Division of Medical Assistance Programs

Targeted Case Management Services Rulebook

Includes:

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2) Current Update Information (changes since last update)
3) Other Provider Resource Information
4) Complete set of Targeted Case Management Administrative Rules

DEPARTMENT OF HUMAN SERVICE

Division of Medical Assistance Programs

DIVISION 138

Targeted Case Management

Update Information (most current Rulebook changes)

Other Provider Resources Information

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Targeted Case Management Services Rulebook

Update Information (correction only)

February 3, 2010

The Division of Medical Assistance Programs (DMAP) updated this Rulebook as follows:

ADOPTED: 410-138-0390

AMENDED: 410-138-0009, 410-138-0020, 410-138-0300, 410-138-0360, 410-138-0380, 410-138-0560, 410-138-0680

REPEALED: 410-138-0320, 410-138-0340, 410-138-0520, 410-138-0620, 410-138-0720

The previously posted Rulebook was missing the above numbers highlighted in red. The rules are now replaced as well.

Having temporarily adopted 410-138-0390 and amended 410-138-0300, 410-138-0360 and 410-138-0380 to expand the defined target group of TCM-HIV clients and to expand the types of qualified TCM providers in Multnomah County, DMAP now permanently adopts these rules effective retroactively to January 1, 2009. Multnomah County is permitted to bill for service dates retroactive to January 1, 2009 in accordance with these rules.

DMAP permanently amended 410-138-0009, 410-138-0020, 410-138-0560 and 410-138-0680 and repealed rules listed above to consolidate “definitions” rules in various TCM programs, remove unnecessary definitions rules and correct references.

The Table of Contents is updated.

If you have questions, contact a Provider Services Representative toll free at 1-800-336-6016 or direct at 503-378-3697 (Salem).

PR 133 RB 915 2/3/10 (correction)

Other Provider Resources

DMAP has developed the following additional materials not found in this Rulebook to help you bill accurately and receive timely payment for your services.

Supplemental Information

The Targeted Case Management (TCM) Services webpage contains important information not found in the rulebook, including:

- ✓ Medicaid/SCHIP Local Match Leveraging Form
- ✓ Babies First Website
- ✓ TCM Provider Tools
- ✓ Tools for New Medical Assistance Providers
- ✓ Other Information not found in the Rulebook
- ✓ Medicaid Management Information System (MMIS)

The above information for the Targeted Case Management Services is found at:

http://www.dhs.state.or.us/policy/healthplan/guides/tcmngmt/main.html

Provider Contact Booklet

This booklet lists general information phone numbers, frequent contacts, phone numbers to use to request prior authorization, and mailing addresses.

Download the Provider Contact Booklet at:

http://www.dhs.state.or.us/healthplan/data_pubs/add_ph_conts.pdf

Other Resources

We have posted other helpful information, including provider announcements, at:

http://www.oregon.gov/DHS/healthplan/tools_prov/main.shtml

Medicaid Management Information System (MMIS)

See the Web page called: “Everything you need to know about the new MMIS” found at http://www.oregon.gov/DHS/healthplan/mmis.shtml

This Web page includes information about the new Provider Web Portal at:

https://www.or-medicaid.gov

And, instructions to use the new Provider Web Portal at:

www.oregon.gov/DHS/healthplan/webportal.shtml

410-138-0000 Purpose- Babies First/Cacoon program

(1) These rules are to be used in conjunction with the Division of Medical Assistance Programs' (DMAP) General Rules (chapter 410 division 120).

(2) Targeted Case Management (TCM) services is a medical assistance program operated by public health authorities. Babies First/Cacoon TCM program, authorized under these rules, is a cost-sharing (Federal Financial Participation (FFP) matching) program in which the TCM provider as a public entity, unit of government, is responsible for paying the non-federal matching share of the amount of the TCM claims. (See 410-138-0005 Payment for Targeted Case Management (TCM) Services Eligible for Federal Financial Participation.) The TCM services rules are designed to assist the TCM provider organization in matching state and federal funds for TCM services defined by section 1915(g) of the Social Security Act, 42 USC (1396n)(g).

(3) The Babies First/Cacoon program TCM services rules define the Oregon Medicaid program for reimbursing services provided under Babies First/Cacoon. This program improves access to needed medical, social, education, and other services for infants and pre-school children (0 through 3 years) covered by Medicaid who are at risk of poor health outcomes as outlined in OAR 410-138-0040, Risk Factors. TCM services are provided by an enrolled Babies First/Cacoon program TCM provider consistent with these rules.

(4) TCM services include management of medical and non-medical services, which address health, psychosocial, economic, nutritional, and other needs. Home visits constitute a significant part of the delivery of targeted case management services. No direct care services are authorized as part of case management activities.

(5) Provision of Babies First/Cacoon program TCM services may not restrict an eligible client's choice of providers:

(a) Eligible clients must have free choice of available Babies First/Cacoon program TCM service providers or other TCM service providers available to the eligible client, subject to the Social Security Act, 42 USC 1396n;

(b) Eligible clients must have free choice of the providers of other medical care within their benefit package of covered services.

Stat. Auth.: ORS 409.010 and ORS 409.110

Stats. Implemented: ORS 414.085

10-2-08 (T) 12-28-08 (P)

410-138-0005 Payment for Targeted Case Management Services Eligible for Federal Financial Participation

(1) All Targeted Case Management (TCM) rules are to be used in conjunction with the Division of Medical Assistance Programs (DMAP) General Rules (chapter 410 division 120) and the TCM supplemental information.

(2) The TCM services rules are designed to assist the TCM provider organization in matching state and federal funds for TCM services defined by Section 1915(g) of the Social Security Act, 42 USC § 1396n(g).

(3) Payment will be made to the TCM provider enrolled with the Department of Human Services (DHS) as a unit of government provider meeting the requirements set forth in the provider enrollment agreement.

(4) Signing the provider enrollment agreement sets forth the relationship between the State of Oregon, DHS and the TCM provider and constitutes agreement by the TCM provider to comply with all applicable rules of DHS, federal and state laws or regulations.

(5) The TCM provider will bill according to administrative rules in chapter 410, division 138 and the TCM supplemental information. Payments will be made using the Medicaid Management Information System (MMIS) and the TCM provider will retain the full payment for covered services provided. The TCM provider must have a Trading Partner Agreement with DHS prior to submission of electronic transactions.

(6) Targeted case management authorized under these rules is a cost-sharing (Federal Financial Participation (FFP) matching) program in which the TCM provider as a public entity, unit of government, is responsible for paying the non-federal matching share of the amount of the TCM claims, calculated using the Federal Medical Assistance Percentage (FMAP) rates in effect during the quarter when the TCM claims will be paid:

(a) The TCM provider's non-federal matching share means the public funds share of the Medicaid payment amount. Pursuant to the Social

Security Act, 42 CFR 433.51, public funds may be considered as the state's share in claiming federal financial participation, if the public funds meet the following conditions:

(A) The public funds are transferred to DHS from public entities that are units of government;

(B) The public funds are not federal funds or they are federal funds authorized by federal law to be used to match other federal funds; and

(C) All sources of funds must be allowable under the Social Security Act 42 CFR 433 Subpart B;

(b) The unit of government TCM provider must pay the non-federal matching share to DHS in accordance with OAR 410-120-0035.

(7) Before DHS pays for TCM claims, DHS must receive the corresponding local match payment as described in this rule.

Failure to timely pay the non-federal matching funds to DHS will delay payment and may require the TCM provider to resubmit the claims.

(8) DHS will not be financially responsible for payment of any claim that the Centers for Medicare and Medicaid Services (CMS) disallows under the Medicaid program. If DHS has previously paid the TCM provider for any claim which CMS disallows, the TCM provider must reimburse DHS the amount of the claim that DHS has paid to the TCM provider, less any amount previously paid by the unit of government TCM provider to DHS for the non-federal match portion for that claim.

(9) Providers can only bill Medicaid for allowable activities in the Targeted Case Management (TCM) program, that assist individuals eligible under the Medicaid State plan to gain access to needed medical, social, education, and other services. One or more of the following allowable activities must occur before billing:

(a) Assessment;

(b) Development of a care plan;

(c) Referral (including follow up); and

(d) Monitoring (including follow up).

(10) TCM claims must not duplicate payments made to:

(a) Public agencies or private entities for any other case management activities or direct services provided under the State Plan or the Oregon Health Plan (OHP), through fee for service, managed care, or other contractual arrangement, that meet the same need for the same client at the same point in time;

(b) A TCM provider by program authorities under different funding authority than the Oregon Health Plan, including but not limited to other public health funding;

(c) A TCM provider for administrative expenditures reimbursed under agreement with DHS or any other program or funding source.

(11) Medicaid is only liable for the cost of otherwise allowable case management services if there are no other third parties liable to pay.

However, while schools are legally liable to provide IDEA-related health services at no cost to eligible children, Medicaid reimbursement is available for these services because section 1903(c) of the Act requires Medicaid to be primary to the U.S. Department of Education for payment for covered Medicaid services furnished to a child with a disability. These services may include health services included in a child's Individualized Education Program (IEP) or Individual Family Service Plan (IFSP) under the IDEA. Payment for those services that are included in the IEP or IFSP would not be available when those services are not covered Medicaid services.

Stat. Auth.: ORS 409.010 & ORS 409.110

Stats. Implemented: ORS 414.085 10-2-08 (T) 12-28-08 (P)

410-138-0007 Targeted Case Management- Covered Services

(1) Targeted case management services may be furnished only to eligible clients. An "eligible client" is a person who is eligible for Medicaid and eligible for case management services (including targeted case management services) as defined in the Medicaid State plan, at the time the services are furnished.

(2) "Targeted case management services" are case management services provided to a specific target group of individuals that assist individuals eligible under the State plan in gaining access to needed medical, social, educational, and other services (such as housing or transportation).

(3) Targeted Case Management Services billed to Medicaid must be for allowable activities and include one or more of the following components:

(a) Assessment of an eligible client in the target group to determine the need for medical, educational, social, or other services as follows:

(A) Taking client history;

(B) Identifying the needs of the client, and completing related documentation;

(C) Gathering information from other sources, such as family members, medical providers, social workers, and educators, if necessary, to form a complete assessment of the eligible client;

(D) Periodically reassessing a client to determine whether the client's needs or preferences have changed. A reassessment must be conducted at least annually or more frequently if changes occur in an individual's condition;

(b) Development of a care plan based on the information collected through the assessment or periodic reassessment, specifying the goals and actions to address the medical, social, educational, and other services needed by the eligible client. These may include:

(A) active participation of the eligible client in the target group; or

(B) working with the eligible client or the eligible client's authorized health care decision maker(s) and others to develop goals and identify a course of action to respond to the assessed needs of the eligible client;

Referral and related activities such as:

(A) scheduling appointments for the client in the target group to obtain needed services; and

(B) activities that help link the eligible client with medical, social, or educational providers, or other programs and services that address identified needs and achieve goals specified in the care plan. The case management referral activity is completed once the referral and linkage has been made;

(d) Monitoring or ongoing face-to-face or other contact;

(A) Monitoring and follow-up activities include activities and contacts:

(i) to ensure the care plan is effectively implemented;

(ii) to help determine whether the services are being furnished in accordance with the eligible client's care plan;

(iii) to determine whether the care plan adequately addresses the needs of the eligible client in the target group;

(iv) to adjust the care plan to meet changes in the needs or status of the eligible client;

(B) Monitoring activities may include contacts with:

(i) the participating eligible client in the target group;

(ii) the eligible client's healthcare decision maker(s), family members, providers, or other entities or individuals when the purpose of the

contact is directly related to the management of the eligible client's care.

Stat. Auth.: ORS 409.010 & ORS 409.110

Stats. Implemented: ORS 414.085

10-2-08 (T) 12-28-08 (P)

410-138-0009 Targeted Case Management- Services Not Covered

(1) Direct delivery of an underlying medical, educational, social or other service, to which the eligible client has been referred.

(2) Providing transportation to a service to which an eligible client is referred.

(3) Escorting an eligible client to a service.

(4) Providing child care so that an eligible client may access a service.

(5) Contacts with individuals who are not eligible for Medicaid, or who are Medicaid eligible but not included in the eligible target population when those contacts relate directly to the identification and management of the non-eligible or non-targeted individual's needs and care.

(6) Assisting an individual, who has not yet been determined eligible for Medicaid, to apply for or obtain this eligibility.

(7) TCM services provided to an individual if the services are case management services funded by Title IV-E or Title XX of the Social Security Act, or federal or state funded parole and probation, or juvenile justice programs.

(8) Activities for which third parties are liable to pay.

Stat. Auth.: ORS 409.010 & ORS 409.110

Stats. Implemented: ORS 414.085

1-1-10

410-138-0020 Targeted Case Management Definitions

(1) Assessment - The act of gathering information and reviewing historical and existing records of an eligible client in a target group to determine the need for medical, educational, social, or other services. To perform a complete assessment, the case manager will gather information from family members, medical providers, social workers, and educators, if necessary.

(2) Care Plan - A Targeted Case Management Care Plan is a multidisciplinary plan, which contains a set of goals and actions required to address the medical, social, educational, and other service needs of the eligible client based on the information collected through an assessment or periodic reassessment.

(3) Case Management - Services performed by a case manager to assist individuals eligible under the Medicaid State plan in gaining access to and effectively using needed medical, social, educational, and other services (such as housing or transportation) in accordance with 42 CFR 441.18. Also see definition for “Targeted Case Management.”

(4) Duplicate payments - Payments are considered “duplicate” if more than one entity is reimbursed for the same services to meet the same need for the same client.

(5) EI/ECSE Case manager (i.e., service coordinator) - An employee of the EI/ECSE contracting or subcontracting agency meeting the personnel standards requirements in OAR 581-015-2900. The EI/ECSE case manager serves as a single point of contact and is responsible for coordinating all services across agency lines for the purpose of assisting an eligible client to obtain needed medical, social, educational, developmental and other appropriate services (such as housing or transportation) identified in the eligible client’s care plan in coordination with the client’s IFSP.

(6) Early Intervention (EI) - A program designed to address the unique needs of a child age 0-3 years with a disability.

(7) Early Childhood Special Education (ECSE) - A program designed to address the unique needs of a child age 3-5 years with a disability.

(8) EI/ECSE - Early Intervention/Early Childhood Special Education services are services provided to a preschool child with disabilities, eligible under the Individuals with Disabilities Education Act (IDEA), from birth until they are eligible to attend public school, pursuant to the eligible child's Individualized Family Service Plan (IFSP).

(9) EI/ECSE Targeted Case Management program- as a service under the State plan, includes case management services furnished to eligible EI/ECSE preschool children age 0-5 with disabilities to gain access to needed medical, social, educational, developmental and other appropriate services (such as housing or transportation) in coordination with the eligible client's IFSP. EI/ECSE TCM Providers must meet the criteria for the provision of special education programs approved by the State Superintendent of Public Instruction qualifying such programs for state reimbursement under OAR 581-015-2710 EI/ECSE; and must be contractors with the Oregon Department of Education in the provision of EI/ECSE services or be sub-contractors with such a contractor. Medicaid reimbursement for EI/ECSE TCM services is available only to eligible clients in the target group and does not restrict an eligible client's free choice of providers. See definition for "eligible client".

(10) Eligible client - An individual who is deemed eligible for Medicaid or the Children's Health Insurance Program (CHIP) by the Department of Human Services (DHS) and eligible for case management services (including targeted case management services) as defined in the Medicaid State plan, at the time the services are furnished.

(11) Individualized Family Service Plan (IFSP) -A written plan of early childhood special education services, early intervention services, and other services developed in accordance with criteria established by the Oregon Department of Education for each child (ages birth to 5 years) eligible for IFSP services. The plan is developed to meet the needs of a child with disabilities in accordance with requirements and definitions in Oregon Administrative Rules, chapter 581, division 15.

(12) Medical Assistance Program - A program that provides and pays for health services for eligible Oregonians. The Oregon Medical Assistance Program includes TCM services provided to clients eligible under the Oregon Health Plan (OHP) Title XIX, and the Children's Health Insurance Program (CHIP) Title XXI. The Medical Assistance Program is administered by the Division of Medical Assistance Programs (DMAP).

(13) Monitoring - Ongoing face-to-face or other contact to conduct follow-up activities with the participating eligible client or the client's health care decision maker(s), family members, providers or other entities or individuals when the purpose of the contact is directly related to managing the eligible client's care to ensure the care plan is effectively implemented.

(14) Reassessment – Periodically re-evaluating the eligible client to determine whether or not medical, social, educational or other services continue to be adequate to meet the goals and objectives identified in the care plan. Reassessment decisions include those to continue, change or terminate TCM services. A reassessment must be conducted at least annually or more frequently if changes occur in an eligible client's condition; or when resources are inadequate or the service delivery system is non-responsive to meet the client's identified service needs.

(15) Referrals - Performing activities such as scheduling appointments that link the eligible client with medical, social, or educational providers, or other programs and services, and follow-up and documentation of services obtained.

(16) Targeted Case Management (TCM) Services - Case management services provided to a specific target group of eligible clients under the Medicaid State plan to gain access to needed medical, social, educational, and other services (such as housing or transportation). TCM services are available only to eligible clients. See definition for "Eligible client."

Stat. Auth.: ORS 409.010 and ORS 409.110

Stats. Implemented: ORS 409.010 and 414.065 1-1-10

410-138-0040 Risk Criteria -- Babies First/Cocoon Program

(1) Medical Risk Factors for infants and preschool children:

(a) Drug exposed infant;

(b) Infant HIV Positive;

(c) Maternal PKU or HIV Positive;

(d) Intracranial hemorrhage (excludes Very High Risk Factor B16);

(e) Seizures (excludes VHR Factor B18);

(f) Perinatal asphyxia;

(g) Small for gestational age;

(h) Birth weight 1500 grams or less;

(i) Mechanical ventilation for 72 hours or more;

(j) Neonatal hyperbilirubinemia;

(k) Congenital infection (TORCH);

(l) CNS infection (e.g., meningitis);

(m) Head trauma or near drowning;

(n) Failure to thrive;

(o) Chronic illness;

(p) Suspect vision impairment;

(q) Vision impairment;

(r) Family history of childhood onset hearing loss.

(2) Social Risk Factors:

(a) Maternal age 16 years or less;

(b) Parents with disabilities or limited resources;

(c) Parental alcohol or substance abuse;

(d) At-risk caregiver;

(e) Concern of parent/provider;

(f) Other evidence-based social risk factors.

(3) Very High Risk Medical Factors:

(a) Inraventricular hemorrhage (grade III, IV) or cystic;

(b) Periventricular leukomalacia (PVL) or chronic subdurals;

(c) Perinatal asphyxia and seizures;

(d) Oromotor dysfunction requiring specialized feeding program (include infants with gastrostomies);

(e) Chronic lung disease on oxygen (includes infants with tracheostomies);

(f) Suspect neuromuscular disorder including abnormal neuromotor exam at NICU discharge.

(4) Established Risk Categories:

(a) Heart disease;

(b) Chronic orthopedic disorders;

(c) Neuromotor disorders including cerebral palsy and brachia nerve plasy;

(d) Cleft lip and palate and other congenital defects of the head and face;

(e) Genetic disorders including fetal alcohol syndrome;

(f) Multiple minor physical anomalies;

(g) Metabolic disorders;

(h) Spina bifida;

(i) Hydrocephalus or persistent ventriculomegaly;

(j) Microcephaly and other congenital defects of the CNS;

(k) Hemophilia;

(l) Organic speech disorders (dysarthria/ dyspraxia);

(m) Suspect hearing or hearing loss;

(n) Burns;

(o) Acquired spinal cord injury etc., paraplegia or quadriplegia.

(5) Developmental Risk Factors:

(a) Borderline developmental delay;

(b) Other evidence-based developmental risk.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

2-1-07

410-138-0060 Provider Requirements -- Babies First/Cocoon Program

(1) Babies First/Cocoon – Targeted Case Management (TCM) organizations must be a public health authority and must meet the following criteria:

(a) Demonstrated capacity (including sufficient number of staff) to provide all core elements of Case Management services including:

(A) Comprehensive client Assessment;

(B) Comprehensive care/service plan development;

(C) Linking/coordination of services;

(D) Monitoring and follow-up of services;

(E) Reassessment of the client's status and needs;

(F) Tracking the infant with follow-up across county lines to assure that no infant is lost to the case management system during the rapid growth and developmental period of the first 48 months of life.

(b) Demonstrated Case Management experience in coordinating and linking such community resources as required by the target population;

(c) Demonstrated experience with the target population;

(d) An administrative capacity to ensure quality of services in accordance with state and federal requirements;

(e) A financial management capacity and system that provides documentation of services and costs;

(f) Ability to link with the Title V Statewide MCH Data System or provide another statewide computerized tracking and monitoring system;

(g) Capacity to document and maintain individual case records in accordance with state and federal requirements, including HIPAA Privacy requirements applicable to Case Management Services, ORS 192.518 – 192.524, ORS 179.505, and ORS 411.320;

(h) Demonstrated ability to meet all state and federal laws governing the participation of providers in the state Medicaid program.

(i) Enrolled as a TCM provider with the Division of Medical Assistance Programs (DMAP).

(2) The case manager must be:

(a) A licensed registered nurse with one year of experience in community health, public health, child health nursing, or be a registered nurse or certified home visitor working under the direction of the above; and

(b) Working under the policies, procedures, and protocols of the State Title V MCH Program and Medicaid.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

2-1-07

410-138-0080 Billing Policy and Codes -- Babies First/Cacoon Program

(1) Payment will be made to a Babies First/Cacoon Targeted Case Management (TCM) Provider enrolled with the Department of Human Services (DHS) as a unit of government provider meeting the requirements set forth in the Provider Enrollment Agreement as the performing provider for those Case Management services provided by the employed staff person.

(2) Signing the Provider Enrollment Agreement sets forth the relationship between the State of Oregon DHS and the TCM Provider and constitutes agreement by the provider to comply with all applicable rules of the Division of Medical Assistance Programs, federal and state laws and regulations.

(3) The TCM Provider will bill according to OAR 410 Division 138 rules. Payments will be made through the Medicaid Management Information System (MMIS) and the TCM Provider will retain the full payment for covered services provided. The TCM Provider must have a trading partner agreement with DHS prior to submission of electronic transactions.

(4) Targeted Case Management authorized under these rules is a cost-sharing (Federal Financial Participation matching) program in which the TCM Provider, as a public entity unit of government, is responsible for paying the non-federal matching share of the amount of the TCM claims, calculated using the Federal Medical Assistance Percentage (FMAP) rate in effect during the quarter when the TCM claims will be paid:

(a) The TCM Provider's non-federal matching share means the public funds share of the Medicaid payment amount. Pursuant to 42 CFR 433.51, public funds may be considered as the State’s share in claiming federal financial participation if the public funds meet the following conditions:

(A) The public funds are transferred to DHS from public entities that are units of government;

(B) The public funds are not federal funds or they are federal funds authorized by federal law to be used to match other federal funds; and

(C) All sources of funds must be allowable under 42 CFR 433 Subpart B;

(b) The TCM Provider must pay its non-federal matching share to DHS in accordance with OAR 410-120-0035.

(5) Failure to timely remit the non-federal share described in subsection (4) will cause a delay in TCM claim processing and payment until DHS receives the TCM Provider's non-federal matching share. If the TCM Provider's non-federal matching share is not paid within a reasonable time, the TCM claims will be denied.

(6) DHS will not be financially responsible for payment of any claim that the Centers for Medicare and Medicaid Services (CMS) disallows under the Medicaid program. If DHS has previously paid the TCM Provider for any claim which CMS disallows, the TCM Provider must reimburse DHS the amount of the claim that DHS has paid to the TCM Provider, less any amount previously paid by the unit of government TCM Provider to DHS for purposes of reimbursing DHS the non-federal match portion for that claim.

(7) Billing criteria for this program are as follows:

(a) Use procedure code "T1016" for Babies First/Cacoon -- Targeted Case Management. Maximum billing for the T1016 procedure code is one time per day per client. One of the three activities listed below must occur in order to bill:

(A) Screening;

(B) Assessment;

(C) Intervention;

(b) Any place of service (POS) is valid;

(c) Prior authorization is not required;

(d) The provider must use Diagnosis Code “V201.”

(8) Duplicate billings are not allowed and duplicate payments will be recovered. Services will be considered as duplicate if the same services are billed by more than one entity to meet the same need. Medical services must be provided and billed separately from Case Management Services.

(9) A unit of service can only be billed once under one procedure code, under one provider number.

Stat. Auth.: ORS 409.010, 409.110 & 409.050
Stats. Implemented: ORS 414.065

7-1-08 (T) 12-28-08 (P)

410-138-0300 Targeted Case Management Human Immunodeficiency Virus Program

(1) This rule is in effect for services rendered retroactive to January 1, 2009.

(2) The Targeted Case Management (TCM) Human Immunodeficiency Virus (HIV) administrative rules are to be used in conjunction with the Division of Medical Assistance Program's (DMAP) General Rules (chapter 410, division 120) and Targeted Case Management Rules 410-138-0005 through 410-138-0009.

(3) The Targeted Case Management (TCM) Human Immunodeficiency Virus (HIV) program is a medical assistance program operated by unit of government providers. Participation by providers is voluntary and subject to approval by the Department of Human Services and the Centers for Medicare and Medicaid Services. The TCM HIV program authorized under these rules is a cost-sharing (Federal Financial Participation (FFP) matching) program in which the TCM provider as a public entity, unit of government, is responsible for paying the non-federal matching share of the amount of the TCM claims. (See 410-138-0005 Payment for Targeted Case Management Services Eligible for Federal Financial Participation.) The TCM program rules are designed to assist the TCM provider organization in matching state and federal funds for TCM services defined by section 1915(g) of the Social Security Act, 42 USC (1396n)(g).

(4) The TCM HIV rules explain the Oregon Medicaid Program's policies and procedures for reimbursing HIV TCM services. This program improves access to needed medical, psychosocial, educational, and other services for Medicaid eligible clients in Multnomah County with symptomatic or asymptomatic HIV disease. Contingent upon and immediately upon receipt of CMS approval, DMAP will begin implementation to extend the TCM HIV program to other counties. Without targeted case management services an eligible client's ability to remain safely in their home may be at risk.

(5) TCM HIV program services include management of medical and non-medical services, which address physical, psychosocial,

nutritional, educational, and other needs. Home visits constitute an integral part of the delivery of TCM services, provided by a TCM HIV case manager consistent with these rules. No direct care services are authorized as part of case management activities.

(6) Provision of TCM HIV services may not restrict an eligible client's choice of providers:

(a) Eligible clients must have free choice of available TCM HIV service providers or other TCM service providers available to the eligible client, subject to the Social Security Act, 42 USC 1396n;

(b) Eligible clients must have free choice of the providers of other medical care within their benefit package of covered services.

Stat. Auth.: ORS 409.010 & ORS 409.110

Stats. Implemented: ORS 414.085

1-1-10

410-138-0360 Targeted Case Management Human Immunodeficiency Virus (HIV) Program - Provider Requirements

(1) This rule is in effect for services rendered retroactive to January 1, 2009.

(2) Targeted Case Management (TCM) HIV provider organizations must be unit of government providers. The providers must demonstrate the ability to provide all core elements of case management services including:

(a) Triage assessment and comprehensive assessment;

(b) Reassessment of the client's status and needs;

(c) Comprehensive care and service plan development;

(d) Referral and linking/coordination of services;

(e) Monitoring and follow-up of referral and related services.

(3) Program providers must demonstrate the following targeted case management experience and capacity:

(a) Coordination and linking of community resources as required by the target population;

(b) Demonstrated and documented experience providing services for the target population;

(c) Staffing levels sufficient to meet the case management service needs of the target population;

(d) An administrative capacity to ensure quality of services in accordance with state and federal requirements;

(e) A financial management capacity and system that provides documentation of services and costs and is able to generate quarterly service utilization reports that can be used to monitor services

rendered against claims submitted and paid. The service utilization reporting requirements are as follows:

(A) Report on the number of unduplicated clients receiving services during the reporting period;

(B) Report on the number of FTE case managers providing services during the reporting period;

(C) Report on the number of distinct case management activities performed during the reporting period (Triage Assessments, Comprehensive Assessments, Re-Assessments, Care Plan Development, Referral and Related Services, and Monitoring and Follow-Up) along with the total number of 15-minute increments associated with each activity category;

(f) The capacity to document and maintain individual case records in accordance with state and federal requirements, including HIPAA Privacy requirements applicable to Case Management Services, ORS 192.518 – 192.524, ORS 179.505, and ORS 411.320;

(g) A demonstrated ability to meet all state and federal laws governing the participation of providers in the state Medicaid program; and

(h) Are enrolled as a unit of government TCM provider with the Department of Human Services (DHS) and meeting the requirements set forth in the provider enrollment agreement.

(4) Case managers must possess the following education and qualifications:

(a) A current active Oregon registered nurse (RN) license or Bachelor of Social Work, or other related health or human services degree from an accredited college or university; and

(b) Documented evidence of completing the Department of Human Services (DHS) HIV Care and Treatment designated HIV Case Manager training, and must participate in DHS on-going training for

HIV case managers. The training must either be provided by DHS, or be approved by DHS and provided by the TCM provider organization.

Stat. Auth.: ORS 409.010 & ORS 409.110

Stats. Implemented: ORS 414.065

1-1-10

410-138-0380 Targeted Case Management Rate Methodology, Billing Criteria and Codes - Human Immunodeficiency Virus (HIV) Program

(1) This rule is in effect for services rendered retroactive to January 1, 2009.

(2) This rule is to be used in conjunction with 410-138-0005 and General Rules (chapter 410, division 120).

(3) Providers shall only bill for allowable activities in the Targeted Case Management (TCM) HIV program that assist individuals eligible under the Medicaid State plan to gain access to needed medical, social, education, and other services. One or more of the activities listed below must occur in order to bill. The maximum number of 15-minute increments allowable per day is shown in parentheses:

(a) Assessment – Initial triage (maximum four 15- minute increments);

(b) Assessment – Comprehensive (maximum six 15- minute increments);

(c) Assessment –Reassessment (maximum four 15- minute increments);

(d) Development of a care plan (maximum nine 15- minute increments);

(e) Referral and related services (including follow-up) (maximum six 15- minute increments);

(f) Monitoring (including follow-up) (maximum three 15- minute increments).

(4) The maximum number of 15- minute units of service which can be performed and billed in any given calendar day (midnight to midnight) will be twenty four units (24 15- minute increments). The assumption is that no more than six hours would ever be provided to the same client, by the same case manager in any twenty four- hour calendar

day. Documentation must be maintained of the number of 15 minute-units of service provided for each activity shown in (3) above.

(5) A unit of service can only be billed under one procedure code and one provider number:

(a) The procedure code to be used is “T1017”;

(b) The provider must use diagnosis code “V08” or “042” for TCM HIV program services.

(6) Any place of service (POS) is valid.

(7) Prior authorization is not required.

(8) DMAP will not allow duplicate payments to other public agencies or private entities under other program authorities for TCM HIV services under the eligible client’s care plan. (“Duplicate payment” is defined in 410-138-0020). DMAP will recover duplicate payments.

(9) DMAP may not reimburse for TCM services if the services are case management services funded by Title IV-E or Title XX of the Social Security Act, federal or state funded parole and probation, or juvenile justice programs. These services must be billed separately.

Stat. Auth.: ORS 409.010, 409.110 & 409.050
Stats. Implemented: ORS 414.065

1-1-10

410-138-0390 Targeted Case Management Retroactive Payments - Human Immunodeficiency Virus (HIV) Program

(1) Providers may submit claims retroactively for services provided to the targeted population described in 410-138-0300 on or after January 1, 2009, if they meet the following criteria:

(a) Services were provided less than 12 months prior to the date of first claim submission, and were allowable services in accordance with 410-138-0380 and 410-138-0007;

(b) The maximum number of 15-minute increments billed does not exceed the maximum described in 410-138-0380;

(c) The case manager was appropriately licensed or certified, and met all current requirements for case managers at the time the service was provided, as described in 410-138-0360;

(d) Documentation regarding provider qualifications and the services that the provider retroactively claims must have been available at the time the services were performed;

(e) Providers must be able to meet the quarterly reporting requirements described in 410-138-0360, for all quarters in which billed services were provided.

(2) HIV TCM claims already paid by DMAP with a monthly rate may not be adjusted or resubmitted for the sole purpose of receiving a different rate.

(3) Prior payment of a monthly rate for a client will be considered payment in full for any case management services received by that client from any HIV TCM case manager during that month.

(4) DMAP will not allow duplicate payments to be made to the same or different providers for the same service for the same client, nor will payment be allowed for services for which third parties are liable to pay (see also 410-138-0005).

Stat. Auth.: ORS 409.010 & ORS 409.110

Stats. Implemented: ORS 414.085

11-16-09 (T) 1-1-10 (P)

410-138-0500 Pregnant Substance Abusing Women and Women with Young Children Targeted Case Management Program

(1) These rules are to be used in conjunction with the General Rules governing the Division of Medical Assistance Programs (DMAP) (chapter 410, division 120).

(2) The Pregnant Substance Abusing Women and Women with Young Children (PWWC) Targeted Case Management (TCM) program is a medical assistance program operated by public health authorities. PWWC TCM services authorized under these rules is a cost-sharing (Federal Financial Participation (FFP) matching) program in which the TCM provider as a public entity unit of government is responsible for paying the non-federal matching share of the amount of the TCM claims. (See 410-138-0005 Payment for Targeted Case Management Services Eligible for Federal Financial Participation.) The TCM services rules are designed to assist the TCM provider organization in matching state and federal funds for TCM services defined by Section 1915(g) of the Social Security Act, 42 USC (1396n)(g).

(3) The TCM rules for Pregnant Substance Abusing Women and Women with Young Children explain the Oregon Medicaid Program for reimbursing PWWC TCM services. This program improves access to needed medical, social, education and other services to Medicaid eligible women living in Marion, Polk, Linn, Benton, Jackson, and Yamhill Counties, provided by an enrolled PWWC TCM provider consistent with these rules.

(4) TCM services include management of medical and non-medical services, which address physical, psychosocial, nutritional and other needs to help this target group remain clean and sober. The provision of TCM services by an enrolled PWWC TCM provider must be consistent with these rules. No direct care services are authorized as part of case management activities.

(5) Provision of PWWC TCM services may not restrict an eligible client’s choice of providers:

(a) Eligible clients must have free choice of available PWWC TCM service providers or other TCM service providers available to the eligible client, subject to the Social Security Act, 42 USC 1396n;

(b) Eligible clients must have free choice of the providers of other medical care within their benefit package of covered services.

Stat. Auth.: ORS 409.010 & ORS 409.110

Stats. Implemented: ORS 414.065

10-2-08 (T) 12-28-08 (P)

410-138-0530 Risk Criteria – Pregnant, Substance Abusing Women and Women with Young Children

(1) Pregnant or have children under the age of five; and,

(2) Are in need of treatment for the abuse of alcohol and other drugs.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

2-1-07

410-138-0540 Provider Requirements -- Pregnant Substance Abusing Women and Women with Young Children Program

(1) (PWWC) – Targeted Case Management (TCM) organizations must be a public health authority and must meet the following criteria:

(a) Demonstrated capacity to provide all core elements of Case Management service activities described above;

(b) Understanding and knowledge of local and state resources/services which may be needed and available to the target population;

(c) Demonstrated case management experience in coordinating and linking the needed community resources with the client and their family as required by the target population;

(d) Demonstrated experience in working with the target population;

(e) Sufficient level of staffing to meet the Case Management service needs of the target population;

(f) An administrative capacity sufficient to monitor and ensure quality of services in accordance with state and federal requirements;

(g) Capacity to document and maintain individual case records in accordance with state and federal requirements, including HIPAA Privacy requirements applicable to Case Management Services, ORS 192.518 – 192.524, ORS 179.505, and ORS 411.320;

(i) Enrolled as a TCM provider with the Division of Medical Assistance Programs (DMAP).

(h) Demonstrated ability to meet all state and federal laws governing the participation of providers in the state Medicaid Program; and

(i) Ability to link with the Title V statewide Maternal and Child Health Data System or provide another computerized tracing and monitoring system to assure adequate follow-up and to avoid duplication.

(2) The case manager must be:

(a) A licensed registered nurse or a licensed clinical social worker with one year of experience coordinating human services, or a licensed registered nurse or social worker without this experience who works under supervision of the above; and

(b) Working in compliance with the policies, procedures and protocols approved by state Title V MCH Program and Medicaid.

Stat. Auth.: ORS 409.010 & ORS 409.110

Stats. Implemented: ORS 414.065

2-1-07

410-138-0560 Rate Methodology, Billing Criteria and Codes -- Pregnant Substance Abusing Women and Women with Young Children

(1) Providers can only bill for allowable activities in the PWWC Targeted Case Management Program that assist individuals eligible under the Medicaid State plan to gain access to needed medical, social, education, and other services. One or more of the activities listed below must occur in order to bill:

(a) Assessment;

(b) Development of a care plan;

(c) Referral (including follow up);

(d) Monitoring (including follow up).

(2) A unit of service can only be billed under one procedure code and one provider number:

(a) Providers must use procedure code “T2023” for Pregnant Substance Abusing Women with Young Children –TCM services. The maximum billing for the T2023 procedure code is one time per calendar month per eligible client;

(b) Providers must use diagnosis code “V6141” For Pregnant Substance Abusing Women with Young Children program –TCM services.

(3) Any place of service (POS) is valid.

(4) Prior authorization is not required.

(5) DMAP will not allow duplicate payments to other public agencies or private entities under other program authorities for TCM services under the eligible client’s care plan. (“Duplicate payment” is defined in 410-138-0020). DMAP will recover duplicate payments.

(6) DMAP may not reimburse for TCM services if the services are case management services funded by Title IV-E or Title XX of the Social Security Act, or federal or state funded parole and probation, or juvenile justice programs. These services must be billed separately.

Stat. Auth.: ORS 409.010, 409.110 & 409.050
Stats. Implemented: ORS 414.065

1-1-10

410-138-0600 Purpose - Federally Recognized Tribal Governments in Oregon

(1) These rules are to be used in conjunction with DMAP General Rules (chapter 410 division 120).

(2) The Federally Recognized Tribal Government (Tribal) Targeted Case Management (TCM) program is a medical assistance program operated by federally recognized tribal governments in Oregon. Tribal TCM services authorized under these rules is a cost-sharing (Federal Financial Participation (FFP) matching) program in which the Tribal TCM provider unit of government entity is responsible for payment of allowable tribal matching funds as the non-federal matching share of the amount of TCM claims. (See 410-138-0005 Payment for Targeted Case Management Services Eligible for Federal Financial Participation.) The TCM services program rules are designed to assist the case management provider organization in matching allowable tribal and federal funds for TCM services defined by Section 1915(g) of the Social Security Act, 42 USC § 1396n(g).

(3) The Tribal TCM rules explain the Oregon Medicaid program to reimburse the TCM services provided by a federally recognized tribal government located in the State of Oregon. This program improves access to needed medical, social, education, and other services for Medicaid eligible adults, children, and pregnant women, served by tribal programs, provided by an enrolled tribal TCM provider consistent with these rules. No direct care services are authorized as part of case management activities.

(4) Tribal TCM services include case management of medical and non-medical services, which address health, psychosocial, economic, nutritional, and other needs.

(5) Provision of Tribal TCM services may not restrict an eligible client's choice of providers:

(a) Eligible clients must have free choice of available Tribal TCM service providers or other TCM service providers available to the eligible client, subject to Social Security Act, 42 USC 1396n;

(b) Eligible clients must have free choice of the providers of other medical care within their benefit package of covered services.

Stat. Auth.: ORS 409.010 & ORS 409.110

Stats. Implemented: ORS 414.085

10-2-08 (T) 12-28-08 (P)

410-138-0610 Targeted Group - Federally Recognized Tribal Governments in Oregon

(1) The target group consists of Oregon Health Plan (OHP) Medicaid eligible individuals served by tribal programs within the State of Oregon, or receiving services from a Federally recognized Indian tribal government located in the State of Oregon, and not receiving case management services under other Title XIX programs. The target group includes elder care; individuals with diabetes; children and adults with health and social service care needs; and pregnant women. These services will be referred to as Tribal Targeted Case Management Services.

(2) An Oregon Health Plan (OHP) Medicaid-eligible individual means an individual who has been determined to be eligible for Medicaid or the Children's Health Insurance Program (CHIP) by the Department of Human Services (DHS). For purposes of these rules, an eligible individual will be referred to as a Client.

(3) This does not include TCM services funded by Title IV and XX of the Social Security Act, and federal and or state funded parole and probation, or juvenile justice programs.

Stat Auth: 409.010 & 409.110

Stat Implemented: 409.010

2-1-07

410-138-0640 Provider Organizations - Federally Recognized Tribal Governments in Oregon

(1) A Tribal Targeted Case Management (TCM) Provider must be an organization certified as meeting the following criteria:

(a) A minimum of three years experience of successful work with Native American children, families, and elders involving a demonstrated capacity to provide all core elements of tribal case management, including: Assessment, Case Planning, Case Plan Implementation, Case Plan Coordination, and Case Plan Reassessment;

(b) A minimum of three years case management experience in coordinating and linking community medical, social, educational or other resources as required by the target population;

(c) Administrative capacity to ensure quality of services in accordance with tribal, state, and Federal requirements;

(d) Maintain a sufficient number of case managers to ensure access to targeted case management services;

(e) A financial management capacity and system that provides documentation of services and costs;

(f) Capacity to document and maintain Client case records in accordance with state and federal requirements, including requirements for recordkeeping in OAR 410-120-1360, and confidentiality requirements in ORS 192.519 – 192.524, ORS 179.505, and ORS 411.320, and HIPAA Privacy requirements in 45 CFR 160 and 164, if applicable;

(g) Demonstrated ability to meet all state and federal laws governing the participation of providers in the state Medicaid program;

(h) Evidence that the TCM organization is a federally recognized tribe located in the State of Oregon;

(i) Enrollment as a TCM provider with the Division of Medical Assistance Programs (DMAP).

Stat Auth: 409

Stat Implemented: 414.065

2-1-07

410-138-0660 Qualifications of Case Managers within Provider Organizations - Federally Recognized Tribal Governments in Oregon

The following are qualifications of Case Managers within Provider Organizations:

(1) Completion of training in a case management curriculum;

(2) Basic knowledge of behavior management techniques, family dynamics, child development, family counseling techniques, emotional and behavioral disorders, and issues around aging;

(3) Skill in interviewing to gather data and complete needs assessment, in preparation of narratives/reports, in development of service plans, and in individual and group communication;

(4) Ability to learn and work with state, federal and tribal rules, laws and guidelines relating to Native American child, adult and elder welfare and to gain knowledge about community resources and link tribal members with those resources;

(5) Knowledge and understanding of these rules and the applicable State Medicaid Plan Amendment.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065

2-1-07

410-138-0680 Cost Rate Methodology, Billing Criteria and Codes - Federally Recognized Tribal Governments in Oregon

(1) DMAP will not allow duplicate payments to other public agencies or private entities under other program authorities for Targeted Case Management (TCM) services under an eligible client's care plan. ("Duplicate payment" is defined in 410-138-0020). DMAP will recover duplicate payments. DMAP may not reimburse for TCM services if the services are case management services funded by Title IV-E or Title XX of the Social Security Act, or federal or state funded parole and probation, or juvenile justice programs. These case management services must be billed separately.

(2) Payment Methodology for Tribal TCM: For the purposes of these TCM rules, the amount of time in a "unit" equals one month. A unit includes at least one documented contact with the client (or other person acting on behalf of the client) and any number of documented contacts with other individuals or agencies identified through the case planning process.

(3) Payment for Tribal TCM services will be made using a monthly rate based on the total average monthly cost per client served by the TCM provider during the last fiscal year for which audited financial statements have been filed with the Department of Human Services (DHS). The costs used to derive the monthly Tribal TCM rate will be limited to the identified costs divided by the number of clients served. Tribal TCM provider costs for direct and related indirect costs that are paid by other federal or state programs must be removed from the cost pool. The cost pool must be updated, at a minimum, on an annual basis using a provider cost report. The rate is established on a prospective basis. In the first year, the rate will be based on estimates of cost and the number of clients served. For subsequent years, the rate will be based on actual eligible TCM costs from the previous year. A cost report must be submitted to DHS at the end of each state fiscal year (at a minimum), and will be used to establish a new rate for the following fiscal year.

(4) Billing criteria: Providers can only bill for allowable activities in the Tribal TCM program, that assist individuals eligible under the Medicaid State plan to gain access to needed medical, social,

education, and other services. One or more of the activities listed below must occur in order to bill:

(a) Assessment;

(b) Development of a care plan;

(c) Referral (including follow up);

(d) Monitoring (including follow up).

(5) A unit of service can only be billed under one procedure code and one provider number:

(a) Providers must use procedure code “T1017” to bill for Federally Recognized Tribal Government TCM procedures. The maximum billing for the T1017 procedure code is one time per month per eligible client;

(b) Providers must use the appropriate diagnosis code and modifier for Federally Recognized Tribal Government TCM services.

(6) Any place of service (POS) is valid.

(7) Prior authorization is not required.

Stat. Auth.: ORS 409.010, 409.110 & 409.050
Stats. Implemented: ORS 414.065

1-1-10

410-138-0700 Early Intervention/Early Childhood Special Education Targeted Case Management Program

(1) These rules are to be used in conjunction with the DMAP General Rules Program (chapter 410, division 120).

(2) The Targeted Case Management (TCM) services rules are designed to assist the Early Intervention/Early Childhood Special Education (EI/ECSE) TCM provider organization in matching state and federal funds for TCM services defined by section 1915(g) of the Social Security Act, 42 USC § 1396n(g).

(3) The EI/ECSE TCM program is a medical assistance program provided by enrolled EI/ECSE TCM providers that meet the criteria for the provision of special education programs approved by the State Superintendent of Public Instruction qualifying such programs for state reimbursement under OAR 581-015-2710 EI/ECSE.

(4) Enrolled EI/ECSE TCM providers must be contractors with the Oregon Department of Education for the provision of EI/ECSE services or be sub-contractors with such a contractor.

(5) EI/ECSE TCM services authorized under these rules is a cost-sharing (Federal Financial Participation (FFP) matching) program in which the enrolled EI/ECSE TCM provider as a public entity, unit of government, is responsible for paying the non-federal matching share of the amount of the TCM claims. (See 410-138-0005).

(6) The rules of the EI/ECSE TCM program explain the Oregon Medicaid program for reimbursing case management services available to Medicaid-eligible preschool children with disabilities, receiving EI/ECSE services from birth until they are eligible for public school (0-5 yrs of age). These services are available on a fee-for-service basis, within the limitations established by the Medical Assistance Program and the chapter 410, division 138 rules, consistent with the requirements of the Individuals with Disabilities Education Improvement Act (IDEIA).

(7) EI/ECSE TCM program services include management of medical and non-medical services, to address an eligible child's medical, social, educational, and other service needs (such as housing or

transportation) in coordination with a child's Individualized Family Service Plan (IFSP), based on information collected through the TCM assessment or periodic reassessment process. No direct services are authorized as part of case management activities.

(8) Provision of EI/ECSE TCM services may not restrict an eligible client's choice of providers.

(a) Eligible clients must have free choice of available EI/ECSE TCM service providers or other TCM service providers available to the eligible client, subject to Social Security Act, 42 USC 1396n(g).

(b) Eligible clients must have free choice of the providers of other medical care within their benefit package of covered services.

Stat. Auth.: ORS 409.010 & ORS 409.110

Stats. Implemented: ORS 414.085

10-2-08 (T) 12-28-08 (P)

410-138-0710 Target Group - Early Intervention/Early Childhood Special Education Targeted Case Management

(1) These rules apply to the population of Oregon Health Plan (OHP) Medicaid eligible clients who are preschool children with disabilities, beginning from birth until eligibility for public school, and who are either eligible for Early Intervention services under OAR 581-015-0946(3); or Early Childhood Special Education services under OAR 581-015-0943 (4), (EI/ECSE). For the purpose of these rules, children in this target group shall be referred to as “eligible children.”

(2) An Oregon Health Plan (OHP) Medicaid-eligible child means a child who has been determined to be eligible for Medicaid or the Children’s Health Insurance Program (CHIP) by the Department of Human Services (DHS).

Stat Auth: 409.010 & 409.110

Stat Implemented: 409.010

2-1-07

410-138-0780 Cost Rate Methodology, Billing Criteria and Codes for Early Intervention/Early Childhood Special Education Targeted Case Management

(1) Billing criteria for this program are as follows:

(a) Providers can only bill for allowable activities in the Early Intervention/Early Childhood Special Education (EI/ECSE) Targeted Case Management (TCM) program that assist Medicaid eligible preschool children with disabilities, from birth until they are eligible for public school (0-5 years of age) to gain access to needed medical, social, educational, and other services, such as housing or transportation. These children must be eligible for EI/ECSE services under the IDEIA and eligible for EI/ECSE TCM services as defined in the Medicaid State plan, at the time the services are furnished. One or more of the activities listed below must occur in order to bill:

(A) Assessment;

(B) Development of a care plan;

(C) Referral (including follow-up);

(D) Monitoring (including follow up).

(2) A unit of service can only be billed under one procedure code and one provider number:

(a) Providers must use procedure code “T1017” and include the “TL” modifier for EI/ECSE. The maximum billing for procedure code T1017 is one time per day per eligible client;

(b) Providers must use diagnosis code “V62.3”: Educational Circumstances.

(3) Any place of service (POS) is valid.

(4) Prior authorization is not required.

(5) DMAP will not allow duplicate payments to other public agencies or private entities under other program authorities for TCM services under the eligible client's care plan. ("Duplicate payment" is defined in 410-138-0020). DMAP will recover duplicate payments.

(6) DMAP may not reimburse for TCM services if the services are case management services funded by Title IV-E or Title XX of the Social Security Act, or federal or state funded parole and probation, or juvenile justice programs. These services must be billed separately.

Stat. Auth.: ORS 409.010, 409.110 & 409.050

Stats. Implemented: ORS 414.065

10-02-08 (T)

410-138-0740 Provider Organizations - Early Intervention/Early Childhood Special Education Targeted Case Management

(1) Qualifications of Early Intervention/Early Childhood Special Education (EI/ECSE) Targeted Case Management (TCM) providers:

(a) TCM Providers must meet the criteria for the provision of special education programs approved by the State Superintendent of Public Instruction qualifying such programs for state reimbursement under OAR 581-015-2710 EI/ECSE; and

(b) Must be contractors with the Oregon Department of Education in the provision of EI/ECSE services or sub-contractors with such a contractor, and must meet the following qualifications:

(A) Demonstrated capacity (including sufficient number of staff that meet the personnel standards requirements in OAR 581-015-2900) to provide EI/ECSE TCM services;

(B) Demonstrated Case Management experience in coordinating and linking such community resources as required by the target population;

(C) Demonstrated experience with the target population;

(D) An administrative capacity to ensure quality of services in accordance with state and federal requirements;

(E) A financial management capacity and system that provides documentation of services and costs;

(F) Capacity to document and maintain individual case records in accordance with state and federal requirements, including requirements for recordkeeping in OAR 410-120-1360, and confidentiality requirements in the Individuals with Disabilities Education Act, ORS 192.518 – 192.524, ORS 179.505, and ORS 411.320, and HIPAA Privacy requirements in 45 CFR 160 and 164, if applicable;

(G) Demonstrated ability to meet all state and federal laws governing the participation of providers in the state Medicaid program; and

(2) In addition to the qualification requirements in subsection (1) of this rule, the EI/ECSE TCM provider must be enrolled as an EI/ECSE TCM provider with the Division of Medical Assistance Programs (DMAP).

(3) The EI/ECSE TCM provider must either be a governmental entity or a subcontractor of a government entity:

(a) The EI/ECSE TCM provider public entity unit of government is solely responsible for providing the EI/ECSE TCM provider's share from public funds for purposes of OAR 410-138-0005 of this rule;

(b) If the EI/ECSE TCM provider is a subcontractor of a governmental entity, the governmental entity is responsible to make the public fund payments in compliance with OAR 410-138-0005.

Stat. Auth.: ORS 409.010, 409.110 & 409.050
Stats. Implemented: ORS 414.065

10-2-08 (T) 12-28-08 (P)

410-138-0760 Provider Requirements - Early Intervention/Early Childhood Special Education Targeted Case Management

(1) Qualification of Case Managers (Service Coordinators).

(2) Case Managers (Service Coordinators) must:

(a) Be employees of the EI/ECSE contracting or subcontracting agency and meet the personnel standards requirements in OAR 581-015-1100;

(b) Have demonstrated knowledge and understanding about:

(A) The Oregon EI/ECSE program, including these rules and the applicable State Medicaid Plan Amendment.

(B) The Individuals with Disabilities Education Improvement Act;

(C) The nature and scope of services available under the Oregon EI/ECSE program, including the TCM services, and the system of payments for services and other pertinent information.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

2-1-07

410-138-0780 Cost Rate Methodology, Billing Criteria and Codes for Early Intervention/Early Childhood Special Education Targeted Case Management

(1) Billing criteria for this program are as follows:

(a) Providers can only bill for allowable activities in the Early Intervention/Early Childhood Special Education (EI/ECSE) Targeted Case Management (TCM) program that assist Medicaid eligible preschool children with disabilities, from birth until they are eligible for public school (0-5 years of age) to gain access to needed medical, social, educational, and other services, such as housing or transportation. These children must be eligible for EI/ECSE services under the IDEA and eligible for EI/ECSE TCM services as defined in the Medicaid State plan, at the time the services are furnished. One or more of the activities listed below must occur in order to bill:

(A) Assessment;

(B) Development of a care plan;

(C) Referral (including follow-up);

(D) Monitoring (including follow up).

(2) A unit of service can only be billed under one procedure code and one provider number:

(a) Providers must use procedure code “T2023” and include the “TL” modifier for EI/ECSE. The maximum billing for procedure code T2023 is one time per month per eligible client;

(b) Providers must use diagnosis code “V62.3”: Educational Circumstances.

(3) Any place of service (POS) is valid.

(4) Prior authorization is not required.

(5) DMAP will not allow duplicate payments to other public agencies or private entities under other program authorities for TCM services under the eligible client's care plan. ("Duplicate payment" is defined in 410-138-0005(10)). DMAP will recover duplicate payments.

(6) DMAP may not reimburse for TCM services if the services are case management services funded by Title IV-E or Title XX of the Social Security Act, or federal or state funded parole and probation, or juvenile justice programs. These services must be billed separately.

Stat. Auth.: ORS 409.010, 409.110 & 409.050

Stats. Implemented: ORS 414.065

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