



Case Management for Children and Pregnant Women

POLICY TITLE: Referral & Intake	POLICY NO: 008
EFFECTIVE DATE: September 1, 2011	REVISED: September 1, 2107

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 on a Referral and Intake Form (CM-01A) and a referral log. (See policy 021, Quality Management Systems.)
2. 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.
3. A provider must accept all referrals unless the following service limitations have been documented:
 - a. Provider status is inactive;
 - b. Provider’s service area does not include the client’s given location; and/or
 - c. Provider application has a limitation that excludes the client, i.e., provider does not serve pregnant women, has age limitations.
4. If a provider is unable to accept a referral for any of the aforementioned reasons, the provider must direct the referral source to the Texas Health Steps hotline within two business days of the receipt of the referral.
5. All intakes must be completed:
 - a. By an approved case manager who has completed HHSC Children and Pregnant Women training,
 - b. By telephone or face-to-face, and
 - c. Within seven business days of the initial referral.
6. The intake must be conducted with:
 - a. A parent or legal guardian of a minor 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, or
 - iii. The minor client has been legally emancipated.
 - b. An individual 18 years of age or older unless the client has a legal court-appointed guardian.
- 7. The Referral and Intake Form (CM-01A) must be 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 the potential case management client, as defined by Case Management for Children and Pregnant Women rule; and
 - b. How the health condition, health risk or high-risk condition impacts the client; and
 - c. Detailed information about the need for assistance with accessing resources related to the health condition/risk or high risk condition; and
 - d. How the case manager will assist with the need.
- 9. If the client's presenting problem or situation is urgent, the intake must be completed within one business day of receipt. Case managers will use professional judgment to determine if the presenting problem or situation is urgent.
- 10. A CM-01A must be completed for each client within a family referred for case management.
- 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 HHSC CM 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.



TEXAS
Health and Human
Services

*Medical and
Social Services*

Case Management for Children and Pregnant Women

POLICY TITLE: Prior Authorizations for Case Management Services	POLICY NO: 009
EFFECTIVE DATE: September 1, 2011	REVISED: September 1, 2017

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 telephone or face-to-face with the client/parent/guardian and submit the Request for Initial Prior Authorization Form (CM-01) to HHSC within three business days of intake for review. All fields of the CM-01 must be completed according to the instructions.
2. If the request is submitted more than three business days after the completion of the intake, the prior authorization will not be processed. The case manager must conduct another intake with the client/parent/guardian to confirm the original needs and/or additional ones. The case manager must submit a new Request for Prior Authorization indicating the date of the new intake on the request.
3. Completed requests for prior authorization should be submitted via the Case Management for Children and Pregnant Women website.
4. 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.)
5. HHSC will review requests within three business days of receipt and determine if requests meet case management eligibility. All requests

submitted after 5:00 pm are considered as received the next business day.

6. 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.
7. 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 HHSC CM.
8. If additional information or clarification regarding a prior authorization request is necessary to make a determination about eligibility, HHSC CM may:
 - a. Email provider/case manager for additional information.
 - i. Providers are required to respond within two business days.
 - ii. Failure to respond may result in the denial of the prior authorization request.
 - iii. Providers who do not respond may be placed on inactive status as per Policy 007.
 - b. Contact the client/parent/guardian.
9. HHSC 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.;
 - 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;
 - iv. Case Management must be provided by the case manager authorized to provide services.
 - 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.

10. Within three business days of determination, HHSC CM 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.
11. 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.
12. 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.
13. The signature date on the CM-06 must be at least one day after the date of the last follow-up visit.
14. HHSC 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;
 - 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;
 - iv. Case Management must be provided by the case manager authorized to provide services.
 - 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. HHSC CM 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.
15. If a provider submits a request for prior authorization (CM-01) and the client has current authorization with another provider, HHSC CM will

follow policy 014, Client Transfer.

16. 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. The case manager must submit a Request for Additional Visits (CM-06) documenting the significant changes and the need for a comprehensive visit.
17. Failure to comply with this policy may jeopardize continued participation as a provider.



TEXAS
Health and Human
Services

*Medical and
Social Services*

Case Management for Children and Pregnant Women

POLICY TITLE:
STAR Kids Service Provision

POLICY NO:
010

EFFECTIVE DATE:
September 1, 2017

PURPOSE: To ensure that services for clients enrolled in STAR Kids Medicaid managed care are handled in a consistent manner.

POLICY: Providers must follow the STAR Kids service provision process.

PROCEDURE:

1. Case managers who receive a referral for a client enrolled in STAR Kids must conduct an intake with the client/parent/guardian and document it on the CM-01A.
 - a. If the intake indicates that the client has the need for assisting, advocating for, and coordinating education/school services, the case manager may submit a prior authorization request.
 - b. The prior authorization request must meet eligibility requirements in order to be approved.
2. The case manager must contact the STAR Kids service coordinator prior to submitting the PA request to inform them that they will be assisting with school related needs.
3. The case manager must document on the PA request that they informed the service coordinator and include the date of contact, name and telephone number of the service coordinator.
4. If the case manager is unable to reach the client's service coordinator, they must provide details including dates, phone numbers, and contact names of two attempts and if they were able to leave a message.
5. If the PA request does not indicate that the case manager contacted or attempted to contact the service coordinator, the case manager will receive an email from HHSC CM asking them to provide that information within seven calendar days from the date of the email. The PA request will remain unprocessed until completed. If the

actions are not completed within seven calendar days, a second intake will need to be completed with client/parent/guardian.

6. If the intake indicates that the client has medical needs and does not have the aforementioned needs (listed in 1.), the case manager must refer the client to their STAR Kids service coordinator for assistance.
7. Case managers who submit a prior authorization request for medical needs will receive a fax from HHSC CM with a notice of “unable to process” and directions to refer the client to their STAR Kids health plan service coordinator for assistance. The prior authorization will not be approved.
8. If authorized for services, the case manager must complete the following documentation:
 - a. All sections of the FNA. For any medical needs listed on the FNA, the client should be referred to their STAR Kids service coordinator.
 - b. The Service Plan with documentation of only school related needs and related tasks.
 - c. The Follow Up Visit form with documentation of school related needs and the status of each need.
9. Non-school related needs may be considered on a case by case basis for authorization.
10. Providers should inform the client/parent/guardian that they may contact the Ombudsman Office for health and human services-related complaints or issues at 1-877-787-8999.
11. Providers and case managers who are dissatisfied with a STAR Kids health plan may file a complaint by submitting an email to HHSC at HPM_Complaints@hhsc.state.tx.us.
12. Failure to comply with this policy may jeopardize continued participation as a provider



TEXAS
Health and Human
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*Medical and
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Case Management for Children and Pregnant Women

POLICY TITLE: Comprehensive Visit	POLICY NO: 011
EFFECTIVE DATE: September 1, 2011	REVISED: September 1, 2017

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 Consent form.
2. The Family Needs Assessment Form (CM-02) and Service Plan Forms (CM-03 and CM-03Con) are available on the Case Management for Children and Pregnant Women website at <http://www.dshs.texas.gov/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 a minor client 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, or
 - iii. The minor client has been legally emancipated.

- b. An individual 18 years of age or older unless the client has a legal court-appointed guardian.
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 Consent form; and
 - g. Dated signature of the case manager with credentials on the SP Consent form.
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 Consent form. 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 019, 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.



TEXAS
Health and Human
Services

*Medical and
Social Services*

Case Management for Children and Pregnant Women

POLICY TITLE: Service Plan Interventions	POLICY NO: 012
EFFECTIVE DATE: September 1, 2011	REVISED: September 1, 2017

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 017, 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.texas.gov/caseman/forms.shtm>
 6. Failure to comply with this policy may jeopardize continued participation as a provider.



Case Management for Children and Pregnant Women

POLICY TITLE: Follow-up	POLICY NO: 013
EFFECTIVE DATE: September 1, 2011	REVISED: September 1, 2017

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 any 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. Evidence that contact was made with client/parent/guardian;
 - b. A review of all outstanding needs on the service plan;
 - c. Evidence of individualized and appropriate interventions;

- d. Evidence of problem solving with the client/parent/guardian when barriers are encountered to address outstanding needs;
 - e. Dated signature of case manager with credentials;
 - f. 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.);
 - g. Client name and Medicaid number on each page; and
 - h. Evidence of continued client eligibility.
6. Follow-up contacts with pregnant women may occur through the 59th day post-partum if the client continues to meet eligibility criteria.
7. 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.
8. 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 015, Case Closure.*)
9. 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.
10. If any changes to the service plan have been made, the Service Plan Consent form (CM-03Con) must be signed and dated by the client/parent/guardian.
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.



TEXAS
Health and Human
Services

Medical and
Social Services

Case Management for Children and Pregnant Women

POLICY TITLE: Case Transfer	POLICY NO: 014
EFFECTIVE DATE: September 1, 2011	REVISED: September 1, 2017

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 HHSC CM.

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 HHSC receives an Initial Prior Authorization Form (CM-01) that has an open authorization with another provider, HHSC CM will attempt to contact the client/parent/guardian:
 - a. If HHSC is able to contact the client/parent/guardian, HHSC:
 - 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 HHSC is unable to contact the client/parent/guardian:
 - i. HHSC 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 HHSC 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 (this may be completed at 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 HHSC to change the authorization to a new case manager.
6. The provider must contact HHSC 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

POLICY TITLE: Case Closure	POLICY NO: 015
EFFECTIVE DATE: September 1, 2011	REVISED: September 1, 2017

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 when provider has made three attempts on different dates to contact client/parent/guardian;
 - 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.texas.gov/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 014, 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.



TEXAS
Health and Human
Services

*Medical and
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Case Management for Children and Pregnant Women

POLICY TITLE: Privacy and Confidentiality	POLICY NO: 016
EFFECTIVE DATE: September 1, 2011	REVISED: September 1, 2017

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 a minor client 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, or
 - iii. The minor client has been legally emancipated.
 - b. An individual 18 years of age or older has a legal court-appointed guardian.
2. The Service Plan Consent form (CM-03Con) serves as an informed consent for case management services. The client/parent/guardian must sign the CM-03Con 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 by informing their client/parent/guardian of the HIPAA Privacy Notice and protecting client information as defined in the HHSC Medicaid Provider Agreement.
4. 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.texas.gov/caseman/forms.shtm>

5. 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 of the CM-03Con and CM-12 must be maintained in the client's record.
 - a. Case managers must 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 must be maintained in the client's record on the CM-12.
 - b. 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.
6. Providers must create Business Associate Agreements with any person or entity who performs certain functions or activities that involve the use or disclosure of protected health information as defined in HHSC Medicaid Provider Agreement.
7. Encryption must be used when sending emails containing any identifying client information to comply with HIPAA regulations.
8. The cover sheet of facsimiles must include a statement of confidentiality.
9. Providers must ensure that client records are stored and disposed in accordance to Medicaid rule.
10. Failure to comply with this policy may jeopardize continued participation as a provider.



Case Management for Children and Pregnant Women

POLICY TITLE: Non-Discrimination Requirements	POLICY NO: 017
EFFECTIVE DATE: September 1, 2011	REVISED: September 1, 2017

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. 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 proficient in the client's language sign as the interpreter.
 - c. The provider's telephone recordings must contain the agency name and 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.



TEXAS
Health and Human
Services

*Medical and
Social Services*

Case Management for Children and Pregnant Women

POLICY TITLE: Reporting of Abuse, Neglect and Exploitation	POLICY NO: 018
EFFECTIVE DATE: September 1, 2011	REVISED: September 1, 2017

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

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

PROCEDURE:

1. Suspected abuse, neglect or exploitation of a child, the elderly or an adult with a disability must be reported to the Department of Family and Protective Services, 1-800-252-5400.
2. The client record must include documentation that a report was made.
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

POLICY TITLE: Services to Children of Migrant Workers	POLICY NO: 019
EFFECTIVE DATE: September 1, 2011	REVISED: September 1, 2017

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.texas.gov/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 014, Case Transfer)
6. Failure to comply with this policy may jeopardize continued participation as a provider.



TEXAS
Health and Human
Services

*Medical and
Social Services*

Case Management for Children and Pregnant Women

POLICY TITLE: Complaints and Appeals	POLICY NO: 020
EFFECTIVE DATE: September 1, 2011	REVISED: September 1, 2017

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 Consent Form (CM-03Con) 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 HHSC. HHSC and 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.



TEXAS
Health and Human
Services

*Medical and
Social Services*

Case Management for Children and Pregnant Women

POLICY TITLE: Quality Management System	POLICY NO: 021
EFFECTIVE DATE: September 1, 2011	REVISED: September 1, 2017

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:
 - i. the name of the approved case manager conducting the review,
 - ii. frequency of the review, and
 - iii. number/percentage of records to be reviewed.
 - c. Case managers may perform a self-review.
 - d. Internal program review which will include the items on the Provider Systems Review Form (CM-15) and frequency of the review.
 - e. 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 HHSC or regional staff 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.



TEXAS
Health and Human
Services

*Medical and
Social Services*

Case Management for Children and Pregnant Women

POLICY TITLE: Technical Assistance	POLICY NO: 022
EFFECTIVE DATE: September 1, 2011	REVISED: September 1, 2017

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

POLICY: Providers must participate in Technical Assistance activities with HHSC and regional staff.

PROCEDURE:

1. All active and inactive providers will receive a technical assistance contact by regional or HHSC Case Management (CM) staff:
 - a. Within 3 months of approval as a provider; and
 - b. Quarterly for the first year of enrollment.
2. HHSC or regional 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 is found during a review of prior authorization requests, an annual Quality Assurance review, or a Utilization Review;
 - c. A complaint is received;
 - d. Inappropriate billing practices are identified; or
 - e. When it is deemed appropriate by HHSC CM or DSHS regional staff.
3. Providers may request technical assistance from HHSC CM or regional staff at any time.
4. Failure to comply with this policy may jeopardize continued participation as a provider.



TEXAS
Health and Human
Services

*Medical and
Social Services*

Case Management for Children and Pregnant Women

POLICY TITLE: Quality Assurance Monitoring and Utilization Review	POLICY NO: 023
EFFECTIVE DATE: September 1, 2011	REVISED: September 1, 2017

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

POLICY: HHSC Case Management (CM) or DSHS regional 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 HHSC or DSHS regional staff.
2. All providers will receive a 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 records; or all records if the provider has less than 5 records;
 - b. A review of program compliance to include status of licensure, Quality Management Systems policy, and independently developed outreach material; and
 - c. A meeting to summarize the findings of the QA review with the provider, regional staff and/or HHSC CM.
3. HHSC CM will randomly select client records.
4. Regional staff will request records at least 5 business days prior to the record review.
5. A provider serving more than one health services region will receive the quality assurance review in the region in which the provider's administrative office is located.
6. HHSC CM 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.

7. HHSC CM will conduct client satisfaction interviews.
8. 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. Improvement Action Plan (IAP) to include a change to inactive status and required training;
 - 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. Probation;
 - g. Suspension; or
 - h. Closure or termination.
9. Failure to comply with record submission, action steps and/or timelines outlined in the QA/UR correspondence will result in being placed on inactive status. Providers placed on inactive status due to their IAP must meet the requirements of their IAP before they can return to active status.
10. Providers who choose to move to a closed status prior to completing their QA requirements must complete the QA process prior to submitting a new provider application.
11. Providers must comply with HHSC CM or regional staffs' request for records at any time.
12. Failure to comply with this policy may jeopardize continued participation as a provider.