Chapter 27. CASE MANAGEMENT FOR CHILDREN AND PREGNANT WOMEN

25 TAC §§27.1, 27.3, 27.5, 27.7, 27.9, 27.11, 27.13, 27.15

§27.1.Definition of Terms.

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

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

(2) Applicant--An agency, organization, or individual who submits an application to the department to provide Case Management for Children and Pregnant Women under this chapter and who meets the applicant qualifications and requirements as stated in §27.9 and §27.11 of this title (relating to Applicant Qualifications and Case Management Provider Requirements).

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

(4) Billable contact--A documented Comprehensive Visit or Follow-up contact that continues to support eligibility of a recipient, by an approved case manager who provides an eligible case management service, as defined in §27.5 of this title (relating to Case Management and Pregnant Women).

(5) Board--The Texas Board of Health.

(6) Case manager--An individual who provides Case Management for Children and Pregnant Women services either independently or as an employee of a case management provider.

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

(8) Case Management for Children and Pregnant Women--The federal enhancement service which assists eligible recipients in gaining access to medically necessary medical, social, educational, and other services.

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

(10) Continuity of care--The degree to which: the care of a child is provided by the same medical home or primary care provider; the system of care remains stable and services are consistent, unduplicated and uninterrupted.

(11) Department--The Texas Department of Health.

(12) EPSDT--Early and Periodic Screening, Diagnosis, and Treatment program. All states participating in the Medicaid program must offer EPSDT to children under age 21 who qualify for Medicaid. EPSDT provides medical and dental services to Medicaid and Texas Health Steps clients under age 21 years. In Texas, EPSDT is known as Texas Health Steps (THSteps).

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

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

(15) High risk pregnant women--Women who are pregnant and have one or more high risk medical and/or personal/psychosocial condition(s) during pregnancy.

(16) Preventive services--Services that include health counseling and education, immunizations, wellness care, nutritional supplementation, family planning and screening aimed at avoiding illness and/or disability.

(17) Primary services--Services that include care for minor illnesses, injuries and abnormalities discovered through screenings.

(18) Prior authorization--A condition for reimbursement, the prior authorization process requires all providers of Case Management for Children and Pregnant Women services to submit documentation of the requested services for approval before such services may be authorized for payment.

(19) State--The State of Texas.

(20) Tertiary services--Services that include care for major illnesses and injuries, and chronic or disabling conditions.

(21) Texas Health Steps Program (THSteps)--In Texas, the name of the federal program known as EPSDT, which is required of states participating in the Medicaid program.

§27.3.Eligible Recipients.

Clients eligible for case management services under this chapter must be either children birth through age 20 with a health condition/health risk or high risk pregnant women who are:

(1) Medicaid eligible in Texas;

(2) in need of services to prevent illness(es) or medical condition(s), to maintain function or slow further deterioration; and

(3) desire case management.

§27.5.Case Management for Children and Pregnant Women Service Provisions.

Case Management for Children and Pregnant Women services, as defined in §27.1 of this title (relating to Definitions), are services provided to assist eligible recipients in gaining access to medically necessary medical, social, educational and other services for which federal financial participation is available in order to: encourage the use of cost-effective health and health-related care; make referrals to appropriate community resources; discourage over-utilization or duplication of services; and reduce morbidity and mortality. Case Management for Children and Pregnant Women is not a "gatekeeper" function.

(1) The following contacts are billable:

(A) Comprehensive Visit--a face-to-face visit that includes the development of:

(i) Family Needs Assessment--a written evaluation of all issues that impact the short and long term health and well being of the eligible recipient and his/her family. Together, the case manager and family shall assess the medical, social, educational and other medically necessary service needs of the eligible recipient. Documentation of the Family Needs Assessment must include, at a minimum:

(I) the assessment of the medical, social/family, nutritional, educational, vocational, developmental and health care transportation needs;

(II) individualized assessment of the client; and

(III) the case manager's dated signature.

(ii) Service Plan--the written summary which:

(I) documents the services to be accessed;

(II) identifies the individual responsible for contacting the appropriate health and human service providers;

(III) designates the time frame within which the eligible recipient should access services;

(IV) may be sent to the medical provider or others as appropriate in accordance with the limits of confidentiality; and

(V) must include, at a minimum: the interventions and referrals for addressing needs identified in the Family Needs Assessment; the time frame for the client to access services; the client/parent/guardian's and case manager's dated signatures.

(B) Follow-up contact--a face-to-face or telephone contact with the eligible recipient and his/her family during which the case manager and the client/family review and reassess the client/family's needs, determine what referrals and services specified in the Service Plan have been received by the client/family, and develop appropriate modifications to the Service Plan. The Follow-up contact includes the review of the referrals that have occurred or are still needed to complete the Service Plan and meet the client/family's needs. 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. Documentation of the Follow-up contacts must include, at a minimum:

(i) a review of the complete Service Plan;

(ii) efforts to ascertain on an ongoing basis which needs specified in the Service Plan have been addressed with appropriate referrals provided and services accessed; and

(iii) evidence of problem solving with client/parent/guardian when needs are not addressed or referrals not accessed.

(2) Case Management for Children and Pregnant Women services will include a non-billable intake with each client/family. The intake will include the collection of demographic information and determination of the client's eligibility.

(3) Only one billable contact per client shall be billed per day.

§27.7.Service Limitations.

(a) Case Management for Children and Pregnant Women services are not reimbursable if they are duplicative of other billed, comprehensive Medicaid case management services.

(b) Following intake completion, the initial prior authorization request for a billable contact must be supported by required documentation and submitted to the department for review and disposition. The amount of billable contacts that are prior authorized will be based on the client's level of need, level of medical involvement and complicating psychosocial factors.

(c) Any additional requests for a billable Case Management for Children and Pregnant Women services must also be prior authorized. Required documentation must be submitted to the department for review and disposition before any additional services may be prior authorized.

§27.9.Applicant Qualifications.

(a) The minimum qualifications for a Case Management for Children and Pregnant Women applicant are:

(1) completion and approval of an application for Case Management for Children and Pregnant Women as defined in §27.1 of this title (relating to Definitions);

(2) agreeing to comply with the department rules, policies and procedures on Case Management for Children and Pregnant Women and the applicable statutory provisions;

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

(4) employment of case managers with the following qualifications:

(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; and

(B) possessing 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;

(5) agreeing to comply with all licensure requirements of the case manager(s) respective state licensure/examining boards including the obligation to report all suspected child abuse/neglect; and

(6) knowledge of and coordination with providers of health and health-related services and other active community resources.

(b) A case manager employed in an approved Targeted Case Management for Pregnant Women and Infants or Texas Health Steps Medical Case Management agency at the time of implementation of these rules but who does not meet the educational and/or experience requirements outlined in subsection (a)(4)(A) and (B) of this section, may continue providing case management services, if the case manager presents a certificate issued by the department attesting that the case manager possesses experience providing services for an approved Targeted Case Management for Pregnant Women and Infants or Texas Health Steps Medical Case Management agency before the implementation date of these rules.

(c) An applicant under investigation or being sanctioned by the department or any other State of Texas or federal governmental agency will not be approved as a case management provider.

§27.11.Case Management Provider Requirements.

In order to remain a case management provider, an individual or agency must:

(1) comply with applicable state and federal laws and regulations governing participation of providers in the Medicaid program;

(2) maintain provider status with the department;

(3) develop and maintain a system for Case Management for Children and Pregnant Women services incorporating the following elements:

(A) case Management for Children and Pregnant Women services in locations convenient for the eligible recipient to facilitate face-to-face contact;

(B) provision of Case Management for Children and Pregnant Women services in order to assist eligible recipients in accessing necessary medical, social, educational, and other services;

(C) an internal quality assurance plan that includes, but is not limited to, chart reviews and staff observation;

(D) a current list of opened and closed client records;

(E) an accounts receivable system through which billed contacts will be tracked and matched with paid claims and client records to assure claims are billed and paid for correct dates of service, were billed with appropriate procedure codes and are not duplicative of other claims for the same client;

(F) outreach activities that assure individualized referrals. The following activities may impede client choice and therefore are prohibited:

(i) door to door, telephone or other cold-call marketing or solicitation of clients by providers;

(ii) the distribution of materials to Case Management for Children and Pregnant Women recipients that impede client choice;

(iii) the distribution of any false or misleading materials to Case Management for Children and Pregnant Women recipients;

(iv) obtaining lists of Medicaid clients without a specific referral;

(v) offering incentives for enrollment into case management services; and/or

(vi) entering into exclusive referral relationships with referral sources;

(4) assure Case Management for Children and Pregnant Women services will be provided by approved case managers who meet the qualifications defined in §27.9 and §27.11 of this title;

(5) assure that approved case managers:

(A) have received department-approved education and training regarding Case Management for Children and Pregnant Women;

(B) have the opportunity to participate in appropriate Medicaid, case management and THSteps workshops, seminars, and training;

(C) assume responsibility for all Case Management for Children and Pregnant Women services they provide to eligible recipients, including services by their designated support staff;

(D) participate in relevant motion or cost studies;

(E) agree to permit the department or its designee access to the Case Management for Children and Pregnant Women provider's records, and permit direct observation of case management

activities for the purpose of determining the provider's suitability to continue participation as a Case Management for Children and Pregnant Women provider; and

(F) participate in local and/or regional case management systems/coalitions in accordance with program policies to assure cooperation and coordination with local health departments, the department's public health region(s), school districts and other Medicaid-approved case management providers as evidenced by:

(i) participation in community coalition meetings in accordance with program policy;

(ii) collaboration in planning case management delivery systems; and

(iii) involvement in resolving case management problems;

(6) share information, within the limits of confidentiality, with the department and collaborating agencies to facilitate referral and monitoring of eligible recipients; and

(7) comply in a timely manner with all department data collection and reporting requirements.

§27.13.Application Process.

(a) Applications to become a Case Management for Children and Pregnant Women provider may be obtained by contacting the department or by accessing the department website.

(b) Applicants must include copies of documentation of all agency licenses, contracts and/or written agreements with their application.

(c) Applications must be typed and accompanied by all required supporting documentation set out in this chapter. An original must be sent to the appropriate department regional office and one copy of the application must be submitted to the department central office.

(d) All applications shall be reviewed by the department staff. The review process shall be completed within 20 working days following receipt of an application.

(e) Incomplete applications shall not be approved and shall be returned to the applicant for completion.

(f) Applications which do not meet department requirements will be denied.

(g) Applicants will be notified in writing of approval or non-approval by the department. Applicants must still enroll as Medicaid providers through Medicaid provider enrollment.

(h) Applicants who have submitted complete applications and who are not approved by the department to provide case management services must wait, at a minimum, 6 months before resubmission of a new application.

§27.15.Case Management Provider Review and Monitoring Process.

(a) Approved providers will be monitored on an as-needed basis for compliance with rules and policies.

(b) Case managers or case management providers who do not comply with program requirements may be terminated, placed on probationary status, referred to appropriate professional licensure entities for review, and/or referred for fraud and abuse investigation as described in department policies and procedures.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on June 16, 2003.

TRD-200303690

Susan K. Steeg

General Counsel

Texas Department of Health

Effective date: September 1, 2003

Proposal publication date: April 4, 2003

For further information, please call: (512) 458-7236