Behavioral Health Case Management & Care Coordination

Last Updated: 2/4/2025 **Last Reviewed: 2/12/2025** **Originally Effective: 1/1/2018**

Last update includes payment policy changes, subject to 28 TAC §3.3703(a)(20)(D)? No

If yes, Texas Last Update Effective Date: n/a **Policy #: RPM058**

Scope

Companies: Moda Partners, Inc. and its subsidiaries & affiliates (All) **Provider Contract Status:** Any

Claim Forms: CMS1500 & CMS1450 (paper and electronic versions) **Claim Dates:** All

Reimbursement Guidelines

A. General

1. Moda Health covers Behavioral Health Case Management and Care Coordination (CM/CC) in full compliance with ORS 743A.168 as amended by the Oregon Legislature in 2017 (HB 3091) and OAR 836-053-1403. These same benefits are allowed for plans in other states outside of the Oregon mandate.

2. This policy focuses on CM/CC services and codes. Other services and codes that may be related to CM/CC services may also be performed and billed when they are within the provider's scope of practice; they are not included in this policy. To determine appropriate codes, reference the provider type listed in the Rendering Provider Types column on the current Oregon Health Authority Behavioral Health Fee Schedule. The OHA "Behavioral Health Peer-Delivered Services Fee-for-Service (Open Card) Billing Guide" [17] is also a helpful resource.

3. Case Management and Care Coordination services are reimbursable only when:
   a. The service provided is within the rendering provider's scope of practice.
   b. Correctly coded and billed, in accordance with the requirements of this policy.
   c. Licensed providers (MD, DO, ND, PA, NP, LCSW, LPC, LMFT, Psychologist, etc.) may provide CM/CC services in any setting.
   d. Certified (non-licensed) providers (QMHA, Peer Support, etc.) may provide CM/CC services under the auspices of a program appropriately licensed or certified by the Oregon Health Authority or the state in which the program operates.

4. Behavioral Health Case Management and Care Coordination (CM/CC) services may be provided by a variety of provider types with different licensure and/or certification levels. However, not every procedure code may be reported by every provider type. Refer to Coding requirements for specific types of providers.

5. Case Management and Care Coordination services are subject to standard correct coding and bundling guidelines.

6. Time-based Services
   For code selection, documentation of time in medical records, and correct reporting of units, see "Medical Records Documentation Standards," [C] section E, Time-based Services.

7. Special coding rules apply when billing E/M services and psychotherapy on the same date of service. See "Evaluation and Management (E/M) Services With Psychotherapy Services." [G]

8. For information about prolonged services, see "2021 & 2023 Updates to Evaluation and Management (E/M) Visits and Prolonged Services." Section E.3 specifically addressing prolonged services for psychotherapy procedure codes. [E]

B. Coding requirements for specific types of providers

CM/CC services are reported with specific procedure codes depending on type of provider.

1. Licensed behavioral health professionals (e.g., LCSW, LPC, LMFT, licensed Psychologist, licensed Psychologist Associate, etc.) may report CM/CC services with the following procedure codes:

Code	Definition	Valid for:
G0323	Care management services for behavioral health conditions, at least 20 minutes …per calendar month. (These services include the following required elements: *** (see full code definition in your coding resources)	Medicare Advantage & Commercial plans only. Not valid for Medicaid plans.
H0039	Assertive community treatment, face-to-face, per 15 minutes	All plans.
H0040	Assertive community treatment program, per diem	All plans.
H2021	Community-based wrap-around services, per 15 minutes	Medicare Advantage & Commercial plans only.
T1016	Case management, each 15 minutes	All plans.
T1017	Targeted case management, each 15 minutes	All plans.

2. Qualified Mental Health Professional (QMHP) and Qualified Mental Health Associate (QMHA) practicing under the auspices of a program appropriately licensed or certified by the Oregon Health Authority may report the following case management/care coordination codes:

Code	Definition	Valid for:
H0039	Assertive community treatment, face-to-face, per 15 minutes	All plans.
H0040	Assertive community treatment program, per diem	All plans.
H2021	Community-based wrap-around services, per 15 minutes	Medicare Advantage & Commercial plans only.
T1016	Case management, each 15 minutes	All plans.
T1017	Targeted case management, each 15 minutes	Medicare Advantage & Commercial plans only.

3. Peer Support, Family Support, Peer Wellness or Youth Support Specialists practicing under the auspices of a program appropriately licensed or certified by the Oregon Health Authority may report the following case management/care coordination codes:

Code	Definition	Valid for:
H0039	Assertive community treatment, face-to-face, per 15 minutes	All plans.
H0040	Assertive community treatment program, per diem	All plans.
T1016	Case management, each 15 minutes	All plans.
T1017	Targeted case management, each 15 minutes	Medicare Advantage & Commercial plans only.

4. Physicians (MD, DO, ND) and NPPs (PA, NP).
   a. Two types of care models exist for case management/care coordination services. A different set of codes are used depending upon which care model is used.
      i. Psychiatric Collaborative Care Model (CoCM):
         1) Behavioral Health Integration (BHI) services under this care model involve: A team of 3 individuals delivers CoCM: a behavioral health care manager, psychiatric consultant, and

treating (billing) practitioner. This model enhances primary care by adding 2 key services to the primary care team:

- Care management support for patients getting behavioral health treatment.
- Regular psychiatric inter-specialty consultation.

2) To bill CoCM services, the primary care physician reports CPT codes 99492–99494 and HCPCS code G2214.

ii. Behavioral Health Integration using models of care other than CoCM:

1) BHI services include elements such as:

- Systemic assessment and monitoring.
- Care plan revision for patients whose condition isn't improving adequately.
- Continuous relationship with an appointed behavioral health care team member.

2) To bill general BHI services, the primary care physician reports CPT codes 99483–99484, 99487, 99489-99491, G2064-G2065. (Note: The behavioral health team member will report G0323.)

b. Physicians (MD, DO, ND) and NPPs (PA, NP) meet the scope of license requirements[F] to report the following E/M codes for case management/care coordination services. They may also bill any of the procedure codes listed for licensed behavioral health professionals if those are more appropriate.

Code	Definition *(*** = Shortened description. See Code Definitions section later in policy for full description.)*	Notes, Comments, & Instructions
99483	Assessment of and care planning for a patient with cognitive impairment, requiring an independent historian, …with all of the following required elements: ***	Use for Commercial, Medicare Advantage, Medicaid, and Medicare Supplement/crossover claims.
99484	Care management services for behavioral health conditions, at least 20 minutes of clinical staff time…per calendar month, with the following required elements: ***.	Use for Commercial, Medicare Advantage, Medicaid, and Medicare Supplement/crossover claims.
99487	Complex chronic care management services, with the following required elements: ***per calendar month	Use for Commercial, Medicare Advantage, Medicaid, and Medicare Supplement/crossover claims.
99489	Complex chronic care management services, with the following required elements: ***; each additional 30 minutes of ***per calendar month (List separately in addition to code for primary procedure)	Use for Commercial, Medicare Advantage, Medicaid, and Medicare Supplement/crossover claims.
99490	Chronic care management services, at least 20 minutes ***per calendar month, with the following required elements: ***.	*Requires 24/7 coverage. *Requires co-morbidities.
99491	Chronic care management services, at least 20 minutes***per calendar month, with the following required elements: ***.	*Requires 24/7 coverage. *Requires co-morbidities.

Code	Definition *(*** = Shortened description. See Code Definitions section later in policy for full description.)*	Notes, Comments, & Instructions
99492	Initial psychiatric collaborative care management, first 70 minutes in the first calendar month of behavioral health care manager activities, in consultation with ***.	Use for Commercial, Medicare Advantage, Medicaid, and Medicare Supplement/crossover claims. See also G2214 for similar code, different time frame.
99493	Subsequent psychiatric collaborative care management, first 60 minutes in a subsequent month of behavioral health care manager activities, in consultation with ***.	Use for Commercial, Medicare Advantage, Medicaid, and Medicare Supplement/crossover claims.
99494	Initial or subsequent psychiatric collaborative care management, each additional 30 minutes in a calendar month of behavioral health care manager activities, in consultation with ***	Use for Commercial, Medicare Advantage, Medicaid, and Medicare Supplement/crossover claims.
G0323	Care management services for behavioral health conditions, at least 20 minutes of clinical psychologist or clinical social worker time, per calendar month. (These services include ***	Billed by the clinical psychologist or clinical social worker for behavioral health integration services, when working in collaboration with a primary care physician.
G0506	Comprehensive assessment of and care planning for patients requiring chronic care management services (list separately in addition to primary monthly care management service)	Do not use in combination with or as add-on code to 99483 or 99485. (See CMS add-on code edit file to identify an appropriate primary procedure codes)
G2064	Comprehensive care management services for a single high-risk disease, e.g., principal care management, at least 30 minutes of physician or other qualified health care professional time per calendar month ***	Similar to 99487 – 99491, but with only one complex condition, and slightly different other requirements.
G2065	Comprehensive care management for a single high-risk disease services, e.g. principal care management, at least 30 minutes***per calendar month ***	Similar to 99487 – 99491, but with only one complex condition, and slightly different other requirements.
G2214	Initial or subsequent psychiatric collaborative care management, first 30 minutes in a month of behavioral health care manager activities***	See also 99492 for different time frame.

C. Reimbursement and Bundling

1. Case Management and Care Coordination (CM/CC) services are reimbursed in accordance with coding definitions, standard correct coding guidelines, documentation requirements, and correct billing practices.

2. CM/CC is denied as a separately billed service when provided by the employee (QMHP, QMHA, Certified Peer Support, Family Support, Peer Wellness or Youth Support Specialist) of an inpatient program or intensive outpatient partial hospitalization program being reimbursed under a per diem rate, unless the service is specifically carved out from the per diem.

3. CM/CC services billed with G0177, H0039, H2011, H2014, H2021, T1016, and/or T1017 are eligible for separate reimbursement in addition to other assessment or treatment services provided when all of the following requirements are met:
   a. The CM/CC is a distinct and separate service performed during a separate time period (not necessarily a separate patient encounter).
   b. The CM/CC is billed with an NCCI-associated modifier appended.
   c. The time for each separate service is clearly documented to not overlap. Any time, effort, and items in the medical records documentation cannot be counted towards more than one service or procedure code.

4. CM/CC services billed with 99483, 99484, 99487, 99489, 99490, 99492, 99493, 99494, G0506, G2064, G2065, and G2214:
   a. Are never eligible to be reported on the same date of service as psychotherapy services, psychoanalysis, narcosynthesis, hypnotherapy, moderate sedation, a variety of other E/M codes, and any other services listed with a CCI PTP edit with modifier indicator of "0."
   b. Are sometimes eligible to be reported on the same day as certain E/M services or other procedures with CCI PTP edits with modifier indicator of "1", but only if all the following requirements are met:
      i. The CM/CC is a distinct and separate service performed during a separate time period (not necessarily a separate patient encounter).
      ii. The CM/CC is billed with an NCCI-associated modifier appended.
      iii. The time for each separate service is clearly documented to not overlap. Any time, effort, and items in the medical records documentation cannot be counted towards more than one service or procedure code.

D. Procedure codes not eligible for separate reimbursement include:

1. Transitional Care Management procedure codes.

   a. Transitional Care Management (TCM) procedure codes (99495 and 99496) are only eligible for separate reimbursement when the member has primary Medicare coverage (Medicare Advantage plan or Original Medicare is primary and the Moda Health plan is secondary to Medicare).
   b. For all other plans, Transitional Care Management procedure codes (99495 and 99496) will be denied to provider write off. The denial explanation code will be:

      2M0 *Service/supply is considered bundled or incidental. Not eligible for separate payment. Always bundled into a related service.*

      835 CARC/RARC denial combination:

      CARC 97 (The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.

      Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.)

      RARC M15 (Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.)

c. Claims for TCM services may be submitted using the following procedure codes:
    i. The face-to-face visit may be billed as usual under the appropriate evaluation and management service code for the place of service in which it occurs (e.g., hospital visit, subsequent office visit).
    ii. Non-face-to-face services:
        1) Any care plan oversight services may be reported under the appropriate Care Plan Oversight CPT codes (99339-99340, 99377-99378, or 99374-99380).
        2) Medical team conferences performed without face-to-face contact with the patient may be billed under 99367-99368.
        3) Additional non-face-to-face services are considered included in the discharge E/M or the subsequent office visit E/M.

2. Other procedure codes.
    a. Procedure codes with a status indicator of "B" on the Medicare Physician Fee Schedule.
    b. Procedure codes which do not specify amount of time; a code with a higher level of specificity is needed: H0006, H0007.
    c. Procedure codes not separately eligible for other reasons: H2022 (use H2021 instead), H2027 (use another code with more specific description).

E. Conversations/Consultations Between Therapist and PCP

When a behavioral health therapist (clinician) of any type of licensure holds a conversation with a medical primary care provider (PCP) regarding a patient that both are treating for the purpose of both treating the patient appropriately, ensuring that medications are managed appropriately, and to coordinate care, the conversation/consultation is reported as follows:

1. Depending upon the time and extent of other care management activities by the primary care provider providing medical care, the PCP reports either:
    a. General Behavioral Health Integration Care Management (99484) [10]
        i. Service must include the following required elements:
            1) Initial assessment or follow-up monitoring, including the use of applicable validated rating scales.
            2) Behavioral health care planning/revision in relation to behavioral/psychiatric health problems.
            3) Facilitating and coordinating treatment such as psychotherapy, pharmacotherapy, counseling and/or psychiatric consultation.
            4) Continuity of care with a designated member of the care team.
            5) A minimum of 20 minutes of clinical staff time, directed by a physician or other qualified health care professional, per calendar month.
        ii. Services less than 20 minutes/calendar month are not reported separately.
    b. Psychiatric Collaborative Care Management Services (99492-99494) [11, 12]
        i. Services less than 36 minutes may qualify for reporting under General Behavioral Health Integration Care Management (99484).
        ii. For the PCP to report 99492-99494, the service must include the following required elements:
            1) Outreach to and engagement in treatment of a patient directed by the treating physician or other qualified health care professional.
            2) Initial assessment of the patient, including administration of validated rating scales, with the development of an individualized treatment plan.
            3) Review by the psychiatric consultant with modifications of the plan if recommended.

4) Entering patient in a registry and tracking patient follow-up and progress using the registry, with appropriate documentation, and participation in weekly caseload consultation with the psychiatric consultant.
5) Provision of brief interventions using evidence-based techniques.

iii. If the above requirements are fully met, the PCP reporting 99492-99494 includes the services of the behavioral health care manager and the psychiatric consultant. [12]

c. The PCP may not report a separate procedure code if the full requirements for the above codes are not met.

2. For dates of service December 31, 2024 and prior, the therapist/behavioral health clinician does not report a separate procedure code for this conversation with the PCP. [12]

3. For dates of January 1, 2025 and following, HCPCS codes G0546-G0551 may be reported by Clinical Psychologists, Clinical Social Workers (behavioral health), Marriage and Family Therapists, and Mental Health Counselors who are performing interprofessional consultations to the patient's treating/requesting medical provider.[21]

Definitions

Acronyms/Abbreviations

Acronym	Definition
AMA	American Medical Association
ASO	Administrative Services Only
BHI	Behavioral Health Integration
CCI	Correct Coding Initiative (see "NCCI")
CM/CC	Case Management and Care Coordination
CMS	Centers for Medicare and Medicaid Services
CoCM	Psychiatric Collaborative Care Model (a specific type of Behavioral Health Integration services)
CPT	Current Procedural Terminology
DCBS	Department of Consumer and Business Services
DO	Doctor of Osteopathic Medicine
DOS	Date of Service
E/M E&M E & M	Evaluation and Management (services, visit) (Abbreviated as "E/M" in CPT book guidelines, sometimes also abbreviated as "E&M" or "E & M" in some CPT Assistant articles and by other sources.)
HCPCS	Healthcare Common Procedure Coding System (acronym often pronounced as "hick picks")
HIPAA	Health Insurance Portability and Accountability Act
IIBHT	Intensive In-Home Behavioral Health Treatment Services (OHA[18])
MD	Medical Doctor
MUE	Medically Unlikely Edits
NCCI	National Correct Coding Initiative (aka "CCI")
ND	Naturopathic Doctor
NP	Nurse Practitioner
NPP	Nonphysician provider
OAR	Oregon Administrative Rules
ORS	Oregon Revised Statute

Acronym	Definition
PA	Physician Assistant
PTP	Procedure-To-Procedure (a type of CCI edit)
QMHA	Qualified Mental Health Associate
QMHP	Qualified Mental Health Professional
RPM	Reimbursement Policy Manual (e.g., in context of "RPM052" policy number, etc.)

Definition of Terms

Term	Definition
Case Management	The management of services that are provided to assist an individual in accessing medical and behavioral health care, social and educational services, public assistance and medical assistance and other needed community services identified in the individual's patient-centered care plan.[20]
Coordination of Care	The process of coordinating patient care activities as well as the facilitation of ongoing communication and collaboration with lay caregivers by community resource providers, health care providers, and agencies to meet the multiple needs of a patient by: (a) Organizing and participating in team meetings; and (b) Ensuring continuity of care during each transition of care.[20]
Peer Support Specialist	"Peer support specialist" means a Peer Wellness Specialist or a Peer Support Specialist, including Family Support Specialist and Youth Support Specialist, as defined in ORS 414.025 and 414.665 and certified under OAR 410-180-0310 to 410-180-0312.
Family Support Specialist	"Family support specialist" means an individual certified as a Family Support Specialist under OAR 410-180-0310 to 410-180-0312.
Peer Wellness Specialist	"Peer Wellness Specialist" means an individual certified as a Peer Wellness Specialist under OAR 410-180-0310 to 410-180-0312.
Youth Support Specialist	"Youth Support Specialist" means an individual certified as a Youth Support Specialist under OAR 410-180-0310 to 410-180-0312.
NPP/Nonphysician practitioner	For purposes of this policy, NPP shall specifically refer to a nonphysician practitioner who is eligible to perform and bill for evaluation and management (E/M) services. (In the broadest sense, NPP or "nonphysician practitioner" could refer to any professional provider who is not a physician (MD, DO, ND, DC). That broad usage shall not apply within this policy.)

Related Policies

A. "Moda Health Reimbursement Policy Overview." Moda Health Reimbursement Policy Manual, RPM001.
B. "Modifiers XE, XS, XP, XU, and 59 - Distinct Procedural Service." Moda Health Reimbursement Policy Manual, RPM027.
C. "Medical Records Documentation Standards." Moda Health Reimbursement Policy Manual, RPM039.
D. "Medically Unlikely Edits (MUEs)." Moda Health Reimbursement Policy Manual, RPM056.
E. "2021 & 2023 Updates to Evaluation and Management (E/M) Visits and Prolonged Services." Moda Health Reimbursement Policy Manual, RPM076.
F. "Scope Of License For Evaluation & Management Codes." Moda Health Reimbursement Policy Manual, RPM080.
G. "Evaluation and Management (E/M) Services With Psychotherapy Services." Moda Health Reimbursement Policy Manual, RPM081.

Resources

1. American Medical Association (AMA). "Health and Behavior Assessment/Intervention Guidelines." *CPT Book, Professional Edition.* Chicago: AMA Press, 2018, p. 676.
2. CMS. *National Correct Coding Initiative Policy Manual*. Chapter 12 Supplemental Services HCPCS A0000-V999, § C.16.
3. CMS. "Frequently Asked Questions about Billing Medicare for Behavioral Health Integration (BHI) Services." April 17, 2018: May 1, 2018. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/Behavioral-Health-Integration-FAQs.pdf .
4. American Medical Association (AMA). "Coding Update: Care Management Services." *CPT Assistant.* Chicago: AMA Press, October 2014, pp. 3-5.
5. American Medical Association (AMA). "Time." *Current Procedural Terminology (CPT), Introduction*. Chicago: AMA Press.
6. American Medical Association (AMA). "Psychotherapy." *2019 Current Procedural Terminology (CPT), Professional Edition*. Chicago: AMA Press, pp. 640-641.
7. American Medical Association (AMA). "Health and Behavior Assessment/Intervention Guidelines." *CPT Book, Professional Edition.* Chicago: AMA Press, 2020, p. 729.
8. American Medical Association (AMA). "Psychotherapy." *2023 Current Procedural Terminology (CPT), Professional Edition*. Chicago: AMA Press, pp. 733-734.
9. American Medical Association (AMA). "Questions and Answers: Evaluation and Management (E/M): E/M Services Guidelines, Medicine: Psychiatry." Chicago: AMA Press, August 2022, Volume 32, Issue 8, pages 15-19.
10. American Medical Association (AMA). "General Behavioral Health Integration Care Management." *CPT Assistant.* Chicago: AMA Press, July 2018, pp. 12-13.
11. American Medical Association (AMA). "Psychiatric Collaborative Care Management Services." *CPT Assistant.* Chicago: AMA Press, November 2017, pp. 3-5.
12. American Medical Association (AMA). "Psychiatric Collaborative Care Management Services." *2023 Current Procedural Terminology (CPT), Professional Edition*. Chicago: AMA Press, pp. 52-56.
13. Hollmann, Peter, MD, Co-Chair CPT/RUC Workgroup on E/M. "E/M 2023: Advancing Landmark Revisions Across More Settings Of Care." Time stamp 40:00 – 44:00. American Medical Association. Webinar recorded August 9, 2022. Last accessed November 18, 2022. https://portal.inxpo.com/ID/NTT/AMA/ .
14. CMS. "Behavioral Health Integration Services." Medicare Learning Network. MLN909432. Last updated May 2023; Last accessed August 23, 2023.
15. CMS. "Frequently Asked Questions about Billing Medicare for Behavioral Health Integration (BHI) Services." Last updated April 17, 2018; Last accessed August 23, 2023. https://www.cms.gov/medicare/medicare-fee-for-service-payment/physicianfeesched/downloads/behavioral-health-integration-faqs.pdf .
16. CMS. "Requirements for a Provider Direct Mailing and Education & Outreach for Behavioral Health Initiatives." CMS Transmittal 12285. Last updated October 5, 2023; Last accessed November 3, 2023.
17. Oregon Health Authority. "Behavioral Health Peer-Delivered Services Fee-for-Service (Open Card) Billing Guide." Last updated June 2024; Last accessed August 2, 2024. https://www.oregon.gov/oha/HSD/OHP/Tools/Peer-Support-Billing-Guide.pdf .
18. Oregon Health Authority. "Behavioral Health Fee Schedule, July 2024." Last updated July 1, 2024. Last accessed August 6, 2024. https://www.oregon.gov/oha/HSD/OHP/DataReportsDocs/bh-fee-schedule-0724.xlsx.
19. Moda. Per September 11, 2024 email notification from Director of Behavioral Health, Commercial plans will cover H0023 for IIBHT, following OHA instructions for coding IIBHT services.

20. OAR. “Definitions of Coordinated Care and Case Management for Behavioral Health Care Services.” OAR 836-053-1403. Last updated June 8, 2021; Last accessed February 5, 2025. OAR 836-053-1403 – Definitions of Coordinated Care and Case Management for Behavioral Health Care Services .
21. CMS. “Medicare Physician Fee Schedule Final Rule Summary: CY 2025.” MLN Matters Number: MM13887.

Policy History

Reminder: The most current version of our reimbursement policies can be found on our provider website. If you are using a printed or saved electronic version of this policy, please verify the current information by going to: https://www.modahealth.com/medical/policies_reimburse.shtml

Date	Summary of Update
2/12/2025	Updated Related Policies and Resources. Replaced information duplicated elsewhere with links to the related policies. Added information on new codes G0546-G0551. Formatting updates. No policy changes.
10/9/2024	Updated information for H0023. Updated References & Resources.
8/14/2024	Updated procedure code lists/tables based on updated OHA behavioral health fee schedule & billing guide. Updated Acronyms, Related Policies, and Resources. Formatting updates. No policy changes.
11/8/2023	G0323 added as valid for licensed behavioral health professionals. Clarified major types of BHI care models for context. Acronyms & Resources updated.
8/15/2023	Updated for 2023 E/M coding updates, no psychotherapy services prolonged services codes. Updated References & Resources. Formatting updated. No policy changes.
8/9/2023	Clarified conversations/consultations between therapist and PCP. Updated procedure codes, Coding Guidelines, and Resources.
6/14/2023	Clarified E/M services with psychotherapy. Updated Coding Guidelines and Resources.
4/12/2023	Clarified E/M coding based on time versus MDM. Updated Cross References. Formatting updated. Policy History entries prior to 2023 omitted (in archive storage). No policy changes.
8/10/2018	Policy document initially approved by the Reimbursement Administrative Policy Review Committee & initial publication.
1/1/2018	Original Effective Date (with or without formal documentation). Policy based on Oregon 2017 HB3091 changes to ORS 743A.168. Also OAR 836-053-1403.