



TEXAS
Health and Human
Services

*Medical and
Social Services*

Case Management for Children and Pregnant Women Policies

A Program of Medicaid-CHIP Services

Revised April 2019 v2

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Case Management for Children and Pregnant Women

POLICY NO: 001
POLICY TITLE: Provider Application Process
EFFECTIVE DATE: September 1, 2011
REVISED DATE: April 1, 2019

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 who 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 Department of State Health Services (DSHS) regional liaison. Applications may only be obtained from the DSHS regional liaison after completing the online Potential Provider Tutorial and pre-planning session.
3. Completed applications must be submitted to the DSHS regional liaison within 90 calendar days of the pre-planning session or the application will be denied. If denied, the applicant must meet with DSHS regional liaison for another pre-planning session and resubmit the application.
4. Completed applications and any requested revisions must be typed and include the following:
 - a. Resume of group owner/case management director
 - b. Resume of case manager(s)
 - c. Licensure of case manager(s)
 - d. Licensure of group owner/case management director, if applicable
 - e. Organizational chart (for groups)
 - f. Copies of Memorandums of Understanding, if applicable
 - g. Conflict of Interest Statements
 - h. Copy of group's name certificate and/or articles of incorporation, if applicable
 - i. Agency licensure, if applicable
5. Applicants requesting to provide services in more than one region must meet with the DSHS regional liaison where the applicant's administrative office is located.

6. Providers or case managers must not present any conflicts of interest. A signed conflict of interest statement must be submitted for each case manager, director and/or owner.
7. The DSHS regional liaison will review the application.
8. The applicant will be contacted by HHSC CM or DSHS regional liaison if it is determined further revisions are needed. The revisions must be submitted within 15 business days from the date of notification by HHSC CM or DSHS regional liaison or the application will be denied.
9. HHSC CM or DSHS regional liaison may contact the applicant or potential case manager to verify and confirm information submitted on the application, or any supporting documentation submitted with the application.
10. Following the review by DSHS regional liaison, the application will be reviewed by HHSC CM.
11. HHSC CM will send an approval letter to the applicant once the application meets all the requirements as stated in Case Management for Children and Pregnant Women rule.
12. HHSC CM will send a denial letter to the applicant if the application does not meet all the requirements as stated in Case Management for Children and Pregnant Women rule.

Case Management for Children and Pregnant Women

POLICY NO: 002
POLICY TITLE: Case Manager Requirements
EFFECTIVE DATE: September 1, 2011
REVISED DATE: April 1, 2019

PURPOSE: To ensure case manager providers meet standard qualification criteria.

POLICY: Case manager providers must meet the minimum education, experience and licensure criteria.

PROCEDURE:

1. All case managers must be approved by HHSC CM 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 Independent Practice Recognition (IPR), and whose license is not temporary or provisional in nature.
3. The following proof of case manager eligibility must be submitted to DSHS regional liaison for review and approval:
 - a. Social Workers licensure and current resume
 - b. Registered Nurses licensure and current resume
4. HHSC CM will send a Minimum Education and Experience Requirements (MEER) certificate to the provider when all of the minimum requirements are met or send a denial letter if not met.
5. HHSC CM or DSHS regional liaison may verify case management experience with a previous or current employer, contractor and/or

internship/practicum supervisor.

6. Case Managers with dual employment must update any change in employment by submitting a CM-10 to HHSC CM with new place of employment; in addition, submit an updated COI.
7. Case managers must not present any conflicts of interest. A signed conflict of interest statement must be submitted for each case manager.
8. Social workers and nurses must adhere to the laws, rules, regulations and standards of care relating to their respective license requirements.
9. Failure to comply with this policy may jeopardize continued participation as a provider or case manager.

Case Management for Children and Pregnant Women

POLICY NO: 003
POLICY TITLE: Enrollment, Training and Activation
EFFECTIVE DATE: September 1, 2011
REVISED DATE: April 1, 2019

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

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

PROCEDURE:

1. Providers must submit the Texas Medicaid Provider Enrollment Application to the Medicaid Claims Administrator, which is currently Texas Medicaid and Healthcare Partnership (TMHP).
 - a. The provider must enroll with Medicaid as a group if HHSC CM approved the provider as a group.
 - b. The provider must enroll with Medicaid as an individual if HHSC CM approved the provider as an individual.
 - c. FQHCs do not need to submit a Texas Medicaid Provider Enrollment Application. FQHCs will use their current Texas Provider Identifier (TPI) number to file claims.
2. Providers must comply with all of the requirements of the Texas Medicaid Provider Procedures Manual (TMPPM), as well as all state and federal laws governing or regulating Medicaid. Providers are responsible for ensuring all case managers comply.
3. Providers must ensure completion of the required training for all approved case managers. (Note: Providers and case managers must have applied and obtained TPI prior to attending training).
 - a. Attendance is recommended but not required for owners and/or administrative staff within a group.
 - b. Following completion of post-training requirements, case managers must download their training certificate and submit certificate to HHSC CM.
4. Providers and case managers must apply to obtain a TPI number from TMHP.
 - a. Each group will be assigned a TPI number and each case manager within the group will be assigned a TPI also known as a Performing Provider Number (PPN).

b. Each individual provider will be assigned one TPI.

5. Providers can change their status to active and begin accepting referrals by completing and submitting the Notification of Significant Provider Changes Form (CM-10).
6. Providers will be placed on the Case Management for Children and Pregnant Women website when the CM-10 has been received by HHSC CM.
7. Case managers who have not submitted any prior authorization requests in twelve months or more will be required to attend the two-day training before being authorized to provide services.
8. Case managers must attend, at minimum, two provider webinars hosted by HHSC CM annually. Attendance will be verified during the annual Quality Assurance (QA) reviews.
9. Failure to comply with this policy may jeopardize continued participation as a provider.

Case Management for Children and Pregnant Women

POLICY NO: 004
POLICY TITLE: Outreach
EFFECTIVE DATE: September 1, 2011
REVISED DATE: April 1, 2019

PURPOSE: To ensure 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 who serve children and pregnant women;
 - c. Participating in community coalition meetings;
 - d. Distributing brochures to medical/mental health professionals, dental providers, 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 potential clients are informed they have a choice of available providers.
5. Providers are encouraged to use the outreach materials developed and provided by HHSC CM. Providers can order outreach materials at:

<https://hhs.texas.gov/doing-business-hhs/provider-portals/health-services-providers/texas-health-steps/thsteps-catalog>

6. Any independently developed outreach materials, including but not limited to, business cards, brochures, posters, flyers, websites, advertisements, social media or client questionnaires, must be submitted to HHSC CM for approval before being used in outreach efforts.
7. 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)
 - d. Title of program
8. Any independently designed materials must not misrepresent eligibility or intent of the service.
9. Exceptions to outreach materials will be made on a case by case basis.
10. Failure to comply with this policy may jeopardize continued participation as a provider.

Case Management for Children and Pregnant Women

POLICY NO: 005
POLICY TITLE: Documentation Requirements
EFFECTIVE DATE: September 1, 2011
REVISED DATE: April 1, 2019

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 documentation complies with:
 - a. Medicaid rule
 - b. Case Management for Children and Pregnant Women rule, and
 - c. Case Management for Children and Pregnant Women policy
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), which are available on website at <https://hhs.texas.gov/doing-business-hhs/provider-portals/health-services-providers/case-management-providers-children-pregnant-women>
5. Documentation must include details supporting the reasons for non-compliance when required time frames for case management activities are not met.
6. All required forms are available on the Case Management for Children and Pregnant Women website. Providers must use the most current forms, which are available on the website at <https://hhs.texas.gov/doing-business-hhs/provider-portals/health-services-providers/case-management-providers-children-pregnant-women>.
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).
10. The HIPAA receipt must be maintained in the client's case management record or in the clinic/agency's master file. If HIPAA receipt is maintained in the master file, the case manager must document this in the client's progress notes.
11. Any documentation provided to a client/parent/guardian must be interpreted or translated in the 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 proficient in the client's language sign as the interpreter.
12. Any documentation that has been translated must be written in English for the client record.
13. Providers may use an electronic system to capture case management activities. The system must include all information that is gathered on approved case management forms. Provider must obtain prior approval from HHSC CM before use of electronic system. (*See Policy 023, Quality Assurance Monitoring and Utilization Review*).
14. Failure to comply with this policy may jeopardize continued participation as a provider.

Case Management for Children and Pregnant Women

POLICY NO: 006
POLICY TITLE: Billing
EFFECTIVE DATE: September 1, 2011
REVISED DATE: September 1, 2017

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. If no claims are submitted for 24 months, provider will be closed.
2. Providers must ensure billing for case management services complies with:
 - a. Medicaid rule
 - b. Case Management for Children and Pregnant Women rule
 - c. Case Management for Children and Pregnant Women policy
3. Providers must contact TMHP to address claims issues or training needs.
4. Providers can only submit claims for services which have been prior authorized by HHSC CM 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 request to change a face-to-face visit to a telephone visit, if desired, by contacting HHSC CM.
6. Services are not billable when a client is an inpatient at 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 provided
 - c. Date the claim 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
 - f. Record of billed services. The Record of Billed Services Form (CM-11) may be used to document claims activities.
8. Documentation which does not support billable services may result in an

Improvement Action Plan (IAP) which may include, but not limited to:

- a. recovery of funds;
- b. referral to Inspector General (IG) Medicaid Program Integrity (MPI) Section; and
- c. referral to the provider's respective licensing/regulatory board.

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

Case Management for Children and Pregnant Women

POLICY NO: 007
POLICY TITLE: Provider Changes
EFFECTIVE DATE: September 1, 2011
REVISED DATE: September 1, 2017

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

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

PROCEDURE:

1. Providers must submit written notice of changes to DSHS regional liaison within three business days of occurrence or knowledge of changes. Providers must submit by mail, fax, or email documentation for the following request:
 - 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, case manager's resume, Conflict of Interest Statement and proof of current licensure. (*See policy 002, Case Manager Requirements.*)
 - c. Expanding service area - The provider must submit a CM-10 when requesting to expand service area.
2. Providers must change their status to inactive by submitting a CM-10 to DSHS regional liaison if the following reasons apply:
 - a. Not accepting new referrals and currently not serving clients
 - b. Not accepting new referrals but will continue to serve current clients
 - c. Not accepting new referrals due to no eligible case manager
3. Providers are responsible to refer clients to an alternate provider if a provider changes their status to inactive or closed and the client has remaining needs. (*See policy 014, Case Transfer.*)
4. Providers on inactive status for twelve or more months must ensure the case manager(s) attend the required training prior to changing to active status.

5. Providers requesting to expand their service area or add a case manager must demonstrate compliance with Case Management for Children and Pregnant Women rule and policies before expansion or addition will be approved.
6. Provider changes (CM-10) may not be approved if the provider has one of the following:
 - a. Open/outstanding investigation with any licensure or regulatory body, DSHS or HHSC
 - b. Unresolved or multiple, validated complaints
 - c. Current improvement action plan
 - d. Noncompliance with Utilization Review or Quality Assurance Review
7. Providers must notify TMHP of provider changes which are outlined in the Texas Medicaid Provider Procedures Manual (TMPPM).
8. HHSC CM 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, HHSC will mail a letter to the provider informing them to contact HHSC CM.
 - a. An active provider will have five business days from the date of the letter to respond or the provider will be placed on inactive status. If contact is not made within 30 calendar days from the date of the letter, the provider will be closed.
 - b. An inactive provider will have 30 calendar days from the date of the letter to respond or the provider will be closed.
9. HHSC CM will change the provider status to closed for the following reasons:
 - a. Provider does not respond to the letter referenced in number 8 above.
 - b. Provider fails to get enrolled as a Medicaid provider within 12 months of the approval date of their HHSC CM application.
 - c. Provider has no claims activity within 24 months.
10. If a provider status is closed, the provider must complete a new application and attend training to initiate services. (*See policy 001, Provider Application Process and policy 003, Enrollment, Training and Activation.*)
11. Failure to comply with this policy may jeopardize continued participation as a provider.

Case Management for Children and Pregnant Women

POLICY NO: 008
POLICY TITLE: Referral & Intake
EFFECTIVE DATE: September 1, 2011
REVISED DATE: April 1, 2019

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 client 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. Providers must accept all referrals unless the following has been documented:
 - a. Provider's status is inactive
 - b. Provider's service area does not include the client's given location
 - c. Provider's application has a limitation that excludes the client (i.e., provider does not serve pregnant women, age limitations)
4. Providers who are unable to accept a referral for any of the above reasons must direct the referral source to the Texas Health Steps hotline within two business days of the receipt of the referral.
5. Providers must not maintain wait lists for case management services.
6. All intakes must be conducted:
 - a. By an approved case manager who has completed Case Management for Children and Pregnant Women training;
 - b. By telephone or face-to-face; and
 - c. Within seven business days of the initial referral.
7. 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 had a legal guardian appointed to them.
8. The Referral and Intake Form (CM-01A) must be maintained in the client's chart.
 9. During an intake, the case manager must obtain the following:
 - a. The health condition(s), health risk or high-risk condition of the potential case management client; and
 - b. How the health condition, health risk or high-risk condition impacts level of functioning; and
 - c. Detailed information about the current need(s) related to the health condition/risk or high risk condition; and
 - d. How the case manager will assist with the current need(s).
 10. Identified needs of the client must be current, not anticipatory and must be confirmed and desired by the client/parent/guardian.
 11. A CM-01A must be completed for each client within a family referred for case management.
 12. The case manager must submit an Initial Prior Authorization Request (CM-01) prior to initiating services if the case manager determines the client is potentially eligible for case management services. (*See policy 009, Prior Authorization for Services.*)
 13. If the provider is an agency which provides additional services (e.g.: counseling, medical services, therapies) the client must have current eligible needs outside of the scope of the agency in order to be eligible for case management services.
 14. The case manager is responsible for providing appropriate information and referrals (I&R) to address the client's needs if the case manager determines a client does not meet case management eligibility criteria.
 15. Failure to comply with this policy may jeopardize continued participation as a provider.

Case Management for Children and Pregnant Women

POLICY NO: 009
POLICY TITLE: Prior Authorizations for Case Management Services
EFFECTIVE DATE: September 1, 2011
REVISED DATE: April 1, 2019

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. All requests for prior authorizations must be submitted by using the HHSC CM electronic portal.
2. All fields of a prior authorization request (CM-01 and CM-06) must be completed according to the instructions.
3. Initial prior authorization requests (CM-01) must be submitted within three business days of the intake. 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 any additional needs. The case manager must submit a new CM-01 indicating the date of the new intake on the request.
4. If it is determined 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 CM will review requests within three business days and determine 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. The PA request form must document needs that are:
 - a. Current,
 - b. Not anticipatory, and
 - c. Confirmed and desired by client/parent/guardian.
8. If the client has urgent needs, the case manager should request an expedited review by clearly documenting the urgency on the prior authorization request and/or contacting HHSC CM.
9. HHSC may email the provider/case manager or call the client/parent/guardian if additional information is needed to determine a PA request. Providers who do not respond to email within two business days may have PA request denied and be placed on inactive status. (See *policy 007, Provider Changes*).
10. HHSC CM will fax a Response to Authorization Request Form indicating the status as approved or denied to the provider.
 - a. 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;
 - iii. Case manager authorized to provide services. (Case Management must be provided by the case manager authorized to provide services.); and
 - iv. Authorization effective and expiration dates. (The *Date Intake Completed* on the PA request will be the date the authorization begins. Authorization period is for one year from the effective date);
 - b. If the request is not completed according to policy or documentation does not support that the client meets eligibility, the request will be denied.
11. 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.
12. 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.
13. 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.
14. The signature date on the CM-06 must be at least one day after the date of the last follow-up visit.
 15. If a provider submits a CM-01 and the client has current authorization with another provider, HHSC CM will follow *policy 013, Client Transfer*.
 16. A comprehensive visit may be requested if there are significant changes in the client's health condition and/or psychosocial situation. The case manager must document the significant changes on a CM-06 and request a comprehensive visit.
 17. Failure to comply with this policy may jeopardize continued participation as a provider.

Case Management for Children and Pregnant Women

POLICY NO: 010
POLICY TITLE: STAR Health and STAR Kids Service Provision
EFFECTIVE DATE: September 1, 2017
REVISED DATE: April 1, 2019

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

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

PROCEDURE:

1. Clients enrolled in STAR Health are not eligible for Case Management for Children and Pregnant Women Services. Their MCO is responsible for their case management needs.
2. 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 the client has the need for assisting, advocating for, and/or 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.
3. The case manager must make, at minimum, one attempt to contact the service coordinator or designee at the client's STAR Kids managed care organization (MCO) prior to submitting the PA request to inform them they will be assisting with school related needs.
4. Contact with STAR Kids MCO must be documented on the PA request form and include the following:
 - a. Date
 - b. Telephone number of contact
 - c. Name (if applicable)
5. If the PA request does not indicate the case manager contacted or attempted to contact the STAR Kids MCO, the case manager will receive an email from HHSC CM asking them to provide the information within five business days from the date of the email. The PA request will remain unprocessed until completed. If the actions are not completed within five business days, a second intake must be completed with the client/parent/guardian.

6. If the intake indicates the client has medical needs and does not have the above mentioned needs (listed in 2.), the case manager must direct the client to their STAR Kids MCO 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 instructions to direct the client to their STAR Kids MCO for assistance. The prior authorization will not be approved.
8. If authorized for services for a client enrolled in STAR Kids, 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 directed to their STAR Kids MCO.
 - 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 for clients enrolled in STAR Kids.
10. If a client/parent/guardian, provider or case manager has a complaint or other issue related to STAR Kids or STAR Health, they may contact the HHS Ombudsman Managed Care at 1-866-566-8989.
11. Failure to comply with this policy may jeopardize continued participation as a provider.

Case Management for Children and Pregnant Women

POLICY NO: 011
POLICY TITLE: Comprehensive Visit
EFFECTIVE DATE: September 1, 2011
REVISED DATE: 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-03 Con) are available on the Case Management for Children and Pregnant Women website at <https://hhs.texas.gov/doing-business-hhs/provider-portals/health-services-providers/case-management-providers-children-pregnant-women>
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. If time frames are not met, documentation must include details supporting reasons for non-compliance.
4. The comprehensive visit must be conducted face-to-face in the location of the client/parent/guardian's choice.
5. 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.

6. 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.
7. The FNA and SP must support client eligibility and address all client and family needs.
8. 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.
9. 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.
10. 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."
11. A copy of the SP must be provided to the client/parent/guardian by the first follow-up visit.
12. 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 SP Consent form. If the service plan is translated into the client/parent/guardian's preferred language, an English version must be included in the client's file.
13. The comprehensive visit must not be billed until the FNA and SP are completed and the SP Consent form is signed by the

client/parent/guardian. If the SP is completed on a different date than the FNA, the billing date of service is the date the SP was completed and the SP Consent form was signed.

14. 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.*)
15. Documentation that does not support the requirements of a billable contact (*see policy 006, Billing*) could result in recovery of funds, a referral to Inspector General (IG) Medicaid Program Integrity (MPI) Section and a referral to the provider's respective licensing/regulatory board.
16. Failure to comply with this policy may jeopardize continued participation as a provider.

Case Management for Children and Pregnant Women

POLICY NO: 012
POLICY TITLE: Service Plan Interventions
EFFECTIVE DATE: September 1, 2011
REVISED DATE: April 1, 2019

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. The Service Plan Consent Form (CM-03 Con) must be signed by the client/parent/guardian at the comprehensive visit and with any additional service plan addendums. Failure to have CM-03 Con signed and filed in the client record may result in recovery of funds.
5. Documentation of referrals must reflect 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.*)
6. 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 <https://hhs.texas.gov/doing-business-hhs/provider-portals/health-services-providers/case-management-providers-children-pregnant-women>
7. Failure to comply with this policy may jeopardize continued participation as a provider.

Case Management for Children and Pregnant Women

POLICY NO: 013
POLICY TITLE: Follow-up
EFFECTIVE DATE: September 1, 2011
REVISED DATE: 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 when the client continues to meet eligibility criteria.
 - a. If all needs related to the health condition have been addressed during a follow-up visit, the case must be closed.
 - b. 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-03 Con) 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 the Inspector General (IG) 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

POLICY NO: 014
POLICY TITLE: Case Transfer
EFFECTIVE DATE: September 1, 2011
REVISED DATE: 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. Client/parent/guardian requests a transfer
 - b. Client/parent/guardian relocates
 - c. Provider service area changes
 - d. Provider changes to inactive or closed status and is unable to provide services
 - e. 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
 - e. Need for interpreter/translation services
3. When HHSC CM 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. With successful contact with client/parent/guardian, HHSC CM will:
 - i. Inform the client/parent/guardian of the current open authorization with another provider,
 - ii. Review the information on the request with the client/parent/guardian,
 - iii. Ask the client/parent/guardian their 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 CM is unable to contact the client/parent/guardian:
 - i. HHSC CM 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 CM 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 CM.
6. The provider must contact HHSC CM 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 NO: 015
POLICY TITLE: Case Closure
EFFECTIVE DATE: September 1, 2011
REVISED DATE: 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 must close cases when the following apply:
 - a. All eligible needs have 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 denied additional visits because documentation does not support continued eligibility
 - h. Client 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
 - 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
 - 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 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 <https://hhs.texas.gov/doing-business-hhs/provider-portals/health-services-providers/case-management-providers-children-pregnant-women>
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 dies
 - d. Client transfers to another provider and transfer is conducted by phone.
7. The client's record must include:
 - a. A copy of the Closure Form, and
 - b. Documentation on Follow-up Forms or Progress Notes supporting the client/parent/guardians' needs have been addressed.
8. Failure to comply with this policy may jeopardize continued participation as a provider.

Case Management for Children and Pregnant Women

POLICY NO: 016
POLICY TITLE: Privacy and Confidentiality
EFFECTIVE DATE: September 1, 2011
REVISED DATE: 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 parent or legal guardian of a minor client unless:
 - a. The case manager receives written consent from the parent/guardian to provide services directly with the minor client, or
 - b. The un-emancipated minor client is pregnant and does not live with her parent/guardian, or
 - c. The minor client has been legally emancipated.
2. Case management services must be conducted with the client if they are 18 years of age or older unless they have a legal court-appointed guardian.
3. The Service Plan Consent form (CM-03 Con) serves as an informed consent for case management services. The client/parent/guardian must sign the CM-03 Con 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.
4. 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.
5. 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 <https://hhs.texas.gov/doing-business-hhs/provider-portals/health-services-providers/case-management-providers-children-pregnant-women>

6. The case manager will ensure 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-03 Con 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.
7. 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.
8. Encryption must be used when sending emails containing any identifying client information to comply with HIPAA regulations.
9. The cover sheet of facsimiles must include a statement of confidentiality.
10. Providers must ensure client records are stored and disposed in accordance to Medicaid policy.
11. Failure to comply with this policy may jeopardize continued participation as a provider.

Case Management for Children and Pregnant Women

POLICY NO: 017
POLICY TITLE: Non-Discrimination Requirements
EFFECTIVE DATE: September 1, 2011
REVISED: April 1, 2019

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, 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.
3. 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.
4. 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.
 - b. 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.

- c. Any documentation provided to a client/parent/guardian must be interpreted or translated for the family. If documentation is interpreted by a third party interpreter, 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.
 - d. It is not required that a case manager who is proficient in the client's language sign as the interpreter.
 - e. 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.
5. If clients are seen in any setting other than their home, the location must be accessible and meet ADA specifications, if warranted.
6. Failure to comply with this policy may jeopardize continued participation as a provider.

Case Management for Children and Pregnant Women

POLICY NO: 018
POLICY TITLE: Reporting of Abuse, Neglect and Exploitation
EFFECTIVE DATE: September 1, 2011
REVISED DATE: April 1, 2019

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. Reports made to DFPS must be documented in client's record under progress notes and indicate reference number.
3. Failure to comply with this policy may jeopardize continued participation as a provider.

Case Management for Children and Pregnant Women

POLICY NO: 019
POLICY TITLE: Services to Children of Migrant Workers
EFFECTIVE DATE: September 1, 2011
REVISED DATE: 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 the family is appropriately linked to resources in the geographic areas in which they live and to which they migrate.
3. 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 <https://hhs.texas.gov/doing-business-hhs/provider-portals/health-services-providers/case-management-providers-children-pregnant-women>
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 of case management services, if the client is temporarily or permanently moving to another area of Texas, meets eligibility, and requests a transfer to a new provider in the 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

POLICY NO: 020
POLICY TITLE: Complaints Process
EFFECTIVE DATE: September 1, 2011
REVISED DATE: April 1, 2019

PURPOSE: To ensure providers and clients are informed of their rights to file a complaint and request a hearing.

POLICY: Providers must follow the complaint process.

PROCEDURE:

1. Case managers must obtain the client/parent/guardians signature on the Service Plan Consent Form (CM-03Con) and ensure they are informed of their right to file a complaint regarding case management services.
2. If a complaint is received from a client/parent/guardian or collateral regarding case management services performed by a case manager/provider, an investigation will be conducted by HHSC CM. The investigation may include:
 - a. telephone call to client/parent/guardian
 - b. request for client files
 - c. telephone calls to collateral contacts
 - d. status change to inactive while under investigation
3. Following the conclusion of the investigation, the provider will be informed in writing of the outcome and any necessary actions. The outcome may include:
 - a. No further actions/no findings
 - b. Technical Assistance
 - c. Improvement Action Plan (IAP)
 - d. IAP with Accelerated Record Review (ACR)
 - e. IAP with status change to inactive and attend required training
 - f. Referral to Texas State Board of Social Work Examiners or the Texas Board of Nurse Examiners
 - g. Referral to Inspector General Medicaid Program Integrity Section
 - h. Probation
 - i. Suspension
 - j. Closure
 - k. Termination
4. A provider has the right to request a hearing if the investigation resulted in termination. (*Texas Administrative Code, Title 1, Part 15, Chapter 357*)

5. Client/parent/guardian or providers may file a complaint about any Medicaid services including Case Management for Children and Pregnant Women program by contacting the HHSC Office of the Ombudsman at 1-877-787-8999.
6. Failure to comply with this policy may jeopardize continued participation as a provider.

Case Management for Children and Pregnant Women

POLICY NO: 021
POLICY TITLE: Internal Quality Management System
EFFECTIVE DATE: September 1, 2011
REVISED DATE: April 1, 2019

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, and internal program review.

PROCEDURE:

1. Develop and maintain an internal quality assurance policy.
2. Maintain a referral log of all persons referred for case management:
 - a. Referral log must include name of person referred, date of birth, Medicaid number, date of referral, and outcome of referral.
 - b. Providers may use the QMS Client Referral Log (CM-18).
3. Incorporate internal client record review procedures, which must include:
 - a. the name of the approved case manager conducting the review (case managers may perform a self-review),
 - b. frequency of the review, and
 - c. number/percentage of records to be reviewed.
4. Complete internal record reviews, which must be:
 - a. documented on the Record Review Tool for Providers Form (CM-16) and
 - b. maintained in the client's chart.
5. Complete an internal program review which must include the items on the Provider Systems Review Form (CM-15) and frequency of the review.
6. Evidence of the internal QA policy and developed procedures will be reviewed on an annual basis. (*See QA policy 023*).
7. Failure to comply with this policy may jeopardize continued participation as a provider.

Case Management for Children and Pregnant Women

POLICY NO: 022
POLICY TITLE: Technical Assistance
EFFECTIVE DATE: September 1, 2011
REVISED DATE: 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 CM and regional liaison.

PROCEDURE:

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

Case Management for Children and Pregnant Women

POLICY NO: 023
POLICY TITLE: Quality Assurance Monitoring and Utilization Review
EFFECTIVE DATE: September 1, 2011
REVISED DATE: April 1, 2019

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

POLICY: HHSC CM or DSHS regional liaison will conduct annual quality assurance and 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 CM or DSHS regional liaison.
2. HHSC CM may conduct UR for the active and inactive providers to identify trends in claims data that indicate potential concerns with the quality of case management services.
3. All providers will receive a QA review once a year to ensure compliance with policies. The review will include:
 - a. Random selection of five percent of client records or a minimum of two records, with a maximum of 15 records;
 - b. Program compliance to include status of licensure, webinar attendance certificates, Quality Management Systems policy, client interviews, and independently developed outreach material; and
 - c. Exit meeting to summarize the findings of the QA review with the provider, DSHS regional liaison and/or HHSC CM.
4. Providers must submit copies of client records within 10 business days as designated on the QA notification letter.
 - a. Copies of records must be submitted to DSHS regional liaison by fax, mail or hand delivered.
 - b. If electronic records are used for case management, HHSC CM or DSHS regional liaison must have access to the electronic records or complete files must be printed and submitted.
5. Providers who fail to submit requested copies of client records within 10

business days will be placed on inactive status.

6. Providers unable to meet the 10 business day deadline may be granted one extension. NOTE: Only one extension will be granted through their time as a provider.
 - a. The request for the extension must be sent via email to the DSHS regional liaison before the record request deadline and state the reason for an extension.
 - b. HHSC CM will review all requests and, if approved, will establish a new record request date.
 - c. Providers will be placed on inactive status until records are submitted.
 - d. Continued noncompliance with record submission will result in closure.
7. Providers serving more than one health service region will receive their QA review in the region where the provider's administrative office is located.
8. Providers will receive a written summary of the QA review and/or UR including any required actions, such as, but not limited to:
 - a. No further action
 - b. Technical Assistance
 - c. Improvement Action Plan (IAP)
 - d. IAP with Accelerated Record Review (ACR)
 - e. IAP with status change to inactive and attend required training
 - f. Referral to the Texas State Board of Social Work Examiners or the Texas Board of Nurse Examiners
 - g. Referral to Inspector General Medicaid Program Integrity Section
 - h. Probation
 - i. Suspension
 - j. Closure
 - k. Termination
9. Providers placed on inactive status by HHSC CM due to non-compliance with QA/UR must meet all QA/UR required action steps before they can return to active status.
10. Providers who change to Closed status prior to completing their QA/UR action steps must complete all steps before submitting a new provider application.
11. Providers must comply with HHSC CM or DSHS regional liaisons' request for records at any time.
12. Providers have the right to request a hearing if the QA/UR resulted in termination. (Texas Administrative Code, Title 1, Part 15, Chapter 357)

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