involved. It is the institution, equipment, personnel, and capability to provide the services necessary to support the required medical care that determine whether a facility is appropriate.

(e) The ambulance services must be provided by an ambulance services supplier and the ambulance must be equipped as an ambulance and operated by trained personnel under appropriate rules, licensing, or regulations of the area in which the ambulance is operated.

Doc. No. 766837

Definitions 326.36.11

These rules are promulgated under the authority of Articles 695c and 695j-1, Texas Civil Statutes.

.001. *General Definitions for Purchased Health Services.* The definitions below apply to terms as they are used generally throughout the department's Purchased Health Services rules. In the context of rules about a particular service, the definition of a term may be altered. When this occurs, the language describing that particular service takes precedence over these generic definitions.

(a) Eligible provider. An institution, facility, agency, person, partnership, corporation, or association approved for and participating in the Texas Medical Assistance Program which accepts payment in accordance with the above, except that such eligible provider must be an eligible Title XIX provider only for Part B Medicare services or supplies and for the Title XIX payment of the deductible and coinsurance liabilities.

(b) Hospital. Any institution licensed as a hospital by the appropriate licensing authority but which is not an institution for tuberculosis, a mental institution, a health resort, nursing home, rest home, or any other institution primarily providing convalescent or custodial care or which is otherwise excluded under this category.

(c) Title XIX hospital. A hospital which is participating as a hospital under Medicare, which has in effect a utilization review plan, approved by the department, applicable to all eligible recipients to whom it provides services or supplies and which has been designated by the department as a Title XIX hospital. A Title XIX hospital may also be a hospital not meeting all of the above requirements but which provides services or supplies for which benefits are provided under Medicare, Section 1814 (d) of the Social Security Act, or would have been provided under such section had the recipients to whom the services or supplies are provided been eligible for and enrolled under Part A of Medicare to the extent of such services and supplies only, and then only if such hospital has been designated by the department as a Title XIX emergency care only hospital or has been approved by the department to provide emergency hospital services and agrees that the reasonable cost of such services or supplies, as defined in Section 1902(a)(13) of the Social Security Act, will be such hospital's total charge for such services and supplies.

(d) Out-of-state hospital. A hospital located outside of the State of Texas which participates as a general and/or acute care hospital under Medicare and/or Title XIX. Examples of institutions which are excluded are institutions primarily for mental disease, pulmonary care or tuberculosis, a health resort, a nursing home, a rest home, or any other institution primarily providing convalescent or custodial care or which is otherwise excluded under this category.

(e) Physician. A Doctor of Medicine or Doctor of Osteopathy legally authorized to practice medicine and surgery at the time and place the service is provided or a Doctor of Dentistry who is legally authorized to practice dentistry at the time and place oral surgery is provided.

(f) Doctor of Chiropractic, Doctor of Optometry, and Doctor of Podiatry. When used, Doctor of Chiropractic, Doctor of Optometry, and Doctor of Podiatry are deemed to have the meaning assigned to them by Subsection B of Article 3.70-2 of the Insurance Code of Texas, or Subsections (1) through (7), Section 3, Article 4590e, Texas Revised Civil Statutes.

(g) Doctor. Doctor means Doctor of Chiropractic (chiropractor), Doctor of Optometry (optometrist), or Doctor of Podiatry (podiatrist).

(h) Approved laboratory. A laboratory which is independent of a hospital or physician's office and which has been approved for and is participating in Medicare and only for the procedures certified to that laboratory under Medicare.

(i) Title XIX home health agency. An agency or organization approved as a home health agency under Medicare and which has been designated by the department as a Title XIX home health agency.

(j) Ambulance service supplier. A person, firm, or institution approved for and participating in Medicare as an air, ground, or boat ambulance service supplier or provider.

(k) Eyeglass supplier. A person, firm, or institution who has entered into a written agreement with the health insuring agent as an eyeglass supplier on a form approved by the department.

(l) Family planning agency. A facility or institution which has been determined by the health insuring agent to qualify as a family planning agency under guidelines established by the department.

(m) Title XIX spell of illness. With respect to inpatient hospital services, spell of illness is a continuous period of hospital confinement. Successive periods of hospital confinement are considered to be continuous unless the last date of discharge and the date of readmission are separated by at least 60 consecutive days.

(n) Inpatient. A person registered and assigned a medical record number by a hospital for bed occupancy in that hospital.

(o) Outpatient. A person registered by a hospital for outpatient services but not as an inpatient.

(p) Day. With respect to inpatient hospital services, the time period of a day is counted for:

(1) hospital bed occupancy each midnight while under registration in a hospital as an inpatient;

(2) each hospital bed occupancy where admission and discharge occur on the same calendar day while under registration in a hospital as an inpatient.

(q) Illness. A bodily disorder, bodily injury, disease, or mental disease.

(r) Oral surgery. Surgery related to the jaw or any structure contiguous to the jaw or the reduction of any fracture of the jaw or any facial bone.

(s) Semi-private room. A two-bed or four-bed accommodation.

(t) Mental disease or disorder. Any condition classified as a neurosis, psychoneurosis, psychopathy, psychosis, or personality disorder.

(u) Prescription. A written order or a countersigned oral order by a physician or doctor for a product or service to be given an eligible recipient.

(v) Non-medical public institution. An institution or facility which is either a unit of or under the administrative control of a state, federal, or local government and which is not approved for participation in the Medical Assistance Program.

(w) Eyeglasses. Eyewear dispensed and delivered which is medically necessary and prescribed by a Doctor of Optometry or physician, is professionally adjudged to be necessary and appropriate for the lens, age, and sex of the eligible recipient, and significantly improves visual acuity or impedes progression of visual problems. The term "eyeglasses" does not include artificial eyes or any item of eyewear for which benefits are not provided in Subcategory .02.

(x) Claim. A request for payment for authorized benefits on the applicable approved form meeting the established itemization requirements.

(y) Utilization review. The methods and procedures related to the review of utilization of covered care and services with respect to medical necessity and to safeguard against inappropriate utilization of care and services.

(z) Recipient month. A calendar month of continuous eligibility for one individual under the Medical Assistance Program. Each month covers eligibility for only one eligible recipient. Multiple recipient months may cover eligibility for one or more eligible recipients or eligibility for the same individual if prior months are involved. Additional months of recipient eligibility may occur due to:

(1) certification of eligibility for up to three months prior to date of application;

(2) eligibility for those individuals who are certified to be eligible recipients after a first of the month;

(3) eligibility certified retroactively;

(4) certification of four months post-eligibility for certain individuals in the non-Medicare related AFDC coverage group; or

(5) appropriately identified error adjustments.

(aa) State plan. The plan for administration of the Medical Assistance Program which is approved by the Secretary of Health, Education, and Welfare in accordance with the provisions of Title XIX of the Social Security Act, as amended.

(bb) State fiscal year. The 12-month period beginning September 1 and ending August 31.

(cc) Medical Assistance Program. The program implemented by the State of Texas under the provisions of Title XIX of the Social Security Act, as amended.

(dd) Third-party liability. The resources that an eligible recipient may have which serve as a source of payment for services provided under the Medical Assistance Program. Such resources include Medicare coverage, Champus coverage, private insurance coverage, and other applicable sources.

(ee) Health insuring agent. An organization legally operating within the state which pays for the cost of certain medical services available under the Title XIX State Plan to eligible recipients in exchange for premiums paid by DPW and which assumes an underwriting risk.

Doc. No. 766838

General Administration 326.36.12

These rules are promulgated under the authority of Articles 695c and 695j-1, Texas Civil Statutes.

.001. Payments to Eligible Providers.

(a) The health insuring agent makes payments to eligible providers on behalf of eligible recipients for authorized benefits as defined in this category when the items of service are medically necessary for diagnosis and/or treatment of illness or injury, or when such items of service are appropriately authorized for prevention of the occurrence of a medical condition, and are prescribed by a physician or doctor, as appropriate to the particular benefits, in accordance with the utilization review provisions of this category.

(b) Subject to the qualifications, limitations, and exclusions set forth in this category, payments for services covered are made only to eligible providers of such services. The provider must have agreed to accept payment of the reasonable charge, reasonable costs, or stipulated fee for service, as appropriate to the eligible provider, as the full and complete payment. The provider cannot charge or take recourse to any eligible recipient for services for which payment is made or will be made, except as may otherwise be specifically provided. Eligible providers are not precluded from charging eligible recipients for medical care and services which are outside the amount, duration, and scope of benefits of the Texas Medical Assistance Program. Payment for medical care and services cannot be made to any eligible recipient.

.002. Payments for Laboratory and X-Ray Services, Radiation Therapy, Physician Services, Podiatry Serv-

ices, Chiropractic Services, Optometric Services, and Ambulance Services. Subject to certain qualifications, limitations, and exclusions as provided elsewhere in this category, payment to eligible providers for laboratory and x-ray services, radiation therapy, physician services, podiatry services, chiropractic services, optometric services, and ambulance services, other than inpatient or outpatient services of a Title XIX hospital, must not exceed the reasonable or prevailing charge for a specific service as provided in this category.

.003. Medical Care or Services Provided Outside of Texas. Payments to eligible providers who are located outside of the State of Texas are made in the amount of the usual, customary, and reasonable cost or charges, or stipulated fee for service, as appropriate for the provider of care. Such payment to practitioners, providers, or suppliers who are reimbursed on a reasonable charge basis may not exceed the lesser of (1) 95 percent of the Title XVIII reasonable or prevailing charge determination for the same service in the State of Texas, or (2) when mutually agreed upon by the health insuring agent and the department, 95 percent of the Title XVIII reasonable or prevailing charge determination for the same service in the state where the service was provided. Such payments made on a reasonable cost basis are mutually determined by the department and the health insuring agent.

.004. Reasonable Charges. Subject to the qualifications, limitations, and exclusions elsewhere in this category, reasonable charges and payments based on reasonable charges to eligible providers are defined and determined by the health insuring agent as follows:

(a) A reasonable charge is a charge for a specific service which is the lowest of:

(1) the eligible provider's customary charge for that service;

(2) the prevailing charges made for similar services in the geographic locality; or

(3) the actual charge of the eligible provider.

(b) The health insuring agent uses a statistical base for making reasonable charge determinations, made up on individual charges gathered from available sources, including Medicare and Title XIX.

(c) Determination of reasonable charges as set forth in this rule are made in accordance with applicable federal requirements and payments are limited to 95 percent of Medicare allowable charges based on specific calendar year profile charge data.

.005. Claims Procedures. The health insuring agent:

(a) rejects all claims not payable under this category;

(b) suspends payments to any eligible provider in accordance with procedures approved by the department or after notification from the department to suspend such payments and promptly provides the department appropriate information pertaining to any such suspension;

(c) notifies any provider submitting the claims of their reduction or rejection and the reason therefor;

(d) collects any payments made in error, as set forth in this category, effects a current record credit to the department, and provides the department with required data relating to such error corrections;

(e) within a period not to exceed 30 days of receipt and determination of proper evidence establishing the validity of claims, invoices, and statements, prepares checks or drafts to providers, except for cases in which the department agrees that a basis exists for further review, suspension, or other irregularity;

(f) with respect to eligible providers who have furnished eligible recipients' benefits, payment for which is to be made on a reasonable cost basis, the health insuring agent makes provisions for payments:

(1) on an interim basis, not less often than once each calendar month, in an amount which will approximate the reasonable cost of such services, and

(2) on a final audited annual basis for the reasonable cost of such services;

(g) when the eligible recipient has such another source of payment, the health insuring agent withholds payment of the claim for a reasonable time to enable the amount of such other benefits to be determined and reported to the health insuring agent by the eligible provider;

(h) employs and assigns a physician or physicians, and other professionals as necessary, to establish suitable standards for the audit of claims for services delivered and payment to eligible providers, to develop and maintain necessary safeguards to ensure the quality of care, and to provide appropriate prior authorizations as required;

(i) requires eligible providers to submit information on claims on forms designated by the health insuring agent and approved by the department.

.006. Review of Questionable Claims. The health insuring agent has physicians, and/or other professional consultants as appropriate, review all questionable claims for:

(a) interpretation of benefit coverage with respect to illness or mental disease;

(b) determinations on questions regarding over-utilization or other misutilization of services by eligible recipients or eligible providers;

(c) determinations on questions regarding excessive charges by eligible providers;

(d) determination of the reasonable amount to be paid when a claim is made for a procedure or service for which a reasonable charge determination has not been established by the health insuring agent. Such deter-

mination is made in comparison with established reasonable charges for other procedures requiring similar degrees of skill, training, or experience and considering the locale in which the service was provided and the characteristics of the patient;

(e) quality of care provided and unethical practices of eligible providers. Cases where quality of service or ethical practices of the eligible provider are in question are identified and not paid until further review.

.007. Verification of Cost Data. The health insuring agent is responsible for verification of all eligible provider cost data where applicable under the Medical Assistance Program for services provided under this category.

.008. Notification to Eligible Providers. The health insuring agent develops and implements procedures to advise eligible providers that they must report and utilize other sources of payment available to eligible recipients to the maximum extent permitted. Payment is reduced to the extent that part of any specified benefits are covered by any health, accident, or other insurance policy or contract. In determining coverage, no exclusion of the insurance policy or benefit system with respect to benefits otherwise payable is taken into account.

.009. Deductible and Coinsurance Portions of Medicare Benefits. Subject to the qualifications, limitations, and exclusions in Rule 326.36.12.013 with respect to benefits for services when provided to an eligible recipient who is concurrently eligible for the same benefits under Medicare, the health insuring agent pays the deductible and coinsurance portions of such valid Medicare claims in the manner and subject to the limitations described below, and thereby discharges its obligation for benefits which would otherwise have been paid under this category had the recipient not been eligible for benefits under Medicare:

(a) valid Part A Medicare deductible and coinsurance liabilities for eligible recipients only with respect to those items of medical care and services in the amount, duration, and scope as provided in this category, and

(b) all deductible and coinsurance liabilities of valid assigned Part B Medicare claims for services provided eligible recipients.

.010. Non-Liability. Neither the department nor the health insuring agent is liable for any act or omission by any eligible provider, their agents, or employees, in caring for a person receiving services for which benefits are provided under this category.

.011. Provider Profile. The health insuring agent provides to any requesting eligible provider a copy of that individual's customary charge profile in accordance with applicable laws and regulations. Cost of the provider profile is borne by the requesting eligible provider.

.012. Exclusions and Limitations.

(a) Benefits do not extend to:

(1) any individual who is an inmate in a public institution (except as a patient in a medical institution approved for participation in the Texas Medical Assistance Program) or is a patient in an institution for tuberculosis, in a mental institution, or in the hospital or nursing sections of institutions for the mentally retarded;

(2) hearing aids, special shoes, or other supportive devices for the feet, ambulation aids (except as provided for in the Home Health Services Program), immunizations, or occupational therapy;

(3) any services provided by military medical facilities, Veterans Administration facilities, or United States Public Health Service hospitals;

(4) care and treatment related to any condition for which benefits are provided or available under the workmen's compensation laws;

(5) dental care and services or any services provided by a Doctor of Dentistry, unless a benefit is provided therefor under Medicare or should have been so provided if the patient had been eligible and enrolled for benefits under both Parts A and B of Medicare, or unless specifically authorized by the department, or unless hospital and physician services are specifically authorized by the Texas Department of Health Resources under the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program;

(6) eyeglasses and examinations for the prescription and fitting thereof, except as provided in this category;

(7) any care or services to the extent that a benefit is paid or payable under Medicare;

(8) any services or supplies delivered to an individual before the effective date of designation by the department as an eligible recipient or after the effective date of denial as an eligible recipient;

(9) any services or supplies provided in connection with cosmetic surgery except as required for the prompt repair of accidental injury or for improvement of the functioning of a malformed body member or when specially authorized by the department;

(10) any services or supplies provided in connection with a routine physical examination except as otherwise provided in this category;

(11) any services provided by an immediate relative of the eligible recipient or member of the eligible recipient's household;

(12) any services or supplies which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, except cosmetic surgery

when specially authorized by the department, unless otherwise specifically provided in this category;

(13) custodial care;

(14) any services or supplies provided to an individual after a finding under utilization review procedures that such services or supplies are not medically necessary;

(15) whole blood or packed red cells except as provided in this category;

(16) any services or supplies outside of the United States except for deductible and coinsurance portions of Medicare benefits as provided for in this category;

(17) any services or supplies not provided for in this category;

(18) any services or supplies for:

(A) the treatment of flat foot conditions and the prescription of supportive devices therefor,

(B) the treatment of subluxations of the foot, or

(C) routine foot care (including the cutting or removal of corns, warts, or calluses, the trimming of nails, and other routine hygiene care).

(b) Benefits for such services and supplies delivered to an individual in diagnosis or treatment of mental disease, psychoneurotic, and personality disorders while not confined as a bed-patient in a hospital may not exceed the lesser of $312.50 or 62.5 percent of the expense of such services and supplies during any one calendar year.

(c) Private room facilities are not considered medically necessary except when, on the basis of medical opinion, critical or contagious illness exists, or when the eligible recipient's condition results in undue disturbance to other patients, or the need for care is emergent and lower cost facilities are not immediately available. The health insuring agent requires hospitals to file with the health insuring agent a physician's certification of such medical necessity.

(d) Separate payments are not made for services and supplies in an institution where the reimbursement formula and vendor payment include such services or supplies as a part of the institutional care.

.013. Freedom of Choice. Eligible recipients have the freedom of choice of an eligible provider. The provider also has the right of choice of serving an eligible recipient; however, in making a determination of whether to serve a recipient, the requirements of the Civil Rights Act of 1964 must be observed. See Rule 326.36.01.003.

.014. Subrogation.

(a) The health insuring agent will be subrogated to any individual's right of recovery against third parties for personal injury or to any other right to payment under any insurance coverage to the extent of the allowable claims paid under this category for services caused by illness or injury.

(b) The health insuring agent and the department, through mutual agreement, establish procedures, controls, and guidelines so as to ensure that all such appropriate cases are discovered, that necessary action is taken, and that all facts necessary are acquired and evaluated to determine if any right of recovery exists.

(c) The health insuring agent and the department mutually agree on guidelines for action to be taken on subrogation claims by the health insuring agent to effectuate recovery of amounts paid under the health insuring contract for services caused by illness or injury. The health insuring agent has authority to commence legal action, compromise, and settle such claims in accordance with the procedures and guidelines so established, and to execute appropriate releases.

(d) The health insuring agent exerts all reasonable efforts to acquire and evaluate all appropriate facts to determine if subrogation rights exist. When a case is reviewed by the health insuring agent, if it appears the facts are such that there are valid rights of recovery, the case is reported by the health insuring agent to the department in accordance with procedures as mutually agreed.

(e) Any sums recovered under subrogation by the health insuring agent, less court costs, attorney's fees, and other costs of litigation, if any, are applied back against the claims involved in accordance with procedures and documentation as approved by the department. Any sums recovered by the department on subrogation claims which the health insuring agent notifies the department of its election not to pursue are retained by the department.

.015. Confidentiality of Information. The health insuring agent and all subcontractors must treat all information which is obtained through performance under the health insuring contract as confidential information to the extent that confidential treatment is provided under law and regulations, and may not use any information so obtained in any manner except as necessary to the proper discharge of obligations and securing of rights as defined in the rules of this category.

.016. Potential Fraud, Program Abuse, and Other Misutilization.

(a) The health insuring agent and the department develop and mutually agree to procedures and safeguards reasonably necessary to prevent and control fraud, program abuse, and other misutilization by eligible recipients, eligible providers, and others.

(b) The health insuring agent in accordance with procedures approved by the department may, or if required by the department will, withhold future payments to eligible providers involved in or suspected of

being involved in potential fraud, program abuse, or other misutilization.

(c) In the event fraud, other violations of law of the State of Texas or the United States, program abuse, or other misutilizations are suspected, the health insuring agent promptly advises the department that such a situation appears to exist and that it has conducted an internal investigation and has determined that said situation is not the result of computer or human error. The health insuring agent in accordance with prior approval by the department independently or in conjunction with the department conducts an initial investigation to acquire and evaluate such facts as are necessary to determine if any offense, violation, program abuse, or other misutilization in fact exists.

(d) The health insuring agent assists the department in the furnishing of any reports or other documentation necessary for the department to acquire and evaluate such facts as are necessary to determine if any offense, violation, program abuse, or other misutilization in fact exists. The department refers cases to the appropriate law enforcement agency if the seriousness of an offense, violation, program abuse, or other misutilization appears to warrant such action.

(e) The health insuring agent, with prior approval of the department on a case-by-case basis and in accordance with guidelines mutually agreed upon by the health insuring agent and the department, pursues and seeks to recover, with or without legal action, any amounts paid as the result of program abuse or other misutilization. The health insuring agent with prior approval of the department on a case-by-case basis compromises, settles, and executes appropriate releases in accordance with generally accepted insurance practice.

(f) Any sums recovered under this rule by the health insuring agent or the department, less court costs, attorney's fees, and other costs of litigation, if any, are applied against the claims involved.

(g) If an eligible provider delivers health care to an individual having a bonafide State Department of Public Welfare Medicaid Care Identification Card, the eligible provider is paid as usual for such services even though it may be determined that the card was obtained by fraudulent means unknown to the provider.

.017. Utilization Review. The health insuring agent performs the following utilization review functions:

(a) studies conducted by the professional and paraprofessional staff to develop, test, revise, implement, and monitor prepayment and post-payment screens relating to medical necessity, appropriateness of care, and setting in which service was delivered;

(b) consultation with professional associations in defining criteria;

(c) publication and distribution of prepayment criteria to appropriate providers;

(d) review of suspended claims to determine medical necessity; review and resolution of claims suspended by the system for professional or paraprofessional determination of medical necessity;

(e) provider communications:

(1) seminars and workshops to the extent that such meetings relate to utilization review;

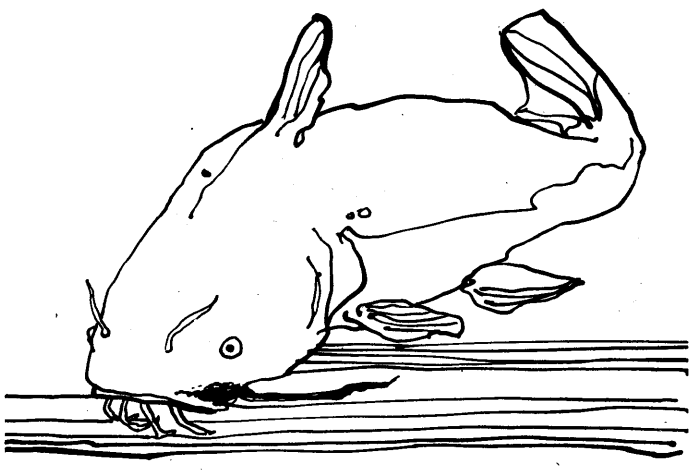
(2) visits to individual physicians, doctors, hospitals, etc., to discuss patterns of practice, billing practices as they directly relate to utilization, and recovery of any funds.

.018. Certification and Recertification. The health insuring agent assists the department in effecting approval of eligible providers. The health insuring agent assists in obtaining signed contracts between the department and hospitals or Title XIX home health agencies. The health insuring agent assigns provider numbers to eligible providers as appropriate.

.019. Fair Hearings. As determined by the department, the health insuring agent participates in all fair hearings requested by applicants, eligible recipients, or eligible providers where issues involve the health insuring agent. Such hearings are arranged by the department and are conducted in accordance with guidelines, rules, and regulations promulgated by the department for such hearings.

.020. Free Services for Recipients. Benefits available free of charge to recipients from other sources are to be considered as a resource in determining what benefits, if any, are available under the Texas Medical Assistance Program.

Doc. No. 766839



Medical Transportation

Ambulance Services 326.43.04

The Department of Public Welfare adopts these repeals under the authority of Articles 695c and 695j-1, Texas Civil Statutes.

.001. Certified Providers. The acceptability of all ambulance services as a benefit item is vested with the health insuring agent. Any ambulance provider who is certified by the health insuring agent as a Medicare provider may also conduct ambulance services under Medicaid. Determination of need for ambulance services is made by the health insuring agent upon receipt of the claim for the provider. Ambulance service is not restricted to emergency service but includes ambulance transportation to and from the nearest hospital or nursing facility having the appropriate facilities for treatment of the injury or illness involved when the service is medically necessary and when any other method of transportation would endanger the patient's health. In both emergency and non-emergency ambulance cases, the health insuring agent requires that the attending physician certify that the transportation of the recipient by ambulance was necessary.

.002. Vehicle Requirements. The vehicle must be a specially designed and equipped automobile or other vehicle (in some areas of the United States this might be a boat or plane) for transporting the sick or injured. It must have customary patient care equipment including a stretcher, clean linens, first aid supplies, and oxygen equipment, and it must also have such other safety and lifesaving equipment as is required by state or local authorities.

.003. Crew Requirements. The ambulance crew must consist of at least two members. Those crew members charged with the care or handling of the patient must include one individual with adequate first aid training, i.e., training equivalent to that provided by the standard and advanced Red Cross first aid courses. Training equivalent to the standard and advanced Red Cross first aid training courses includes ambulance service training and experience acquired in military service; successful completion by the individual of a comparable first aid course furnished by or under the sponsorship of state or local authorities, an educational institution, a fire department, a hospital, a professional organization, or other such qualified organization. On-the-job training involving the administration of first aid under the supervision of or in conjunction with trained first aid personnel for a period of time sufficient to ensure the trainee's proficiency in handling the wide range of patient care services that may have to be performed by a qualified attendant can also be considered as equivalent training.

.004. Verification of Compliance. In determining whether the vehicles and personnel of each supplier meet all of the above requirements, carriers may accept the supplier's statement (absent information to the contrary) that its vehicles and personnel meet all of the requirements if:

(a) the statement describes the first aid, safety, and other patient care items with which the vehicles are equipped;

(b) the statement shows the extent of first aid training acquired by the personnel assigned to those vehicles;

(c) the statement contains the supplier's agreement to notify the carrier of any change in operations which could affect the coverage of his ambulance services; and

(d) the information provided indicated that the requirements are met. The statement must be accompanied by documentary evidence that the ambulance has the equipment required by state and local authorities.

.005. Air Ambulance Service. An ambulance is defined as a ground vehicle, airplane, or boat, properly equipped and staffed. For a Medicaid recipient's ambulance transportation to be compensated, the following conditions must be met as Title XVIII restrictions:

(a) The patient is suffering from an illness or injury which contraindicates transportation by other means.

(b) The patient is transported to the nearest appropriate facility.

(c) The trip must be considered medically necessary and reasonable.

(d) In non-emergency cases, the patient must be severely disabled.

If all of the above conditions are met, air ambulance is only compensated at the rate a ground ambulance is paid. Air ambulance service is handled by the health insuring agent under their contractual agreement with the department and should not have prior authorization by departmental staff. The transportation officers in the regions and the other worker staff refer such cases directly to the health insuring agent for determination of coverage.

.006. Service for Severely Disabled.

(a) Severely disabled Medicaid recipients may utilize ambulance services for transportation to and from medical providers even though the trip is for a regularly scheduled appointment. No emergency need exist for this service to be authorized and reimbursement made by the health insuring agent. A "severely disabled" person is defined as an individual whose physical handicaps limit his mobility to the extent that he must be transported by litter or while remaining in a wheelchair.

(b) Upon receipt of an ambulance request from an individual who states that he or she is a severely disabled Medicaid recipient, the following procedures should be adhered to:

(1) Ambulance services for the severely disabled must be medically necessary and reasonable. Medical necessity is established when a recipient's condition is such that the use of any other method of transportation is contraindicated and no other suitable trasportation is available. If the recipient is not severely disabled, other means of transportation are normally available within the community for assisting the aged and partially disabled.

(2) The severely disabled recipient must be transported to and from the provider of his choice, who is generally available and used by other residents of the community for any appropriate medical care included under the department's Title XIX plan. If no participating provider of the appropriate care is available within the community, transportation will be to and from the nearest provider who can provide the appropriate medical care. Examples of medical providers are: doctor's offices, hospitals, radiation units, laboratories, x-ray facilities, and outpatient hospitals.

(3) Upon arrival at the medical treatment facility, the ambulance provider shall obtain from the attending physician or other responsible parties a written statement, on the bottom of the claim form, which indicates that the individual transported is, in fact, severely disabled as defined above and that the movement by ambulance was medically necessary and reasonable. Other responsible parties are intended to mean doctors or interns only.

(c) This additional service is provided only to Medicaid recipients. Should a Medicare claim be denied on a severely disabled Medicare/Medicaid recipient, the denial should be forwarded to the health insuring agent for consideration.

Doc. No. 766840

Billing and Payment Procedures 326.43.05

The Department of Public Welfare adopts these repeals under the authority of Articles 695c and 695j-1, Texas Civil Statutes.

.004 Review of Claims by Health Insuring Agent. In order for the health insuring agent to properly review a claim for payment, the following elements must be considered: medical necessity, reasonableness, destination, locality, appropriate facilities, doctor's office, and partial coverage of ambulance trip.

(a) Medical necessity is based on the patient's condition and would be established when it would be hazardous to the patient's health to be transported by any other means. If transportation other than an ambulance could be utilized without endangering the individual's health, whether or not other transportation is actually available, no payment may be made for ambulance service.

(b) Reasonableness. A claim may be denied on the grounds that the use of ambulance service was unwarranted in the treatment of the illness or injury.

(c) Destination. As a general rule, only local transportation by ambulance is covered. This means that the patient must have been transported to an institution (hospital or skilled nursing facility) whose locality (see (d) below) encompasses the place where the ambulance transportation of the patient began and which would ordinarily be expected to have the appropriate facilities for the treatment of the injury or illness involved.

(d) Locality. The term with respect to ambulance service means the service area surrounding the institution from which individuals normally come or are expected to come for hospital or skilled nursing service.

(e) Appropriate facilities. The term appropriate facilities means the institution is generally equipped to provide the needed hospital or skilled nursing care for the injury or illness involved. Appropriate facilities are determined by the institution, equipment, personnel, and capability to provide necessary services to support the required medical care.

The fact that a more distant institution is better equipped to care for the patient does not warrant a finding that a closer institution does not have appropriate facilities. The individual physician who practices in a hospital is not a consideration in determining whether the hospital has appropriate facilities. Ambulance service to a more distant facility than the closest appropriate facility which is otherwise a covered Medicare expense will be reimbursed in the amount which would have been paid for a trip to the closest appropriate facility. In any instance where a patient must be transferred to other than a local institution, an explanation should be attached giving the reason for the transfer.

(f) Ambulance service to a physician's office is not covered. There may be situtations where in the course of transporting a patient to a hospital the ambulance stops at the physician's office because of the patient's dire need for professional attention, and immediately thereafter the ambulance continues the trip to the hospital. In such cases, the patient will be deemed not to have been transported to the physician's office and payment may be made for the entire trip. A transfer from a hospital or place of residence to a radia-

tion center for treatment and return is considered a noncovered trip per specific instructions issued to Medicare carriers.

(g) Partial ambulance coverage. Partial reimbursement may be made for otherwise covered ambulance service (medical necessity did exist-- see (a) above). Such payment would be based on the amount that would have been payable had the patient been transported from the pickup point to the nearest appropriate facility or from the nearest appropriate facility to his residence where he is being returned from a distant institution.

.005. Statement of Eligibility. A Statement of Eligibility form must be submitted to the health insuring agent in order to establish a Medicare identification and payment number for ambulance service.

.006. Duplicate Claims. Duplicate claims occur when:

(a) both the supplier and the patient send in a claim from to the health insuring agent;

(b) continuous billing statements are submitted that contain previously billed services;

(c) duplicate claim forms are submitted before the first claim has had time to pay.

A claim may be delayed by the health insuring agent for valid reasons, therefore, the provider should wait a minimum of 45 days before sending a second claim form. If the claim forms are marked "second request," etc., the health insuring agent's procedure is to enter them into the system as a new claim and the provider and/or the patient will receive a copy of the settlement. If the provider inquires with a letter, the health insuring agent will give a response.

A duplicate claim message on the Medicare Explanation of Medicare Benefits form which reads "Dup-- Not Yet Paid" and has a referring internal control number listed signifies that a duplicate claim has been received and is in some stage of processing but has not yet been paid. The claim should pay shortly.

.007. Split Payments. Receipt of multiple checks in payment of one claim may be caused by the limitation of the number of services that can be listed on the Explanation of Medicare Benefits form. Also, Medicare requires charges for services provided in different calendar years to be processed separately since the deductible is on a calendar year basis.

.008. Quality Requirements. The Social Security Administration issues instructions on the quality requirements in Medicare Part B and the definition of what constitutes an error. Primarily, these instructions pertain to claim documentation. There are three particular items which receive close attention:

(a) Beneficiary signature. All claims, both assigned and non-assigned must have the beneficiary's signature or an acceptable signature for the beneficiary. Someone other than the beneficiary can sign a claim form only in the following conditions:

(1) If the beneficiary is unable to sign the claim form because of a mental or physical condition, the claim can be signed by someone else as long as they write in the beneficiary's name, indicate who signed the claim form, their relationship to the beneficiary, and the reason the beneficiary cannot sign. The physician's office personnel cannot sign for the beneficiary.

(2) The only other situation when someone can sign for the beneficiary is in an institution providing him care which includes a retirement home, a hospital or skilled nursing facility, and a nursing home. An employee of this institution may be authorized to act as his representative and sign claim forms; however, the person signing the claim must identify himself as the employee of the institution. The same documentation as required above must be noted on the claim form.

.009. Eligibility Information. The most common mistake on a claim form is an incorrect or incomplete name or health insurance claim (HIC) number. Eligibility information is not maintained by the health insuring agent and therefore, they must contact either the beneficiary, the physician, or the Social Security Administration to correct the claim form. It is necessary that the health insuring agent has the first name, middle initial, last name; the sex; and the complete HIC number before a claim can be processed. Accurate information can be obtained from the beneficiary's health insurance identification card.

Doc. No. 766841

Medical Assistance Programs

Title XIX Hospitals 326.46.01

The Department of Public Welfare adopts these repeals under the authority of Articles 695c and 695j-1, Texas Civil Statutes.

.001. Inpatient Psychiatric Services. Effective September 1, 1975, Title XIX vendor payments for inpatient psychiatric care were discontinued to public and private psychiatric hospitals. This action affects all those individuals age 65 and older who are either recipients of Supplemental Security Income (SSI) or Medical Assistance Only (MAO) and are inpatients in public or private psychiatric hospitals. This does not affect medically necessary services in general hospitals, including treatment for mental disease. Inpatient care in a general hospital, when medically necessary, will continue to be available to eligible individuals, subject to program limitations.

Those state mental institutions which are affected by this action are: Austin State Hospital, Big Springs State Hospital, Kerrville State Hospital, Rusk State Hospital, San Antonio State Hospital, Terrell State Hospital, Vernon Center and Annex, and Wichita Falls State Hospital.

.002. Approved Hospitals. An approved hospital is one which has been licensed by the Texas Department of Health Resources as a hospital and has been approved for and is participating in Title XVIII Medicare. This approved hospital must have submitted a Request for Designation as a Title XIX Hospital or a Request for Designation as a Title XIX Emergency Care Only Hospital to DPW and be approved by DPW for participation. This request and approval constitute an agreement between the hospital and DPW.

.003. Emergency Hospital Services. Payment will be made for emergency hospital services which are necessary to prevent the death or serious impairment of the health of the eligible individual and which, because of the threat to life or health of the individual, necessitate the use of the most accessible hospital equipped to furnish such services. The hospital must be approved for Title XIX Medicaid participation by DPW.

.004. Inpatient Hospital Services.

(a) When an eligible individual is admitted as an inpatient to an approved hospital upon the recommendation of a physician, payment will be made for a maximum of 30 days for each Title XIX spell of illness while care in the hospital is medically necessary. The 30 days are counted as running concurrently for Title XIX Medicaid and Title XVIII Medicare.

(b) Included in inpatient hospital services are the first three pints of whole blood or packed red cells when not available without cost from other source.

(c) Room rates will be based upon the most prevalent charge for semi-private accommodations; however, bed and board in private accommodations will be provided in full if required for medical reasons. Semi-private room means two-bed, three-bed, or four-bed accommodations. Title XIX Medicaid payments for inpatient hospital services will be on the basis of reasonable cost, as determined by the same methods used by Title XVIII Medicare.

.005. Spell of Illness Under Title XIX.

(a) The term "spell of illness" is not a medical term, but an insurance term which refers to a period of time. The definition used in the Texas Medical Assistance Program, Title XIX is: A spell of illness begins when an individual is admitted to a hospital as an inpatient. A spell of illness ends when the individual has not been an inpatient in a hospital for 60 consecutive days. He is eligible for a new Title XIX spell of illness when he has not been a hospital inpatient for 60 consecutive days. This is different from Title XVIII Medicare "spell of illness" or benefit period which is defined as follows: A spell of illness begins when a person is admitted to a hospital and ends when that person has not been an inpatient in a hospital, extended care facility, or facility providing skilled nursing care for 60 consecutive days.

(b) While the stay of a patient in an extended care facility or in a skilled nursing facility extends a spell of illness under Title XVIII Medicare, such a stay does not extend a spell of illness under Title XIX.

.006. Outpatient Hospital Services. Payment will be made for usual hospital services when an eligible individual receives care other than inpatient care in an approved hospital, if provided by or under the direction of a licensed physician. If a Title XIX hospital provides outpatient services without charge upon payment of a registration fee, payment will be made for a registration fee.

Doc. No. 766842

Physician and Professional Services 326.46.03

The Department of Public Welfare adopts these repeals under the authority of Articles 695c and 695j-1, Texas Civil Statutes.

.003. Podiatry Examinations. Podiatry examinations consist of examinations rendered by a Doctor of Podiatry. No benefits will be provided for radiological services, laboratory examinations, or therapeutic services.

.004. Optometric Services. Optometric services include post-surgical lenses (including frames) required during convalescence following cataract surgery, or one set of other prosthetic lenses (including frames) required by an individual lacking the organic lens of the eye, and one examination of the eyes by refraction by either a Doctor of Optometry or a physician during each fiscal year.

.005. Laboratory, X-Ray Services, and Radiation Therapy.

(a) Laboratory, x-ray services, and radiation therapy provided by an approved laboratory outside a hospital by or under the direction of a physician are approved professional services.

(b) Payment will be made for diagnostic laboratory and x-ray services when these services are provided in an approved laboratory or x-ray service.

Doc. No. 766843

Benefits Under Title XIX 326.46.05

The Department of Public Welfare adopts these repeals under the authority of Articles 695c and 695j-1, Texas Civil Statutes.

.003. Out-of-State Hospital Benefits. The DPW worker shall forward instructions to the out-of-state agency for submitting the bill for medical care. The only major difference in the basis for payment for services provided outside Texas and services provided in Texas is that for inpatient hospital services the health insuring agent will pay 85 percent of the billed charges or reasonable cost if the out-of-state hospital provides a cost statement to the health insuring agent.

(a) If the client is 65 years of age or over, the appropriate Medicare claim form should be used. The out-of-state vendor must be advised to enter the appropriate DPW identification of the claim. Since the Medicare form must be filed with the Medicare intermediary in the locality in which the service is given, it is important that the out-of-state Medicare intermediary, after processing the Medicare claim, forward the claim data to the department's health insuring agent in order for Title XIX deductible and co-insurance to be paid.

(b) If the client is under 65 years of age, the out-of-state vendor should write to the department's health insuring agent advising that they have a Texas recipient who needs medical care and requesting the health insuring agent to send the appropriate forms and billing instruction.

.004. Emergency Hospital Services. In the event that a severe emergency arises and the most accessible hospital has not been approved for Title XIX participation, the deputy commissioner for medical programs must be notified in detail of the circumstances which necessitated the use of an unapproved hospital.

.005. Certification to Health Insuring Agent of an Individual's Eligibility. Reports to the department's health insuring agent of the eligibility status of recipients of financial and/or medical assistance in all categories will be handled by the Data Systems Bureau. Eligibility information from the master file is sent to the health insuring agent on a monthly basis, via computer tape, so that the health insuring agent will have accurate and current data regarding medical eligibility.

.006. Procedures When Payment Has Already Been Made by the Patient.

(a) The provider of services agrees, upon accepting the vendor payment from the department's health insuring agent or the department, to accept the vendor payment as full charge for his services; therefore, no additional payment should be made by the patient as the patient cannot be reimbursed for payments he has already made.

(b) In instances where the patient has already made payment for the services and the patient bills the health insuring agent, the health insuring agent will return the bill to the patient with notification that Title XIX does not permit reimbursement to the patient.

(c) If the patient has filed a non-assigned claim with Medicare and has received payment from Medicare of this claim, an assigned claim for the same service(s) cannot be paid by either Medicare or Medicaid.

Issued in Austin, Texas, on December 31, 1976.

Doc. No. 766844

Raymond W. Vowell
Commissioner
State Department of Public Welfare

Effective Date: January 1, 1977
Expiration Date: April 30, 1977

For further information, please call (512) 475-4601.

House of Representatives

Bills Introduced

Pre-Filed Bills

The Texas House of Representatives began pre-filing of bills on November 8, 1976, for introduction during the up-coming 65th Legislative Session. Bills will be assigned to committees after the session convenes on January 11, 1977; committee assignments will be published at that time.

For copies of bills, contact House Bill Distribution at (512) 475-2073.

In the following list, the bill number appears first, the author(s) second, and the subject of the bill last. HB indicates house bill; HJR indicates house joint resolution; HCR indicates house concurrent resolution; HSR indicates house simple resolution.

HB 229 Sullivant, Bird-- Prohibiting telecommunications utilities from charging for and the Public Utility Commission from approving charges for telephone directory assistance.

HB 230 Olson-- Relating to the compensation and expenses of members of the Texas State Board of Podiatry Examiners.

HB 231 Nabers-- Relating to the disposition of animals abandoned with veterinarians.

HB 232 Bryant-- Relating to the prohibition and disclosure of conflicts of interests of board members of community centers for mental health and mental retardation.

HB 233 Maloney-- Relating to the effect in juvenile delinquency proceedings of the testimony of an accomplice.

HB 234 Maloney-- Relating to photographing children in connection with the investigation of criminal offenses.

HB 235 Maloney-- Relating to a criminal offense of failure to supervise a child.

HB 236 Maloney-- Relating to payments for the support of a child detained pending adjudication of a petition alleging delinquent conduct or conduct indicating a need for supervision.

HB 237 Maloney-- Relating to the grounds for the detention of a child taken into custody.

HB 238 Maloney-- Relating to the taking of a child into custody by a probation officer.

HB 239 Maloney-- Relating to the prosecution as adults of persons 15 years old or over who are alleged to have committed certain offenses.

HB 240 G. Green-- Relating to the percentage of damages to be paid insured on delay in payment of claims under certain policies of insurance.

HB 241 G. Green-- Relating to authorization and regulation of group marketing of motor vehicle insurance for persons over 55 years of age.

HB 242 G. Green-- Relating to the use of an alias driver's license by a law enforcement officer under certain circumstances.

HB 243 G. Green-- Relating to the classification of certain public junior college students for tuition purposes.

HB 244 G. Green-- Amending Section 99, Texas Election Code, as amended, to permit young children to accompany parents into polling places and voting booths.

HB 245 Torres-- Relating to determining a school district's average daily attendance for purposes of allocating personnel units under the Foundation School Program.

HB 246 Torres-- Relating to allocation of funds under the Foundation School Program for the education of certain alien students.

HB 247 Torres-- Relating to admission of children under the age of 18 years to the public schools.

HB 248 Torres-- Relating to the establishment of an upper-level educational center of Pan American University.

HB 249 Torres-- Relating to the allocation of personnel units under the Foundation School Program to school districts that experience marked increases or decreases in daily student attendance because of the enrollment of children of migrant agricultural farm workers.

HB 250 McDonald-- Relating to the number of days of instruction for pupils and inservice training for professionals during a school year.

HB 251 Maloney-- Relating to agreement by the judge to a continuance by consent of the parties in a criminal action.

HB 252 Ezzell-- Relating to the provision of protective services for elderly persons.

HB 253 Kubiak-- Relating to the age of minors entitled to assistance payments as survivors of certain peace officers.

HB 254 F. Green-- Relating to the percentages of crude protein and equivalent protein from nitrogen in commercial feeds.

HB 255 Sullivant-- Relating to the definition of criminal episode.

HB 256 Hollowell-- Relating to the inheritance tax owed by Class A estates.

HB 257 Hollowell-- Relating to the acceptance of certain funds by the adjutant general.

HB 258 L. Jones-- Relating to fraud in obtaining information concerning public assistance.

HB 259 L. Jones-- Relating to penalties for certain unauthorized uses of food stamp coupons and authorizations to purchase food stamp coupons.

Filed: January 4, 1977, 12:05 p.m.

Doc. No. 770031

HB 260 G. Green-- Relating to requiring safety guards or flaps on certain vehicles.

HB 261 G. Green-- Relating to possession of a firearm by a felon, a person found incompetent to stand trial on a felony charge, or a person acquitted of a felony by reason of insanity.

HB 262 G. Green-- Relating to the regulation of vehicles hauling loose materials and the measure of damages resulting from violations.

HB 263 G. Green-- Relating to the classification of certain students at institutions of higher education for tuition purposes.

HB 264 G. Green-- Relating to the recovery of unearned premiums under the Texas Property and Casualty Insurance Guaranty Act.

HB 265 G. Green-- Relating to mailing cancellation and nonrenewal notices on certain policies of insurance.

HB 266 Cates-- Relating to proof of financial responsibility on registration of a motor vehicle.

HB 267 Cates-- Relating to the creation of the 247th Judicial District composed of Gray County.

HB 268 Bird-- Relating to training for persons who take into protective custody mental patients who are absent without authority from mental hospitals.

HB 269 Hudson-- Relating to the disqualification of a trial judge because of political endorsement by a party or an attorney representing a party in a case.

HB 270 Hudson-- Relating to the creation of community service authorities and providing for the issuance of bonds by the authorities.

HB 271 Madla-- Relating to eligibility of public school students for transportation cost allotments under the Foundation School Program.

HB 272 Madla-- Relating to eligibility of public school students for transportation cost allotments under the Foundation School Program.

HB 273 Madla-- Relating to requiring competitive bidding for certain personal property to be sold to public school students.

HB 274 Madla-- Relating to the qualification of administrative officers under the Foundation School Program.

HB 275 Madla-- Relating to the educational requirements for visiting teachers.

HB 276 Madla, Bigham-- Relating to the establishment of a state program to provide compensation to certain victims of crime.

HB 277 Moreno-- Relating to the application of state workmen's compensation laws to farm and ranch laborers.

HB 278 Moreno-- Relating to the method of electing members of governing bodies of certain cities.

HB 279 Moreno-- Relating to the duty of landlord and tenant to maintain residential rental premises in a condition fit for human habitation.

HB 280 Hendricks-- Relating to the applicability of the Uniform Wildlife Regulatory Act to the wildlife resources of Rockwall County.

HB 281 Kubiak-- Relating to licensing and regulation of clinical counselors.

HB 282 Olson-- Relating to the authority of the Coordinating Board, Texas College and University System, to contract with medical schools, licensed hospitals, and non-profit corporations for the purpose of providing state funds to family practice residency training programs.

HB 283 Watson-- Relating to the time period for filing of current-year registration license receipt and properly assigned certificate of title or other evidence of title of transferred used or secondhand vehicle with the county tax assessor-collector.

HB 284 Watson-- Relating to establishing the liability of school districts for certain medical expenses incurred by students injured in certain school athletic programs and requiring school districts to carry insurance to cover their liability.

HB 285 Watson-- Establishing a procedure for absentee voting by persons who become sick or disabled near or after the close of the regular absentee voting period.

HB 286 Johnson-- Relating to the provision of protective services (assistance necessary to maintain physical and mental health and safety) for certain elderly persons.

HB 287 Reyes-- Relating to the payment of unemployment compensation in labor disputes.

HB 288 Watson-- Relating to the minimum wage applicable to tipped employees.

HB 289 Ezzell-- Relating to the appointment of an attorney *ad litem* in a proceeding for the appointment of a permanent guardian of an adult.

HB 290 Semos-- Relating to the inclusion of judges of statutory county courts in the state judicial retirement system and credit for prior service as a judge of these courts.

HB 291 Smith-- Relating to evidence of the origin of certain game fish possessed by persons selling fish.

HB 292 Smith-- Relating to the disposal of confiscated game fish.

HB 293 Smith-- Relating to the penalty for shooting on a public road.

HB 294 Smith-- Relating to commercial fishing by the holder of a fish farmer's license and certain qualifications for holding a fish farmer's license.

HB 295 Smith-- Relating to the identification of aquatic products in the hands of holders of wholesale and retail fish dealer's truck licenses.

HB 296 Smith-- Relating to fish traps.

HB 297 Massey-- Relating to the authority of school districts to charge student fees.

HB 298 Lalor-- Relating to the uses to which local hotel occupancy taxes may be put.

HB 299 Lauhoff-- Relating to the regulation of ambulance services and ambulance service personnel by the Coordinated Emergency Medical Service Division of the State Department of Health Resources.

HB 300 Vaughan, Semos-- Relating to the creation of the Metric System Advisory Council and the study of a transition to the metric system.

Filed: January 3, 1977, 3:51 p.m.

Doc. No. 770015

Senate

Meetings

Interim senate committee hearings now being conducted before the January legislative session are subject to frequent changes in agendas and meeting cancellations. The meetings listed below may or may not have been altered on momentary notice. For current information relating to these meetings, telephone the Research Director of the Senate at (512) 475-5818. Telephone numbers for each committee appear with each notice for persons desiring further specific information.

Meetings Filed January 6, 1977

Subcommittee on Consumer Affairs, Lieutenant Governor's Committee Room, State Capitol, on January 12, 1977, at 9 a.m., to consider the final report. Telephone (512) 475-3090.

Administration Committee, Lieutenant Governor's Committee Room, State Capitol on January 12, 1977, at 2 p.m., for an organizational meeting and discussion of pending and unfinished business. Telephone (512) 475-3837.

Filed: January 6, 1977, 9:32 a.m.

Doc. No. 770056

The Open Meetings Act (Article 6252-17, Texas Civil Statutes) requires that an agency with statewide jurisdiction have notice posted for at least seven days before the day of a meeting. A political subdivision covering all or part of four or more counties, or an institution of higher education, must have notice posted for at least 72 hours before the scheduled meeting time. Notice of an emergency meeting or an emergency addition or amendment to an agenda must be posted for at least two hours before the meeting is convened. Although some notices may be received and filed too late for publication before the meetings are held, all filed notices will be published in the *Register*. Each notice published includes the date and time of filing. Notices are posted on the bulletin board outside the offices of the Secretary of State on the first floor in the East Wing of the State Capitol.

Texas Animal Health Commission

Meeting

A meeting of the Texas Animal Health Commission will be held on Thursday, January 20, 1977, 9 a.m., in Room 117, Sam Houston Building, Austin.

The agenda includes a public hearing on EIA Regulations 421 and on Interstate Regulations 420; discussion of the systems study report, on legislation-- calfhood vaccination, the letter sent to brucellosis quarantine herd owners, UMR changes, cattle scabies, the proposed new program in the Pullorum-Typhoid Program, and fever ticks; and a request for permission to move packer cows out of Texas into Mexico for slaughter.

Additional information may be obtained from Jo Anne Conner, 1020 Sam Houston Building, Austin, Texas 78701, telephone (512) 475-4111.

Filed: January 6, 1977, 9:15 a.m.

Doc. No. 770054

Texas Board of Architectural Examiners

Meeting

A meeting of the Texas Board of Architectural Examiners will be held at 1 p.m., Friday and at 9 a.m., Saturday, January 14 and 15, 1977, at 202 Richmond Building, 1411 West Avenue, Austin. The agenda includes a report on the January meeting with the State Board of Landscape Architects; consideration of legislation, examinations, and violations; signing certificates of registration; election of officers; and consideration of reinstatements, 1977 renewals, and other miscellaneous business.

Additional information may be obtained from Philip D. Creer, 1411 West Avenue, Austin, Texas 78701, telephone (512) 475-2629.

Filed: January 4, 1977, 2:20 p.m.

Doc. No. 770033

Employees Retirement System of Texas

Meeting

A meeting of the Board of Trustees of the Employees Retirement System of Texas will be held on Monday, January 17, 1977, 10 a.m., at 1705 San Jacinto, Austin.

The agenda includes the oaths of office for George Hall Watkins, final action on proposed rule 335.30.00.112(b), the appointment of a member to the Group Insurance Advisory Committee to fill an unexpired term, a report on the Group Insurance Program, the actuarial report, and a general discussion of prefiled and prospective legislation.

Additional information may be obtained from Everett L. Anschutz, P. O. Box 12337, Capitol Station, Austin, Texas 78711, telephone (512) 476-6431.

Filed: January 5, 1977, 3:10 p.m.

Doc. No. 770049

Good Neighbor Commission of Texas

Meeting

A meeting of the Inter-Agency Task Force on Migrant Labor of the Good Neighbor Commission of Texas will be held on Monday, January 10, 1977, 9 a.m., in Room 118, Stephen F. Austin Building, Austin.

The agenda includes a follow-up on resolutions passed at the November 30, 1976, meeting of the Task Force; a report from the Governor's Office on Migrant Affairs regarding the population survey; an overview of FY 1977-1978 for migrant manpower programs in Texas; recommendations and resolutions; and other topics of discussion.

Additional information may be obtained from Roberto S. Guerra, Box 12007, Austin, Texas 78711, telephone (512) 475-3581.

Filed: January 3, 1977, 9:51 a.m.

Doc. No. 770001

Governor's Special Advisor on Natural Resources

Emergency Meeting

An emergency meeting of the Interagency Council on Natural Resources and the Environment of the Governor's Special Advisor on Natural Resources was held on Monday, January 10, 1977, 9:30 a.m., at the Hilton Inn, Austin.

The agenda included the Washington report, the Mitigation Committee report, the Texas Natural Resource Information System Task Force report, and other committee reports, as needed. The importance of the representatives of agencies of the Interagency Council on Natural Resources and the Environment being briefed on recent developments in court and in the Congress, in order to coordinate a plan of action from the State natural resource agencies to developments affecting the agencies and the citizens of Texas, constituted an urgent public necessity.

Additional information may be obtained from Ben Turner, P.O. Box 13006, Capitol Station, Austin, Texas 78711, telephone (512) 475-7876.

Filed: January 5, 1977, 2:04 p.m.

Doc. No. 770048

Texas Department of Health Resources

Meeting

A meeting of the Texas Occupational Safety Board of the Texas Department of Health Resources will be held on Tuesday, January 11, 1977, 1:30 p.m., in the board room on the 1st floor of the Main Building, 1100 West 49th Street, Austin.

The agenda includes review of 1978-79 budget requests, review of the Consultative Inspection Program and the National Emphasis Program, a discussion of recent developments in OSHA, and board member reports.

Additional information may be obtianed from G. R. Herzik, Jr., 1100 West 49th Street, Austin, Texas 78756, telephone (512) 458-7541.

Filed: January 4, 1977, 12:46 p.m.

Doc. No. 770029

Meeting

A meeting of the Texas Emergency Medical Services Advisory Council of the Texas Department of Health Resources will be held on Friday, January 14, 1977, 2 p.m., in the 5th floor conference room, 1100 West 49th Street, Austin.

The agenda includes the division director report, consideration of new television and radio spots in relation to public education, evaluation of emergency medical services systems, consideration of legislation, and presentations on citizen abuse of the emergency medical services system.

Additional information may be obtained from Charles E. King, 1100 West 49th Street, Austin, Texas 78756, telephone (512) 458-7259.

Filed: January 4, 1977, 12:45 p.m.

Doc. No. 770030

Texas Historical Commission

Meeting

A meeting of the Texas Historical Commission will be held on Friday, January 14, 1977, 8 a.m., in the Driskill Room, Driskill Hotel, 117 East 7th. Austin.

The agenda includes approval and designation of official Texas historical markers, and the following reports: financial, chairman's, executive director's, Historic Sites Acquisition and Development Program of the Texas Parks and Wildlife Department, Texas Historical Foundation, director of Programs', director of Research's, director of Museum Services', Communications Department, National Register Department, State Archeologist's, and the Nominating Committee. A detailed agenda is posted in the East Wing of the State Capitol.

Additional information may be obtained from Truett Latimer, 1511 Colorado, Austin, Texas 78701, telephone (512) 475-3092.

Filed: January 5, 1977, 9:43 a.m.
Doc. No. 770057

State Board of Insurance

Emergency Meeting

An emergency meeting of the State Board of Insurance was held on Tuesday, January 4, 1977, 2 p.m., in Room 408, 1110 San Jacinto, Austin, to make a decision on the appeal of the Beacon Insurance Group.

Additional information may be obtained from William J. Harding, 1110 San Jacinto, Austin, Texas 78786, telephone (512) 475-2950.

Filed: January 4, 1977, 8:50 a.m.
Doc. No. 770016

Texas Judicial Council

Meeting

A meeting of the Texas Judicial Council will be held on Friday, January 14, 1977, 10 a.m., at 1414 Colorado, Austin, for a discussion of court reporting, court administration and council financing, and other council business.

Additional information may be obtained from C. Raymond Judice, Suite 312, 308 West 15th., Austin, Texas 78701, telephone (512) 475-2421.

Filed: January 4, 1977, 10:38 a.m.
Doc. No. 770025

North Texas State University

Addition to Agenda

An addition is being made to the agenda of a meeting of the Board of Regents of North Texas State University to be held on Friday, January 14, 1977, 9:30 a.m., in the board room on the 2nd floor of the Administration Building, NTSU campus, Denton, to include modification of guidelines for administration of the NTSU state tuition scholarships.

Additional information may be obtained from Dr. Roy K. Busby, P.O. Box 13108, NT Station, Denton, Texas 76203, telephone (817) 788-2275.

Filed: January 6, 1977, 11:02 a.m.
Doc. No. 770059

Texas Organized Crime Prevention Council

Meeting

A meeting of the Texas Organized Crime Prevention Council was held on Monday, January 10, 1977, 10 a.m., in the attorney general's conference room on the 7th floor of the Supreme Court Building, Austin. The agenda included discussion of the statewide study on organized crime; presentation of the proposed organized crime legislative package; discussion of the council's annual report to the governor; and a report from the co-chairman regarding organized crime in narcotic trafficking.

Additional information may be obtained from Ralph L. Bowman, Suite 400, 7600 Chevy Chase Drive, Austin, Texas 78752, telephone (512) 475-6536

Filed: January 3, 1977, 2:09 p.m.
Doc. No. 770014

Public Utility Commission of Texas

Meeting

A meeting will be held on Friday, January 14, 1977, 2 p.m., in Suite 450N, 7800 Shoal Creek Boulevard, Austin, to adopt a final order in Docket 81, the rate application of Continental Telephone Company of Texas.

Additional information may be obtained from Roy J. Henderson, Suite 450N, 7800 Shoal Creek Boulevard, Austin, Texas 78757, telephone (512) 475-7921.

Filed: January 4, 1977, 3:47 p.m.
Doc. No. 770035

Meeting

A meeting of the Public Utility Commission of Texas will be held on Friday, January 14, 1977, 3 p.m., in Suite 450N, 7800 Shoal Creek Boulevard, Austin, to hear argument to rule on the Central Power and Light Company's motion for consolidation of all appeals filed by it and its motion requesting temporary rates (Dockets 181-255).

Additional information may be obtained from Roy J. Henderson, Suite 45ON, 7800 Shoal Creek Boulevard, Austin, Texas 78757, telephone (512) 475-7921.

Filed: January 4, 1977, 3:47 p.m.

Doc. No. 770036

Hearing Rescheduled

A hearing by the Public Utility Commission of Texas in Docket 124, originally set for January 5, 1977, is rescheduled for Thursday, January 20, 1977, 9 a.m., Suite 45ON, 7800 Shoal Creek Boulevard, Austin. The commission will consider a service dispute between Texas Selling Network, Inc. and Southwestern Bell Telephone Company, arising from Southwestern Bell's notice that it would disconnect service to Texas Selling Network, Inc., on the grounds that Texas Selling Network, Inc., had violated Southwestern Bell's tariff by providing long distance message toll service.

Additional information may be obtained from Roy J. Henderson, Suite 45ON, 7800 Shoal Creek Boulevard, Austin, Texas 78757, telephone (512) 475-7921.

Filed: January 5, 1977, 10:38 a.m.

Doc. No. 770044

State Department of Public Welfare

Meeting

A meeting of the State Board of Public Welfare of the State Department of Public Welfare will be held on Thursday, January 13, 1977, 9:30 a.m., in Room 411, John H. Reagan Building, Austin.

The agenda includes the proposed implementation of the management effectiveness and efficiency plan; the physician profile update--proposed premium adjustment and proposed increase to 100 percent of Medicare; the proposed dentist profile update; a status report on the maximum allowable cost and estimated acquisition cost for the vendor drug program; an amendment to Title XX State Plan; the AFDC non-caretaker grant adjustment; consideration of positions under the classification system; the proposed revisions to personnel grievance procedures; a status report and approval of emergency rules filed with the *Texas Register* on purchased health services; technical amendments to program policies and procedures; approval of final rule--Amendment 36 to the Title XIX State Plan, on Professional Standards Review Organization responsibilities in the Medicaid program; and a meeting with the Task Force for the evaluation of Medicaid in Texas, 2 p.m., State Senate Chamber.

Additional information may be obtained from William Woods, John H. Reagan Building, Austin, Texas 78701, telephone (512) 475-6297.

Filed: January 5, 1977, 4:44 p.m.

Doc. No. 770051

Meeting

A meeting of the Task Force for the Evaluation of Medicaid in Texas of the State Department of Public Welfare will be held at 2 p.m., Thursday and 8:30 a.m., Friday, January 13 and 14, 1977, in the Senate Chambers of the State Capitol, for organization and orientation of the Task Force, subcommittee work assignments, and meetings.

Additional information may be obtained from John Frannea, John H. Reagan Building, Austin, Texas 78701, telephone (512) 475-4720.

Filed: January 5, 1977, 4:44 p.m.

Doc. No. 770052

Texas Eastern University

Meeting

A meeting of the Campus and Building Committee of the Board of Regents of Texas Eastern University will be held on Thursday, January 13, 1977, 4 p.m., at 3900 University Boulevard, Tyler.

The agenda includes the architect's review of Phase II construction documents (90 percent complete); review of the revised Campus Plan; a report on Phase I construction, including final payment and University Center red oak flooring; the construction progress report on health and physical education facilities; contract changes; architectural statements; and any and all business that may properly come before the meeting concerning the affairs of the Campus and Building Committee of the board of regents.

Additional information may be obtained from James H. Stewart, Jr., 3900 University Boulevard, Tyler, Texas 75701, telephone (214) 566-1471.

Filed: January 6, 1977, 11:02 a.m.
Doc. No. 770060

Tourist Development Agency

Meeting

A meeting of the Board of the Tourist Development Agency will be held on Friday, January 21, 1977, 9:30 a.m., in Room 1033, Stephen F. Austin Building, Austin. The agenda includes the status of the FY 1977 budget and the budget request for the 1978-79 biennium, the Texas arts and crafts program, and miscellaneous reports.

Additional information may be obtained from Margaret Younger, P. O. Box 12088, Austin, Texas 78711, telephone (512) 475-4326.

Filed: January 4, 1977, 10:30 a.m.
Doc. No. 770027

Texas Water Quality Board

Emergency Amendments/Additions to Agenda

Emergency amendments/additions were made to the agenda of a meeting of the Texas Water Quality Board held on Thursday and Friday, January 6 and 7, 1977, 9 a.m. daily, in Room 118, Stephen F. Austin Building, 1700 North Congress, Austin. The revised agenda included various deletions and additions.

Additional information may be obtained from Michael W. McKinney, 1700 North Congress, Austin, Texas 78701, telephone (512) 475-6497.

Filed: January 5, 1977, 9:52 a.m.
Doc. No. 770039

Hearing

A hearing by the Hearings Division of the Texas Water Quality Board will be held on Thursday, February 10, 1977, 9 a.m., in the Houston-Galveston Area Council Conference Room, 3701 West Alabama, Houston.

The board will consider applications for permits by Best Industries, Inc., Houston, and Drew Spencer (Drew Spencer Motor Inn), Conroe, and applications for amendments to permits by the City of La Porte (Sewage Treatment Plant 1), La Porte, Permit 10206; Blue Ridge West Municipal Utility District (Sims Bayou Plant), Houston, Permit 11553; and the Harris County Fresh Water Supply District 52, Houston, Permit 10528. The complete hearing notices are posted in the East Wing of the State Capitol.

Additional information may be obtained from Jack Cox, P.O. Box 13246, Capitol Station, Austin, Texas 78711, telephone (512) 475-7856.

Filed: January 5, 1977, 9:52 a.m.
Doc. No. 770040

Hearing

A hearing by the Hearings Division of the Texas Water Quality Board will be held on Friday, February 11, 1977, 10 a.m., in the council chamber, City Hall, 216 West Sealy, Alvin, to consider an application for a permit by Keeshan and Company, Manvel. The complete hearing notice is posted in the East Wing of the State Capitol.

Additional information may be obtained from Jack Cox, P.O. Box 13246, Capitol Station, Austin, Texas 78711, telephone (512) 475-7856.

Filed: January 5, 1977, 9:53 a.m.
Doc. No. 770042

Hearing

A hearing by the Hearings Division of the Texas Water Quality Board will be held on Thursday, February 10, 1977, 11 a.m., in Conference Room C of the Municipal Building, 509 East 7th, Amarillo.

The board will consider an application for an amendment to permit by Southwestern Public Service Company (Plant X), Amarillo, Permit 01842, and applications for permits by Texas Tech University (Pantex Tech Farms), Lubbock, and the City of Amarillo-Utilities Division (Old Air Force Base), Amarillo. The complete hearing notices are posted in the East Wing of the State Capitol.

Additional information may be obtained from Larry Soward, P.O. Box 13246, Capitol Station, Austin, Texas 78711, telephone (512) 475-7856.

Filed: January 5, 1977, 9:53 a.m.
Doc. No. 770041

Texas Water Rights Commission

Emergency Meeting

An emergency meeting of the Texas Water Rights Commission was held on Monday, January 3, 1977, 2:30 p.m., at the Stephen F. Austin Building, 1700 North Congress, Austin, at the request of the attorney general for subpoenas of certain commission staff members, relative to Application CA-327 of Houston Lighting and Power Company.

Additional information may be obtained from Mary Ann Hefner, P.O. Box 13207, Capitol Station, Austin, Texas 78711, telephone (512) 475-4514

Filed: January 3, 1977, 12:19 p.m.

Doc. No. 770013

Meeting

An emergency meeting of the Texas Water Rights Commission will be held on Wednesday, January 12, 1977, 9:30 a.m., at the Stephen F. Austin Building, 1700 North Congress, Austin, for consideration of a staff motion to re-open contest hearings for additional legal argument regarding the adjudication of water rights in the Upper Guadalupe River Segment. The issuance of the final determination adopted by the commission on November 16, 1976, on this segment is pending on the resolution of matters encountered by the staff which need immediate commission consideration to avoid any further delay.

Additional information may be obtained from Mary Ann Hefner, P.O. Box 13207, Capitol Station, Austin, Texas 78711, telephone (512) 475-4514.

Filed: January 6, 1977, 11:59 a.m.

Doc. No. 770071

Meeting/Hearing

A meeting/hearing by the Texas Water Rights Commission will be held on Monday, January 17, 1977, 10 a.m., at the Stephen F. Austin Building, 1700 North Congress, Austin.

The agenda includes consideration of applications by Timber Lane Utility District of Harris County; Post Wood Municipal Utility District of Harris County; Earl Waddell, Inc.; J. B. Byars and Mona Robertson; Grove Hill Memorial Park; Jack E. Skaggs; Gerald S. Pitts, Ltd. No. 1; Wright Brothers Sand and Gravel; Calvert County Club Inc.; J. W. McFarlane; and T. D. Gholson; dismissal of Section 5.121 of application by Tolbert Aaron Nelson; adjudication of water rights in the upper Guadalupe River segment of the Guadalupe River Basin; and a petition for the creation of Harris County Municipal Utility District 145. The commission hearing includes consideration of requests for extension of time by J. H. Strain and Sons, Inc.; applications by Webb County and the City of Grapevine; proposed amendments to Rules 129.07.05.005(e), 129.06.15.003(c), and 129.07.30.004(c); and a conference with Eduardo Roberto Rodriguez on the Duval County Conservation and Reclamation District. The complete agenda is posted in the East Wing of the State Capitol.

Additional information may be obtained from Mary Ann Hefner, P.O. Box 13207, Austin, Texas 78711, telephone (512) 475-4514.

Filed: January 5, 1977, 3:45 p.m.

Doc. No. 770050

Emergency Meeting

An emergency meeting of the Texas Water Rights Commission was held on Monday, January 6, 1977, 3 p.m., at the Stephen F. Austin Building, 1700 North Congress, to include consideration of a request by the attorney general for commissions to take depositions of parties involved in Application CA-327 of Houston Lighting and Power Company. The hearing was scheduled for January 11, 1977, at 10 a.m. The request by the attorney general to take the depositions prior to the January 11, 1977, hearing date necessitated consideration of the request at the earliest possible time.

Additional information may be obtained from Mary Ann Hefner, P. O. Box 13207, Capitol Station, Austin, Texas 78711, telephone (512) 475-4514.

Filed: January 6, 1977, 11:58 a.m.

Doc. No. 770070

Quasi-State Agencies

Meetings Filed January 3, 1977

The CETA Consortium Region XI will meet at 216 North 5th Street, Waco, on January 11, 1977, at 10:30 a.m. Further information may be obtained from Tony Byars, 216 North 5th Street, Waco, Texas 76701, telephone (817) 756-7171, extension 255.

The Copano Bay Soil Conservation District 329 will meet in the Refugio City Hall Council Room, Refugio, on January 24, 1977, at 7 p.m. Further information may be obtained from Jim Wales, Drawer 340, Refugio, Texas 78377, telephone (512) 526-2334.

The Panhandle Regional Planning Commission, Panhandle Health Systems Agency, will meet at the Texas Tech University Regional Academic Health Center, 1400 Wallace Boulevard, Amarillo, on January 13, 1977, at 7:30 p.m. Further information may be obtained from George Loudder, P.O. Box 9257, Amarillo, Texas 79105, telephone (806) 372-3381.

Doc. No. 770006

Meetings Filed January 4, 1977

The Copano Bay Soil Conservation District 329 met in the Refugio City Hall Council Room, Refugio, on, January 10, 1977, at 2 p.m., instead of on January 24, 1977, as previously announced. Further information may be obtained from Jim Wales, Drawer 340, Refugio, Texas 78377

Doc. No. 770018

Meetings Filed January 5, 1977

The Brazos Valley MH/MR Center, Board of Trustees, will meet on the 3rd floor in the grand jury room of the Brazos County Courthouse, Bryan, on January 11, 1977, at 5 p.m. Further information may be obtained from Dean G. Breitinger, 202 East 27th Street, Bryan, Texas 77801, telephone (713) 779-6467.

The Canadian River Municipal Water Authority, Board of Directors, will meet at the Hilton Hotel, 128 West Sixth, Plainview, on January 12, 1977, at 10:30 a.m. Further information may be obtained from Ronald L. Ebenkamp, P.O. Box 99, Sanford, Texas 79078, telephone (806) 865-3325.

The Maverick Multi-County Meals Program, Regional Project Council, will meet at the Public Library, Eagle Pass, on January 17, 1977, at 4 p.m. Further information may be obtained from John H. Stein, P.O. Box 1461, Del Rio, Texas 78840.

The Sabine Valley Regional MH/MR Center, Board of Trustees, will meet at the Oak Haven Recovery Center, Route 5, Box 120, Marshall, on January 13, 1977, at 7:30 p.m. Further information may be obtained from Frances H. Willis, P.O. Box 1224, Marshall, Texas 75670, telephone (214) 938-7721.

Doc. No. 770038

Meetings Filed January 6, 1977

The Colorado River Municipal Water District, Board of Directors, will meet at 400 East 24th Street, Big Spring, on January 13, 1977, at 10 a.m. Further information may be obtained from O. H. Ivie, Box 869, Big Spring, Texas 79720, telephone (915) 267-6341.

The Deep East Texas Council of Governments Area Agency on Aging, Aging Advisory Council, will meet in Room 209 of the Science Building, Angelina College, on January 14, 1977, at 1:30 p.m. Further information may be obtained from Martha Jones, P.O. Drawer 1170, Jasper, Texas 75901, telephone (713) 384-5704.

The Education Service Center Region VI, Board of Directors, will meet at Hilltop Lakes, Normangee, on January 27, 1977, at 5 p.m. Further information may be obtained from M. W. Schlotter, P.O. Box 2201, Huntsville, Texas 77341, telephone (713) 295-9161.

The Education Service Center Region XVI, Board of Directors, will meet at 1601 South Cleveland, Amarillo, on January 20, 1977, at 1 p.m. Further information may be obtained from Kenneth M. Laycock, 1601 South Cleveland, Amarillo, Texas 79102, telephone (806) 376-5521.

The Lubbock Regional MH/MR Center, Human Development Center, will meet on the 4th floor, 1210 Texas Avenue, Lubbock, on January 11, 1977, at 4:30 p.m. Further information may be obtained from Gene Menefee, 1210 Texas Avenue, Lubbock, Texas 79401, telephone (806) 763-4213.

The Middle Rio Grande Development Council, Regional Advisory Committee on Aging, will meet at the public library, Eagle Pass, on January 17, 1977, at 2 p.m. Further information may be obtained from Betty Mann, P.O. Box 1461, Del Rio, Texas 78840, telephone (512) 775-1581.

The Panhandle Regional Planning Commission, Criminal Justice Advisory Board, will meet at the Amarillo Building, 3rd and Polk, Amarillo, on January 11, 1977, at 3 p.m. Further information may be obtained from George Loudder, P.O. Box 9257, Amarillo, Texas 79105, telephone (806) 372-3381.

The Permian Basin Health Systems Agency, Governing Body, will meet at the Air Terminal Office Building, Midland, on January 17, 1977, at 7:30 p.m. Further information may be obtained from Harley Reeves, P.O. Box 6391, Midland, Texas 79701, telephone (915) 563-1061.

The West Texas Council of Governments, Advisory Committee on Rural Affairs, will meet at City Hall, Marfa, on January 12, 1977, at 2 p.m. Further information may be obtained from E. Ray Hill, 1200 North Mesa, El Paso, Texas 79902, telephone (915) 544-3827.

Doc. No. 770058

Governor's Energy Advisory Council

Energy Policy Monitor

Solar Energy

In the December 31, 1976, issue of the "Energy Policy Monitor," the Governor's Energy Advisory Council reported that on December 29, the Energy Research and Development Administration (ERDA) announced that a study performed by the MITRE Corporation for ERDA concludes that solar heating can now compete economically with electric baseboard heating for well-insulated new homes throughout most of the U.S. The study also concluded that a 25-percent drop in the cost of solar heating would make it competitive with fuel oil or electric heat pumps in many areas, and that a 50-percent cost reduction would make solar heating competitive with all fuels, including natural gas, in most regions. ERDA hopes to achieve a 50-percent cost reduction by 1980 "through market competition, improved performance, reduced cost of equipment and installation, and possible incentives." The current price of solar collectors is roughly $20 per square foot or $6,000 to $9,000 for a 1,500-square-foot home.

Among the areas surveyed was Dallas/Fort Worth, where the study showed: (1) at $20 per square foot of solar collector, fuel savings over comparable electric baseboard heating costs would exceed annual payments of principal and interest on solar equipment in three years; (2) at $15 per square foot of solar collector, savings over electric baseboard heating would exceed payments in two years; (3) at $10 per square foot of solar collector, fuel savings would exceed the costs of electric baseboard heating in one year, electric heat pumps in three years, fuel oil in two years, and natural gas heating in three years.

The study suggests that in Dallas/Fort Worth solar heating at $20 or $15 per square foot of solar collector would not be cost competitive with electric heat pumps, oil, or gas. However, as the price of conventional fuels rises, solar heating may be economically attractive to the homeowner sooner than projected.

Doc. No. 770053

Comptroller of Public Accounts

Administrative Decisions

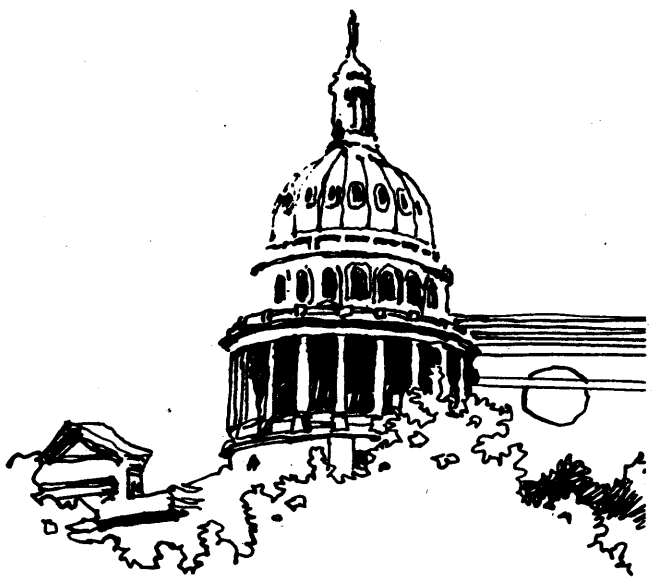
Summary of Administrative Decision H-7901

Summary of Decision: Tangible personal property which is purchased outside of Texas and is to be assembled in Texas into a licensed and certificated carrier is not exempt under Article 20.04(G)(3)(a), Texas Taxation-- General Annotated (1969), because the property is not a carrier when it enters the state, in accordance with Comptroller's Sales Tax Rule .017.

For copies of recent opinions selected and summarized by the Legal Services Division, contact Harriet Burke, Legal Services Division, P.O. Box 13528, Austin, Texas 78711. Copies will be edited to comply with confidentiality statutes.

Filed: January 5, 1977, 11:22 a.m.

Doc. No. 770046



Voter Registration Blank

Printed below is a copy of the new voter registration application form. If you are not currently registered to vote, you may complete and return it to your local county tax assessor-collector.

Persons in the following categories probably will need to register to vote: (1) those who have just moved into the state or county of current address; (2) those whose 18th birthdays fall within 60 days of registration; (3) those who did not vote in the general or primary election in Texas in 1974; (4) those who have not registered to vote since 1971; (5) those who moved into the county of current residence more than 90 days before an election.

Registered voters receive a blue registration card in the mail. If a person has not received this blue certificate, he or she is advised to return a completed registration form to the local county tax assessor-collector. The blank below may be filed at any future time.

For Further Information, Call Toll-Free
1-800-292-9602

Certificate Number (for Official use only) | Election Pct. #

VOTER REGISTRATION APPLICATION

Mail or deliver to Tax Assessor-Collector of county of residence after completing every blank. Effective on 30th day after delivery to Tax Assessor-Collector.

TYPE OR PRINT IN INK

* FILL IN ALL BLANKS BELOW DOUBLE LINE

Application Number (for Official use only)

Last name

First name (do not use husband's first name)

Middle name

Maiden surname if married woman

PERMANENT RESIDENCE ADDRESS:

Street & apt. # or route # or location (not P.O. Box)

City Zip

MAILING ADDRESS IF DIFFERENT FROM ABOVE:

Street or P.O. Box

City

State Zip

Social Security No. SEX (M/F)

Birth Date Month Day Year

Phone #

Birth Place City or County

State or Foreign Country

If naturalized, court or its location:

If now registered in another Texas County Name of County

Last Residence Address in County

City Zip

I certify that the applicant is a citizen of the United States, has met all legal requirements, and holds legal residence in this county. I understand that the giving of false information to procure the registration of a voter is a felony.

SIGNATURE OF VOTER OR AGENT

X

Agent must be a registered voter and must be only: (Circle one applicable)

Husband-Wife-Mother-Father-Son-Daughter

* The disclosure of social security number is voluntary only, is solicited by authority of Section 45b, Texas Election Code, and will be used only by election officials to maintain the accuracy and integrity of the registration records.

Texas Register Binders

The State Bar of Texas, in cooperation with the Office of the Secretary of State, is offering for sale three-inch square-ring binders designed to hold issues of the *Texas Register*. The brown vinyl binders, lettered in gold, contain index and monthly tabs and spine insert identification cards.

Binders may be purchased by sending your name and address, along with $7.50 per binder plus five percent sales tax, to: Texas Register Binders; State Bar of Texas; P.O. Box 12487; Austin, Texas 78711.

For mail orders, add $2 postage and handling for up to four binders. Checks should be made payable to the State Bar of Texas. The binders may also be purchased at the State Bar Headquarters, 5th floor, American Bank Tower, 221 West 6th Street, Austin. Further information is available by calling (512) 476-6823.

Second Class Postage

PAID

Austin, Texas
And Additional Entry Offices

TEXAS REGISTER

Please use the blank below to order a new subscription, to renew existing subscriptions, or to indicate change of address. Questions concerning existing subscriptions should refer to the subscription number on the mailing label from the back of an issue. If copies of back issues are desired, this form may be used for that purpose, also. Specify in the appropriate blank the number of new or renewed subscriptions requested, or the exact dates of the back issues ordered. All subscriptions are $25 per year, plus $1.25 sales tax, for 100 issues. Each copy of back issues is $1, plus five cents sales tax, for a total of $1.05 per copy. Please allow three weeks for processing.

For information concerning the *Texas Register* call:
(512) 475-7886

APPLICATION FORM

For Renewal or Change of Address, Affix Label

FIRST NAME (Please Type or Print)

LAST NAME

OR

COMPANY, FIRM OR AGENCY

ADDRESS

CITY STATE ZIP CODE

_____ New Subscriptions at $25 plus $1.25 sales tax (if applicable) per year (TOTAL $26.25)
_____ Renewed Subscriptions at $25 plus $1.25 sales tax (if applicable) per year (TOTAL $26.25)
_____ Copies of back issues at $1 plus $ .05 sales tax (if applicable) per copy (TOTAL $1.05)
Please specify dates of issues desired:

$ _____ Amount Enclosed

Mail To:
MARK WHITE, Secretary of State
Texas Register Division
P.O. Box 12887, Capitol Station
Austin, Texas 78711

PLEASE MAKE CHECKS OR MONEY ORDERS PAYABLE TO SECRETARY OF STATE