

TAC, Title 25, Part 1, Chapter 27

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SUBCHAPTER A. GENERAL PROVISIONS.

§27.1. Purpose and Application.

(a) Case Management for Children and Pregnant Women is a Medicaid benefit that assists eligible clients in gaining access to the necessary medical, social, educational, and other service needs related to their health condition/health risk or, for a pregnant women, a high-risk condition. The Department of State Health Services (department), by authorization of the Health and Human Services Commission (HHSC), operates and administers the components of this program.

(b) The rules in this chapter apply to Case Management for Children and Pregnant Women services, client eligibility for these services, provider qualifications to provide these services, and oversight of the administration of Case Management for Children and Pregnant Women services.

§27.3. Definitions.

The following words or terms, when used in this chapter, have the following meanings unless the context clearly indicates otherwise.

(1) Access--The ability of an eligible client to obtain health and health-related services, as determined by factors such as: the availability of Texas Health Steps services; service acceptability to the eligible child, pregnant woman, or both; the location of health care facilities and other resources; transportation; hours of facility operation; and length of time available to see the health care provider.

(2) Active Providers--Providers who have reported that they are currently accepting referrals. Inactive providers are those who have reported that they are not accepting referrals or have been placed on inactive status by the department due the department's inability to make contact with them.

(3) Applicant--An agency, organization, or individual who submits an application to the department for approval as a provider of Case Management for Children and Pregnant Women services.

(4) Application process--Submission of an application to provide Case Management for Children and Pregnant Women services, and the department's ensuing review and disposition of the application.

(5) Case manager--An individual qualified under §27.21 of this title (relating to Case Manager Qualifications) who provides Case Management for Children and Pregnant Women

services, either as an independent provider, or as an employee or contractor of a case management provider.

(6) Case Management for Children and Pregnant Women services--In reference to the federal regulation (42 C.F.R. §440.169) definition of case management, those services that assist eligible clients in gaining access to necessary medical, social, educational, and other services related to their health condition/health risk or high-risk condition.

(7) Children with a health condition/health risk--Children birth through age 20 who have or are at risk for a medical condition, illness, injury, or disability that results in limitation of function, activities, or social roles in comparison with healthy peers of the same age in the general areas of physical, cognitive, emotional, or social growth and development.

(8) Client--An individual who is eligible for Medicaid and receives services described under this chapter, or the client's parent or legal guardian acting on the client's behalf.

(9) Client choice--Clients are given the freedom to choose a provider, to the extent possible, from among three providers.

(10) Family--A basic unit in society having at its nucleus: one or more adults living together and cooperating in the care and rearing of their biological or adopted children; or a person or persons acting as an individual's family, foster family, or identifiable support person(s).

(11) Health and health-related services—Services which are provided to meet the comprehensive (preventive, primary, tertiary, and specialty) health needs of the eligible client, including, but not limited to, medical and dental checkups, immunizations, acute care visits, pediatric specialty consultations, physical therapy, occupational therapy, audiology, speech language services, mental health professional services, pharmaceuticals, medical supplies, prenatal care, family planning, adolescent preventive health, durable medical equipment, nutritional supplements, prosthetics, eyeglasses, and hearing aids.

(12) High-risk condition--Applies to women who are pregnant and have a medical and/or psychosocial condition(s) that places them and their fetuses at a greater than average risk for complications, either during pregnancy, delivery, or following birth.

(13) Medicaid--Medical assistance program implemented by the State of Texas under the provisions of Title XIX of the Social Security Act, as amended, at 42 U.S.C., §1396, *et seq.*

(14) Prior authorization--The department's approval of a provider's request for permission to perform a comprehensive visit and follow-up contacts with a client, based on the department's receipt and review of documentation supporting the client's eligibility for services under this chapter. Prior authorization is a condition of reimbursement, not a guarantee of payment.

(15) Provider--An agency or individual approved by the department to provide Case Management for Children and Pregnant Women services and enrolled as a Medicaid provider.

(16) Quality Assurance Review--A review of a provider's client records, internal quality assurance policy, case manager's licensure, outreach materials, and their compliance with the department's rules and policies.

(17) State--The State of Texas.

(18) TMPPM--Texas Medicaid Provider Procedures Manual.

(19) Utilization Review--A review of claims data in which trends have been identified that could indicate potential concerns with the quality of case management services.

SUBCHAPTER B. CLIENT SERVICES.

§27.5. Client Eligibility.

A client eligible for services under this chapter must be either a child with a health condition/health risk or a pregnant woman with a high-risk condition who:

- (1) is Medicaid-eligible in Texas;
- (2) is in need of Case Management for Children and Pregnant Women services; and
- (3) desires such services.

§27.7. Client Rights.

(a) Use of services is voluntary. Acceptance or refusal of services does not affect eligibility for or receipt of any other Medicaid services, or for future case management services.

(b) All records about clients are considered confidential information, in accordance with the standards and requirements described in §27.9 of this title (relating to Client Confidentiality).

(c) Clients have the right to:

- (1) actively participate in case management decisions, including the right to refuse services from the provider;
- (2) receive prior authorized services when services are requested and informed consent is given;
- (3) receive services free from abuse or harm from the case manager and the case management provider;

(4) have freedom of choice to choose any active provider in their residing county;

(5) have freedom of choice to request a transfer to another case manager in the client's service area at any time; and

(6) request a fair hearing, conducted in accordance with the rules in 1 TAC, Chapter 357, Subchapter A (relating to Uniform Fair Hearing Rules), within 90 days after receiving written notification that services have been denied, reduced, suspended, or terminated.

§27.9. Client Confidentiality.

(a) Federal and state laws and regulations prohibit the disclosure of information about Medicaid clients without effective consent by the client or on behalf of the client, except for purposes directly connected with the administration of the Medicaid program, as described in 42 U.S.C., §1396a(a)(7); 42 C.F.R. §§431.301 - 431.306; Human Resources Code, §12.003 and §21.012; and Government Code, §552.101. Case management providers are not considered directly connected with the administration of the program. Although case management providers are not entitled to confidential information without prior consent, they are able to verify a client's eligibility status.

(b) Entities with which HHSC or the department contracts to perform certain administrative functions, including contractors for outreach, informing, and transportation services, may receive confidential information without the client's consent, but only to the extent necessary to perform and administer the contract. These contracted entities are bound by the same standards of confidentiality applicable to the Medicaid program, and they must provide effective safeguards to ensure confidentiality.

§27.11. Components of Case Management for Children and Pregnant Women Services.

The following are the essential components of Case Management for Children and Pregnant Women services and explanation of billable components.

(1) Intake--A case manager's contact with the client/family/guardian that includes the collection of demographic, health, and other information relevant to the determination of the client's potential eligibility.

(2) Comprehensive visit--A case manager's face-to-face meeting with the client/family/guardian that includes the development of a:

(A) Family Needs Assessment. A comprehensive face-to-face assessment of client needs to determine the need for any medical, educational, social, or other services required to address short- and long-term health and well-being of the client. These assessment activities must be documented on a Family Needs Assessment form and must include:

(i) taking a client's history;

(ii) identifying the client's needs, assessing and addressing family issues that impact the client's health condition/risk or high-risk condition and completing related documentation; and

(iii) gathering information from other sources, such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the client.

(B) Service Plan. A document developed with the client that determines a planned course of action based upon the information collected through the assessment. The Service Plan must be documented on a Service Plan form and must:

(i) include activities and goals that are developed in consultation with the client, involve the participation of the client, and address the medical, social, educational, and other services needed by the client;

(ii) identify a course of action to respond to the assessed needs of the client, including identifying the individual responsible for contacting the appropriate health and human service providers, and designating the time frame within which the client should access services; and

(iii) include a Service Plan Addendum if there are revisions or if additional needs have been identified following the initial Service Plan development. The Service Plan Addendum shall be completed and documented during a follow-up visit.

(3) Referral and related activities to help the client obtain needed services, including activities that help link the client with:

(A) medical, social, and educational providers; and

(B) other programs and services that can provide needed services, such as making referrals to providers for needed services and scheduling appointments for the client.

(4) Follow-up contacts by a case manager necessary to ensure the service plan is implemented and adequately addresses the client's needs.

(A) Follow-up contacts shall be conducted as frequently as necessary to determine whether the following conditions are met:

(i) services are being furnished in accordance with the client's service plan;

(ii) services in the service plan are adequate; and

(iii) the service plan and service arrangement are modified when the client's needs or status change.

(B) Follow-up contacts by case manager for clients who are pregnant women with a high-risk condition shall occur as needed through the 59th day postpartum.

(5) Case management may include collateral contacts with non-eligible individuals that are directly related to identifying the needs and supports for helping the client access services and managing the client's care.

(6) The case management components that are eligible for Medicaid reimbursement are the comprehensive visit and each follow-up contact performed in accordance with this section.

(7) Case management services are not reimbursable if they:

(A) are provided to clients who do not meet the definition for client eligibility in §27.5 of this title (relating to Client Eligibility);

(B) are not prior-authorized in accordance with §27.13 of this title (relating to Prior Authorization); or

(C) are provided to a client who has already received another case management service on the same day from the same billing provider.

§27.13. Prior Authorization.

(a) The department may establish policies and procedures that providers must follow in order to obtain prior authorization for services.

(b) Following intake completion, the initial prior authorization request must be supported by required documentation and submitted to the department for review and disposition. If the documentation supports eligibility, a comprehensive visit and follow-up visit(s) will be prior-authorized. The number of follow-up visit(s) that is prior-authorized will be based on the client's level of need, level of medical involvement, and complicating psychosocial factors documented on the request.

(c) Any additional requests for comprehensive or follow-up visit(s) must be prior-authorized. Required documentation must be submitted to the department for review and disposition before any additional services may be prior-authorized.

SUBCHAPTER C. PROVIDER QUALIFICATIONS AND RESPONSIBILITIES.

§27.15. Provider Qualifications.

A provider shall not be approved as a provider of Case Management for Children and Pregnant Women unless they meet the following qualifications:

(1) completion of application process and approval by the department;

(2) agreeing to comply with the rules, policies, and procedures of the department relating to Case Management for Children and Pregnant Women;

(3) agreeing to comply with applicable state and federal laws governing participation of providers in the Medicaid program and to enroll as a state Medicaid provider;

(4) be a provider who meets, or employs or contracts with, one or more case managers who each meet, the qualifications specified in §27.21 of this title (relating to Case Manager Qualifications); and

(5) has never been terminated by the department and is not listed on the HHSC Office of Inspector General's Excluded Individual Listing.

§27.17. Provider Approval Process.

(a) To become an approved provider, an applicant must submit a completed application to the department.

(b) The department will review the application and provide a response within timeframes specified in policies and procedures. An application will not be reviewed and considered until all information is provided in a clear and understandable manner.

(c) Providers approved by the department must also enroll with the Medicaid Claims Administrator as a Medicaid provider.

(d) Providers who fail to submit an application to enroll as a state Medicaid provider within twelve months of approval by the department must submit a new application to the department.

§27.19. Provider Responsibilities.

Providers must:

(1) operate in accordance with the laws, rules, regulations, and standards of care relating to the practice of their respective license(s); ensure that their case managers are operating within the laws, rules, regulations, and standards of care relating to the practice of their respective license(s); and ensure that their case managers operate only within the scope of their respective license(s);

(2) provide services according to policies and procedures as published in the TMPPM and Medicaid bulletins, and in accordance with the policies and procedures of the department;

(3) cease providing services and notify the department if the professional license of a provider is suspended or revoked, with such notification to be provided to the department no later than seven calendar days after the date that the suspension or revocation is imposed;

(4) assure that case managers attend required trainings provided by the department;

(5) develop and maintain a quality management system for the provision of services with the primary goal of assisting clients in accessing necessary medical, social, educational, and other services related to their health condition/health risk or high-risk condition;

(6) ensure that outreach activities do not impede freedom of client choice, and that they comply with 1 TAC §371.27 (relating to Prohibition against Solicitation of Medicaid or CHIP Recipients); and

(7) ensure that clients are given choice of providers for case management.

§27.21. Case Manager Qualifications.

An individual shall not be approved to provide Case Management for Children and Pregnant Women unless they meet the following qualifications:

(1) licensed in the State of Texas as a registered nurse (with a bachelor or advanced degree in nursing), whose license is not temporary or provisional in nature; or

(2) licensed in the State of Texas as a registered nurse (with an associate degree in nursing), whose license is not temporary or provisional in nature. The individual must also possess two years of cumulative paid full-time work experience or two years of supervised, full-time educational internship/practicum experience in the past ten years with children, up to age 21, and/or pregnant women. Experience must include assessing the psychosocial and health needs of and making community referrals for these populations; or

(3) licensed in the State of Texas as a social worker with licensure appropriate for his/her practice, including the practice of Independent Social Work, and whose license is not temporary or provisional in nature; and

(4) has completed the department's standardized case management training.

§27.23. Case Manager Responsibilities.

Case managers must:

(1) comply with all licensure requirements of the appropriate state licensure/examining board, including the obligation to report all suspected child abuse/neglect;

(2) cease providing services and notify the department if the case manager's professional license is suspended or revoked, with such notification to be provided to the department no later than seven calendar days after the date that the suspension or revocation is imposed;

(3) provide services convenient to clients, either in their home, an office setting, or other place of client's preference; and

(4) have knowledge of, and coordinate services with, providers of health and health-related services and other active community resources.

§27.25. Utilization and Quality Assurance Reviews and Compliance.

(a) The purpose of a utilization or quality assurance review is to ensure program fiscal integrity, to address the federal mandate requiring program funds be spent only as allowed under federal and state laws and regulations, and to ensure that services are appropriately provided to clients.

(b) During each fiscal year, the department will conduct quality assurance and utilization reviews of all active and inactive providers to monitor claims, quality of case management services and compliance with Case Management for Children and Pregnant Women rule and policy.

(c) Providers must cooperate with the quality assurance and utilization reviews. Providers will be given notification of upcoming reviews in accordance with the department's policies and procedures.

(d) If the results of the utilization or quality assurance review indicate overpayment, the department will notify HHSC of the overpayment and the provider will be given information about how to arrange for repayment.

(e) Providers must voluntarily notify the Medicaid claims administrator to arrange for repayment if they become aware that they received an overpayment.

§27.27. Termination, Suspension, Probation, and Reprimand of Providers.

A provider's violation or non-compliance with federal and or state Medicaid laws, rules and regulations, rules under this chapter, or Case Management and Pregnant Women policies and procedures may result in one or more of the following actions taken by the department.

(1) Notification to the Medicaid claims administrator through HHSC that the department has terminated the case management provider. Providers will receive written notice of termination. Providers who are terminated will not be approved if they reapply.

(2) Suspension of a provider in accordance with the department's policies and procedures. Providers will receive written notice of suspension.

(3) Probation of a provider in accordance with the department's policies and procedures. Providers will receive written notice of probation.

(4) Reprimand of a provider in accordance with the department's policies and procedures. Providers will receive written notice of reprimand.

(5) Report and referral to the appropriate professional licensure entity.

(6) Report and referral to HHSC Office of Inspector General.

(7) Report to a law enforcement agency.