



# Texas Department of State Health Services

Case Management for Children and Pregnant  
Women Policies

FY2016

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## Case Management for Children and Pregnant Women

<b>POLICY TITLE:</b> Application Process	<b>POLICY NO:</b> 001
<b>EFFECTIVE DATE:</b> September 1, 2011	<b>REVISED:</b> September 1, 2014

**PURPOSE:** To ensure a consistent application process.

**POLICY:** Applications will be reviewed in a consistent and timely manner.

### **PROCEDURE:**

1. Providers may be a group, an individual or a Federally Qualified Health Center (FQHC). At the time of application, all applicants must have an eligible case manager that meets minimum requirements as defined by Case Management for Children and Pregnant Women program rule. (*See policy 002, Case Manager Requirements.*)
2. Applicants must coordinate the provider application process with DSHS regional staff. Applications may only be obtained from the DSHS regional staff after completing the online Potential Provider Tutorial.
3. Completed applications must be submitted to the DSHS regional staff within 90 calendar days of the pre-planning session or the application will be denied. If denied, the provider must meet with regional staff for another pre-planning session and resubmit the application. Completed applications and any requested revisions must be typed.
4. If an applicant is applying to provide services in more than one health services region, the DSHS regional staff in the region in which the applicant's administrative office is located will coordinate the review of the application with the other region(s).
5. The DSHS regional staff will review the application within 15 business days of receipt.
6. If revisions to the application are needed, the applicant will be contacted by DSHS regional staff. All requested revisions must be submitted to the region within 15 business days or the application will be denied.
7. Following the review by DSHS regional staff, the application will be forwarded to DSHS central office staff for final review.

8. DSHS central office staff will review all applications and revisions.
  - a. If it is determined that further revisions are needed, the applicant will be contacted by DSHS central office or regional staff. The revisions must be submitted within 15 business days from the date of notification by DSHS staff or the application will be denied.
  - b. If the application meets all the requirements as stated in Case Management for Children and Pregnant Women rule, DSHS will send an approval letter to the applicant.
  - c. If the application does not meet all the requirements as stated in Case Management for Children and Pregnant Women rule, DSHS will send a denial letter to the applicant.



## Case Management for Children and Pregnant Women

<b>POLICY TITLE:</b> Case Manager Requirements	<b>POLICY NO:</b> 002
<b>EFFECTIVE DATE:</b> September 1, 2011	<b>REVISED:</b> September 1, 2014

**PURPOSE:** To ensure case managers meet standard qualification criteria.

**POLICY:** Case managers must meet the minimum education, experience and licensure criteria.

### **PROCEDURE:**

1. All case managers must be approved by DSHS to provide case management services and bill Medicaid for services rendered.
2. Case managers must meet one of the following eligibility requirements:
  - a. 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,
  - b. 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,
  - c. 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.
3. Documentation of case manager eligibility must be submitted to DSHS for review and approval.
  - a. Social Workers must submit proof of licensure.
  - b. Registered Nurses must submit proof of licensure and a current resume.
  - c. If all of the minimum requirements are met, DSHS will send a Minimum Education and Experience Requirements (MEER) certificate to the provider.

- d. If the minimum requirements are not met, DSHS will send a denial letter to the provider.
4. DSHS may verify case management experience with a previous or current employer, contractor and/or internship/practicum supervisor.
5. Providers and/or case managers must attend additional training as required by DSHS central office.
6. Case managers must not present any conflicts of interest.
7. Social workers and nurses will adhere to the laws, rules and regulations and standards of care relating to their respective license requirements.
8. Failure to comply with this policy may jeopardize continued participation as a provider.



## Case Management for Children and Pregnant Women

<b>POLICY TITLE:</b> Enrollment, Training and Activation	<b>POLICY NO:</b> 003
<b>EFFECTIVE DATE:</b> September 1, 2011	<b>REVISED:</b> September 1, 2014

**PURPOSE:** To establish requirements for enrollment, training and activation.

**POLICY:** Approved case managers must complete required training prior to providing case management services. Providers must enroll as a Medicaid provider prior to filing claims for case management services.

### **PROCEDURE:**

1. Providers must:
  - a. Submit the Texas Medicaid Provider Enrollment Application to the Medicaid Claims Administrator, which is currently Texas Medicaid and Healthcare Partnership (TMHP).
    - i. If DSHS approved the provider as a group, the provider must enroll with Medicaid as a group.
    - ii. If DSHS approved the provider as an individual, the provider must enroll with Medicaid as an individual.
    - iii. FQHCs do not need to submit a Texas Medicaid Provider Enrollment Application. FQHCs will use their current TPI to file claims.
  - b. Comply with all of the requirements of the Texas Medicaid Provider Procedures Manual, as well as all state and federal laws governing or regulating Medicaid. Provider is responsible for ensuring all case managers also comply.
  - c. Ensure completion of the required training for all approved case managers. (Note: The Texas Medicaid Provider Enrollment application must be submitted prior to attending training.)
    - i. Attendance is recommended but not required for owners and/or administrative staff within a group.

- ii. Following completion of post-training requirements, case managers must download their training certificate and submit certificate to DSHS Central Office.
  - d. Obtain a Texas Provider Identifier (TPI) number from TMHP.
    - i. Each group will be assigned a Texas Provider Identifier (TPI) number and each case manager within the group will be assigned a TPI also known as a Performing Provider Number (PPN).
    - ii. Each individual provider will be assigned one TPI.
  - e. Determine their start date for activation and accepting referrals.
    - i. Complete the Notification of Significant Provider Changes Form (CM-10) changing status to active.
    - ii. Submit to DSHS regional staff.
    - iii. Providers will be placed on the DSHS website when the CM-10 has been received by DSHS central office.
- 2. Failure to comply with this policy may jeopardize continued participation as a provider.



## Case Management for Children and Pregnant Women

<b>POLICY TITLE:</b> Outreach	<b>POLICY NO:</b> 004
<b>EFFECTIVE DATE:</b> September 1, 2011	<b>REVISED:</b> September 1, 2015

**PURPOSE:** To ensure that communities and potential clients are informed about case management services in an appropriate and accurate manner.

**POLICY:** Providers will disseminate accurate information regarding case management services to health, education and human service professionals, community organizations and potential clients, in an effort to generate referrals.

### PROCEDURE:

1. Providers should conduct outreach activities to potential referral sources.
2. Outreach activities can include but are not limited to:
  - a. Participating in community outreach events such as health fairs;
  - b. Networking with community agencies that serve children and pregnant women;
  - c. Participating in community coalition meetings;
  - d. Distributing brochures to medical/mental health professionals, dental providers, governmental agencies (such as WIC), community resources and schools; and,
  - e. Conducting presentations.
3. Outreach activities must ensure individualized referrals. The following activities may impede client choice and therefore are prohibited:
  - a. Door to door, telephone or other cold-call marketing or solicitation (any un-invited contact with a potential client or a potential client's family);
  - b. The distribution of any false or misleading materials to potential clients;
  - c. Obtaining lists of Medicaid clients without a specific referral;
  - d. Offering incentives for enrollment into case management services; and/or,
  - e. Entering into exclusive referral relationships with referral sources.

4. When conducting outreach activities, providers must ensure that potential clients are informed that they have a choice of available providers.
5. Providers are encouraged to use the outreach materials developed and provided by DSHS. Providers can order outreach materials at:  
<http://www.dshs.state.tx.us/thsteps/THStepsCatalog.shtm>
6. Any independently developed outreach materials, including, but not limited to, business cards, brochures, posters, websites, social media or client questionnaires, must be submitted to the DSHS regional staff for approval before being utilized in outreach efforts. The provider will be notified in writing within ten business days of receipt of the request. Any independently designed materials must incorporate all information included in the DSHS designed materials and must not misrepresent eligibility or intent of the service. Materials must include the following information:
  - a. 1-877-THSteps (847-8377) hotline;
  - b. Case management eligibility criteria (not required for business cards, social media or advertisements);
  - c. Description of case management services (not required for business cards, social media or advertisements); and,
  - d. Title of program.
  - e. Exceptions to this policy will be made on a case by case basis.
7. Failure to comply with this policy may jeopardize continued participation as a provider.



## Case Management for Children and Pregnant Women

<b>POLICY TITLE:</b> Documentation Requirements	<b>POLICY NO:</b> 005
<b>EFFECTIVE DATE:</b> September 1, 2011	<b>REVISED:</b> September 1, 2015

**PURPOSE:** To ensure standardized requirements for documentation of case management services.

**POLICY:** Providers must accurately and appropriately document all services provided to clients.

### **PROCEDURE:**

1. Providers must ensure that documentation complies with Medicaid rule, Case Management for Children and Pregnant Women rule and policy requirements.
2. All completed forms and documents and all contacts with or on behalf of the client/parent/guardian must be documented and maintained in the client record.
3. All entries in the client record must be legible, dated, and signed with the appropriate credentials of the case manager. The case manager's signature affirms all of the documentation is accurate.
4. Documentation of activities, not otherwise documented on required forms, must be recorded on progress notes. Case manager may use the Progress Note form (CM-05).
5. If required time frames for case management activities are not met, documentation must include details supporting the reasons for non-compliance.
6. All required forms and instructions for completing those forms are available on the DSHS website. Providers must use the most current forms, which are available on the Case Management for Children and Pregnant Women website at <http://www.dshs.state.tx.us/caseman/forms.shtm>.
7. Errors must be marked through with a single line, initialized and dated by the case manager. Liquid correction must not be used on any documentation.

8. If case management services have been approved for multiple clients within a family, a separate client record must be maintained for each client. Documentation must be individualized for each client.
9. Providers are responsible for ensuring records or copies of records are maintained and retained according to Medicaid Rule and Health Insurance Portability and Accountability Act of 1996 (HIPAA). The HIPAA receipt must be maintained in the client's case management record or in the clinic/agency's master file.
10. Any documentation provided to a client/parent/guardian must be interpreted or translated in client's preferred language. If documentation is not translated in the client's preferred language, it must be interpreted and signed by the interpreter (*See policy 016, Non-Discrimination Requirements.*) It is not required that a case manager who is bilingual in the client's language sign as the interpreter.
11. Any documentation that has been translated must be written in English for the client record.
12. Failure to comply with this policy may jeopardize continued participation as a provider.



**Case Management for Children and Pregnant Women**

<b>POLICY TITLE:</b> Billing	<b>POLICY NO:</b> 006
<b>EFFECTIVE DATE:</b> September 1, 2011	<b>REVISED:</b> September 1, 2015

**PURPOSE:** To ensure standardized requirements for billing of case management services.

**POLICY:** Providers must comply with billing procedures.

**PROCEDURE:**

1. Providers must submit claims for rendered case management services to TMHP.
2. Providers must ensure that billing for case management services complies with Medicaid rule, Case Management for Children and Pregnant Women rule and policy requirements.
3. Providers must contact TMHP to address claims issues or claims training needs.
4. Providers can only submit claims for services that have been prior authorized by DSHS and provided by the approved case manager for the authorization. (*See policy 009, Prior Authorization for Services.*)
5. Providers must perform visits as authorized. A provider may change a face-to-face visit to a telephone visit if desired.
6. Services are not billable when a client is an inpatient in a hospital or other treatment facility.
7. Providers must develop and maintain an accounts receivable system which includes, at a minimum:
  - a. Client name and Medicaid number;
  - b. Date service was provided;
  - c. Date the claim was filed;
  - d. Remittance and Status reports which include the date the claim was paid, denied, suspended, or adjusted;
  - e. Notation if the claim was appealed; and,
  - f. Record of billed services. The Billed Services Form (CM-11) may be utilized to document claims activities.
8. Providers who do not submit a claim within 24 months will be closed and a notification letter will be sent to the address on file.

9. Documentation that does not support billable services may result in a recovery of funds, a referral to Office of Inspector General (OIG) Medicaid Program Integrity (MPI) Section and a referral to the provider's respective licensing/regulatory board.
10. Failure to comply with this policy may jeopardize continued participation as a provider.



## Case Management for Children and Pregnant Women

<b>POLICY TITLE:</b> Provider Changes	<b>POLICY NO:</b> 007
<b>EFFECTIVE DATE:</b> September 1, 2011	<b>REVISED:</b> September 1, 2014

**PURPOSE:** To ensure accurate and current provider information is maintained.

**POLICY:** Providers must submit written notice of any significant changes.

### **PROCEDURE:**

1. All providers must submit written notice of changes to DSHS regional staff within three business days of occurrence or knowledge of changes. Providers must submit by mail, fax or email documentation for the following requests:
  - a. Changing significant provider information - The provider must submit a Notification of Significant Provider Changes (CM-10) form when requesting to make changes to case management staff, agency status (active, inactive or closure), changes in counties served within current region (additions or deletions), or demographic changes (address, telephone number, fax number or email address).
  - b. Adding a case manager - The provider must submit a CM-10 and proof of current licensure. In addition all nurses must submit a current resume. (*See policy 002, Case Manager Requirements.*)
  - c. Expanding service area - The provider must submit a CM-10 when requesting to expand service area in a new region.
2. Providers that are unable to accept new referrals must submit a CM-10 to DSHS regional staff indicating a change in status to inactive for one of the following reasons:
  - a. Not accepting new referrals and currently not serving clients;
  - b. Not accepting new referrals but will continue to serve current clients; or,
  - c. Not accepting new referrals due to no eligible case manager.
3. If a provider changes status to inactive or closed and has clients with remaining needs that they will no longer serve, providers are responsible for the transition of

clients to alternate providers within the requirement of client choice. *(See policy 013, Case Transfer.)*

4. If a provider is on inactive status for twelve or more months, they must attend the required training prior to changing to active status.
5. If a provider is requesting to expand their service area, providers must demonstrate compliance with Case Management for Children and Pregnant Women rule and policies in the current service area before expansion will be approved. If the request to expand indicates a potential impact to the quality of the provision of case management services, the provider may be required to provide additional information to support the feasibility of the request. A request may not be approved if the provider has one of the following:
  - a. Open/outstanding investigation with any licensure or regulatory body or DSHS;
  - b. Unresolved or multiple, validated complaints;
  - c. A current corrective action plan; or,
  - d. Noncompliance with Utilization Review or Quality Assurance Review.
6. Providers requesting expansion to a new region will receive written notification of approval or denial.
7. Providers are also required to notify TMHP of certain provider changes.
8. Requirements for notification of provider changes are outlined in the Texas Medicaid Provider Procedures Manual (TMPPM).
9. DSHS may change a provider's status to inactive and/or closed due to an inability to contact a provider or a provider's failure to respond. After two unsuccessful attempts to contact the provider by telephone and/or email, the provider will be notified in writing to contact DSHS.
  - a. An active provider must contact DSHS within five business days of the date of the letter or the provider will be placed on inactive status. If contact is not made within 30 calendar days of the letter, the provider will be closed.
  - b. An inactive provider must contact DSHS within 30 calendar days of the letter or the provider will be closed.
10. DSHS will close a provider for the following reasons:
  - a. When the provider does not respond to the letter referenced in procedure nine (9).
  - b. A provider fails to get a TPI within 12 months of the approval date of their application.
  - c. A provider has no claims activity within 24 months.
11. If a provider is closed, the provider must complete a new application and attend training to initiate services. *(See policy 001, Application Process and policy 003, Enrollment, Training and Activation.)*
12. Failure to comply with this policy may jeopardize continued participation as a provider.



## Case Management for Children and Pregnant Women

<b>POLICY TITLE:</b> Referral & Intake	<b>POLICY NO:</b> 008
<b>EFFECTIVE DATE:</b> September 1, 2011	<b>REVISED:</b> September 1, 2015

**PURPOSE:** To ensure a standardized intake process and eligibility criteria to access case management services

**POLICY:** Providers will complete an intake for every referral for case management services.

### **PROCEDURE:**

1. All referrals and intakes must be documented.
2. Referrals must be documented on a Referral and Intake Form (CM-01A) and a referral log. (*See policy 021, Quality Management Systems.*)
3. A referral for case management services cannot be denied based on race, color, sex, religion, national origin, language preference, sexual orientation, or type or extent of the high risk or disabling condition.
4. A provider must accept all referrals unless the following service limitations have been documented:
  - a. Provider status is inactive;
  - b. Client resides in a county not covered by the provider; and/or,
  - c. Provider application has a limitation that excludes the client, (i.e., provider does not serve pregnant women, age limitations).
5. If a provider is unable to accept a referral for any of the aforementioned reasons, the provider must contact the Texas Health Steps hotline within two business days of the receipt of the referral to request case management services.
6. An intake must be completed by telephone or face-to-face by an approved case manager who has completed DSHS training for all clients referred for case management services. Intakes must be completed within seven business days of the initial referral. The intake must be conducted with:
  - a. A parent or legal guardian of an un-emancipated minor (individual under 18 years of age, not married or not had disabilities of a minor legally removed) unless:

- i. The case manager receives written consent from the parent/guardian to provide services directly with the minor client; or,
    - ii. The un-emancipated minor client is pregnant and does not live with her parent/guardian.
  - b. An individual 18 years of age or older unless the client has had a legal guardian appointed to them.
- 7. An intake must be documented on the Referral and Intake Form (CM-01A) and maintained in the client's chart.
- 8. During an intake the case manager must obtain information related to case management eligibility requirements to include:
  - a. The health condition(s), health risk or high-risk condition of potential case management clients, as defined by Case Management for Children and Pregnant Women rule and how the health condition, health risk or high-risk condition impacts the client; and,
  - b. Detailed information about the need for assistance with accessing resources related to the health condition/risk or high risk condition and how the case manager will assist with the need.
- 9. If the client's presenting problem or situation is of an urgent nature, the intake must be completed within one business day of receipt. Case managers should use professional judgment to determine if the presenting problem or situation is of an urgent nature.
- 10. If there are multiple clients within a family referred for case management, a case manager will complete an intake for each client.
- 11. Following an intake, if the case manager determines that the client is potentially eligible for case management services, the case manager must submit an Initial Prior Authorization Request (CM-01) prior to initiating services. Case management eligibility will be determined by DSHS central office staff based on submitted documentation. (*See policy 009, Prior Authorization for Services.*)
- 12. If the provider is an agency that provides additional services (e.g.: counseling, medical services, therapies) the client must have needs outside of the scope of the agency in order to be eligible for case management services.
- 13. If during the intake the case manager determines that a client does not meet case management eligibility criteria, the case manager is responsible for providing appropriate information and referrals to address the client's needs. Documentation of these intakes must be maintained.
  - a. If only routine medical and dental needs are identified, the case

manager must refer the client to the Texas Health Steps Hotline or the Medicaid Managed Care plan to address the needs.

b. If only routine medical transportation needs are identified, the case manager must refer the client to the Medical Transportation Program.

c. If only basic needs are identified, the case manager must refer the client to 2-1-1 Texas or to other appropriate community resources.

14. Failure to comply with this policy may jeopardize continued participation as a provider.



## Case Management for Children and Pregnant Women

<b>POLICY TITLE:</b> Prior Authorizations for Case Management Services	<b>POLICY NO:</b> 009
<b>EFFECTIVE DATE:</b> September 1, 2011	<b>REVISED:</b> September 1, 2015

**PURPOSE:** To ensure a standardized process for requesting prior authorization for case management services.

**POLICY:** Providers must follow required procedures to request prior authorization for case management services. Prior authorization is required in order to bill Medicaid for case management services.

### **PROCEDURE:**

1. To obtain initial prior authorization for case management services, an approved case manager must complete an intake (documenting this on the Referral and Intake Form (CM-01A) by phone or face-to-face with the client/parent/guardian and submit the Request for Initial Prior Authorization Form (CM-01) to DSHS central office staff within three business days of intake for review. All fields of the CM-01 must be completed according to the instructions.
2. Completed requests for prior authorization should be submitted via the Case Management for Children and Pregnant Women website.
3. If it is determined that multiple family members have the same needs, a provider must submit a Request for Prior Authorization (CM-01) for only one family member. (Exception: family members have the same needs but have individual school, medical or other meetings/appointments in which the case manager will be attending.)
4. DSHS will review requests within three business days of receipt and determine if requests meet case management eligibility. A client eligible for services must be either a child with a health condition/health risk or a pregnant woman with a high-risk condition who:
  - a. is Medicaid eligible in Texas;
  - b. is in need of 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; and,

- c. desires such services.
5. If the client has urgent needs, the case manager should request an expedited review by clearly documenting the urgency on the CM-01 and/or contacting DSHS central office staff.
  6. If additional information or clarification regarding a prior authorization is necessary to make a determination about eligibility, DSHS central office staff may contact the case manager and/or the client/parent/guardian.
  7. DSHS central office staff will fax a Response to Authorization Request Form indicating the status as approved or denied to the provider.
    - a. If it is determined that the request meets case management eligibility requirements, the request will be approved. Approved requests will include the following:
      - i. Prior authorization number (PAN) assigned to the case manager documented on the CM-01. Case Management must be provided by the case manager authorized to provide services;
      - ii. Number of authorized visits; and,
      - iii. Authorization effective and expiration dates .The signature date on the prior authorization request will be the date the authorization begins. Authorization period is for one year from the effective date. If the request is submitted more than three business days after the completion of the intake, the beginning authorization date may be later than the signature date or subject to denial.
    - b. If the request is not completed according to policy or documentation does not support that the client meets case management eligibility, the request will be denied.
  8. Within three business days of determination, DSHS central office staff will send a letter to the client/parent/guardian indicating the status of the request for prior authorization as approved or denied. The denial notification letter will include a reason for the denial and information about the right to appeal.
  9. The number of authorized visits will be based on the documentation provided that supports the client’s level of need, level of medical involvement and complicating psychosocial factors.
  10. Requests for additional visits for current or closed cases must be completed on a Prior Authorization Request for Additional Visits Form (CM-06). Additional visits may be requested after all previously authorized visits have been conducted if:
    - a. The client continues to meet eligibility requirements;
    - b. Documentation supports the need for additional visits to resolve previously identified needs and/or newly identified needs; and,
    - c. Documentation includes barriers encountered and reason(s) original needs have not been addressed.
  11. The signature date on the CM-06 must be at least one day after the date of the last

follow-up visit.

12. DSHS will fax a Response to Authorization Request Form indicating the status as approved or denied to the provider.

a. If it is determined that the request for additional visits meets case management eligibility requirements, the request will be approved.

Approved requests will include the following:

- i. Prior authorization number (PAN) assigned to the case manager documented on the CM-06. Case Management must be provided by the case manager authorized to provide services;
- ii. Number and type of authorized visits; and,
- iii. Authorization effective and expiration dates. The signature date on the prior authorization request for additional visits will be the date the authorization begins. Authorization period is for one year from the effective date.

b. If the request for additional visits is not completed according to policy or documentation does not support that the client meets case management eligibility, the request will be denied. DSHS central office staff will also send a letter to the client/parent/guardian within three business days indicating that the request for additional visits was denied. The denial notification letter will include a reason for the denial and information about the right to appeal.

13. If a provider submits a request for prior authorization (CM-01) and the client has current authorization with another provider, DSHS central office staff will follow policy 013, Client Transfer.

14. For cases that have been closed, another comprehensive visit can be authorized if documentation supports significant changes in the health condition and/or psychosocial situation.

15. Failure to comply with this policy may jeopardize continued participation as a provider.



## Case Management for Children and Pregnant Women

<b>POLICY TITLE:</b> Comprehensive Visit	<b>POLICY NO:</b> 010
<b>EFFECTIVE DATE:</b> September 1, 2011	<b>REVISED:</b> September 1, 2014

**PURPOSE:** To ensure a standardized process for the completion and billing of the initial comprehensive visit.

**POLICY:** Approved case managers must complete a comprehensive visit according to Case Management for Children and Pregnant Women Rule and Medicaid policy for every client authorized for case management services.

### PROCEDURE:

1. During a comprehensive visit, the case manager must complete the Family Needs Assessment (FNA), the Service Plan (SP) and Service Plan Signature Page.
2. The Family Needs Assessment Form (CM-02) and Service Plan Forms (CM-03 and CM-03Sig) are available on the Case Management for Children and Pregnant Women website at <http://www.dshs.state.tx.us/caseman/forms.shtm>.
3. The comprehensive visit must be completed with the client/parent/guardian by an approved case manager within seven business days of the approval of the prior authorization request. The visit must be conducted face-to-face in the location of the client/parent/guardian's choice. If time frames are not met, documentation must include details supporting reasons for non-compliance.
4. The comprehensive visit must be conducted with:
  - a. A parent or legal guardian of an un-emancipated minor (individual under 18 years of age, not married or not had disabilities of a minor legally removed) unless:
    - i. The case manager receives written consent from the parent/guardian to provide services directly with the minor client; or,

- ii. The un-emancipated minor client is pregnant and does not live with her parent/guardian.
  - b. A client who is 18 years of age or older and does not have a legal guardian appointed to them.
5. If a client has urgent needs, the comprehensive visit must be completed within two business days of approval of the prior authorization request. Case managers should use their professional judgment to determine if the needs are urgent.
  6. The FNA and SP must support client eligibility and address all client and family needs.
  7. The FNA must include:
    - a. Client name and Medicaid number on each page;
    - b. All of the needs identified on the request for prior authorization;
    - c. Assessment of medical, social, family, nutritional, educational, vocational, developmental and health care transportation needs of the client; and,
    - d. Dated signature of case manager with credentials.
  8. The SP must include:
    - a. Client name and Medicaid number on each page;
    - b. Documentation of all needs identified during the FNA;
    - c. Documentation of the action plan which outlines interventions and referrals to be completed;
    - d. Identification of the individual responsible for conducting the action step;
    - e. Designation of the time frame in which each action step will be completed;
    - f. Dated signature of the client/parent/guardian on the SP signature page; and,
    - g. Dated signature of the case manager with credentials on the SP signature page.
  9. The time frame for follow-up must be individualized to the client need, for example “a specific date,” “within two weeks,” or “when [meeting/appointment] is scheduled”. The plan for follow-up contact must not state “PRN” or “as needed.”
  10. A copy of the SP must be provided to the client/parent/guardian by the first follow-up visit.
  11. The SP must be translated or interpreted in the client’s preferred language. If the service plan is interpreted or translated, the interpreter/translator must sign the signature page. If the service plan is translated into the client/parent/guardian’s preferred language, an English version must also be included in the client’s file.
  12. The comprehensive visit must not be billed until both the FNA and SP are

completed. If the SP is completed on a different date than the FNA, the billing date is the date the SP was completed.

- 13.If the client is a family member of a migrant worker, the Migrant Information Form (CM-02A) must be completed. (*See policy 018, Services to Children of Migrant Workers.*)
- 14.Documentation that does not support the requirements of a billable contact (*see policy 006, Billing*) could result in recovery of funds, a referral to Office of Inspector General (OIG) Medicaid Program Integrity (MPI) Section and a referral to the provider's respective licensing/regulatory board.
- 15.Failure to comply with this policy may jeopardize continued participation as a provider.



## Case Management for Children and Pregnant Women

<b>POLICY TITLE:</b> Service Plan Interventions	<b>POLICY NO:</b> 011
<b>EFFECTIVE DATE:</b> September 1, 2011	<b>REVISED:</b> September 1, 2013

**PURPOSE:** To ensure a standardized process for service plan implementation.

**POLICY:** Case managers must address service plan needs with individualized and appropriate interventions.

### PROCEDURES:

1. Case managers must address all needs identified on the service plan by:
  - a. Coordinating services with third parties on behalf of the client/parent/guardian including, but not limited to, medical/behavioral health providers, government agencies, community resources, schools, Medicaid managed care plans, other service coordinators, medical equipment and supply providers and medical transportation agencies;
  - b. Conducting collateral contacts with third parties on behalf of the client/parent/guardian in order to find resources, obtain information or provide information related to service plan needs;
  - c. Participating in meetings as needed to ensure access to services;
  - d. Providing individualized and appropriate referrals and resource information to address the needs of the client and family; and,
  - e. Solving problems and advocating for client needs.
2. Case managers must provide immediate interventions and/or resource information if urgent needs are identified.
3. Case managers must document all service plan intervention activities on the Service Plan (CM-03), Follow-up Form (CM-04), or the Progress Notes (CM-05). Documentation of these activities must be included in the client record.
4. Documentation of referrals must reflect that client choice is offered and:
  - a. An explanation for limited referral choice when only one referral source is provided; and,

- b. A copy of the referral must be translated or interpreted in the client's preferred language. (*See policy 016, Non-Discrimination Requirements.*)
5. The case manager may use the optional Referral Form (CM-07) to document the referrals. The CM-07 is available on the Case Management for Children and Pregnant Women website at <http://www.dshs.state.tx.us/caseman/forms.shtm>.
6. Failure to comply with this policy may jeopardize continued participation as a provider.



## Case Management for Children and Pregnant Women

<b>POLICY TITLE:</b> Follow-up	<b>POLICY NO:</b> 012
<b>EFFECTIVE DATE:</b> September 1, 2011	<b>REVISED:</b> September 1, 2013

**PURPOSE:** To ensure standardized procedures for billable follow-up contacts.

**POLICY:** Case managers must conduct follow-up contacts as needed to address identified client needs and must be completed according to Case Management for Children and Pregnant Women rule and Medicaid policy.

### **PROCEDURE:**

1. All billable follow-up contacts must be prior authorized. (*See policy 009, Prior Authorization for Services.*) All follow-up contacts are authorized as face-to-face visits unless the provider requests telephone follow-up visits. The case manager must conduct and bill follow-up visits according to the type of visit authorized.
2. The case manager must provide services convenient to clients, either in their home, an office setting, or other place of client's preference.
3. During each billable follow-up contact, case managers must:
  - a. Review all outstanding needs documented on the Service Plan with the client/parent/guardian;
  - b. Problem solve with the client/parent/guardian when barriers have been encountered to address outstanding needs;
  - c. Problem solve when the client/parent/guardian has not followed through with identified Service Plan action steps;
  - d. Assess for new needs with the client/parent/guardian; and,
  - e. Determine next course of action to address outstanding needs.
4. Case managers must document all follow-up contacts on the Follow-up Forms (CM-04 and CM-04A).
5. Documentation of each follow-up contact must include:
  - a. Client name and Medicaid number on each page;
  - b. Evidence of continued client eligibility;

- c. Evidence that contact was made with the client/parent/guardian;
  - d. A review of all outstanding needs on the service plan;
  - e. Evidence of individualized and appropriate interventions;
  - f. Evidence of problem solving with the client/parent/guardian when barriers are encountered to address outstanding needs;
  - g. Dated signature of case manager with credentials; and,
6. Date of next follow-up contact which must be individualized and reasonable to meet the client's need, for example "a specific date," "within two weeks," or "when meeting/appointment is scheduled". (*See policy 005, Documentation Requirements.*)
  7. Follow-up contacts with pregnant women may occur through the 59th day post- partum if the client continues to meet eligibility criteria.
  8. Activities that occur between follow-up contacts are necessary components of case management but are not billable. These activities must be documented on a progress note. These activities may include, but are not limited to:
    - a. Phone calls to the client/parent/guardian between billable follow-up visits; and,
    - b. Collateral contacts on behalf of a client/parent/guardian;
  9. Follow-up contacts are only billable if the client continues to meet eligibility criteria. If all needs, related to the health condition, have been addressed during a follow-up visit, the case should be closed. If the remaining service plan needs do not have a direct impact on the client's health condition, the case manager cannot bill for any additional follow-up contacts. The case manager must provide appropriate resource information and close the case. (*See policy 014, Case Closure.*)
  10. If new service needs are identified during a follow-up contact, those needs must be documented on a new Service Plan Form (CM-03) with the addendum box checked. The Service Plan addendum is not a separate billable service but is part of the follow-up contact when a new service need is identified.
  11. Documentation that does not support billed contacts could result in recovery of funds, a referral to Office of Inspector General (OIG) Medicaid Program Integrity (MPI) Section and a referral to the provider's respective licensing/regulatory board.
  12. Failure to comply with this policy may jeopardize continued participation as a provider.



## Case Management for Children and Pregnant Women

<b>POLICY TITLE:</b> Case Transfer	<b>POLICY NO:</b> 013
<b>EFFECTIVE DATE:</b> September 1, 2011	<b>REVISED:</b> September 1, 2015

**PURPOSE:** To ensure a standardized process for the transfer of clients.

**POLICY:** Providers must transfer clients in a consistent manner and follow the procedures established by DSHS.

### **PROCEDURE:**

1. A transfer may occur, if the client continues to meet eligibility criteria, for the following reasons:
  - a. The client/parent/guardian requests a transfer;
  - b. The client/parent/guardian relocates;
  - c. The provider service area changes;
  - d. The provider changes to inactive or closed status and is unable to provide services; or,
  - e. There is a need to change to another case manager within an agency.
2. Cases must not be transferred solely on the basis of:
  - a. Lack of provider resources;
  - b. Costs associated with service provision;
  - c. Lack of community resource knowledge;
  - d. Complex issues of a client; or,
  - e. Need for interpreter/translation services.
3. When DSHS Central Office receives an Initial Prior Authorization Form (CM-01) that has an open authorization with another provider, DSHS Central Office staff will attempt to contact the client/parent/guardian:
  - a. If DSHS Central Office staff is able to contact the client/parent/guardian, Central Office staff:
    - i. Will inform the client/parent/guardian of the current open authorization with another provider.
    - ii. Will review the information on the request (s) with the client/parent/guardian.
    - iii. Will determine the client's choice of provider.

- 1) If the client/parent/guardian chooses the new provider, the initial authorization will be reviewed and approved or denied according to prior authorization policy. (*See policy 009, Prior Authorization for Case Management Services.*)
  - 2) If the client/parent/guardian chooses to remain with the current provider, the initial prior authorization request submitted by the new provider will be denied.
- b. If DSHS Central Office staff is unable to contact the client/parent/guardian:
- i. DSHS Central Office staff will inform the new provider of the open authorization with another provider.
  - ii. Within three business days, the new provider must:
    - 1) Contact the client/parent/guardian to discuss their choice of providers and
    - 2) Inform DSHS Central Office of the outcome of the contact.
  - iii. If the new provider is unable to reach the client/parent/guardian, the prior authorization request will be denied.
4. A client/parent/guardian may request to transfer if there is an open authorization with another provider. The new provider must:
- a. Document the client/parent/guardian's request to transfer on the Initial Request for Prior Authorization (CM-01).
  - b. Complete a Case Transfer Form (CM-09) and include:
    - i. Reason for transfer;
    - ii. Dated signature of the case manager with credentials; and,
    - iii. Dated signature of the client/parent/guardian. If the request was conducted by telephone, the provider must document that the client/parent/guardian has verbally requested a case transfer and then obtain the signature from the client/parent/guardian during the comprehensive visit.
  - c. File Case Transfer Form in client record.
5. If a case manager within a group is unable to continue providing services, the client/parent/guardian must be given a choice to transfer services to another case manager within the group or be referred to a case manager outside of the group. If the client/parent/guardian chooses to transfer to another case manager within an agency, the provider must submit a Request to Change to Another Case Manager Form (CM 06-A) to DSHS central office to change the authorization to a new case manager.

6. The provider must contact DSHS central office staff when assistance is needed with transferring clients. Providers who stop providing services to clients without appropriate transfer are operating outside of program policy.
7. Once the transfer process has been completed, any further contact with the client/parent/guardian initiated by the previous provider is prohibited.
8. Failure to comply with this policy may jeopardize continued participation as a provider.



## Case Management for Children and Pregnant Women

<b>POLICY TITLE:</b> Case Closure	<b>POLICY NO:</b> 014
<b>EFFECTIVE DATE:</b> September 1, 2011	<b>REVISED:</b> September 1, 2013

**PURPOSE:** To ensure cases are closed appropriately.

**POLICY:** Providers must follow standard procedures when closing a case.

### **PROCEDURE:**

1. All case closure decisions must be based on the individualized needs of the client(s) being served.
2. Providers will close cases when the following occur:
  - a. Client no longer eligible for case management due to all their eligible needs having been addressed or resolved;
  - b. Client no longer eligible for case management due to an improvement in their health condition/health risk;
  - c. Child reaches 21 years of age;
  - d. Pregnant woman reaches 59 days postpartum;
  - e. Client no longer eligible for Medicaid and does not anticipate obtaining Medicaid in the near future;
  - f. Client no longer desires services;
  - g. Client is denied additional visits because documentation does not support continued eligibility;
  - h. Client is lost to follow-up. The provider must document at least three attempts to contact the client/parent/guardian. The three attempts must occur on different dates;
  - i. Client relocates or transfers to a new provider; or,
  - j. Client dies.
3. Cases must not be closed solely on the basis of:
  - a. Lack of provider resources;
  - b. Costs associated with service provision;
  - c. Staffing issues;
  - d. Lack of community resource knowledge;
  - e. Complex issues of a client; or,

- f. Need for interpreter/translation services.
4. Providers have the right to close a case if the client/parent/guardian is disruptive, unruly, threatening, or uncooperative to the extent that the client/parent/guardian seriously impairs the provider's ability to render services or if the client/parent/guardian's behavior jeopardizes his/her own safety, or the provider's. The provider should also contact the appropriate authority when necessary.
  5. The Closure Form (CM-08) is available on the Case Management for Children and Pregnant Women website at <http://www.dshs.state.tx.us/caseman/forms.shtm>.
  6. The closure form must include reason for closure, dated signature of the client/parent/guardian and dated signature of the case manager with credentials. The client/parent/guardian signature is not required if:
    - a. Client/parent/guardian refuses to sign;
    - b. Client is lost to follow-up;
    - c. Client transfers to another provider and transfer is conducted by phone; (*See policy 013, Case Transfer;*) or,
    - d. Client dies.
  7. The client's record must include:
    - a. A copy of the Closure Form; and,
    - b. Documentation on Follow-up Forms or Progress Notes that supports that the client/parent/guardian has all needed information and referral resources.
  8. Failure to comply with this policy may jeopardize continued participation as a provider.



## Case Management for Children and Pregnant Women

<b>POLICY TITLE:</b> Privacy and Confidentiality	<b>POLICY NO:</b> 015
<b>EFFECTIVE DATE:</b> September 1, 2011	<b>REVISED:</b> September 1, 2015

**PURPOSE:** To ensure client privacy and confidentiality.

**POLICY:** Providers must follow required procedures to ensure client privacy and confidentiality.

### **PROCEDURE:**

1. Case management services must be conducted with:
  - a. A parent or legal guardian of an un-emancipated minor (individual under 18 years of age, not married or not had disabilities of a minor legally removed) unless:
    - i. The case manager receives written consent from the parent/guardian to provide services directly with the minor client; or
    - ii. The un-emancipated minor client is pregnant and does not live with her parent/guardian.
  - b. An individual 18 years of age or older unless the client has had a legal guardian appointed for them.
2. The Service Plan Signature page (CM-03Sig) serves as an informed consent for case management services. The client/parent/guardian must sign the CM-03Sig as an agreement to receive case management services and as permission to release information to any third party entity documented on the Service Plan. A copy must be maintained in the client's record.
3. Providers must comply with the U.S. Health Insurance Portability and Accountability Act of 1996 (HIPAA) established standards for protection of client information.
  - a. Providers must create a HIPAA Privacy Notice and a form indicating receipt of the Privacy Notice to provide to all clients. The client/parent/guardian must sign the receipt indicating that they received the HIPAA Privacy Notice. The HIPAA receipt must be maintained in the

- client's case management record or in the clinic/agency's master file.
- b. The case manager must obtain a signed consent form for the release of information to or request of information from a third party entity not listed on the Service Plan. Providers may use the Authorization to Disclose Personal Health Information Form (CM-12) available on the Case Management for Children and Pregnant Women website at <http://www.dshs.state.tx.us/caseman/forms.shtm>. The case manager will ensure that the client/parent/guardian understands the information and/or content of any documents to be released to a third party. A copy must be maintained in the client's record.
  - c. Case managers will only release authorized information as requested except within the limits of Case Management for Children and Pregnant Women rule and state/federal law. Documentation of the information released will be maintained in the client's record.
  - d. The client/parent/guardian has the right to choose not to release information to a third party except within the limits of state/federal law.
  - e. Providers must create Business Associate Agreements when any person or entity who performs certain functions or activities that involve the use or disclosure of protected health information.
  - f. Encryption must be used when sending emails containing any identifying client information to comply with HIPAA regulations.
  - g. The cover sheet of facsimiles must include a statement of confidentiality.
  - h. Providers must ensure that client records are stored and disposed in accordance to Medicaid rule.
4. Failure to comply with this policy may jeopardize continued participation as a provider.



## Case Management for Children and Pregnant Women

<b>POLICY TITLE:</b> Non-Discrimination Requirements	<b>POLICY NO:</b> 016
<b>EFFECTIVE DATE:</b> September 1, 2011	<b>REVISED:</b> September 1, 2014

**PURPOSE:** To ensure all case management services are delivered in compliance with the Texas Health and Human Services Commission (HHSC) non-discrimination policies and the federal civil rights statutes and regulations as mandated by Title VI of the Civil Rights Act of 1964 and Section 504 of the Rehabilitation Act of 1973.

**POLICY:** Providers must comply with federal and state non-discrimination policies and procedures and deliver case management services in a culturally sensitive manner.

### **PROCEDURE:**

1. Case management services cannot be denied based on race, color, sex, religion, national origin, language preference, sexual orientation, or type or extent of the high risk or disabling condition.
2. The provider must comply with HHSC non-discrimination policies and procedures, Medicaid rule and federal Civil Rights statutes and regulations. The provider must ensure compliance with addressing the needs of clients with limited English proficiency (LEP) as required by Title VI of the Civil Rights Act of 1964 and the non-discrimination and accessibility provisions of the Americans with Disabilities Act and Section 504 of the Rehabilitation Act of 1973.
3. All verbal and written communication with clients/families must be delivered in a format sensitive to language, culture and educational differences.
  - a. Interpreter and translation services must be provided, when needed, to ensure case management is delivered in a culturally sensitive, educationally sensitive and timely manner. Interpreters must be provided for a client/parent/guardian with Limited English Proficiency (LEP) and for a client/parent/guardian who is deaf or hard of hearing and the cost cannot be

transferred to the client. Providers are expected to make all reasonable accommodations.

- b. Any documentation provided to a client/parent/guardian must be interpreted or translated for the family. If documentation is interpreted, the interpreter must sign the documentation. If documentation is translated into the client/parent/guardian's preferred language, an English version must also be maintained in the client's file. It is not required that a case manager who is bilingual in the client's language sign as the interpreter.
  - c. The provider's telephone recordings must contain the agency name, hours of operation and must be in both English and Spanish. Providers must answer the phone with the name of their agency.
4. If clients are seen in any setting other than their home, the location must be accessible and meet ADA specifications, if warranted.
  5. Failure to comply with this policy may jeopardize continued participation as a provider.



**Case Management for Children and Pregnant Women**

<b>POLICY TITLE:</b> <b>Reporting of Abuse, Neglect and Exploitation</b>	<b>POLICY NO:</b> <b>017</b>
<b>EFFECTIVE DATE:</b> <b>September 1, 2011</b>	<b>REVISED:</b> <b>September 1, 2014</b>

**PURPOSE:** To ensure appropriate reporting of abuse, neglect and exploitation of a child or adult with a disability.

**POLICY:** Providers must comply with abuse, neglect and exploitation reporting requirements.

**PROCEDURE:**

1. In the event, abuse or neglect of a child is suspected; providers must follow child abuse and neglect reporting requirements of Chapter 261 of the Texas Family Code. The client record must include documentation that a report was made.
2. In the event abuse, neglect or exploitation of an adult with a disability is suspected, providers must follow the requirements of the Human Resource Code Sec 48.051 when abuse, neglect or exploitation of an adult with a disability is suspected.
3. Client records will be monitored to ensure compliance with the abuse and neglect reporting requirements specified in the Texas Medicaid Provider Procedures Manual (TMPPM).
4. Failure to comply with this policy may jeopardize continued participation as a provider.



## Case Management for Children and Pregnant Women

<b>POLICY TITLE:</b> Services to Children of Migrant Workers	<b>POLICY NO:</b> 018
<b>EFFECTIVE DATE:</b> September 1, 2011	<b>REVISED:</b> September 1, 2013

**PURPOSE:** To ensure that case management services are accessible for children of migrant workers.

**POLICY:** Case managers will assist children of migrant workers with coordinating and accessing appropriate care.

### **PROCEDURE:**

1. Providers located in regions of the state with a migrant or seasonal worker population should be aware of organizations that address the specific and unique needs of this population.
2. If a child of a migrant worker meets eligibility criteria for case management services, the provider must ensure that the family is appropriately linked to resources in the geographic areas in which they live and to which they migrate. The case manager must complete the Migrant Information Form (CM-02A) during the Comprehensive Visit. The CM-02A is available on the Case Management for Children and Pregnant Women website at <http://www.dshs.state.tx.us/caseman/forms.shtm>.
3. The Migrant Information Form must include:
  - a. A list of the family members who migrate;
  - b. The migration schedule;
  - c. The medical and educational service providers in each location to which the family migrates; and,
  - d. The organizations that provide assistance to the family with migration issues.
4. The case manager must contact the client's PCP, dentist or Medicaid health care plan for the purpose of coordinating expedited medical services and/or client advocacy as needed.

5. The case manager must assist a client/parent/guardian with a transfer if the client is temporarily or permanently moving to another area of Texas, meets eligibility, and requests a transfer to a new provider in that area. (*See policy 013, Case Transfer.*)
6. Failure to comply with this policy may jeopardize continued participation as a provider.



## Case Management for Children and Pregnant Women

<b>POLICY TITLE:</b> Assistance Locating Clients Birth Through Age 20	<b>POLICY NO:</b> 019
<b>EFFECTIVE DATE:</b> September 1, 2011	<b>REVISED:</b> September 1, 2013

**PURPOSE:** To assist providers in locating clients.

**POLICY:** Providers may follow the established procedure to locate clients birth through 20.

### **PROCEDURE:**

1. After three unsuccessful attempts to locate a client, a provider has the option to contact THSteps Outreach and Informing (O&I) for assistance in locating a client.
2. Providers may complete and fax the THSteps Provider Outreach Referral form to THSteps Outreach and Informing. The form can be accessed on the Case Management for Children and Pregnant Women website:  
<http://www.dshs.state.tx.us/caseman/forms.shtm>.
3. Attempts to locate clients through THSteps Outreach and Informing must be documented in the client record.



**Case Management for Children and Pregnant Women**

<b>POLICY TITLE:</b> <b>Complaints and Appeals</b>	<b>POLICY NO:</b> <b>020</b>
<b>EFFECTIVE DATE:</b> <b>September 1, 2011</b>	<b>REVISED:</b> <b>September 1, 2013</b>

**PURPOSE:** To ensure that complaints and appeals are handled in a consistent manner.

**POLICY:** Providers must follow the complaint and appeal process.

**PROCEDURE:**

1. Case managers must inform client/parent/guardian of their right to file a complaint regarding case management services :
  - a. The client/parent/guardian’s signature on the Service Plan Signature page (CM-03 sig) ensures that the case manager has informed the client/parent/guardian of this right.
  - b. The client must be informed of the statewide toll free number 1-877-THSTEPS (1-877-847-8377) if they have a complaint.
2. Providers may file a complaint about Case Management for Children and Pregnant Women by:
  - a. Contacting the Branch Manager at 1-888-963-7111 extension 6664.
  - b. Contacting the HHSC Office of the Ombudsman at 1-877-787- 8999 if the provider’s issue is not resolved.
3. All complaints will be reviewed by DSHS in accordance with DSHS policy. DSHS central office staff and DSHS regional staff will respond to any complaint according to policy.
4. When appropriate, complaints will be referred to the Texas State Board of Social Work Examiners, the Texas Board of Nurse Examiners and/or Office of Inspector General (OIG) Medicaid Program Integrity (MPI) Section.
5. Failure to comply with this policy may jeopardize continued participation as a provider.



## Case Management for Children and Pregnant Women

<b>POLICY TITLE:</b> Quality Management System	<b>POLICY NO:</b> 021
<b>EFFECTIVE DATE:</b> September 1, 2011	<b>REVISED:</b> September 1, 2013

**PURPOSE:** To monitor the provision of services for quality case management.

**POLICY:** Providers must develop and implement a policy for internal quality assurance to include documentation of all clients referred, internal record review, internal program review, and process for complying with Medicaid Provider Responsibilities.

### **PROCEDURE:**

1. A quality management system must include the following:
  - a. A log of all clients referred for case management.
  - b. Internal client record review procedures which must include the individual conducting the review, frequency of the review and number/percentage of records to be reviewed. The individual reviewing the records must be an approved case manager. Case managers may perform a self-review.
  - c. Internal program review which will include the items on the Provider Systems Review Form (CM-15) and frequency of the review.
  - d. The process for complying with Medicaid Provider Responsibilities as outlined in the Texas Medicaid Provider Procedures Manual (TMPPM.)
2. Evidence of implementation must be documented, maintained and provided to DSHS upon request:
  - a. Documentation of all clients referred must include client name, date of birth, client's Medicaid number, date of referral, and outcome of referral. Providers may use the Client Referral Log (CM-18).

- b. Completed internal record reviews must be documented on the Record Review Tool for Providers Form (CM-16.) A copy of the CM-16 from internal record review must be maintained in the client's chart.
  - c. The completed internal program review must be documented on the CM-15
- 3. Failure to comply with this policy may jeopardize continued participation as a provider.



## Case Management for Children and Pregnant Women

<b>POLICY TITLE:</b> Technical Assistance	<b>POLICY NO:</b> 022
<b>EFFECTIVE DATE:</b> September 1, 2011	

**PURPOSE:** To ensure that providers receive consistent and appropriate technical assistance (TA).

**POLICY:** Providers must participate in Technical Assistance (TA) activities with DSHS staff.

### **PROCEDURE:**

1. All active and inactive providers will receive a technical assistance contact by DSHS staff:
  - a. Within 3 months of approval as a provider; and,
  - b. Quarterly for the first year of enrollment.
2. DSHS staff will initiate a technical assistance contact in the following circumstances:
  - a. A review of prior authorization (PA) requests identifies the need for additional education regarding Case Management for Children and Pregnant Women rule or policy or the provision of case management services;
  - b. Policy non-compliance during a review of prior authorization requests, during an annual QA review or during a Utilization Review;
  - c. A complaint is received;
  - d. Inappropriate billing practices are identified; or,
  - e. When deemed appropriate by DSHS staff.
3. Providers may request technical assistance from DSHS staff at any time.
4. Failure to comply with this policy may jeopardize continued participation as a provider



## Case Management for Children and Pregnant Women

<b>POLICY TITLE:</b> Quality Assurance Monitoring and Utilization Review	<b>POLICY NO:</b> 023
<b>EFFECTIVE DATE:</b> September 1, 2011	<b>REVISED:</b> September 1, 2015

**PURPOSE:** To ensure that providers receive consistent and appropriate quality assurance and utilization reviews.

**POLICY:** DSHS staff will conduct annual quality assurance and semi-annual utilization reviews of all active and inactive providers to monitor quality of case management services and compliance with Case Management for Children and Pregnant Women rule and policy.

### **PROCEDURE:**

1. Providers must participate in Quality Assurance (QA) and Utilization Review (UR) activities conducted by DSHS staff.
2. All providers will receive a quality assurance (QA) review once a year to ensure compliance with policies. The review will include:
  - a. A review of 5 % of client records, or a minimum of 5 records, whichever is greater. A maximum of 15 charts will be reviewed and if the provider has less than 5 records, all records will be reviewed. Records will be randomly selected. DSHS regional staff will request client records at least 5 business days prior to the record review;
  - b. A review of program compliance, to include status of licensure, Quality Management Systems policy, and independently developed outreach material; and,
  - c. A meeting with DSHS regional staff and the provider to summarize the findings of the QA review.
3. A provider serving more than one health services region will receive the

- quality assurance review from the DSHS regional staff in the region in which the provider's administrative office is located.
4. DSHS central office staff will conduct a semi-annual utilization review (UR) for the active and inactive providers to identify trends in claims data that indicate potential concerns with the quality of case management services.
  5. DSHS central office staff will conduct client satisfaction interviews.
  6. Providers will receive a written summary of the QA review and/or UR, including any required actions to be taken which may include but are not limited to:
    - a. No further action;
    - b. Technical Assistance;
    - c. Corrective Action Plan;
    - d. Referral to the Texas State Board of Social Work Examiners or the Texas Board of Nurse Examiners;
    - e. Referral to the Office of Inspector General Medicaid Program Integrity Section for suspected Medicaid waste, abuse and/or fraud;
    - f. Suspension; or,
    - g. Termination.
  7. Providers must comply with DSHS' request for records at any time. Failure to comply with record submission and/or action steps outlined in the QA/UR correspondence will result in being placed on inactive status.
  8. Failure to comply with this policy may jeopardize continued participation as a provider.