Texas Department of State Health Services

Case Management for Children and Pregnant Women (CPW) Policies

September 1, 2005

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CPW Program	
POLICY TITLE: **Application and Review Process**	**POLICY NO:** **001**
EFFECTIVE DATE: **January 1, 2005**	

PURPOSE: **To provide information that assures conformity in the application and review process.**

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

PROCEDURE:

1. Applicants must coordinate the application process with the Director of Social Work and/or Designee in the Regional office in the geographical area of coverage. Applications may only be obtained from the Director of Social Work and/or Designee in the Regional office in the geographical area of coverage at a face-to-face application pre-planning session with the Director of Social Work and/or Designee in the Regional office. A list of the Director of Social Work and/or Designee in the Regional offices may be found on the DSHS website at: http://www.dshs.state.tx.us/caseman/default.shtm
2. Applications will be accepted from any provider meeting the requirements as stated in the CPW Rules. Applications and any addendums must be typed.
3. Completed original applications must be submitted to the Director of Social Work and/or designee within 40 working days of attending the pre-planning session or the application will be denied.
4. Applicants applying to become a provider in more than one region must submit a duplicate application to the Social Work Director/Designee for each region. The DSHS staff in the region in which the applicant's administrative office is located will coordinate review of the application among the other regions.
5. The Director of Social Work and/or designee will review the application within 15 working days of receipt. If the DSHS Regional Director of Social Work and/or designee recommends approval, the application will be forwarded to DSHS central office for review.
6. If changes are needed to the application it will be returned to the applicant by the Director of Social Work and/or designee for an amendment completion. The

amendment must be received by the region within 20 working days or the application will be denied.

7. Central office CPW staff will review all applications and addendums received from the Director of Social Work and/or designee within 5 working days of receipt. If the application meets all the requirements, the provider will receive a DSHS approval letter and instructions to enroll as a CPW provider with the Medicaid Claims Administrator.
8. If the application does not meet all requirements, central office CPW staff will communicate the deficiencies to the applicant through a written letter.
9. If the applicant chooses to make the requested changes, they have 20 working days from receipt of the letter to submit revisions/amendments to DSHS central office or the application will be denied.
10. Within 20 working days of submitting the final application addendum, the applicant will be notified in writing by DSHS if application is denied or approved.
11. No more than two addendums to an application will be allowed per applicant.

CPW Program	
POLICY TITLE: **CPW Enrollment and Service Initiation**	**POLICY NO:** **002**
EFFECTIVE DATE: **September 1, 2005**	**REVISED:** **July 2007**

PURPOSE: To provide information regarding the enrollment requirement and process for CPW as well as information necessary for the implementation of CPW Services.

POLICY: CPW providers will enroll with the Medicaid Claims Administrator and comply with training requirements prior to providing CPW services.

PROCEDURE:

1. Approved CPW providers should complete the following to ensure appropriate enrollment with the Medicaid claims administrator:
    a. For providers who are an agency: a completed claims administrator provider enrollment application for the agency and performing provider enrollment forms for all case managers with a copy of the approval letter(s) must be submitted to the claims administrator to receive a Group Texas Provider Identifier (TPI) number and individual performing provider numbers (PPN) for each case manager prior to CPW services being billed.
    b. For individual providers: a completed claims administrator provider enrollment application with a copy of the approval letter(s) must be submitted to the claims administrator to receive a Texas Provider Identifier (TPI) number.
    c. For FQHC's: enrollment with the Medicaid claims administrator for CPW is not necessary. The FQHC TPI will be used for CPW claims.
2. Approved providers will not be listed on the CPW website until the provider enrolls with the Medicaid Claims Administrator and receives a TPI number. If an applicant wants to accept referrals prior to receipt of TPI number/Medicaid enrollment, they must complete a CPW-10 form indicating they would like to begin accepting referrals. The form should be sent to the DSHS regional office per CPW policy number 003. Approved providers

who have not submitted this form will be considered inactive until issued a TPI number and will not be able to obtain prior authorization to provide services to clients. As soon as the approved provider has been issued a TPI number, the provider should submit a CPW-10 with the TPI number stating the provider will now begin accepting referrals. Claims submission information is included in the TMHP Provider Procedures Manual.

3. If a provider chooses to accept referrals prior to TPI number issuance and has submitted a CPW-10 form to the DSHS regional office, they have 95 days from the date the TPI number is issued to file the claim. See TMHP Provider Manual for more details.

4. If a provider does not submit a Medicaid claim for eighteen (18) consecutive months, the Medicaid claims administrator will deactivate their TPI number and/or performing provider number(s). The provider and case managers will be required to reapply as a new provider for CPW as well as re-enroll with the claims administrator to be able to provide CPW services.

5. Prior to providing and billing for CPW services, an approved case manager must attend the DSHS Regional case management training. In addition, one representative from each newly approved CPW provider must attend the CPW Regional administrative training. All regions will provide monthly training unless requests for training are received for less than two case managers. Providers may attend training in an alternate region if one is not available in their region at the time training is necessary. Training dates are available on the DSHS case management website at: http://www.dshs.state.tx.us/caseman/default.shtm

   Each approved provider must ensure a copy of the CPW policies and rules is available to each case manager. Each case manager should bring a copy of the policies and rules with them to training.

6. DSHS Central Office will mail a certificate of attendance to DSHS regional staff for all case management provider staff that attends the training session. Case management providers will be responsible for the distribution of training certificates to the individual case managers within their agency. DSHS Central Office will mail certificates for all case managers who meet the education and experience requirements to DSHS regional staff who will distribute certificates to case management providers.

CPW Program	
POLICY TITLE: **Notification Requirement of Significant Provider Changes**	**POLICY NO:** **003**
EFFECTIVE DATE: **September 1, 2005**	

PURPOSE: **To ensure accurate and current information is maintained in a Provider Look Up database, provider list and DSHS case management website.**

POLICY: Approved providers are responsible for submitting written notice of any significant changes that differ from the original application. Notice must be submitted in writing within five working days of change.

PROCEDURE:

1. All providers will submit written notice of significant changes (case management supervisory personnel, case management staff, active or temporary inactive status, not accepting or accepting new referrals, business closing, change of address, telephone number, fax number, email address or change of ownership, TPI number) within five working days of occurrence or knowledge of change.
2. Notice will be submitted, by mail, fax, or e-mail, on the Notification of Significant Provider Changes, Form CPW-10, to the Regional Director of Social Work/ Designee in all regions where services are provided by the agency.
3. In the event DSHS is unable to contact a provider after three attempts, the provider will be placed on inactive status. The provider will be notified in writing at the last known address of this status change and must contact DSHS in order to return to active status. If a provider's phone number is found to be no longer in service the provider will be placed on inactive status immediately.
4. Providers who will continue to follow current clients but cannot accept any new clients must indicate they are not accepting new referrals until further notice on a CPW-10 and forward to DSHS.

5. Providers are responsible for the transition of clients they cannot serve to alternate providers within the requirements of client choice. For additional information see policy 015, Case Transfer.
6. Notification to DSHS of significant provider changes are in addition to the requirement to inform the claims administrator of provider changes. Requirements for notification of provider changes to the claims administrator are outlined in the Texas Medicaid Provider Procedures Manual.
7. All CPW-10 forms for new case managers must have proof of the case manager's education, experience (including description of job duties and time frames for work experience), and verification of current Social Work or RN license attached. The following documents should be attached to each CPW-10 for new case managers:
    a. Verification of current licensure
    b. A resume with education and experience OR a MEER certificate OR a certificate indicating the case manager is eligible to continue providing services due to being a case manager with Targeted Case Management for Pregnant Women and Infants and/or THSteps Medical Case Management prior to September 1, 2003.
8. All new case managers with an agency (excluding FQHC's) will need to enroll with the claims administrator to receive a Performing Provider Number.
9. Failure to submit significant provider changes according to policy may jeopardize continued participation as a provider.

CPW Program	
POLICY TITLE: **Expansion of Service Area**	**POLICY NO:** **004**
EFFECTIVE DATE: **September 1, 2005**	

PURPOSE: **To ensure uniform criteria for the review of case management expansion applications.**

POLICY: Requests for expansion of service area will be reviewed to ensure conformity of services and consistency of review.

PROCEDURE:

1. The following sections of the case management application must be completed for applications to expand into a new regions:
    a. Section 1-Demographics;
    b. Section 3 (for any new staff); and
    c. Section 4-Provider Assurances.
2. The review process and time frames for an expansion in a new region is the same as the Application Review Process Policy Number 1. Providers must coordinate expansion applications with a face-to-face application pre-planning session with the Director of Social Work and/or Designee in the Regional office of the new region. Providers requesting expansion into a new region will need to send the documents as outlined above to the Social Work Director/designee of the new region.
3. Providers cannot expand into a new DSHS region until they have billed for services in their original region for six months.
4. In order to expand into a new county or counties within the original region, the provider should complete a Significant Change Form (CPW-10) and specify which counties they intend to serve. The CPW-10 should be sent to the Director of Social Work and/or Designee in the Regional office.
5. Providers cannot expand into a new county within their original region until they have billed for service in their original county for a minimum of two months.
6. Providers must demonstrate compliance with CPW Rules and case management policies in the current service area before an application for expansion will be

approved to new counties or a new region. In order to be approved for expansion in a service area a provider must:

a. Not be currently in the quality assurance sanctioning process;
b. Not have unresolved or multiple, validated complaints or;
c. Not have an open/outstanding investigation with any licensure or regulatory body.

7. Providers will receive written notification of approval or denial for service area expansion.
8. Providers expanding service areas will not need to re-enroll with the claims administrator and will utilize the same Medicaid TPI number. Providers adding case managers in the new service area will need to assure those case managers enroll with the claims administrator in order to receive a Performing Provider Number (excluding FQHC's) and be able to bill for services.

CPW Program	
POLICY TITLE: **Case Management Personnel Requirements**	**POLICY NO:** **005**
EFFECTIVE DATE: **September 1, 2005**	

PURPOSE: **To ensure provider personnel meet standard qualification criteria and compliance with rules regarding case management staff license requirements.**

POLICY: Case managers will meet the minimum criteria established in program rule. All case managers providing services will maintain appropriate licensure. If appropriate license is not maintained, billing is in violation of Medicaid and CPW rule.

PROCEDURE:

1. A provider will ensure that the minimum criteria defined by CPW rule is maintained by all staff providing case management services billed to Medicaid by maintaining verification of current licensure as well as proof of education and experience in case manager personnel records.
2. CPW case managers must be a registered nurse (with a diploma, an associate's, bachelor's or advanced degree) or social worker (with bachelor's or advanced degree), currently licensed by the respective Texas licensure board and whose license is not temporary or provisional in nature. All case managers must have maintained their professional licenses as determined by the respective Texas examiner's boards.
3. Case managers must possess:
    a. Two years of cumulative paid full-time work experience in the past ten years and/or
    b. Two years of supervised, full-time educational internship/practicum experience in the past ten years and
    c. Experience must include working with children, up to age 21, and/or pregnant women and
    d. Experience must include assessing the psychosocial and health needs and making community referrals for these populations.

4. A case manager employed in an approved Targeted Case Management for Pregnant Women and Infants or Texas Health Steps Medical Case Management agency prior to September 1, 2003 but who does not meet the educational and/or experience requirements outlined in number 4, may continue providing case management services, if the case manager presents a certificate issued by DSHS attesting that the case manager's education and/or experience was grand-fathered.
5. Proof of case manager's licensure, education and experience must be provided upon application or expansion, notification of new staff via a CPW 10 and, at least, 48 hours before a case manager attends DSHS training. If a case manager is attending training in an alternate region, providers must submit proof of licensure, experience and education to the region of the provider's headquarters. Providers must maintain documentation of current licensure for all case managers.
6. All case managers (except for case managers employed by an FQHC) are required to enroll with the claims administrator as a performing provider. Individual case managers are enrolled with the claims administrator as a performing provider when issued their TPI.
7. Proof of attendance at the DSHS orientation/training must be maintained in the personnel file and available for review when requested by HHSC, DSHS or state officials.
8. Case managers must not have any conflicts of interest that prevent them from responding to their client's needs and advocating on their behalf. Case managers functioning in a dual role, for example, providing clinical services, must not act as a gatekeeper by restricting or directing a client's receipt of case management services. The advocacy role must be maintained above all other roles in case management service provision.
9. Social workers and nurses will adhere to their license requirements and code of ethics of their respective disciplines.
10. Ineligible case management staff providing case management services billed to Medicaid may jeopardize continued participation as a provider. All claims by an ineligible case manager will be subject to recovery of Medicaid funds.

CPW Program	
POLICY TITLE: **Billing/ Documentation**	**POLICY NO:** **006**
EFFECTIVE DATE: **September 1, 2005**	

PURPOSE: **To ensure standardized billing requirements for case management services. To ensure standardized compliance with documentation requirements for case management billing.**

POLICY: Providers will follow approved guidelines for billing of CPW services. Documentation that supports billing will be recorded on forms that were developed by or approved by DSHS and will meet CPW rule and policy requirements.

PROCEDURE:

1. Providers will ensure that billing for case management complies with Medicaid rule and policy requirements.
2. Approved providers will receive a Texas Medicaid Provider Procedures Manual from the claims administrator. The manual along with this policy will be used as a reference guide for billing and documentation of case management services.
3. All CPW services must be prior authorized according to policy. Prior authorized visits must be completed and billed as approved (face-to-face and/or telephone) as approved by DSHS and returned on the Response for Prior Authorization Request.
4. Billing may be submitted by approved providers only after a case manager has attended training from DSHS. Services provided by a case manager prior to completing the DSHS training are not billable.
5. Documentation, which does not meet CPW rule and case management policy requirements, will not support the billing of that service to Medicaid.
6. All contacts with the client and any activity related to the service billed will be maintained on forms created by DSHS (available on the DSHS CPW website), authorized electronic forms, and/or forms developed by the provider that have been approved by DSHS for use. Non-billable activities must not be documented on forms for billable contacts; these activities must be documented on other forms.

7. Requests for modifications to DSHS provided forms and/or forms developed by an agency for the assessment, the service plan, follow-up visits and closure must be sent in writing to DSHS Central Office for approval. Requests may be faxed, emailed or mailed to DSHS Central Office. Modified or agency developed forms cannot be used until provider receives written approval.
8. Providers must develop and maintain an accounts receivable system which includes, at a minimum:
    a. Client name and Medicaid number
    b. Date service was provided
    c. Date claim was filed
    d. Date claim was returned on R&S and disposition (paid, denied, suspended, adjusted)
    e. Notation if claim was appealed

    Form CPW-11 may be utilized to document the accounts receivable system.
9. A photocopied document may not be utilized in a client's record as supportive documentation for a billable contact.
10. Forms that the client/parent/guardian will sign as well as referrals must be completed in the client's preferred language. An English and client's preferred language version of the completed form must be included in the client record.
11. Liquid correction must not be used on any documentation in a client's record. Mistakes must be marked out with one line and the case manager must initial & date.
12. A case manager must sign all documents with appropriate credentials. The case manager's signature indicates all the documentation on the form or document is accurate.
13. Any need for change in the assigned case manager within an agency must be documented along with the client/parent's desire to continue case management services. To receive prior authorization for the new case manager, changes in case manager must be submitted to DSHS in writing using form CPW-06A within one week of a change in case managers.
14. All documentation is the property of the approved provider. The approved provider is responsible for ensuring records or copies of records are maintained according to Medicaid and DSHS policy when outside their office in the possession of individual case management staff.
15. Providers must maintain confidentiality. Providers must assure:
    a. Records are stored in a locked cabinet
    b. Confidentiality while transporting records is maintained
    c. Appropriate confidential disposal of duplicate records
16. Lack of documentation of components to support billing of a service may result in recovery of funds, or referral for investigation to Medicaid Program Integrity (MPI), and will jeopardize continued participation as a provider.

CPW Program	
POLICY TITLE: **Client Eligibility/Referral**	**POLICY NO:** **007**
EFFECTIVE DATE: **September 1, 2005**	

PURPOSE: **To ensure uniform criteria for and equal access to case management services**

POLICY: A client is eligible for case management services if he or she is:

(a) A child, birth through age 20 with a health condition/health risk or a high-risk pregnant woman;
(b) Medicaid eligible in Texas;
(c) In need of services to prevent illness(es) or medical condition(s), to maintain function or slow further deterioration; and
(d) Desires case management.

Providers will serve all clients referred who meet the criteria listed. Services cannot be denied based on race, color, sex, religion, national origin, language preference, sexual orientation, and type or extent of high risk or disabling condition.

PROCEDURE:

1. CPW providers will serve all clients referred who meet the eligibility criteria unless DSHS is notified of service limitations.
2. Case managers must document for CPW clients the health conditions/risks or high-risks, as defined in the respective case management rule and how the health condition/risk or high-risk impacts the client.
3. A post-partum woman is not eligible to be enrolled as a new client.
4. Client/families must be having difficulties accessing resources with which the case manager can assist in order to be considered in need of case management services. The need for case management must be documented in detail.
5. Case management services must be individualized to the needs of each client in a family when billing for more than one client in a household. The needs of each eligible client must be reflected throughout the client record.

6. Records of multiple clients in a family will be monitored during the CPW prior authorization process and the DSHS case management quality assurance process. Technical Assistance will occur as a result of identified issues/concerns.
7. A waiting list may not be maintained. Referrals of eligible clients, who a provider is unable to serve, must be made to the DSHS Regional Director of Social Work. The referral of clients, which the provider is unable to serve, must take place on the first working day following receipt of the request for services. Acceptable reasons for not being able to serve a client include:
    a. Provider status is inactive or not accepting new referrals;
    b. Client resides in a county not covered by the provider;
    c. Provider application has a limitation that excludes the client, i.e., provider does not serve pregnant women;
8. Providers unable to accept new referrals due to staffing limitations must complete the Notice of Significant Change Form (CPW-10) and submit to the DSHS Regional Director of Social Work within five (5) working days. After receipt of the Notice of Significant Change form (CPW-10), the provider will be made inactive and identified as not accepting new referrals.
9. Noncompliance with this policy will jeopardize continued participation as a provider.

CPW Program	
POLICY TITLE: **Community Education/Client Outreach**	**POLICY NO:** **008**
EFFECTIVE DATE: **September 1, 2005**	

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

POLICY: Case management providers will furnish information regarding the availability and importance of case management services to health, education and human service professionals, lay persons, clients and community organizations within the limitations of the CPW rules.

PROCEDURE:

1. Outreach Activities can include but are not limited to:
    a. Educating potential clients through health fairs, awareness campaigns, Public Service Announcements, brochures, etc.;
    b. Increasing awareness through community networking/coalition meetings;
    c. Educating service providers (Physicians, Dentists, Therapists, Schools) in communities about CPW services;
    d. Encouraging utilization of THSteps and prenatal services; and
    e. Reinforcing health education.
2. Providers must outreach and explain case management eligibility and service benefits, as defined in rule and policy to referral sources, including physician/dental offices.
3. Providers must make referral sources aware of the need to inform potential clients of referrals to case management.
4. Providers must ensure that clients are always made aware of freedom of choice from available case management providers.
5. Outreach activities must assure 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) of

clients by providers;

b. The distribution of materials to Case Management for Children and Pregnant Women recipients that impede client choice;
c. The distribution of any false or misleading materials to Case Management for Children and Pregnant Women recipients;
d. Obtaining lists of Medicaid clients without a specific referral;
e. Offering incentives for enrollment into case management services; and/or
f. Entering into exclusive referral relationships with referral sources.

6. Providers are encouraged to use the outreach materials developed and provided by DSHS. Any independently developed outreach materials, including brochures, posters, websites, advertisements or commercials, must be submitted to the DSHS central office for approval before being utilized in outreach efforts. The provider will be notified in writing, within ten working days of receipt of the request, of the approval or any required changes to the materials. Any independently designed materials must incorporate all information included in the DSHS designed materials and must not misrepresent eligibility or intent of the service.
7. Outreach materials are available for order through THSteps Products Management: http://www.thstepsproducts.com/#casemgmt
8. Noncompliance with this policy may jeopardize continued participation as a provider.

CPW Program	
POLICY TITLE: **Prior Authorizations for CPW Services**	**POLICY NO:** **009**
EFFECTIVE DATE: **September 1, 2005**	

PURPOSE: **To ensure adequate understanding of the prior authorization process for initial CPW services.**

POLICY: Providers will comply with all requirements of CPW Rules and will follow required procedures to request prior authorization of initial services.

PROCEDURE:

1. To obtain initial prior authorization for CPW services providers must submit the completed Request for Initial Prior Authorization (CPW-01) to DSHS Central Office within three working days of intake for review in accordance with DSHS policies and procedures for prior authorization.
2. Additional services must be requested after the completion of the visits previously approved. Additional services should be requested if the client still meets eligibility requirements and the client and provider agree more visits are necessary to meet needs. Requests for prior authorization for additional services should be completed on a CPW-06, including requests for clients whose cases were closed and reopened. Requests for additional services must be submitted to DSHS Central Office within five days of the date on the request.
3. Completed requests for prior authorization may be faxed, mailed or submitted via the CPW website.
4. The number of billable contacts that are prior authorized will be based on the client's:
    a. Level of need;
    b. Level of medical involvement; and
    c. Complicating psychosocial factors.
5. Services will be denied for requests not completed according to policy or for clients found not to be eligible for services.

6. Prior authorization requests submitted with an assigned case manager who is not on record with DSHS will be returned to the provider with a response form that indicates the request cannot be reviewed.
7. DSHS will respond to requests within three working days of receipt of request. DSHS central office CPW staff may contact providers and/or clients for additional information or clarification regarding a prior authorization when necessary.
8. If the client has needs that indicate he/she should be seen immediately, the provider should contact DSHS central office by phone to request an expedited review.
9. Approved requests for service will be authorized to a case manager's individual performing provider number and the agency's group number (Services for an FQHC will be authorized to the TPI for the FQHC; performing provider numbers are not required). Transfers to another case manager within an agency must be submitted to DSHS central office using form CPW 06-A for a change to the prior authorization. Prior authorized visits must be completed and billed as requested and approved (face-to-face and/or telephone).
10. The effective date for prior authorizations numbers will be the date of the signature on the prior authorization request.
11. Continued inappropriate trends/quality issues in requests for prior authorization will place a provider at higher risk for a QA review.
12. Noncompliance with this policy will result in denial of claims and jeopardize continued participation as a provider.

CPW Program	
POLICY TITLE: **Intake for Services**	**POLICY NO:** **010**
EFFECTIVE DATE: **September 1, 2005**	

PURPOSE: **To ensure implementation of the intake component for case management.**

POLICY: Intake will be completed for every referral to case management. All case management service providers will record intakes in a manner consistent with program rule. Intake will include documentation of a client's demographics and eligibility for case management

PROCEDURE:

1. A standard Request for Initial Prior Authorization form (CPW-01) provided by DSHS is available for use by all case management providers as the required intake form.
2. Forms may be duplicated or downloaded from the CPW website at http://www.dshs.state.tx.us/caseman/default.shtm .
3. Documentation included on the Intake form will include client demographics and determination of client eligibility.
4. Intake must be completed within seven working days of the initial referral.
5. If the client's presenting problem or situation is of an urgent nature, the intake must be completed within two working days of receipt. Case managers should use professional judgment to determine if the presenting problem or situation is of an urgent nature.
6. During intake, case managers must determine if clients or their family members are receiving case management services from another agency and inform clients of their options in case management providers. A client/family with an existing case manager should be referred back to that provider, unless the client/family believes their needs are not being addressed.

CPW Program	
POLICY TITLE: **Family Needs Assessment**	**POLICY NO:** **011**
EFFECTIVE DATE: **September 1, 2005**	

PURPOSE: **To ensure standardized implementation and billing of the family needs assessment (FNA) component of case management**

POLICY: A FNA will be completed for every client eligible for case management. The assessment will be an evaluation of all needs that affect the short and long term health and well being of the eligible recipient and his or her family.

PROCEDURE:

1. A FNA form (CPW-02), provided by DSHS, is available for use by all CPW providers Forms may be duplicated or downloaded from the CPW website at http://www.dshs.state.tx.us/caseman/default.shtm.
2. A CPW provider may develop an FNA to be used by their case managers. Provider developed forms cannot be used without written approval from DSHS Case Management Branch. A migrant worker form must be submitted to DSHS for approval along with the provider developed FNA or the information required for a migrant form may be incorporated into the FNA. CPW rule and Medicaid policy requires the FNA include at a minimum:
    a. Client name and Medicaid number
    b. Documentation of all issues that affect the short and long term health and well-being of the eligible recipient and his/her family
    c. Assessment of medical, social, family, nutritional, educational, vocational, developmental and health care transportation needs of the client
    d. Dated signature of case manager with credentials
3. A FNA must be completed by a qualified case manager within seven days of approval of the prior authorization of services for all clients found eligible for case management services.
4. If a client's presenting problem or situation is of an urgent nature, the assessment must be completed within two working days of the prior authorization of services.

Case managers should use professional judgment to determine if the presenting problem or situation is of an urgent nature.

5. The FNA must support client eligibility and reflect a client-centered, family-focused approach to service delivery.
6. The FNA, in conjunction with the service plan (SP), comprise the billable comprehensive service. The visit is not complete and billable until the SP is completed and signed and dated by the client/parent/guardian in their preferred language.
7. If the FNA and SP cannot be completed in one contact due to the complexity of the client/family situation, time constraints of the family and/or family preference, a second contact may be made to complete the comprehensive service. Appropriate documentation is required to explain the reason for non-completion in one visit. The comprehensive service must not be billed until both the FNA and SP are completed and can only be billed once.
8. Documentation that does not support billed visits could result in recovery of funds or a referral to Medicaid Program Integrity. Continued non-compliance will jeopardize participation as a provider.

CPW Program

POLICY TITLE: Service Plan Development	**POLICY NO:** 012
EFFECTIVE DATE: September 1, 2005	

PURPOSE: **To ensure standardized implementation and billing of the client service plan (SP) component of case management**

POLICY: The client SP will document the client needs, as determined by the client/parent and case manager, what action is to be taken and by whom, the time frame in which the need is to be addressed and when the task has been completed.

PROCEDURE:

1. A service plan (CPW-03 and CPW-03Sig), provided by DSHS, may be used by CPW providers. Forms may be duplicated or downloaded from the CPW website at http://www.dshs.state.tx.us/caseman/default.shtm. The provider will be responsible for providing clients and others, when required by policy, copies of all documentation. NCR paper or photocopies are acceptable.
2. A CPW provider may develop service plan forms to be used by their case managers. Agency developed forms cannot be used without written approval from DSHS Case Management Branch. The CPW provider must submit a Spanish language service plan form when submitting a service plan for review. CPW rule and Medicaid policy requires the service plan include at a minimum:
    a. Client name and Medicaid number;
    b. The interventions and referrals for addressing needs identified in the family needs assessment;
    c. Documentation of the services to be accessed;
    d. Identification of the individual responsible for contacting the appropriate health and human service providers;
    e. Designation of the time frame within which the eligible recipient should access services;
    f. Dated signature of the client/parent/guardian; and
    g. Dated and credentialed signature of the case manager.

3. Establish a time frame for first follow-up contact. The plan for the next follow-up contact must not state "PRN" or "as needed". The follow-up plan must be individualized to the client need, for example "within two days," "within two weeks," or "within two months."
4. New needs, identified after the development of the SP and not resolved during follow-up at which identified, must be documented on a service plan addendum. The SP addendum is not a billable service but may be completed during a follow-up.
5. A copy of the service plan must be provided to the client/parent/guardian by the first follow-up and may be provided to the client's medical provider or others as appropriate within the limits of confidentiality
6. The SP is completed at the time of the FNA. Both comprise the billable comprehensive service. Billing for the SP will adhere to CPW Rule, DSHS policy and procedure and Medicaid guidelines.
7. Documentation that does not support billed visits could result in recovery of funds or a referral to Medicaid Program Integrity. Continued non-compliance will jeopardize continued participation as a provider.

CPW Program	
POLICY TITLE: **Client Referrals**	**POLICY NO:** **013**
EFFECTIVE DATE: **September 1, 2005**	

PURPOSE: **To ensure standard procedures and documentation for client referrals.**

POLICY: **All client referrals to Medicaid providers and community resources must ensure client choice is offered and clients are not referred or directed to a specific Medicaid provider or community resource.**

PROCEDURE:

1. A referral form (CPW-07) provided by DSHS may be used by CPW providers. Forms may be duplicated or downloaded from our website at http://www.dshs.state.tx.us/caseman/default.shtm. The provider will be responsible for providing clients and others, when required by policy, copies of all documentation. NCR paper or photocopies are acceptable.
2. Case management providers may choose to document referrals using pre-printed referral information, a substitute referral form or in documentation on follow up forms.
3. Documentation of client choice must be included in the client record.
4. When only one referral resource is provided to client, documentation in the client record must provide explanation for limited referral choice.
5. If a copy of the referral form is provided to client/parent/guardian a copy must be placed in the client record.

CPW Program	
POLICY TITLE: **CPW Follow-up**	**POLICY NO:** **014**
EFFECTIVE DATE: **September 1, 2005**	

PURPOSE: **To ensure standardized implementation of and billing for the follow-up component of case management**

POLICY: Follow-up will occur as needed by the client. The follow-up component of case management will occur in a consistent manner and follow the guidelines established by DSHS.

PROCEDURE:

1. A follow-up form (CPW-04 and CPW-04A) provided by DSHS may be used by CPW providers to document follow-up contacts. Forms may be duplicated or downloaded from the CPW website at http://www.dshs.state.tx.us/caseman/default.shtm
2. A CPW provider may develop follow-up forms to be used by their case managers. Agency developed forms cannot be used without written approval from DSHS Case Management Branch. CPW rule and Medicaid policy require the follow-up contact include at a minimum:
    a. Client name and Medicaid number
    b. Documentation that continues to support client eligibility
    c. A review of the complete service plan
    d. Efforts to ascertain on an ongoing basis which needs specified in the service plan have been addressed with appropriate referrals provided and services accessed
    e. Evidence of problem solving with client/parent/guardian when needs are not addressed or referrals not accessed
    f. Dated and credentialed signature of case manager.
    g. Date of next follow-up contact. The plan for the next follow-up contact must be appropriate to SP and individual client/family needs. The time frame for the next follow-up contact must not state “PRN” or “as needed”.

The follow-up plan must be individualized to the eligible client's need, for example "within two days," "within two weeks," or "within two months."

3. Follow-up contacts and documentation must be individualized to the eligible client's needs and appropriate to the SP.
4. Follow-up contacts for children should occur as needed. Follow-up contacts for pregnant women should occur as needed through the 59th day post-partum.
5. Follow-up contacts are only billable if they are a contact with the client/parent/guardian and include all components identified in this policy.
6. Collateral contacts on behalf of a client/parent/guardian are necessary components of case management but are not billable. Collateral contacts should be documented on a progress note. Collateral contacts may include:
    a. Phone calls to the client/family, PCP and third parties during which the service plan is not reviewed;
    b. Face-to-face contacts with the family members who are not the designated caregiver;
    c. Activities performed with a third party to solve problems, advocate, refer, or coordinate care when the client/family is not present.
7. All follow-up contacts must be prior authorized according to the policies for Prior Authorization of Initial Services and Prior Authorization of Additional services.
8. All outstanding needs on the SP must be reviewed with client/parent/guardian during each follow-up. The case manager must document activity on at least one need on the SP to justify the need for the follow-up contact.
9. The client's eligibility ends when all needs related to the client's health condition are met. When the follow-up documentation does not indicate that global needs or other family members needs have a direct impact on the client's condition, the follow-up should not be billed even though approved authorizations exist. The last follow-up visit is billable if documentation shows the case manager determines that the client's eligibility ends during the visit.
10. Documentation that does not support billed visits could result in recovery of funds or a referral to Medicaid Program Integrity. Continued non-compliance will jeopardize continued participation as a provider.

CPW Program	
POLICY TITLE: **Case Transfer (CPW-09)**	**POLICY NO:** **015**
EFFECTIVE DATE: **September 1, 2005**	

PURPOSE: **To ensure standardized transfer of case management clients.**

POLICY: Transfers of case management clients will occur in a consistent manner and follow the guidelines established by DSHS.

Case Transfer:

1. A Case Transfer form (CPW-09) provided by DSHS will be used by all CPW providers.
2. Forms may be duplicated or downloaded from our website at http://www.dshs.state.tx.us/caseman/default.shtm. The provider will be responsible for providing clients and others, when required by policy, copies of all documentation. NCR paper or photocopies are acceptable.
3. All transfer decisions will be based on the needs of the client(s) being served. Cases will not be transferred solely on the basis of lack of provider resources, cost, staff, or complex issues for a child with special health care needs.
4. A copy of the Case Transfer form must be kept in the client's record.
5. Acceptable reasons for case transfers include:
    (a) Client/family relocates;
    (b) Client/family requests a transfer;
    (c) Client is enrolled in another case management program;
    (d) Provider's service area changes; or
    (e) Provider is unable to provide service and changes to inactive status.
6. Upon transfer of a case, providers will ensure and document that the client/parent/guardian has needed information and referral resources.
7. When a provider is informed that a client with an open case management case has elected to transfer to another case management provider, this constitutes a transfer of provider and the following must occur:
    (a) The provider that originally opened the case is the responsible party for completing the transfer form. If a provider receives a referral and the client indicates they have previously received case management services,

the provider must obtain a transfer form from the original provider or a copy from the client/parent/guardian.

(b) If the new provider is unable to obtain a transfer form from the original provider within three business days or if the original provider is no longer active, or if the client/family has relocated the new provider may complete the transfer form.

(c) If the new provider completes the transfer form, they must send a copy of the transfer form to the original provider.

(d) The client/parent/guardian must receive a copy of the transfer form.

8. Although cases may be transferred to another case management provider, the needs and desires of the client take precedence over a triage agreement or any Memoranda of Understanding.
9. For a case transfer, the original provider is responsible for ensuring that a client appropriately transitions to a new provider and a copy of all documentation is forwarded to the new provider within 7 working days of receipt of the client/parent/guardian's written permission. Client records must not be transferred without written signed consent of client/parent/guardian.
10. The provider of transfer will be responsible for requesting prior authorization for continued services. The provider of transfer is the new provider receiving the transferred client. Prior authorization numbers are specific to providers. Prior authorization numbers do not transfer with clients. A provider must complete an Initial Prior Authorization request form (CPW-01) on all referrals. The CPW-01 and a copy of the transfer form must be faxed to DSHS central office for prior authorization to be received by the new provider. See transfer procedure 14 regarding signatures on transfer form. DSHS central office CPW staff will end date the prior authorization for the original provider on the effective date of an approved prior authorization for the provider of transfer. DSHS central office CPW staff will notify the original provider in writing of the end date of the prior authorization.
11. If a provider requests status as an inactive provider or closes, all clients with open cases must be contacted and assisted with transition to a provider of the client/parent/guardian's choice. If a provider goes inactive in a service delivery area, the provider is responsible for notifying their clients as outlined below.

(a) As soon as a provider decides to go inactive or close, the provider must contact all clients to discuss transfer to another provider or case closure, as appropriate for the client's situation. At a minimum, the client must be informed of the date services will end and provided with a list of alternate providers (or the 877 THSTEPS number).

(b) If providers make face-to-face contact with a client and the client selects another provider, the provider must complete a transfer form.

(c) Contact with the client must be documented in the client record.

(d) Once the transfer process has been completed and the client is receiving services from a new provider, any further contact with the client initiated

by the provider for the purpose of reactivating a case will be considered solicitation.

12. Documentation on the Case Transfer form will include the reason for case transfer. The client's record must contain documentation of the client/parent/guardian agreement. All referrals provided to a client/family at time of transfer should be documented on a follow-up form or progress note.
13. If a client/family does not cooperate with or participate in case management services, all efforts should be made and documented to engage the family. Providers must assess the situation/barriers and the client's ability to follow through with the SP and referrals. If necessary, a transfer to another case management provider may be considered. Clear documentation of all efforts to engage the family must be recorded within the record.
14. A qualified case manager and client/parent/guardian must sign the CPW-09 as agreement with decision to transfer the case. If a transfer form is completed over the phone with a client/parent/guardian, documentation on the form should indicate the transfer was conducted over the phone. The transfer form may be signed by the client/parent/guardian at the comprehensive visit.
15. Excessive inappropriate client transition may jeopardize a provider's continued participation.
16. If a provider needs assistance with transferring clients, the provider must contact their DSHS Regional representative as soon as the need is identified. Providers that cease to serve clients without appropriate transfer are operating outside of program policy.

CPW Program

POLICY TITLE: Case Closure (CPW-08)	**POLICY NO:** 016
EFFECTIVE DATE: September 1, 2005	

PURPOSE: **To ensure appropriate case closure and continuity of case management services with client transfers.**

POLICY: All providers will follow standard procedures when determining the need for case closure.

PROCEDURE:

Case Closure:

1. A Closure Form (CPW-08), provided by DSHS, may be used by CPW providers. Forms may be duplicated or downloaded from the CPW website at http://www.dshs.state.tx.us/caseman/default.shtm. The provider will be responsible for providing clients and others, when required by policy, copies of all documentation. NCR paper or photocopies are acceptable.
2. A CPW provider may develop a closure form to be used by their case managers. Agency developed forms cannot be used without written approval from DSHS Case Management Branch. The CPW provider must submit a Spanish language closure form when submitting a closure form for review. The closure must include, at a minimum:
    (a) The reason for closure;
    (b) The case manager's credentialed and dated signature;
    (c) The client signature; and
    (d) The date.
3. All closure decisions will be based on the needs of the client(s) being served. Cases will not be closed solely on the basis of lack of provider resources, cost, staff, or complex issues for a child with special health care needs.
4. A copy of the Closure form must be kept in the client's record.
5. Acceptable reasons for case closures include:
    (a) When child reaches 21 years of age;
    (b) When a pregnant woman reaches 59 days postpartum;

(c) Client no longer eligible for Medicaid and does not anticipate obtaining Medicaid in the near future;
(d) Client no longer desires services;
(e) Client no longer eligible for case management due to an improvement in their health condition/health risk;
(f) Client no longer eligible for case management due to all their needs having been addressed/resolved;
(g) Client is denied extended services due to lack of necessity;
(h) Client is lost to follow-up and provider documents at least three attempts have been made to locate the client/family including at least one home visit in 30 days. (The three attempts must occur on different dates. A provider that conducts all CPW services in a clinic setting may substitute an attempt to locate the client by certified mail for the home visit.); or
(i) Client dies.

6. Upon closure of a case, providers will ensure and document that the client/parent/guardian has needed information and referral resources.
7. Documentation on the Closure form will include the reason for closure. The client's record must contain documentation of the client/parent/guardian agreement. All referrals provided to a client/family at closure should be documented on a follow-Up form or a Progress Note.
8. If a client/family does not cooperate with or participate in case management services, all efforts should be made to engage the family and these efforts should be documented. Providers must assess the situation/barriers and the client's ability to follow through with the SP and referrals. Clear documentation of all efforts to engage the family must be recorded in the client's record.
9. A qualified case manager and client/parent/guardian must sign the case closure as agreement with decision to close the case. If the client/parent/guardian is not available/refuses to sign the form the case manager must document the reason it is not signed. Closure forms for clients lost to follow-up do not need to be signed by the client/parent/guardian.
10. Excessive inappropriate closure, inappropriate documentation of closure, lack of referrals at closure and/or lack of appropriate client transition at closure may jeopardize a provider's continued participation.

CPW Program	
POLICY TITLE: **Children of Migrant Workers Access to Services**	**POLICY NO:** **017**
EFFECTIVE DATE: **September 1, 2005**	

PURPOSE: **To ensure that services are accessible to and appropriate for children of migrant workers.**

POLICY: Providers located in areas of the state where migrant workers reside or work will be aware of the special needs of this population, ensure awareness of and access to services, and have established relationships with referral resources that address specific migrant worker issues.

PROCEDURE:

1. Providers located in regions of the state with a migrant worker population must establish relationships with organizations supporting those individuals and their unique needs.
2. The following organizations must be included in networking efforts: United Farm Workers; Migrant Health Centers; National Center for Farm Worker Health; Migrant Clinician Network; School Districts; and other organizations as appropriate within individual communities.
3. Clients who are children of migrant workers will either have the DSHS Migrant Information form (CPW-02A) or a provider developed and DSHS approved migrant form) completed and attached to their family needs assessment or the information regarding children of migrant workers included in the FNA form. The following information must be included in the documentation of migrant information:
    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. Providers must ensure that a migrant client/family receiving case management services is appropriately linked to resources in the geographic areas to which they migrate. Appropriate case management documentation, with the family's permission, must follow the child/family.
5. Migration does not necessitate a closure/transfer as it is assumed they will return. Exceptions are if a family requests closure/transfer or needs are met. If client is moving to another area of Texas, linkage to a case management provider in that area must occur.
6. Providers must communicate and coordinate with Medicaid Managed Care/Care Coordinators to ensure expedited services for children of migrant workers.

CPW Program	
POLICY TITLE: **Confidentiality**	**POLICY NO:** **018**
EFFECTIVE DATE: **September 1, 2005**	

PURPOSE: **To ensure client confidentiality is maintained for case management services.**

POLICY: Case management providers must ensure client confidentiality.

PROCEDURE:

1. Case managers must demonstrate privacy and confidentiality when providing all services to clients.
2. The case manager will ensure that the client/family understands the content of any documents to be released to a third party. Documentation of the information released will be maintained in the client record.
3. The client/parent/guardian must sign an authorization in the client/parent/guardian's preferred language to release records.
4. Clients/families have the right to choose not to release information to a source other than the case management provider or DSHS.
5. Case managers will release only authorized information as requested.
6. Case management services for a client that is an un-emancipated minor (individual under 18 years old, not married or not had disabilities of a minor legally removed) must be conducted with the parent or legal guardian of the minor. Case management services can be conducted with a pregnant teen, under 18 years old, with written consent of the parent/guardian. If the client is an un-emancipated minor (individual under 18 years old, never married nor had the disabilities of a minor legally removed), the provider must secure consent from the child's parent or legal guardian before case management services may be provided to the minor client. The parent/guardian must sign the service plan for an un-emancipated minor.
7. Case management services to an individual 18 years of age or older, must be provided directly to the individual unless the client has had a legal guardian appointed for them.
8. The cover sheet of facsimiles must include a statement of confidentiality.

CPW Program	
POLICY TITLE: **Culturally Sensitive Accessible Services**	**POLICY NO:** **019**
EFFECTIVE DATE: **September 1, 2005**	

PURPOSE: **To ensure all services are delivered in a culturally sensitive manner.**

POLICY: Case management services will be delivered in a culturally sensitive manner.

PROCEDURE:

1. Interpreter services must be provided, when needed, to ensure case management is delivered in a culturally sensitive, educationally sensitive and timely manner.
2. The Americans with Disabilities Act (ADA) requires that sight and hearing interpreters be provided and the cost not be transferred to the client. Providers are expected to make all reasonable accommodations.
3. If clients are seen in any setting other than their home, the facility must be accessible and meet ADA specifications.
4. Title VI of the Civil Rights Act of 1964 requires that interpreters be provided for clients with Limited English Proficiency (LEP) and the cost not transferred to the client. Providers are expected to make all reasonable accommodations.
5. All verbal and written communication with clients/families must be delivered in a culturally and educationally sensitive manner. All written materials meant for distribution to clients/families must be provided in a format that is sensitive to language, culture and educational differences.
6. Any record documentation provided to a family and requiring parent signature, must be interpreted/translated for the family. Any record documentation written in the client's preferred language must also be documented in English on either the same form or a separate form.
7. Provider telephone recordings must contain the agency name, hours of operation and must be in both English and Spanish. Providers must answer the phone with the name of their agency.
8. The Civil Rights poster must be displayed in any locations operated by the provider where clients are served. Posters are available from the DSHS Warehouse or

through your Regional contact. Please add the following information to the bottom of the poster where it requests name, address, and phone number:

Texas Health and Human Services Commission
Civil Rights Office
701 W. 51st
Austin, Texas 78751
(888) 388-6332
TDD (512) 438-2960

CPW Program

POLICY TITLE: **Non-discrimination requirements**	**POLICY NO:** **020**
EFFECTIVE DATE: **September 1, 2005**	

PURPOSE: **To ensure all services are delivered in compliance with the Texas Department of State Health Services (DSHS) 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: CPW providers must have written and implemented policies and procedures to ensure the provision of services according to federal and state non-discrimination policies and procedures.

PROCEDURE:

1. The provider must have written and implemented non-discrimination policies and procedures established for compliance with DSHS policies, and federal Civil Rights statutes and regulations.
2. The provider must complete the Self-Evaluation Checklist for Non-Discrimination Policies and Procedures.
3. The provider must have written and implemented policies and procedures that address the needs of clients with limited English proficiency (LEP) as required by Title VI of the Civil Rights Act of 1964.
4. The provider must complete the Self-Evaluation Checklist for Limited English Proficiency (LEP) Policies and Procedures.
5. The provider must have written and implemented policies and procedures established for compliance with the non-discrimination and accessibility provisions of the Americans with Disabilities Act and Section 504 of the Rehabilitation Act of 1973.
6. The provider must complete the Self-Evaluation Checklist for ADA/Section 504 Policies and Procedures. If the provider serves clients at the provider's office or other facility, the ADA Checklist for Readily Achievable Barrier Removal must also be completed.

7. Non-discrimination policies and procedures, all completed self-evaluation checklists for policies and procedures, and the ADA Checklist for Readily Achievable Barrier Removal (if applicable) must be maintained as documentation of compliance with this component of the Case Management Program's requirements.
8. Providers may access the website of the Texas Health and Human Services Commission Civil Rights Office at www.dshs.state.tx.us/cro/default.htm for information and guidance regarding Title VI including the Civil Rights Act, the Americans with Disabilities Act (ADA) and Section 504 of the Rehabilitation Act, Title VI/Limited English Proficiency (LEP), the self-evaluation checklists for policies and procedures, and the ADA Checklist for Readily Achievable Barrier Removal.

CPW Program	
POLICY TITLE: **Assistance Locating Clients Under Age 21 who are Lost to Follow Up**	**POLICY NO:** **021**
EFFECTIVE DATE: **September 1, 2005**	

PURPOSE: **To enhance the likelihood that clients access THSteps services and to assist in location of clients lost to follow-up.**

POLICY: Case management staff have access to assistance locating clients lost to follow-up.

PROCEDURE:

1. A case management provider may refer clients through age 20 to THSteps Outreach and Informing to assist in location of a client lost to follow-up after three documented attempts to locate a client.
2. Providers should complete the THSteps Missed Appointment Referral form for verification of client address for clients who are lost to follow-up. The form is available at: (website). The provider must indicate in the appropriate space the instructions to THSteps staff for communication regarding the client information. The form should be faxed to: 512-821-1781.
3. Documentation of attempts to locate clients through THSteps Outreach and Informing should be included in the client record.

CPW Program	
POLICY TITLE: **Child Abuse Reporting**	**POLICY NO:** **022**
EFFECTIVE DATE: **September 1, 2005**	

PURPOSE: **To assure appropriate reporting of child abuse by case management providers**

POLICY: Case management providers must comply with child abuse reporting requirements.

PROCEDURE:

1. CPW providers must follow child abuse reporting requirements of Chapter 261 of the Texas Family Code.
2. CPW providers will be monitored according to the child abuse reporting requirements specified in the Medicaid claims administrator provider procedures manual.

CPW Program	
POLICY TITLE: **Complaints/Appeals**	**POLICY NO:** **023**
EFFECTIVE DATE: **September 1, 2005**	

PURPOSE: **To ensure that individuals have access to the complaint process and to further ensure those complaints are handled in a consistent manner.**

POLICY: Clients/Providers will be aware of the complaint process.

PROCEDURE:

1. Clients must be informed of their rights and educated on how to lodge any complaints via the 1-877-THSteps phone number.
2. A provider or client who chooses to make a complaint related to any THSteps service or provider, including medical, dental, case management and medical transportation, should be directed to the statewide toll free number 1-877-847-8377 (1-877-THSteps).
3. Complaints will be logged and investigated by DSHS central office CPW staff. Documentation of investigation outcome will be made.
4. All complaints will be reviewed by DSHS in accordance with DSHS policy. Central office CPW staff and the Director of Social Work/THSteps Designee in the appropriate region will respond according to policy.
5. When appropriate, complaints will be referred to the Texas State Board of Social Work Examiners, the Texas Board of Nurse Examiners and/or Medicaid Program Integrity.
6. Substantiated complaints against a provider that recur or are not responded to with an appropriate corrective action plan will jeopardize a provider's continued participation.

CPW Program	
POLICY TITLE: **Coalition Participation and Service Coordination**	**POLICY NO:** **024**
EFFECTIVE DATE: **September 1, 2005**	

PURPOSE: **To ensure that case management services are coordinated and not duplicated. To share knowledge of community resources necessary to provide case management services.**

POLICY: Case management providers, within an interagency coalition structure, will cooperate and coordinate services with community case management providers and agencies, local health departments, regional health departments, other state agencies. Case managers will coordinate services with other community agencies and Medicaid managed care plans when indicated based on the needs of clients and roles of the managed care plans.

PROCEDURE:

1. Each case manager must attend a minimum of two coalition meetings per calendar year in their respective service area. Proof of attendance must be documented and available for review.
2. Client choice takes precedence over all Memoranda of Understanding and Triage Agreements.
3. Case management providers must participate in any Community Resource Coordination Group (CRCG) staffing and/or ARD meeting when requested by parents or guardians for children who are served by the provider.
4. The case manager must contact the client's PCP, managed health care plan or health insurance for the purpose of coordinating medical services and/or client advocacy as needed.
5. Case managers must document all coordination activities with community-based agencies for the purpose of implementing service plans.

CPW Program

POLICY TITLE: **Internal Quality Assurance**	**POLICY NO:** **025**
EFFECTIVE DATE: **September 1, 2005**	

PURPOSE: **To ensure that all case management providers maintain quality services and that agencies implement internal Quality Assurance processes that comply with state requirements**

POLICY: Providers will implement an Internal Quality Assurance Plan or Internal Quality Assurance Policy consistent with program rule and DSHS requirements.

PROCEDURE:

1. The provider's Internal Quality Assurance (QA) Plan or Policy must be documented and include all components required in DSHS policy and CPW rule (record review, case manager observation and satisfaction surveys). Case management programs in agencies, which receive additional DSHS funding, must assure that QA activities for case management are integrated into the agency's overall QA plan.
2. Providers must complete satisfaction surveys as detailed in the Satisfaction Survey Policy. Providers are expected to incorporate the results of these surveys in their internal QA Plan.
3. Time periods and identification of sampling must be identified for activities:
    a. Record and Billing reviews-Consider 10% or a minimum number of records quarterly (the sample needs to be large enough to identify problems if there are any); and,
    b. Case manager observation at least annually.
4. Individuals who will carry out activities, e.g. record reviews and observations, should be identified in the Internal QA Plan or Policy. A qualified case manager who has attended the DSHS training must conduct record review and case management observations. Within an agency provider, case managers may perform peer review of records and observation of services. Independent providers may agree to internal QA with other providers as long as both providers ensure the agreement meets state and federal privacy requirements.

5. The provider Internal QA Plan or Policy must clearly identify how and by whom any needed corrective actions, which are warranted as a result of the QA process and satisfaction survey results, will be implemented.
6. The provider Internal QA Plan or Policy must clearly identify how required staff development, as a result of internal QA findings, will be implemented.
7. Evidence of the implementation of required Internal QA activities must be documented and provided when requested by DSHS.
8. Evidence of failure to meet the minimum requirements of CPW Rules, policy and procedure or Medicaid guidelines may jeopardize the provider's continued participation.

CPW Program	
POLICY TITLE: **Satisfaction Surveys**	**POLICY NO:** **026**
EFFECTIVE DATE: **September 1, 2005**	

PURPOSE: **To ensure a standard method of surveying satisfaction with case management services.**

POLICY: Case management providers will survey 100% of their closed/transferred clients at the time of closure/transfer.

PROCEDURE:

1. Providers may use client satisfaction survey (CPW-13) to survey all clients. Providers may develop and implement their own client satisfaction survey but the survey must include all the questions on the CPW-13.
2. Providers do not need to survey clients who have been closed due to inability to locate the client/family or due to client death.
3. Survey responses must be maintained as a component of the internal quality assurance process.
4. Negative responses must be addressed and documented in the internal QA process.
5. Evidence of failure to meet the minimum requirements of CPW, policy and procedure or billing agency guidelines may jeopardize a provider's continued participation.

CPW Program	
POLICY TITLE: **Technical Assistance and Quality Assurance (QA) Monitoring**	**POLICY NO:** **027**
EFFECTIVE DATE: **September 1, 2005**	

PURPOSE: **To ensure that all case management providers are monitored by DSHS in a consistent manner and that QA monitoring reviews support continued participation as a case management provider.**

POLICY: Providers will allow and participate in Technical Assistance (TA) and QA reviews by DSHS personnel to include random record review and review of documentation of adherence to other case management program policy requirements.

PROCEDURE:

1. Upon DSHS request, providers will allow DSHS personnel to perform onsite TA that may include random record reviews and review of documentation of internal QA reviews and adherence to other case management program policy requirements.
2. Providers will receive a technical assistance visit or phone contact, at a minimum, quarterly. All providers will receive an on site technical assistance visit, to include record review, at a minimum of once a year.
3. Case management providers will receive QA reviews as often as necessary in response to trends in billing, service provision, complaints and results of TA contacts.
4. The case management provider must comply with all DSHS Quality Assurance Monitoring Branch provider policies.
5. If a provider is referred to the case management program subsequent to a DSHS Quality Assurance Monitoring Branch sanctions period, DSHS central office staff, in coordination with DSHS Regional staff will review documentation of QA monitoring results and determine, based on severity of findings, whether the provider will be (one or more of the following could occur):
    a. Recommended for QA monitoring sanctions;
    b. Required to re-attend DSHS case management training;

c. Placed on probation status with the CPW program;
d. Referred to the billing agency for recoupment of funds through the Health and Human Services Commission;
e. Referred to appropriate professional licensure entities for review;
f. Referred to the Medicaid Provider Integrity Unit for fraud and abuse investigation; and/or
g. Terminated as a case management provider. If a provider is recommended for termination, the provider will be notified in writing and offered an administrative hearing according to Section 32.034 of the Human Resources Code.