OPTIONAL HEALTH CARE SERVICES NOTIFICATION

Mark an "X" in the appropriate column to indicate each optional health care service the county chooses to provide or chooses to discontinue providing.

PROVIDE	DISCONTINUE	
☒	☐	**1. Advanced Practice Nurse** (APN), specifically a nurse practitioner, a clinical nurse specialist, a Certified Nurse Midwife (CNM), and a Certified Registered Nurse Anesthetist (CRNA)
☒	☐	**2. Ambulatory Surgical Center** (ASC), Freestanding
☒	☐	**3. Colostomy Medical Supplies and/or Equipment**, namely colostomy bags/pouches, cleansing irrigation kits, paste or powder, and skin barriers with flange/wafers
☒	☐	**4. Counseling Services.** Check the ones the county chooses to provide. ☒ A. Licensed Clinical Social Worker (LCSW) ☒ B. Licensed Marriage Family Therapist (LMFT) ☒ C. Licensed Professional Counselor (LPC) ☒ D. Ph.D. Clinical Psychologist
☐	☐	**5. Dental Care**, namely an annual routine dental exam, an annual routine cleaning, one set of annual x-rays and the least costly service for emergency dental conditions for the removal or filling of a tooth due to abscess, infection, or extreme pain
☒	☐	**6. Diabetic Supplies and/or Equipment**, namely test strips, alcohol prep pads, lancets, glucometers, insulin syringes, humulin pens, and the needles required for the humulin pens
☒	☐	**7. Durable Medical Equipment (DME).** Check the ones the county chooses to provide. ☐ A. Blood Pressure Measuring Appliances ☐ B. Canes ☐ C. Crutches ☒ D. Home Oxygen Equipment only ☐ E. Hospital Beds ☐ F. Walkers ☐ G. Wheelchairs, Standard
☐	☐	**8. Emergency Medical Services**, namely ground transportation only
☐	☐	**9. Federally Qualified Health Center** (FQHC)
☒	☐	**10. Occupational Therapy**
☒	☐	**11. Physical Therapy**
☒	☐	**12. Home and Community Health Care**
☒	☐	**13. Physician Assistant** (PA)
☐	☐	**14. Vision Care**, namely one exam by refraction and one pair of prescription glasses every 24 months
☒	☐	**15. Other** medically necessary services or supplies determined to be cost effective by the entity.

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Signature of County Judge/Designee _____ Date _____

Printed Name of Person Signing This Form 120	Title
County	Mailing Address
Telephone Number (Include area code.)	City/State/ZIP

Definitions of CIHCP Optional Health Care Services

1. **Advanced Practice Nurse (APN)** services must be medically necessary and provided within the scope of practice of an APN and covered by the Texas Medicaid Program when provided by a licensed physician.

2. **Ambulatory Surgical Center (ASC)** services must be provided in a freestanding ASC, and are limited to items and services furnished in reference to an ambulatory surgical procedure, including those services on the Center for Medicare and Medicaid Services (CMS)-approved list and selected Medicaid-only procedures.

3. **Colostomy medical supplies and/or equipment** must be medically necessary and prescribed by a physician or an APN if this is within the scope of their practice in accordance with the standards established by the Board of Nurse Examiners and published in 22 TAC §221.13. Items covered are colostomy bags/pouches, cleansing irrigation kits, paste or powder, and skin barriers with flange/wafers. The county may require the supplier to receive prior authorization.

4. **Counseling (psychotherapy)** services must be medically necessary based on a referral from a physician or an APN if this is within the scope of their practice in accordance with the standards established by the Board of Nurse Examiners and published in 22 TAC §221.13. Psychotherapy services must be provided by a Licensed Clinical Social Worker (LCSW), Licensed Marriage Family Therapist (LMFT), Licensed Professional Counselor (LPC), or a Ph.D. Psychologist.

5. **Dental care** must be medically necessary and provided by a DDS, DMD, or DDM. Items covered are: an annual routine exam, annual routine cleaning, one set of annual x-rays, and the least costly service for emergency dental conditions for the removal or filling of a tooth due to abscess, infection, or extreme pain. The county may require prior authorization.

6. **Diabetic supplies and/or equipment** must be medically necessary and prescribed by a physician or an APN if this is within the scope of their practice in accordance with the standards established by the Board of Nurse Examiners and published in 22 TAC §221.13. Items covered are: test strips, alcohol prep pads, lancets, glucometers, insulin syringes, humulin pens, and the needles required for the humulin pens. The county may require the supplier to receive prior authorization.

7. **Durable medical equipment (DME)** must be medically necessary; meet the Medicare/Medicaid requirements; and be provided under a written, signed and dated prescription from a physician or an APN if this is within the scope of their practice in accordance with the standards established by the Board of Nurse Examiners and published in 22 TAC §221.13. Items may be purchased or rented, whichever is least costly. Items covered are: blood pressure measuring appliances that are reasonable and appropriate, canes, crutches, home oxygen equipment (including masks, oxygen hose, and nebulizers), hospital beds, walkers, and standard wheelchairs. The county may require the supplier to receive prior authorization.

8. **Emergency medical service** covers ground transportation only for medically necessary, life-threatening conditions.

9. **Federally Qualified Health Center (FQHC)** services must be provided in an approved FQHC by a physician, physician's assistant, nurse practitioner, clinical psychologist, or clinical social worker.

10. **Occupational therapy** services must be medically necessary and may be covered if provided in a physician's office, a therapist's office, in an outpatient rehabilitation or free-standing rehabilitation facility, or in a licensed hospital. Services must be within the provider's scope of practice, as defined by Occupations Code, Chapter 454.

11. **Physical therapy** services must be medically necessary and may be covered if provided in a physician's office, a therapist's office, in an outpatient rehabilitation or free-standing rehabilitation facility, or in a licensed hospital. Services must be within the provider's scope of practice, as defined by Occupations Code, Chapter 453.

12. **Home and community health care** must be medically necessary, meet the Medicare/Medicaid requirements;,and be provided by a certified home health agency. A plan of care must be recommended, signed, and dated by the recipient's attending physician prior to care being given. Items covered are R.N. visits for skilled nursing observation, assessment, evaluation, and treatment provided by a physician who specifically requests the R.N. visit for this purpose. A home health aide to assist with administering medication is also covered. Visits made for performing housekeeping services are not covered. A county may require prior authorization.

13. **Physician Assistant (PA)** services must be medically necessary and provided by a PA under the direction of an M.D. or a D.O. and must be billed by and paid to the supervising physician.

14. **Vision care** covers one exam by refraction and one pair of prescribed glasses every 24 months that meet Medicaid criteria.

15. **Other** medically necessary services or supplies that the local governmental municipality/entity determines to be cost effective.

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Instructions for Form 120

Mark an "X" in the appropriate column to indicate each optional health care service the county chooses to provide or chooses to discontinue providing. Sign and date the bottom of the form, and submit the Form 120 electronically to the TDSHS Primary Care Group by emailing it to: CIHCP@dshs.state.tx.us.

If you are unable to submit the form electronically, you may fax it to the TDSHS at 512/776-7203.

It is not necessary to submit the Form 120 by mail once it has been faxed and received by TDSHS Primary Care Group.

Maintain the records at least until the end of the third complete state fiscal year.

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