



Oregon

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September 2004

To: OMAP Targeted Case Management Program Providers

From: Joan M. Kapowich, Manager 
OMAP Program and Policy

Re: Targeted Case Management Services Program, Rulebook Revision 1

Effective: October 1, 2004



OMAP updated the Targeted Case Management Program Rulebook with the following administrative rule revisions:

Amended: 410-138-0000, 410-138-0020, 410-138-0040, 410-138-0060,
410-138-0080, 410-138-0300, 410-138-0320, 410-138-0340,
410-138-0360, 410-138-0380, 410-138-0500, 410-138-0520,
410-138-0540, 410-138-0560

OMAP adopted 410-138-0530 and amended the rules listed above to create a contractual relationship between providers and OMAP, by use of rules, and by using the Provider Enrollment Application as the authorizing document. These changes clarify the differences between the various Targeted Case Management programs and update the codes used for billing. OMAP repealed 410-138-0100 and 410-138-0400 to remove unnecessary text from rule.

- If you are reading this letter on OMAP's website: (www.dhs.state.or.us/policy/healthplan/rules/), this Rulebook contains a complete set of administrative rules for this program, including the above revisions.
- If you receive hardcopy of revisions, this letter is attached to the revised rules to be used as replacements in your Targeted Case Management Program Rulebook. Each rule is numbered individually for easy replacement.

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

TR 574 10/1/04

"Assisting People to Become Independent, Healthy and Safe"
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DEPARTMENT OF HUMAN SERVICES

MEDICAL ASSISTANCE PROGRAMS

DIVISION 138

TARGETED CASE MANAGEMENT -- BABIES FIRST

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

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) Intraventricular 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 palsy;

(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