DHS Oregon Department of Human Services

Health Services
Office of Medical Assistance Programs

Targeted Case Management Services Rulebook

Includes:

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2) Current Update Information (changes since last update)

3) Complete set of Targeted Case Management Services Program Administrative Rules

DEPARTMENT OF HUMAN SERVICE

MEDICAL ASSISTANCE PROGRAMS

DIVISION 138

Targeted Case Management

Update Information (most current Rulebook changes)

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Targeted Case Management Services Rulebook

Update Information
for
July 1, 2006

OMAP updated the Targeted Case Management Services Program Rulebook. In February 2006, OMAP temporarily revised the following administrative rules to describe the requirements applicable to qualified providers, establish reimbursement mechanisms, and authorize payment for targeted case management services by qualified providers:

410-138-0600, 410-138-0610, 410-138-0620, 410-138-0640, 410-138-0660, 410-138-0680, 410-138-0700, 410-138-0710, 410-138-0720, 410-138-0740, 410-138-0760, 410-138-0780

OMAP permanently adopted these rules, effective July 1, 2006. Having made no changes to the text of the rules from the temporary rule status, the Rulebook is updated with the permanent date (7-1-06) at the bottom of each rule.

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

410-138-0000 Babies First/Cocoon Program

(1) Babies First/Cocoon Targeted Case Management (TCM) Services is a medical program operated by public health authorities, which matches public funds with matching Federal Funds for Oregon Health Plan (OHP) Medicaid eligible clients. These rules are to be used in conjunction with the General Rules governing the OMAP Programs (OAR 410 Division 120). The TCM Services rules are a user's manual 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).

(2) The rules of the Babies First/Cocoon -- Targeted Case Management Plan define Oregon Medicaid's program to reimburse the services provided under Babies First/Cocoon. This program expands preventive services for all infants and pre-schoolers (0 through 3 years) covered by Medicaid who are at risk of poor health outcome as outlined in OAR 410-138-0040, Risk Factors, provided by an enrolled Babies First/Cocoon – TCM provider consistent with these rules.

(3) Services include management of non-medical services, which address health, psychosocial, economic, nutritional and other services. Home visits constitute a significant part of the delivery of services.

Stat. Auth.: ORS 409.010 & ORS 409.110

Stats. Implemented: ORS 414.085

10-1-04

410-138-0020 Definitions -- Babies First/Cocoon Program

(1) "Assessment" -- The systematic ongoing collection of data to determine current status and identify needs in physical, environmental, psychosocial, developmental, educational, behavioral, emotional, and mobility areas. Data sources include interviews, existing available records, needs assessment, the use of standardized assessment tools (i.e., NCAST and Regional X Screening Standards), and contacts with the primary care provider, other professionals, and other parties on behalf of the client.

(2) "Case Management" -- Activities which will assist the client in gaining access to and effectively utilizing needed health, psychosocial, nutritional, and other services.

(3) "Intervention":

(a) Linkage -- Establishing, maintaining, and documenting a referral process with pertinent individuals and agencies which avoids duplication of services to clients. Referral must include documentation of client authorization and follow-up;

(b) Planning -- Identifying needs, writing goals and objectives, and determining resources to meet those needs in a coordinated, integrated fashion;

(c) Implementation -- Putting the plan into action and monitoring its effectiveness;

(d) Support -- Support is provided to assist the family reach the goals of the plan, especially, if resources are inadequate or service delivery system is non-responsive.

(4) "Screening" -- Use of a single tool(s) or procedure(s) to identify a potential problem. Screening is not designed to diagnose the problem, but to sort the target population into two groups: Those at risk for a particular problem and those not at risk.

Stat. Auth.: ORS 409.010 & ORS 409.110

Stats. Implemented: ORS 409.010

10-1-04

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

10-1-04

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 Office of Medical Assistance Programs.

(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

10-1-04

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

(1) Payment will be made to the enrolled Targeted Case Management Provider 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, Department of Human Services and the TCM provider and constitutes agreement by the provider to comply with all applicable rules of the Medical Assistance Program, federal and state laws or regulations;

(3) The TCM provider will bill according to OAR 410 division 138 rules. Payments will be made through the Medical Management Information System (MMIS). 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 addition to the requirements set forth in this rule, and pursuant to 42CFR433.10, DHS may monthly, but will no less than quarterly, invoice the TCM provider for their non-federal matching share based on the current Federal Medical Assistance Percentage (FMAP) rate. The TCM provider shall pay the amount stated in the invoice within 30 days of the date of the invoice;

(a) The TCM provider's share means the public funds share of the Medicaid payment amount. Pursuant to 42CFR433.51, public funds may be considered as the State’s share in claiming federal financial participation if the public funds meet the following conditions: The public funds are transferred to DHS from public agencies, and the public funds are not federal funds or are federal funds authorized by federal law to be used to match other federal funds;

(b) The TCM provider's non-federal matching share shall be based on the current Federal Medical Assistance Percentage (FMAP) rate for Oregon provided annually by the Centers for Medicare and Medicaid Services. This percentage can vary each federal fiscal year. The DHS

invoice shall be based on the FMAP in effect at the time of the State's payment to the TCM provider;

(c) The TCM provider shall submit to OMAP an original signed document certifying that the public funds transferred to OMAP (for the non-federal matching share) by the TCM provider under this rule are not federal funds or are federal funds authorized by federal law to be used to match other federal funds.

(5) Failure to timely remit the non-federal share described in subsection (4) will constitute an overpayment and will make the provider subject to overpayment recoupment or other remedy pursuant to OMAP General Rules, OAR 410-120-1400 through 410-120-1685.

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

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

(a) The procedure code to be used is “T1016” for Babies First/Cocoon -- Targeted Case Management. Maximum billing for the T1016 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

Stats. Implemented: ORS 414.065

10-1-04

410-138-0300 HIV Program

(1) HIV -- Targeted Case Management (TCM) Services is a medical program operated by public health authorities, which matches public funds with matching Federal Funds for Oregon Health Plan (OHP) Medicaid eligible clients. These rules are to be used in conjunction with the General Rules governing the OMAP Programs (OAR 410 Division 120). The TCM Services rules are a user's manual 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).

(2) The rules of the HIV -- Targeted Case Management Plan define Oregon Medicaid's Program to reimburse the services provided under HIV -- Targeted Case Management. This program expands services to all Medicaid eligible clients in Multnomah County with symptomatic HIV disease and one or more risk factors which result in an inability to remain in a home environment without ongoing management of support services (see OAR 410-138-0340, Risk Criteria).

(3) Services include management of non-medical services, which address physical, psychosocial, nutritional, educational, and other needs. Home visits constitute a significant part of the delivery of services, provided by an enrolled HIV – TCM provider consistent with these rules.

Stat. Auth.: ORS 409.010 & ORS 409.110

Stats. Implemented: ORS 414.085

10-1-04

410-138-0320 Definitions – HIV Program

(1) "Assessment" -- The systematic ongoing collection of data to determine current status and identify a client's physical, psychosocial, and educational need. An HIV nursing assessment tool will measure ability of the client to manage care at home including pain control, medication management, nutritional needs, personal care needs, home safety assessment, coping with symptoms and disease process, as well as education and service needs that might enhance the client's ability to maintain an independent lifestyle as long as possible. Data sources will include client and support person interviews, information from the referral source, communication with health care team members, and existing available records.

(2) "Case Management" -- Activities which will assist the client in gaining access to and effectively utilizing needed physical, psychosocial, nutritional, and other services.

(3) "Comprehensive Care/Services Plan Development" -- Identifying needs, writing goals and objectives, and determining resources to meet those needs in a coordinated, integrated fashion. Emphasis is placed on client independence and client participation in planning of his/her own care. Natural support systems include family members, partners, and friends.

(4) "Intervention/Implementation" -- Putting the Case Management Plan into action and monitoring its status. When possible, intervention is provided in the home where client retention of information is improved, the cost of clinic space is saved, and support persons can be included. Intervention/implementation of the Case Management Plan include identifying, referring and arranging for needed support services such as:

(a) Medication management systems, including safe levels of pain control;

(b) Nutritional support programs (teaching, Meals on Wheels, arranging for a volunteer);

(c) Care plans for the coordination of volunteers;

(d) Disease specific education of clients and caregivers;

(e) Caregiver respite;

(f) Childcare;

(g) Grief and loss counseling;

(h) Personal care decisions;

(i) Benefits eligibility;

(j) Stress reduction;

(k) Mental health assessments;

(l) Substance abuse treatment;

(m) Spiritual counseling;

(n) Emotional support to clients, partners, and family members;

(o) Facilitating early hospital discharge by assuring that support systems are in place prior to patient discharge;

(p) Coordination of client care;

(q) Coordination of home health agency and hospice nursing services.

(5) "Coordination/Linking of Services" -- Establishing and maintaining a referral process with pertinent individuals and agencies to avoid duplication of services to clients, to assist clients in accessing resources, and to solicit referrals from the community into the managed care system. Support and coordination is provided to assist the client and service providers to reach the goals of the plan; especially if resources are inadequate or service delivery system is nonresponsive.

(6) "Evaluation" -- Each visit will include a reassessment of the client's status and needs, review and update of the care plan, appropriate action and referral, and accurate record keeping.

Stat. Auth.: ORS 409.010 & ORS 409.110

Stats. Implemented: ORS 409.010

10-1-04

410-138-0340 Risk Criteria – HIV Program

Risk Factors:

(1) Advanced HIV-related dementia-confusion, severe memory loss, aggressive behavior.

(2) Need for assistance to ambulate and/or transfer between bed and chair.

(3) Suicidal ideation with plan for action.

(4) Need for assistance with activities of daily living based on severe fatigue and weakness.

(5) Care providers/family members overwhelmed by needs of the person with HIV disease.

(6) Uncontrolled pain.

(7) Loss of ability to manage medically prescribed care at home (medication, skin care, IVs).

(8) Significant weight loss associated with frequent diarrhea, nausea, vomiting and/or anorexia.

(9) Inability to maintain adequate nutrition.

(10) Decreased mobility -- Potential for falls.

(11) Presence of substance abuse in conjunction with advanced HIV disease.

(12) Presence of chronic mental illness in conjunction with advanced HIV disease.

(13) Complex family situations (e.g., both spouses or partners infected).

(14) Families with children affected by HIV (parent or child infected).

(15) Homelessness or inadequate housing/heat/ sanitation.

(16) Inability to manage household activities due to advanced HIV disease.

Stat. Auth.: ORS 409.010 & ORS 409.110

Stats. Implemented: ORS 414.065

10-1-04

410-138-0360 Provider Requirements -- HIV Program

(1) HIV – 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 services including:

(A) Comprehensive nursing 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.

(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) A sufficient number of staff to meet the case management service needs of the target population;

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

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

(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 Office of Medical Assistance Programs.

(2) The case manager must be:

(a) A licensed registered nurse with a minimum of one year of experience in public health or home health and HIV disease or a registered nurse working under the supervision of the above;

(b) Working under the guidelines of the enrolled HIV – TCM provider organization.

Stat. Auth.: ORS 409.010 & ORS 409.110

Stats. Implemented: ORS 414.065

10-1-04

410-138-0380 Billing Policy and Codes -- HIV Program

(1) Payment will be made to the enrolled Targeted Case Management Provider 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, Department of Human Services and the TCM provider and constitutes agreement by the provider to comply with all applicable rules of the Medical Assistance Program, federal and state laws or regulations;

(3) The TCM provider will bill according to OAR 410 division 138 rules. Payments will be made through the Medical Management Information System (MMIS). 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 addition to the requirements set forth in this rule, and pursuant to 42CFR433.10, DHS may monthly, but will no less than quarterly, invoice the TCM provider for their non-federal matching share based on the current Federal Medical Assistance Percentage (FMAP) rate. The TCM provider shall pay the amount stated in the invoice within 30 days of the date of the invoice;

(a) The TCM provider's share means the public funds share of the Medicaid payment amount. Pursuant to 42CFR433.51, public funds may be considered as the State’s share in claiming federal financial participation if the public funds meet the following conditions: The public funds are transferred to DHS from public agencies, and the public funds are not federal funds or are federal funds authorized by federal law to be used to match other federal funds;

(b) The TCM provider's non-federal matching share shall be based on the current Federal Medical Assistance Percentage (FMAP) rate for Oregon provided annually by the Centers for Medicare and Medicaid Services. This percentage can vary each federal fiscal year. The DHS

invoice shall be based on the FMAP in effect at the time of the State's payment to the TCM provider;

(c) The TCM provider shall submit to OMAP an original signed document certifying that the public funds transferred to OMAP (for the non-federal matching share) by the TCM provider under this rule are not federal funds or are federal funds authorized by federal law to be used to match other federal funds.

(5) Failure to timely remit the non-federal share described in subsection (4) will constitute an overpayment and will make the provider subject to overpayment recoupment or other remedy pursuant to OMAP General Rules, OAR 410-120-1400 through 410-120-1685.

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

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

(a) Use Procedure Code “T2023” for HIV -- Targeted Case Management. Maximum billing for the T2023 code is one time per calendar month per client. At least one of the five activities listed below must occur during the month in order to bill:

(A) Assessment;

(B) Comprehensive Care/Services Plan Development;

(C) Intervention/Implementation;

(D) Coordination/Linking of Services;

(E) Evaluation.

(b) Any Place of Service (POS) is valid;

(c) Prior Authorization is not required;

(d) Provider must use Diagnosis Code “V08” or “042”.

(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 & ORS 409.110

Stats. Implemented: ORS 414.065

10-1-04

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

(1) Pregnant Substance Abusing Women and Women with Young Children (PWWC)-- Targeted Case Management (TCM) Services is a medical program operated by public health authorities, which matches public funds with matching Federal Funds for Oregon Health Plan (OHP) Medicaid eligible clients. These rules are to be used in conjunction with the General Rules governing the OMAP Programs (OAR 410 Division 120). The TCM Services rules are a user's manual 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).

(2) The rules of the Targeted Case Management Program for Pregnant Substance Abusing Women and Women with Young Children define Oregon Medicaid's Program to reimburse the services provided under this program. This Program expands 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.

(3) Services include screening and assessment, case plan development, and intervention/implementation of non-medical services, which address health, educational, vocational, mental health, housing, child care and other services necessary to help this target group remain clean and sober.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

10-1-04

410-138-0520 Definitions -- Pregnant Substance Abusing Women and Women with Young Children Program

(1) "Screening and Assessment" -- The gathering of information to assess the client's need for various services, foremost being treatment for alcohol and drug abuse/addiction. Information will be gathered from the criminal justice system, the Housing Authority, and other sources as appropriate. A uniform assessment tool will be used for screening clients and identifying needed services.

(2) "Case Plan Development" -- The development of an individualized case plan utilizing the input of a treatment team that will consist of the case manager, alcohol and drug treatment counselor, criminal justice system representatives, prenatal care provider, and others instrumental in the client's life. The case plan will include components for alcohol and other drug abuse treatment, medical care, housing, education, child care, parenting, vocational, and mental health services. Goals and objectives will be written, and resources will be identified to meet the client's needs in a coordinated, integrated fashion. The case plan will be refined, and the client's progress in meeting goals and objectives will be assessed, in periodic meetings of the treatment team as treatment progresses.

(3) "Intervention/Implementation" -- The linking of the client with appropriate community agencies and services identified in the case plan through calling or visiting these resources. The case manager will facilitate implementation of agreed-upon services through assisting the client, increasing the services and through assuring that the clients and providers fully understand how these services support the agreed-upon case plan.

Stat. Auth.: ORS 409.010 & ORS 409.110

Stats. Implemented: ORS 414.010

10-1-04

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

10-1-04

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 Office of Medical Assistance Programs.

(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

10-1-04

410-138-0560 Billing Policy and Codes -- Pregnant Substance Abusing Women and Women with Young Children

(1) Payment will be made to the enrolled Targeted Case Management Provider 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, Department of Human Services and the TCM provider and constitutes agreement by the provider to comply with all applicable rules of the Medical Assistance Program, federal and state laws or regulations;

(3) The TCM provider will bill according to OAR 410 division 138 rules. Payments will be made through the Medical Management Information System (MMIS). 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 addition to the requirements set forth in this rule, and pursuant to 42CFR433.10, DHS may monthly, but will no less than quarterly, invoice the TCM provider for their non-federal matching share based on the current Federal Medical_Assistance Percentage (FMAP) rate. The TCM provider shall pay the amount stated in the invoice within 30 days of the date of the invoice;

(a) The TCM provider's share means the public funds share of the Medicaid payment amount. Pursuant to 42CFR433.51, public funds may be considered as the State’s share in claiming federal financial participation if the public funds meet the following conditions: The public funds are transferred to DHS from public agencies, and the public funds are not federal funds or are federal funds authorized by federal law to be used to match other federal funds;

(b) The TCM provider's non-federal matching share shall be based on the current Federal Medical Assistance Percentage (FMAP) rate for Oregon provided annually by the Centers for Medicare and Medicaid Services. This percentage can vary each federal fiscal year. The DHS

invoice shall be based on the FMAP in effect at the time of the State's payment to the TCM provider;

(c) The TCM provider shall submit to OMAP an original signed document certifying that the public funds transferred to OMAP (for the non-federal matching share) by the TCM provider under this rule are not federal funds or are federal funds authorized by federal law to be used to match other federal funds.

(5) Failure to timely remit the non-federal share described in subsection (4) will constitute an overpayment and will make the provider subject to overpayment recoupment or other remedy pursuant to OMAP General Rules, OAR 410-120-1400 through 410-120-1685.

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

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

(a) The procedure code to be used is “T2023” for Pregnant Substance Abusing Women with Young Children –Targeted Case Management. Maximum billing for the T2023 code is one time per calendar month 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) Provider must use Modifier Code “HF” and Diagnosis Code “V6141”.

(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 & ORS 409.110

Stats. Implemented: ORS 414.065

10-10-04

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

(1) The Targeted Case Management (TCM) Services program is a medical assistance program, that leverages Office of Medical Assistance Programs (OMAP) certified Case Management Provider Organization allowable tribal funds with matching Federal Funds for Oregon Health Plan (OHP) Medicaid eligible clients. These rules are to be used in conjunction with the OMAP (OAR 410 Division 120). 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).

(2) The rules of the Federally Recognized Tribal Government Targeted Case Management program define Oregon Medicaid's program to reimburse the TCM services provided by a federally recognized tribal government located in the State of Oregon.

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

(4) Provision of tribal TCM services may not restrict an eligible Client's choice of providers. Clients must have free choice of available tribal TCM service providers or other TCM service providers available to the eligible Client, subject to 42 USC 1396n. 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

2-7-06 (T) 7-1-06 (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. 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

2-7-06 (T) 7-1-06 (P)

410-138-0620 Definitions - Federally Recognized Tribal Governments in Oregon

(1) "Assessment" – After the need for tribal targeted case management services has been determined, the tribal case manager assesses the specific areas of concern, family strengths and resources, community resources and extended family resources available to resolve those identified issues. At assessment, the tribal case manager makes preliminary decisions about needed medical, social, educational, or other services and the level or direction tribal case management will take.

(2) "Case Planning" – The tribal case manager develops a case plan, in conjunction with the Client and family (where applicable), to identify the goals and objectives, which are designed to resolve the issues of concern identified through the assessment process. Case planning includes setting of activities to be completed by the tribal case manager, the family and Client. This activity will include accessing medical, social, educational, and other services to meet the Clients' needs.

(3) "Case Plan Implementation" – The tribal case manager will link the Client and family with appropriate agencies and medical, social, educational or other services through calling or visiting these resources. The tribal case manager will facilitate implementation of agreed-upon services through assisting the Client and family to access them and through assuring the Clients and providers fully understand how these services support the agreed-upon case plan.

(4) "Case Plan Coordination" – After these linkages have been completed, the tribal case manager will ascertain, on an ongoing basis, whether or not the medical, social, educational, or other services have been accessed as agreed, and the level of involvement of the Client and family. Coordination activities include, personal, mail and telephone contacts with providers and others identified by the case plan, and well as meetings with the Client and family to assure that services are being provided and used as agreed.

(5) "Case Plan Reassessment" – In conjunction with the Client, the tribal case manager will determine whether or not medical, social,

educational or other services continue to be adequate to meet the goals and objectives identified in the case plan. Reassessment decisions include those to continue, change or terminate those services. Reassessment will also determine whether the case plan itself requires revision. This may include assisting Clients to access different medical, social, educational or other needed services beyond those already provided. Reassessment activities include, staffing and mail, personal, and telephone contacts with involved parties.

Stat. Auth.: ORS 409.010 & ORS 409.110
Stats. Implemented: ORS 409.010

2-7-06 (T) 7-1-06 (P)

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 Office of Medical Assistance Programs.

Stat Auth: 409

Stat Implemented: 414.065

2-7-06 (T) 7-1-06 (P)

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

2-7-06 (T) 7-1-06 (P)

410-138-0680 Payment, Methodology, and Billing Instructions and codes - Federally Recognized Tribal Governments in Oregon

(1) Payment for case management services under the plan shall not duplicate payments made to public agencies or private entities under other program authorities for this same purpose. Targeted Case Management (TCM) services may not be reimbursed under this rule if the services are case management 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.

(2) Payment Methodology for Tribal Targeted Case Management: For the purposes of these TCM rules, "Unit" is defined as a month. A unit consists of 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 (Department). 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 the Department 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) Payment will be made to the enrolled tribal TCM organization as the performing provider for those services provided by the employed staff person.

(5) Signing the Provider Enrollment Agreement sets forth the relationship between the State of Oregon, Department of Human Services and the TCM provider and constitutes agreement by the provider to comply with all applicable rules of the Medical Assistance Program, federal and state laws or regulations.

(6) The TCM provider will bill according to OAR 410 division 138 rules. Payments will be made through the Medical Management Information System (MMIS).

(7) Targeted Case Management for the Office of Medical Assistance Programs (OMAP) certified case management providers, is a cost-sharing (Federal Financial Participation matching) program. In addition to the requirements set forth in subsections (1) through (6) of this rule, and pursuant to 42CFR433.10, DHS may monthly, but will no less than quarterly, invoice the TCM provider for their non-federal matching share based on the current Federal Medical Assistance Percentage (FMAP) rate. The TCM provider shall pay the amount stated in the invoice within 30 days of the date of the invoice:

(a) The TCM provider's share means the tribal funds share of the Medicaid payment amount. Pursuant to 42CFR433.51, tribal funds may be considered as the State's share in claiming federal financial participation if the tribal funds meet the following conditions: The tribal funds are transferred to DHS from a tribal government; and, the tribal funds are not federal funds or are federal funds authorized by federal law to be used to match other federal funds;

(b) The TCM provider's non-federal matching share shall be based on the current Federal Medical Assistance Percentage (FMAP) rate for Oregon provided annually by the Centers for Medicare and Medicaid Services. This percentage can vary each federal fiscal year. The DHS invoice shall be based on the FMAP in effect at the time of the State's expenditure to the TCM provider;

(c) The TCM provider shall submit to OMAP an original signed document certifying that the allowable tribal funds transferred to OMAP (for the non-federal matching share) by the TCM provider under this rule are not federal funds, or are federal funds authorized by federal law to be used to match other federal funds.

(8) Failure to timely remit the non-federal share described in subsections (1) will constitute an overpayment, and will make the provider subject to overpayment recoupment or other remedy pursuant to OMAP General Rules, OAR 410-120-1400 through 410-120-1685.

(9) Billing criteria for this program is as follows:

(a) The procedure code to be used for Federally Recognized Tribal Government -- Targeted Case Management is “T1017.” One of the activities listed below must occur in order to bill. Maximum billing code is one time per month per client:

(A) Assessment;

(B) Case Planning;

(C) Case Plan Implementation;

(D) Case Plan Coordination;

(E) Case Plan Reassessment.

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

(c) Prior authorization is not required;

(d) Appropriate Diagnosis Code and Modifier must be used.

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

2-7-06 (T) 7-1-06 (P)

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

(1) The Targeted Case Management (TCM) Services Program is a medical assistance program, that leverages Office of Medical Assistance Programs (OMAP) certified Case Management Provider Organization General Funds with matching Federal Funds for Oregon Health Plan (OHP) Medicaid eligible clients. These rules are to be used in conjunction with the OMAP General Rules Program (OAR 410 Division 120). The TCM Services rules are designed to assist the Targeted Case Management 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).

(2) The rules of the Early Intervention/Early Childhood Special Education Targeted Case Management program define Oregon Medicaid's program to reimburse the TCM services provided under Early Intervention/Early Childhood Special Education. This TCM program provides services to eligible preschool children with disabilities, birth until eligible for public school.

(3) EI/ECSE TCM program services include management of non-medical services, which address health, psychosocial, economic, nutritional and other services.

(4) Provision of EI/ECSE TCM program services may not restrict an eligible child's choice of providers. Eligible children must have free choice of available EI/ECSE TCM service providers or other TCM service providers available to the eligible child, subject to 42 USC 1396n. Eligible children must have free choice of the available 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

2-7-06 (T) 7-1-06 (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.

Stat Auth: 409.010 & 409.110

Stat Implemented: 409.010

2-7-06 (T)

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.

Stat Auth: 409.010 & 409.110

Stat Implemented: 409.010

2-7-06 (T) 7-1-06 (P)

410-138-0720 Definitions - Early Intervention/Early Childhood Special Education Targeted Case Management

(1) “Case management” is provided to eligible children in the target group to assist and enable the eligible child to gain access to needed medical, social, educational, developmental and other appropriate services. The case manager (aka service coordinator) is responsible for assisting the child and family in gaining access to and coordinating all services across agency lines and serving as the single point of contact in helping the child and family obtain the services and assistance they need. Case management may be delivered in person, electronically, or by telephone for the purpose of enabling the child and family to gain access to and obtain the needed services. Case management services include:

(a) "Intake and Needs Assessment" -- The systematic ongoing collection of data to determine current status and identify needs in physical, environmental, psychosocial, developmental, educational, social, behavioral, emotional, and mobility areas. Data sources include family interview, existing available records, and needs assessment;

(b) "Plan of Care: Development of the Targeted Case Management Plan Coordinated with the Individualized Family Service Plan (IFSP)" -- The case manager (service coordinator) develops a targeted case management plan coordinated with the IFSP, in conjunction with the family and other IFSP team members to identify goals, objectives and issues identified through the targeted case management assessment process. Targeted case management case planning includes determining activities to be completed by the case manager, in support of the eligible child and family. These activities include accessing appropriate health and mental health, social, educational, vocational, and transportation services to meet the eligible child’s needs.

(2) "Service Coordination and Monitoring":

(a) Linkages - establishing and maintaining a referral process with pertinent individuals and agencies which avoids duplication of services to the eligible child and family;

(b) Planning - Identifying needs, writing goals and objectives, and determining resources to meet those needs in a coordinated, integrated fashion with the family and other IFSP team members;

(c) Implementation - Putting the targeted case management plan into action and monitoring its status;

(d) Support - Support is provided to assist the family to reach the goals of the plan, especially if resources are inadequate or the service delivery system is non-responsive;

(3) “Reassessment and Transitioning Planning”: The case manager (service coordinator), in consultation with the family and other IFSP team members, determines whether or not the linked services continue to meet the eligible child and family’s needs, and if not, adjustments are made and new or additional referrals are made to adequately meet the defined child and family needs. These services:

(a) Assist families of eligible children in gaining access to EI/ECSE services and other medical or social services identified in the targeted case management plan;

(b) Permit coordinating of EI/ECSE services and other medical or social services (such as medical services for other than diagnostic and evaluation purposes) that the eligible child needs or is being provided;

(c) Assist families in identifying available medical and social service providers;

(d) Permit coordination and monitoring the delivery of available medical or social services;

(e) Inform families of the availability of medical/social services;

(f) Maintain a record of targeted case management activities in each eligible child’s record.

Stat. Auth.: ORS 409.010 & ORS 409.110
Stats. Implemented: ORS 409.010 2-7-06 (T) 7-1-06 (P)

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

(1) Qualifications of EI/ECSE TCM Provider Organizations: TCM Provider organizations must be contractors with the Oregon Department of Education in the provision of EI/ECSE services or be a sub-contractor with such a contractor, and must meet the following criteria:

(a) Demonstrated capacity (including sufficient number of staff) to provide 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 and Improvement 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

(h) Enrollment as a TCM provider with the Office of Medical Assistance Programs.

(2) In addition to the requirements in subsection (1) of this rule, the EI/ECSE TCM Provider must either be a governmental entity or a subcontractor of a government entity. The TCM Provider must submit written documentation that a governmental entity is solely responsible for providing the TCM provider's share from public funds for purposes of OAR 410-138-0780 of this rule. If the TCM provider is a subcontractor of a governmental entity, the documentation shall include a copy of the subcontract that expressly identifies the State of Oregon Department of Human Services as a named third party beneficiary of the governmental entity's obligation to make the public fund payments. Such documentation is subject to approval by DHS.

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

2-7-06 (T) 7-1-06 (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

2-7-06 (T) 7-1-06 (P)

410-138-0780 Payment, Payment Methodology, and Billing Instructions and codes - Early Intervention/Early Childhood Special Education Targeted Case Management

(1) Payment for EI/ECSE TCM services, under these rules, will not duplicate payments made to public or private entities under other program authorities for this same purpose.

(2) Payment Methodology for EI/ECSE Targeted Case Management: Payment for Targeted Case Management will be based on a monthly encounter rate.

(a) The rate for reimbursement of the case management services is computed as follows. Compute the annual case manager salary and fringe benefits, plus other operating cost including travel, supplies, telephone, and occupancy cost, plus direct supervisory cost, plus average indirect administrative cost of provider organization; that will equal the total annual cost per case manager. Then divide by 12; that will equal the monthly cost per case manager. Then divide by the number of children to be served during the month, that will equal the total monthly cost per child;

(b) The total cost, per case manager, is the sum of the case manager's salary, direct supervisory costs, indirect administrative costs of the provider organization and other operating costs such as travel, supplies, occupancy, and telephone usage. Dividing the statewide average cost, per case manager, by twelve (12) months yields the average monthly cost per case manager. Dividing the monthly cost, per case manager, by the number of children to be served during the month results in the total monthly costs per child. This is the encounter rate to be used for the monthly billing whenever a Medicaid eligible client receives a TCM service during that month.

(3) Payment will be made to the enrolled Targeted Case Management Organization as the performing provider for those services provided by the employed staff person.

(4) Signing the Provider Enrollment Agreement sets forth the relationship between the State of Oregon, Department of Human Services and the TCM provider and constitutes agreement by the

provider to comply with all applicable rules of the Medical Assistance Program, federal and state laws or regulations.

(5) The TCM provider will bill according to OAR 410 division 138 rules. Payments will be made through the Medical Management Information System (MMIS).

(6) Targeted Case Management for TCM Provider organizations certified as eligible to enroll under OAR 410-138-0740 is a cost-sharing (Federal Financial Participation matching) program. In addition to the requirements set forth in subsections (1) through (5) of this rule, and pursuant to 42CFR433.10, DHS may monthly, but will no less than quarterly, invoice the governmental TCM provider or the TCM Provider's responsible governmental entity for their non-federal matching share based on the current Federal Medical Assistance Percentage (FMAP) rate. The governmental TCM provider or its responsible governmental entity shall pay the amount stated in the invoice within 30 days of the date of the invoice.

(a) The TCM provider's share means the public funds share of the Medicaid payment amount. Pursuant to 42CFR433.51, 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 agencies; and, the public funds are not federal funds or are federal funds authorized by federal law to be used to match other federal funds;

(B) The public funds transferred to DHS may not be derived by the governmental entity from donations or taxes that would not otherwise be recognized as the non-federal share under 42 CFR 433 Subpart B;

(b) The TCM provider's non-federal matching share shall be based on the current Federal Medical Assistance Percentage (FMAP) rate for Oregon provided annually by the Centers for Medicare and Medicaid Services. This percentage can vary each federal fiscal year. The DHS invoice shall be based on the FMAP in effect at the time of the State's expenditure to the TCM provider;

(c) The governmental TCM provider or its responsible governmental entity shall submit to OMAP an original signed document certifying that the public funds transferred to OMAP (for the non-federal matching share) under this rule are not federal funds, or are federal funds authorized by federal law to be used to match other federal funds, and that the transferred funds are not derived from donations or taxes that would not otherwise be recognized as the non-federal share under 42 CFR 433 Subpart B.

(7) Failure to timely remit the non-federal share described in subsection (6) or failure to comply with the public funds requirements of subsection (6) will constitute an overpayment, and will make the provider subject to overpayment recoupment or other remedy pursuant to OMAP General Rules, OAR 410-120-1400 through 410-120-1685. Failure to comply with the public funds requirements in this rule may result in termination of the TCM provider enrollment agreement.

(8) Billing criteria for this program is as follows:

(a) The procedure code to be used is “T2023” for Early Intervention/Early Childhood Special Education -- Targeted Case Management. One of the activities listed below must occur in order to bill. Maximum billing code is one time per month per client:

(A) Intake and Needs Assessment;

(B) Plan of Care: Development of the Targeted Case Management Plan Coordinated with the Individual Family Service Plan (IFSP);

(C) Service Coordination and Monitoring;

(D) Reassessment and Transitioning Planning.

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

(c) Prior authorization is not required;

(d) Diagnosis Code “V62.3” must be used.

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

2-7-06 (T) 7-1-06 (P)