

Title 25. Health Services  
Part 1. Department of State Health Services  
Chapter 412. Local Mental Health Authority Responsibilities  
Subchapter I. Mental Health Case Management Services  
Repeals §§412.401 - 412.417  
Subchapter I. MH Case Management  
New §§412.401 - 412.416

### Adoption Preamble

The Executive Commissioner of the Health and Human Services Commission (commission), on behalf of the Department of State Health Services (department), adopts the repeal of §§412.401 - 412.417 and new §§412.401 - 412.416, concerning mental health case management services. New §§412.401 - 412.403, 412.407, and 412.414, are adopted with changes to the proposed text as published in the August 3, 2012, issue of the *Texas Register* (37 TexReg 5715). The repeal of §§412.401 - 412.417 and new §§412.404 - 412.406, 412.408 - 412.413, 412.415 and 412.416 are adopted without changes and, therefore, the sections will not be republished.

### BACKGROUND AND PURPOSE

The repeals and new sections stipulate the requirements for providing mental health case management services. In addition, the proposed subchapter addresses the requirement in Health and Safety Code, §533.0354, that the provision of mental health services for adults with bipolar disorder, schizophrenia, or clinically severe depression, and for children with serious emotional illnesses be accomplished using disease management practices.

The requirements for providing mental health case management services described in the proposed subchapter are based on the department's mental health service delivery system and the Medicaid State Plan. This model promotes the uniform provision of services that are based on clinical evidence and recognized best practices. In addition, the model promotes effective mental health case management services by utilizing individual-specific information that identifies an individual's mental health care needs, matches those needs to a particular type(s) of case management service, and evaluates the effectiveness of the service provided.

Government Code, §2001.039, requires that each state agency review and consider for readoption each rule adopted by that agency pursuant to the Government Code, Chapter 2001 (Administrative Procedure Act). Sections 412.401 - 412.417 have been reviewed and the department has determined that reasons continue to exist for readopting some of the sections because rules on this subject are needed as more particularly described in the section-by-section summary.

### SECTION-BY-SECTION SUMMARY

Section 412.401 describes the subchapter's purpose by setting out the requirements for providing mental health case management services.

Section 412.402 sets forth the subchapter's application to providers of mental health case management services.

Section 412.403 revises and adds definitions that are used in the subchapter. Definitions that are readopted are the terms "adolescent," "adult," "business day," "child," "individual," and "utilization management guidelines." Revised or new definitions of terms that are included in the text are "assessment or reassessment," "case manager," "CFR," "community based," "community mental health center or CMHC," "community resources," "community services specialist or CSSP," "crisis," "department," "designee," "dual relationship," "employee," "individual," "institution for mental diseases or IMD," "intensive case management," "intensive case management plan or plan," "legally authorized representative or LAR," "level of care or LOC," "life domains," "medically necessary," "mental health (MH) case management services," "monitoring and follow-up," "primary caregiver," "provider," "qualified mental health professional-community services or QMHP-CS," "recovery," "recovery planning," "recovery plan or treatment plan," "referral and linkage," "routine case management," "site based," "staff member," "strengths based," "TAC," "uniform assessment," and "wraparound process planning or other department-approved model." Definitions for the terms "family partner" and "MH case management plan" are not used in the text and have been deleted.

Section 412.404 revises the requirements for providers of mental health case management services and reorganizing the section to promote readability.

Section 412.405 revises the eligibility requirements for receiving mental health case management services. Clarifying language about diagnoses has been added and the term "mental retardation" has been replaced with the new term "intellectual or developmental disability."

Section 412.406 revises the process for authorizing mental health case management services. The section title was revised to more accurately reflect the section's content. Minor revisions were made within the section to promote clarity and the subsections were reordered. New subsection (a)(1) incorporates language to clarify that a uniform assessment will be conducted at intervals specified by the department. Paragraph (3) was added to the subsection clarifying that a licensed practitioner of the healing arts must verify and document that the mental health services recommended by the individual's level of care are medically necessary.

Section 412.407 revises the standards for providing routine and intensive case management services. The new section categorizes the standards for all mental health case management services and separates those that are unique to routine case management services and intensive case management services. Federal requirements governing the department's Medicaid State Plan were revised. Therefore, it was necessary to submit a state plan amendment to incorporate the new federal requirements for providing case management services. The state plan amendments included the addition of a documented timeline for obtaining needed services, a timeline for reevaluating the plan, and documentation of coordination with other case managers. Additionally, because routine case management does not require a formalized plan, the medical record of individuals receiving routine case management must include the following: a comprehensive documentation note that identifies the problems to be addressed, a timeline for addressing the problems, and a timeline for reevaluating the need for services and outcomes.

Following federal review of the state plan amendment and subsequent feedback, the following additional changes were made. An individual's needs for medical, educational, social, or other services must be clinically assessed and determined clinically necessary. Concerning monitoring and follow-up activities, other people in addition to those already listed in the standard may be contacted to provide information about the individual. The LAR, with or without the child or adolescent being present, may provide a case management service that assists a child or adolescent in gaining and coordinating access to necessary care and services. For intensive case management for children and adolescents, subsection (d) concerning wraparound process planning was revised to accurately reflect evidence-based practice, which indicates wraparound process planning is most effective when provided to those with the highest intensity needs.

Section 412.408 revises the requirement that the provider must, in accordance with department rules in §§404.151 - 404.169 concerning rights of individuals receiving mental health services, notify the individual and legally authorized representative in writing about the provider's process for submitting a complaint about mental health case management services.

Section 412.409 outlines the limitations to providing mental health case management services; such as an existing dual relationship or there is a conflict of interest.

Section 412.410 revises the criteria for when a provider is to notify the department or its designee such as when an individual no longer meets eligibility criteria, has refused services, or cannot be located. The section also addresses when to terminate services such as when an individual no longer meets eligibility criteria. The requirement to document the reason for terminating services was added.

Section 412.411 revises the required qualifications for mental health case managers and case manager supervisors.

Section 412.412 stipulates the requirements that providers must meet to ensure that their employees who are case managers or case manager supervisors are qualified and competent to provide and supervise mental health case management services, respectively.

Section 412.413 provides the requirements for documenting the provision of mental health case management services.

Section 412.414 revises the current requirements that providers must meet in order to obtain Medicaid reimbursement for mental health case management services to provide clarity, adds a new requirement that a provider's claim for these services must be made in accordance with the department's Mental Health Case Management Guidelines, and adds a provision allowing the provider to bill for providing a face-to-face case management service to an LAR on behalf of a Medicaid-eligible child or adolescent.

Section 412.415 states the current provisions relating to the rights of Medicaid-eligible individuals to request a fair hearing and an appeal of a decision regarding their eligibility for mental health case management services and adds new text to clarify these rights.

Section 412.416 revises the list of guidelines that are referenced in this subchapter, replaces some current guidelines with new guidelines, and adds Internet web addresses to access the guidelines electronically.

## COMMENTS

The department, on behalf of the commission, has reviewed and prepared responses to the comments received regarding the proposed rules during the comment period, which the commission has reviewed and accepts. The commenter was the Texas Council of Community Mental Health and Mental Retardation Centers, Austin. The commenter was in favor of the rules, and was not against the rules in their entirety; however, the commenter suggested recommendations for change as discussed in the summary of comments.

Comment: Concerning §412.403(8), the commenter requested that the definition of the term "community based" be revised to include routine or intensive case management services.

Response: The department responds by making the suggested revision. The department clarifies that routine case management services are most often provided in the offices of the LMHA and intensive case management services are most often provided in the community such as at an individual's home or school.

Comment: In §412.405, the commenter asked that the term "intellectual or developmental disability" be replaced by the term "pervasive intellectual or developmental disability."

Response: The department declines to make the revision because the person first language adopted by the 82nd Texas Legislature authorized use of the term "intellectual disability" or "developmental disability" to replace the terms "mental retardation" and "developmental disorder." No change was made as a result of the comment.

Comment: In §412.410(a)(4), the commenter requested that the timeframe required for locating an individual be reduced from two consecutive months to 30 days to allow for consistency with the TRAG and to allow the LMHAs to move individuals off the waiting list in a more timely manner.

Response: The department declines to reduce the timeframe for locating individuals because it believes that the two-consecutive-month timeframe is necessary to keep a specialized, vulnerable population enrolled in services. The 30-day timeframe is simply not enough time to find an individual with a limited ability to pay phone bills or who may move often, be hospitalized, or be incarcerated. No change was made as a result of the comment.

Comment: The commenter suggested that the routine case management documentation requirements in §412.413(a)(1) duplicate the treatment plan requirements in §412.407.

Response: The department agrees that the sections parallel each other. Because of the new routine case management service documentation required by federal regulators, the department

believes it important to clarify those requirements for routine case management services. No change was made as a result of the comment.

In §412.401 and §412.402, concerning "Purpose" and "Application," respectively, minor editorial revisions were made.

Concerning §412.407(b)(10), the department has added a provision authorizing Medicaid reimbursement for meeting face-to-face with the LAR, with or without the child or adolescent being present, to provide a service that assists the child or adolescent in gaining and coordinating access to necessary care and services. Accordingly, the remaining paragraphs in the subsection were renumbered.

In §412.414(a), the authorization for reimbursement of child and adolescent services under §412.407(b)(10) was added to this section.

## LEGAL CERTIFICATION

The Department of State Health Services General Counsel, Lisa Hernandez, certifies that the rules, as adopted, have been reviewed by legal counsel and found to be a valid exercise of the agencies' legal authority.

## STATUTORY AUTHORITY

The repeals and new sections are authorized by Health and Safety Code, §534.058, which requires the department to develop standards of care for the services provided by local mental health authorities and their subcontractors; and Government Code, §531.0055, and Health and Safety Code, §1001.075, which authorize the Executive Commissioner of the Health and Human Services Commission to adopt rules and policies necessary for the operation and provision of health and human services by the department and for the administration of Health and Safety Code, Chapter 1001. Review of the sections implements Government Code, §2001.039.

Sections for repeal.

§412.401. Purpose.

§412.402. Application.

§412.403. Definitions.

§412.404. Provider Requirements.

§412.405. Eligibility for MH Case Management Services.

§412.406. Establishing Type, Amount, and Duration of MH Case Management Services.

§412.407. MH Case Management Services.

§412.408. Service Limitations.

§412.409. Notification and Terminations.

§412.410. Staff Qualifications.

§412.411. Staff Training

§412.412. Documentation of MH Case Management Services.

§412.413. Medicaid Reimbursement.

- §412.414. Fair Hearings.
- §412.415. Guidelines.
- §412.416. References.
- §412.417. Distribution.

§412.401. Purpose.

The subchapter describes requirements for providing mental health case management services (MH case management services) funded by or through the department.

§412.402. Application.

The subchapter applies to providers of MH case management services.

§412.403. Definitions.

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

(1) Adolescent--An individual who is at least 13 years of age, but younger than 18 years of age.

(2) Adult--An individual who is 18 years of age or older.

(3) Assessment or reassessment--A systematic process for determining an individual's need for any clinically necessary medical, educational, social, or other services (e.g., taking client history, gathering information from other sources, identifying the needs of the individual, and completing related documentation).

(4) Business day--Any day except a Saturday, Sunday, or legal holiday listed in the Texas Government Code, §662.021.

(5) Case manager--An employee who provides MH case management services.

(6) Child--An individual who is at least three years of age, but younger than 13 years of age.

(7) CFR--Code of Federal Regulations.

(8) Community based--A description of the location where routine or intensive case management services are provided (i.e., in an individual's community).

(9) Community mental health center or CMHC--An entity established in accordance with the Texas Health and Safety Code, §534.001, as a community mental health center or a community mental health and mental retardation center.

(10) Community resources--People or entities providing services that address the identified needs of individuals receiving MH case management services (e.g., providers of medical care, food, clothing, child care, employment, or housing).

(11) Community services specialist or CSSP--A staff member who, as of August 31, 2004:

(A) has received:

(i) a high school diploma; or

(ii) a high school equivalency certificate issued in accordance with the law of the issuing state; and

(B) has had three continuous years of documented full-time experience in the provision of MH case management services; and

(C) has demonstrated competency in the provision and documentation of MH case management services in accordance with this subchapter and the *MH Case Management Billing Guidelines*.

(12) Crisis--A situation in which:

(A) the individual presents an immediate danger to self or others;

(B) the individual's mental or physical health is at risk of serious deterioration; or

(C) an individual believes that he or she presents an immediate danger to self or others or that his or her mental or physical health is at risk of serious deterioration.

(13) Day--A calendar day, unless otherwise specified.

(14) Department--Department of State Health Services (DSHS).

(15) Designee--A person or entity named by the department to act on its behalf.

(16) Dual relationship--A situation that occurs if a case manager interacts with an individual in more than one capacity, whether it be before, during, or after the professional, social, or business relationship. Dual relationships can occur simultaneously or consecutively.

(17) Employee--A person who receives a W2 Wage and Tax Statement from a provider.

(18) Individual--A person seeking or receiving MH case management services.

(19) Institution for mental diseases or IMD--Based on 42 CFR §435.1009, a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing psychiatric diagnosis, treatment, or care of individuals with mental illness, including medical attention, nursing care, and related services.

(20) Intensive case management--A focused effort to coordinate community resources that assist a child or adolescent in gaining access to necessary care and services appropriate to the child's or adolescent's needs. The standards for providing intensive case management services are set forth in §412.407 of this title (relating to MH Case Management Services Standards).

(21) Intensive case management plan or plan--A written document that is part of the medical record and is developed by a case manager, in collaboration with the individual and the individual's LAR or primary caregiver, that identifies services needed by the individual and sets forth a plan for how the individual may gain access to the identified services.

(22) Legally authorized representative or LAR--A person authorized by law to act on behalf of an individual with regard to a matter described in this subchapter, including, but not limited to, a parent, guardian, or managing conservator.

(23) Level of care or LOC--A designation given to the department's standardized packages of mental health services, based on the uniform assessment and the utilization management guidelines, which specify the type, amount, and duration of MH case management services to be provided to an individual.

(24) Life domains--Areas of life in which a child or adolescent has unmet needs, including, but not limited to safety, health, emotional, psychological, social, educational, cultural, and legal needs.

(25) Medically necessary--A clinical determination made by an LPHA that services:

(A) are reasonable and necessary for the treatment of a mental health disorder or to improve, maintain, or prevent deterioration of functioning resulting from such a disorder;

(B) are provided in accordance with accepted standards of practice in behavioral health care;

(C) are furnished in the most appropriate and least restrictive setting in which services can be safely provided;

(D) are at the most appropriate level or amount of service that can be safely provided;  
and

(E) could not have been omitted without adversely affecting the individual's mental and/or physical health or the quality of care rendered.

(26) Mental health (MH) case management services--Activities that assist an individual in gaining and coordinating access to necessary care and services appropriate to the individual's needs. Case management activities include assessment, recovery planning, referral and linkage, and monitoring and follow up. Activities may be provided as routine case management or intensive case management.

(27) Monitoring and follow-up--Activities and contacts that are necessary to ensure that referrals and linkages are effectively implemented and adequately addressing the needs of the individual. The activities and contacts may be with the individual, LAR, primary caregiver, family members, providers, or other people and entities to determine whether services are being furnished, the adequacy of those services, and changes in the needs or status of the individual.

(28) Primary caregiver--A person 18 years of age or older who:

(A) has actual care, control, and possession of a child or adolescent; or

(B) has assumed responsibility for providing shelter and care for an adult.

(29) Provider--A community mental health center that has a contract with the department to provide general revenue-funded MH case management services, Medicaid-funded MH case management services, or both.

(30) Qualified mental health professional-community services or QMHP-CS--A staff member who meets the definition of a QMHP-CS set forth in Subchapter G of this chapter (relating to Mental Health Community Services Standards).

(31) Recovery--A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

(32) Recovery plan or treatment plan--A written plan developed with the individual and, as required, the LAR and a QMHP-CS that specifies the individual's recovery goals, objectives, and strategies/interventions in conjunction with the uniform assessment that guides the recovery process and fosters resiliency as further described in §412.322(e) of this title (relating to Provider Responsibilities for Treatment Planning and Service Authorization) concerning content and timeframe of treatment plan.

(33) Recovery planning--A systematic process for ensuring the individual's active participation and allowing the LAR, and the primary caregiver and others to develop goals and identify a course of action to respond to the clinically assessed needs. The assessed needs may address medical, social, educational, and other services needed by the individual.

(34) Referral and linkage--Activities that help link an individual with medical, social, and educational providers, and with other programs and services that are capable of providing needed services (e.g., referrals to providers for needed services and scheduling appointments).

(35) Routine case management-- Services that assist an individual in gaining and coordinating access to necessary care and services appropriate to the individual's needs. The standards for providing routine case management services are set forth in §412.407 of this title.

(36) Site based--The location where routine case management services are usually provided (i.e., the case manager's place of business).

(37) Staff member--Provider personnel, including a full-time and part-time employee, contractor, or intern, but excluding a volunteer.

(38) Strengths based--The concept used in service delivery that identifies, builds on, and enhances the capabilities, knowledge, skills, and assets of the child, adolescent, LAR, or primary caregiver, and family, their community, and other team members. The focus is on increasing functional strengths and assets rather than on the elimination of deficits.

(39) TAC--Texas Administrative Code.

(40) Uniform assessment--An assessment adopted by the department that is used for recommending an appropriate level of care (LOC).

(41) Utilization management guidelines--Guidelines developed by the department that establish the type, amount, and duration of MH case management services for each LOC.

(42) Wraparound process planning or other department-approved model--A strengths-based course of action involving a child or an adolescent and family, including any additional people identified by the child or adolescent, LAR, primary caregiver, and family, that results in a unique set of community services and natural supports that are individualized for the child or adolescent to achieve a positive set of identified outcomes.

#### §412.404. Provider Requirements.

(a) The provider must comply with Subchapter G of this title (relating to Mental Health Community Services Standards).

(b) The provider must assign a case manager to an individual within two business days after receiving notification from the department or its designee that the individual has been authorized to receive MH case management services.

(c) The provider must ensure that an alternate case manager acts as the individual's assigned case manager if an individual's assigned case manager is not available.

(d) The provider must maintain case manager-to-individual ratios sufficient to perform the responsibilities of a case manager in accordance with this subchapter.

(e) The provider is responsible for a case manager's compliance with this subchapter.

#### §412.405. Eligibility for MH Case Management Services.

For an individual to be eligible for MH case management services, the individual must:

(1) be a resident of the State of Texas;

(2) be an adult with a severe and persistent mental illness, or a child or adolescent with a serious emotional disturbance who may have a diagnosis described in paragraph (3) of this section;

(3) not have a single diagnosis of an intellectual or developmental disability or a substance use disorder; and

(4) qualify for an LOC that includes MH case management services.

#### §412.406. Authorization for MH Case Management Services.

(a) A provider must:

(1) ensure that a QMHP-CS administers the uniform assessment to the individual at intervals specified by the department and obtain a recommended LOC for the individual;

(2) evaluate the clinical needs of the individual to determine if the amount of MH case management services associated with the recommended LOC described in the utilization management guidelines is sufficient to meet those needs; and

(3) ensure that an LPHA reviews the recommended LOC and verifies whether the services are medically necessary.

(b) If the provider determines that the type of MH case management services associated with the recommended LOC is sufficient to meet the individual's needs, the provider must submit to the department or its designee a request for service authorization according to the recommended LOC.

(c) If the provider determines that the type of MH case management services associated with the recommended LOC is not sufficient to meet the individual's needs, the provider must submit to the department or its designee:

(1) a request for an authorization of an LOC that is sufficient to meet the individual's need or a request for authorization of additional units of service; and

(2) the clinical justification for the request.

(d) The department or its designee makes the initial determination of an individual's LOC using the uniform assessment which is referenced in §412.416 of this title (relating to Guidelines) and the utilization management guidelines, which are referenced in §412.416 of this title. If the LOC includes MH case management services, the department or its designee will authorize the individual to receive either routine or intensive case management services.

(e) Upon receipt of a request submitted according to subsection (c) or (d) of this section, the department or its designee will:

(1) review the documentation submitted by the provider;

(2) based on the review of documentation and an evaluation of available resources, authorize or deny an LOC for the individual, and if authorized, it authorizes the individual to receive either routine or intensive MH case management services; and

(3) communicate to the individual or LAR, no longer than seven business days after the determination has been made, whether the service has been authorized or denied.

#### §412.407. MH Case Management Services Standards.

(a) Assessment. An individual is assessed according to §412.406 of this title (relating to Authorization for MH Case Management Services) to determine the LOC necessary to address the individual's needs. If the individual needs either routine or intensive case management the provider must assign a case manager according to §412.404(b) of this title (relating to Provider Requirements). MH case management services, as well as attempts to provide case management, must be documented according to §412.413 of this title (relating to Documenting MH Case Management Services).

(1) MH case management services must:

(A) be delivered according to the department's utilization management guidelines, which are described in §412.415 of this title (relating to Fair Hearings and Appeal Processes); and

(B) include regular, but at least annual, monitoring of service effectiveness and proactive crisis planning and management.

(2) Case managers must recognize that:

(A) an LAR as authorized by law may act on behalf of an individual in matters such as accepting or declining services; and

(B) a primary caregiver who is not the individual's LAR is included in recovery planning and discussions that relate to the individual if written permission is obtained from the individual or LAR.

(b) Routine case management. Routine case management is provided to eligible adults, children, or adolescents and is primarily a site-based service. A case manager assigned to an individual who is authorized to receive routine case management services must:

(1) meet face-to-face with the individual and the individual's LAR or primary caregiver within 14 days after the case manager is assigned to the individual or document why the meeting did not occur;

(2) assist the individual in identifying the individual's immediate needs and in determining access to community resources that may address those needs;

(3) identify the strengths, service needs, and assistance required to address the identified needs;

(4) identify the goals and actions required to meet the individual's identified needs;

(5) specify the goals and actions to be accomplished;

(6) develop a timeline for obtaining the needed services;

(7) take the steps that are necessary to accomplish the goals required to meet the individual's identified needs by using referral, linking, advocacy, and monitoring;

(8) meet face-to-face with the individual upon the individual's, the LAR's, or the primary caregiver's request, or document why the meeting did not occur;

(9) reassess the individual's needs at least annually or as changes occur;

(10) meet face-to-face with the LAR, with or without the child or adolescent being present, to provide a service that assists the child or adolescent in gaining and coordinating access to necessary care and services;

(11) meet face-to-face with the individual and the LAR or primary caregiver upon notification of a clinically significant change in the individual's functioning, life status, or service needs, or document why the meeting did not occur;

(12) if notified that the individual is in crisis, coordinate with the appropriate providers of emergency services to respond to the crisis, as described in Chapter 412, Subchapter G, specifically §412.321 of this title (relating to Crisis Services); and

(13) develop a timeline for reevaluating the individual's needs.

(c) Intensive case management. Intensive case management is provided to eligible children and adolescents and is primarily community-based. A case manager assigned to a child or adolescent who is authorized to receive intensive case management services must:

(1) develop an intensive case management plan (plan) based on the child's or adolescent's needs that may include information across life domains from relevant sources, including:

(A) the child or adolescent;

(B) the LAR or primary caregiver;

(C) other agencies and organizations providing services to the child or adolescent;

- (D) the individual's medical record; and
- (E) other sources identified by the individual, LAR, or primary caregiver;
- (2) meet face-to-face with the child or adolescent and the LAR or primary caregiver:
  - (A) within seven days after the case manager is assigned to the child or adolescent;
  - (B) within seven days after discharge from an inpatient psychiatric setting, whichever is later; or
  - (C) document the reasons the meeting did not occur;
- (3) meet face-to-face with the child or adolescent and the LAR or primary caregiver according to the child's or adolescent's plan or document why the meeting did not occur;
- (4) identify the child or adolescent's strengths, service needs, and assistance that will be required to address the identified needs in the plan;
- (5) comply with subsection (b)(4) - (13) of this section;
- (6) incorporate wraparound process planning or other department-approved model in developing a plan that addresses the child's or adolescent's unmet needs across life domains, in accordance with the department's utilization management guidelines and subsection (d) of this section;
- (7) take steps that are necessary to assist the child or adolescent in gaining access to the needed services and service providers, including:
  - (A) making referrals to potential service providers;
  - (B) initiating contact with potential service providers;
  - (C) arranging, and if necessary to facilitate linkage, accompanying the child or adolescent to initial meetings and non-routine appointments;
  - (D) arranging transportation to ensure the child's or adolescent's attendance;
  - (E) advocating with service providers; and
  - (F) providing relevant information to service providers;
- (8) monitor the child's or adolescent's progress toward the outcomes set forth in the plan, including:

(A) gathering information from the child or adolescent, current service providers, LAR, primary caregiver, and other resources;

(B) reviewing pertinent documentation, including the child's or adolescent's clinical records, and assessments;

(C) ensuring that the plan was implemented as agreed upon;

(D) ensuring that needed services were provided;

(E) determining whether progress toward the desired outcomes was made;

(F) identifying barriers to accessing services or to obtaining maximum benefit from services;

(G) advocating for the modification of services to address changes in the needs or status of the child or adolescent;

(H) identifying emerging unmet service needs;

(I) determining whether the plan needs to be modified to address the child's or adolescent's unmet service needs more adequately;

(J) revising the plan as necessary to address the child's or adolescent's unmet service needs;

(K) a description of the intensive case management services to be provided by the case manager; and

(L) a statement of the maximum period of time between face-to-face contacts with the child or adolescent, and the LAR or primary caregiver, determined in accordance with the utilization management guidelines.

(d) Wraparound process planning. Wraparound process planning or other department-approved model may include, but is not limited to:

(1) a list of identified natural strengths and supports;

(2) a crisis plan developed in collaboration with the LAR, caregiver, and family that identifies circumstances to determine a crisis that would jeopardize the child's or adolescent's tenure in the community and the actions necessary to avert such loss of tenure;

(3) a prioritized list of the child's or adolescent's unmet needs that includes a discussion of the priorities and needs expressed by the child or adolescent and the LAR or primary caregiver;

(4) a description of the objective and measurable outcomes for each of the unmet needs as well as a projected time frame for each outcome;

(5) a description of the actions the child or adolescent, the case manager, and other designated people take to achieve those outcomes; and

(6) a list of the necessary services and service providers and the availability of the services.

#### §412.408. Making a Complaint.

A provider must, in accordance with Chapter 404, Subchapter E of this title (relating to Rights of Persons Receiving Mental Health Services), notify the individual or LAR and, if the individual is a child or adolescent, the primary caregiver in writing of the process for making a complaint to the provider's client rights officer.

#### §412.409. Service Limitations.

(a) A case manager must not provide MH case management services to an individual if a dual relationship exists.

(b) Activities that do not constitute MH case management services are identified in the department's *MH Case Management Billing Guidelines* as referenced in §412.416 of this title (relating to Guidelines).

(c) The provider must ensure that a conflict of interest does not exist if the same case manager is providing other, non-case management services.

(d) The provider must ensure that providers of case management services cannot authorize services.

(e) The receipt of MH case management services cannot be conditioned upon receipt of other services.

#### §412.410. Notification and Terminations.

(a) Notification. The provider must notify the department or its designee if the provider has reason to believe that:

(1) the individual no longer meets the eligibility criteria for MH case management services as set forth in §412.405 of this title (relating to Eligibility for MH Case Management Services);

(2) the LAR of an individual has refused MH case management services on behalf of the individual;

(3) the adult or LAR has refused MH case management services;

(4) the provider cannot locate the individual and the provider has documented multiple attempts to locate the individual over a period of two consecutive months;

(5) the individual has died;

(6) the individual has established or intends to establish residency outside of the provider's service area; or

(7) if MH case management services are terminated for any reason described in paragraphs (1) - (6) of this subsection, the provider shall document the reason for terminating MH case management services.

(b) Termination. The department or designee shall terminate MH case management services provided to an individual if:

(1) the department or designee is notified of any of the circumstances described in subsection (a) of this section;

(2) it is determined that the individual no longer meets the eligibility criteria for MH case management services as set forth in §412.405 of this title; or

(3) the individual is not eligible for Medicaid and the department or its designee determines that there are insufficient resources to continue to provide MH case management services to the individual.

#### §412.411. MH Case Management Employee Qualifications.

(a) A case manager must be:

(1) a QMHP-CS or a CSSP;

(2) an employee of the provider; and

(3) competent according to §412.412 of this title (relating to MH Case Management Employee Competencies).

(b) The provider may require additional education and experience for a case manager.

(c) An employee who supervises a case manager must be an employee of the provider and either:

(1) be a QMHP-CS;

(2) be competent according to §412.412 of this title and have experience in providing MH case management services; or

(3) hold a master's degree in a related field;

(4) demonstrate competency according to §412.412 of this title;

(5) demonstrate competency in knowledge of community resources; and

(6) demonstrate competency in MH case management evidenced-based practices.

#### §412.412. MH Case Management Employee Competencies.

(a) The provider must implement a process to ensure the competency of a case manager and a case manager supervisor that, at a minimum, ensures:

(1) an accurate knowledge of the requirements of this subchapter and the following subchapters of this title:

(A) Chapter 412, Subchapter G of this title (relating to Mental Health Community Services Standards);

(B) Chapter 404, Subchapter E of this title (relating to Rights of Persons Receiving Mental Health Services);

(C) Chapter 414, Subchapter L of this title (relating to Abuse, Neglect, and Exploitation in Local Authorities and Community Centers); and

(D) Chapter 411, Subchapter N of this title (relating to Standards for Services to Individuals with Co-Occurring Psychiatric and Substance Use Disorders (COPSD));

(2) an accurate understanding of the nature of mental illness and serious emotional disturbance;

(3) an awareness and sensitivity in communicating and coordinating services with an individual who has a special physical need such as a hearing or visual impairment;

(4) the ability to respond to an individual's language and cultural needs through knowledge of customs, beliefs, and values of various, racial, ethnic, religious, and social groups;

(5) the ability to complete the uniform assessment;

(6) the ability to understand and apply the utilization management guidelines;

(7) the ability to develop and implement a plan if the case manager is providing intensive case management services to a child or adolescent;

(8) the ability to identify an individual in crisis;

(9) knowledge of appropriate actions to take in managing a crisis;

(10) an understanding of the developmental needs of an adult, a child, or an adolescent;

(11) an understanding of the wraparound planning process or other department-approved model, if the case manager is providing intensive case management services to a child or adolescent;

(12) knowledge of health and human services available to a child or adolescent as described in Texas Government Code, §531.0244, if the case manager is providing intensive case management services to a child or adolescent;

(13) knowledge of available resources within the local community;

(14) knowledge of strategies for advocating effectively on behalf of individuals; and

(15) the ability to document the MH case management services described in §412.413 of this title (relating to Documenting MH Case Management Services).

(b) The provider shall require each case manager and case manager supervisor, prior to providing MH case management services, to:

(1) demonstrate the competencies described in subsection (a) of this section; and

(2) ensure that documentation verifying competencies is maintained in the personnel record of each case manager and case manager supervisor.

#### §412.413. Documenting MH Case Management Services.

(a) Location of documentation. MH case management services, as well as attempts to provide MH case management services, as described in this section, must be documented in the individual's medical record.

(1) For routine case management, the case manager must document the information required by §412.407(b)(3) - (6) of this title (relating to MH Case Management Services Standards), as well as the steps taken to meet the individual's goals and needs as required by §412.407(b)(7) of this title, in the individual's medical record.

(2) For intensive case management:

(A) the assigned case manager must include the intensive case management plan required by §412.407(c)(1) of this title in the individual's medical record; and

(B) the assigned case manager must document steps taken to meet the individual's goals and needs as required by §412.407(c)(7) of this title in the individual's progress notes.

(b) Assessment and reassessment. As a result of the face-to-face meetings, assessments, and reassessments required in §412.407 of this title, the case manager must document the individual's:

(1) identified strengths, service needs, and assistance given to address the identified need; and

(2) specific goals and actions to be accomplished.

(c) Service documentation. The case manager must document the following for all services provided:

(1) the event or behavior that occurs while providing the MH case management service or the reason for this specific encounter;

(2) the person, persons, or entity, including other case managers, with whom the encounter or contact occurred;

(3) the recovery plan goal(s) that was the focus of the MH case management service, including the progress or lack of progress in achieving recovery plan goal(s);

(4) the timeline for obtaining the needed services;

(5) the specific intervention that is being provided;

(6) the plan to proceed based upon the facts presented in this encounter or the resolution, if any;

(7) the date the MH case management service was provided;

(8) the begin and end time of the MH case management service;

(9) the location where the MH case management service was provided and whether it was a face-to-face or telephone contact;

(10) the signature of the employee providing the MH case management service and their credentials; and

(11) the timeline for reevaluating the needed services.

(d) Crisis service documentation. In addition to the requirements described in subsection (a) of this section, a provider must document the following for crisis intervention services:

(1) the documentation required by Chapter 412, Subchapter G, specifically §412.321(e) of this title (relating to Crisis Services); and

(2) the outcome of the individual's crisis.

(e) Refusing MH case management services. If the individual refuses MH case management services, the case manager must:

(1) document the reason for the refusal in the progress notes of the individual's medical record; and

(2) request that the individual sign a waiver of MH case management services that is filed in the individual's medical record.

(f) Documentation retention. The provider must retain documentation in compliance with applicable records retention requirements in federal and state laws, rules, and regulations.

#### §412.414. Medicaid Reimbursement.

(a) In accordance with §412.407 of this title (relating to MH Case Management Services Standards), a billable event is a face-to-face contact during which the case manager provides an MH case management service to an:

(1) individual who is Medicaid eligible; or

(2) LAR on behalf of a child or adolescent who is Medicaid eligible.

(b) A unit of service for MH case management services is 15 continuous minutes.

(c) The department shall not reimburse a provider for Medicaid MH case management services if:

(1) the individual who was provided the service did not meet the eligibility requirements set forth in §412.405 of this title (relating to Eligibility for MH Case Management Services) at the time the service was provided;

(2) the service provided was an integral and inseparable part of another service;

(3) the service was provided by a person who was not qualified in accordance with §412.411(a) of this title (relating to MH Case Management Employee Qualifications);

(4) the service provided was not the type, amount, and duration authorized by the department or its designee;

(5) the service was not provided or documented in accordance with this subchapter;

(6) the service provided is in excess of eight hours per individual per day; or

(7) the services provided do not conform to the requirements set forth in the department's *MH Case Management Billing Guidelines*.

(d) The department shall not reimburse a provider for Medicaid MH case management services for coordination activities that are included in the provision of:

(1) rehabilitative crisis intervention services, as described in Chapter 419, Subchapter L, specifically §419.457 of this title (relating to Crisis Intervention Services); or

(2) psychosocial rehabilitative services, as described in Chapter 419, Subchapter L, specifically §419.459 of this title (relating to Psychosocial Rehabilitative Services).

(e) If Medicaid-funded MH case management services are continued prior to a fair hearing, as required by 1 TAC, §357.11 (relating to Notice and Continued Benefits), the provider may file a claim for such services.

(f) An individual is eligible for Medicaid-funded MH case management services if, in addition to the criteria set forth in §412.405 of this title, the individual is:

(1) eligible for Medicaid;

(2) not an inmate of a public institution, as defined in 42 CFR §435.1009;

(3) not a resident of an intermediate care facility for persons with mental retardation as described in 42 CFR §440.150;

(4) not a resident of an IMD;

(5) not a resident of a Medicaid-certified nursing facility, unless the individual has been determined through a pre-admission screening and resident review assessment to be eligible for the specialized service of MH case management services or the individual is expected to be discharged to a non-institutional setting within 180 days;

(6) not a recipient of MH case management services under another Medicaid program (e.g., the Home and Community Services waiver program or Texas Health Steps); and

(7) not a patient of a general medical hospital.

§412.415. Fair Hearings and Appeal Processes.

(a) Right of Medicaid-eligible individual to request a fair hearing. Any Medicaid eligible individual whose request for eligibility for MH case management services is denied or is not acted upon with reasonable promptness, or whose MH case management services have been

terminated, suspended, or reduced by the department, is entitled to a fair hearing in accordance with 1 TAC, Chapter 357, Subchapter A (relating to Uniform Fair Hearing Rules).

(b) Right of non-Medicaid eligible individual to request an appeal. Any individual who has not applied for or is not eligible for Medicaid whose request for eligibility for MH case management services is denied or is not acted upon with reasonable promptness, or whose MH case management services have been terminated, suspended, or reduced by a local mental health authority or its contractor, is entitled to notification and right of appeal in accordance with the department's rules concerning such matters for non-Medicaid-eligible individuals.

#### §412.416. Guidelines.

The following guidelines, as revised, are referenced in this subchapter. For information about obtaining copies of the guidelines contact the Department of State Health Services, Mental Health Program Services, P.O. Box 149347, Mail Code 2018, Austin, TX 78714-9347, (512) 467-5427 or access them electronically.

(1) Uniform assessment guidelines are available online at:  
<http://www.dshs.state.tx.us/mhprograms/RDMAssess.shtm>.

(2) Utilization management guidelines for adults and children are available online at:  
<http://www.dshs.state.tx.us/mhprograms/RDMClinGuide.shtm>.

(3) *MH Case Management Billing Guidelines* are available at:  
<http://www.dshs.state.tx.us/Layouts/ContentPage.aspx?PageID=35712&id=8589961742&terms=billing+guidelines>.