

**DEPARTMENT OF HUMAN SERVICES
SENIORS AND PEOPLE WITH DISABILITIES DIVISION
OREGON ADMINISTRATIVE RULES**

CHAPTER 411

**DIVISION 350
MEDICALLY FRAGILE CHILDREN SERVICES**

**Standards and Procedures for the Provision of Care and Services to
Children Receiving Medically Fragile Children Services**

411-350-0010 Purpose
(Effective 6/1/2004)

These rules establish the policy of and prescribe the standards and procedures for the provision of Medically Fragile Children (MFC) Services. These Administrative Rules are established to ensure that MFC Services augment and support independence, empowerment, dignity, and development of the child through the provision of flexible and efficient services to eligible families. MFC Services are exclusively intended to allow a child who is medically fragile to have a permanent and stable familial relationship. The services provide the support necessary to enable the family to meet the needs of caring for a medically fragile child. MFC Services are intended to supplement families' natural supports and services.

Stat. Auth.: ORS 409.050, 417.340 - 417.355 & 430.041

Stats. Implemented: ORS 430.215, 427.005 - 427.007 & 417.340 - 417.355

411-350-0020 Definitions
(Effective 6/1/2004)

(1) "Activities of Daily Living (ADL)" means tasks usually performed in the course of a normal day in a child's life; such as eating, dressing, bathing and personal hygiene, mobility, bowel and bladder control, usual developmental tasks, such as play and social development.

(2) "Aide" means a nonlicensed caregiver who may or may not be certified as a Certified Nursing Assistant.

(3) "Billing Provider" means an organization that enrolls with the Department and contracts with the Department to provide MFC In-Home Daily Care (IHDC) through its employees and bills the Department for the performing provider's services.

(4) "Child" means a person who is under the age of 18 and accepted for services by the MFCU.

(5) "Clinical Criteria" means the assessment tool, Form DHS 0519 (Revised 9/03), used by the MFCU to evaluate the intensity of the care and IHDC needs of children.

(6) "Comprehensive Plan of Care (CPC)" means a written document developed by the service coordinator with the family or foster family that describes the needs of the child and the needs of the family that impact the child and how those needs will be met. It includes the Nursing Care Plan when one exists.

(7) "Cost Effective" means that in the opinion of the MFCU service coordinator a specific service meets the child's service needs and costs less than or is comparable to other service options considered.

(8) "Delegation" means that a registered nurse authorizes an unlicensed person to perform nursing tasks and confirms that authorization in writing. Delegation occurs only after assessment of the specific situation, the abilities of the unlicensed person, teaching the task and ensuring supervision. Delegation shall only occur to the extent allowed by Oregon Board of Nursing's administrative rules. Delegation by physicians is also allowed.

(9) "Department" means Department of Human Services, Seniors and People with Disabilities, an organizational unit within the Department that focuses on the planning of services, policy development and regulation of programs for persons that have developmental disabilities, or are elderly or have physical disabilities.

(10) "Eligible Range" means that the score on the Clinical Criteria is at or above 50.

(11) "Hospital Model Waiver" means the waiver program granted by the federal Health Care Financing Administration that allows Title XIX funds to be spent on children in their family home who otherwise would have to be served in a hospital if the waiver program was not available.

(12) "In-Home Daily Care (IHDC)" means essential supportive shift care delivered by a qualified provider that enables a child to remain or return to his or her family's home.

(13) "Medically Fragile Children (MFC)" means children who have a health impairment that requires long term, intensive, specialized services on a daily basis and have been accepted for services by the MFCU.

(14) "Medically Fragile Children's Unit (MFCU)" means the program administered by the Department of Human Services for MFC.

(15) "Nurse" means a person who holds a valid, current license as an Registered Nurse (RN) or Licensed Practical Nurse (LPN) from the Oregon Board of Nursing.

(16) "Nursing Care Plan" means a plan of care developed by the RN that describes the medical, nursing, psychosocial, and other needs of the child and how those needs will be met. It includes which tasks will be taught, assigned or delegated to the qualified provider or family. When one exists, it becomes a part of the Comprehensive Plan of Care.

(17) "Nursing Tasks or Services" means the care or services that require the education and training of a licensed professional nurse to perform. They may be delegated.

(18) "Primary Caregiver" means the parent or foster parent who provides the direct care of the child at the times that a provider is not available.

(19) "Provider or Performing Provider" means the individual who is qualified to receive payment from the Department for In-Home Daily Care and meets the requirements of OAR 411-350-0080. Performing Providers work directly

with MFC children. Providers may be employees of Billing Providers, employees of the family or independent contractors.

(20) "Service Coordinator" means a person who ensures a child's eligibility for MFCU services and provides assessment, case planning, service implementation, and evaluation of the effectiveness of the services.

Stat. Auth.: ORS 409.050, 417.340 - 417.355 & 430.041

Stats. Implemented: ORS 430.215, 427.005 - 427.007 & 417.340 - 417.355

411-350-0030 Eligibility

(Effective 6/1/2004)

(1) In order to be eligible for MFC Services, the child must meet the following criteria:

(a) Be eligible for Title XIX (Medicaid) or Title XXI (CHIPS); and

(b) Be under the age of 18; and

(c) Be accepted by the MFCU as eligible for MFC services by having a condition:

(A) That is likely to last for more than 2 months; and

(B) That makes MFC services medically necessary as defined by scoring 50 or greater on the Clinical Criteria; and

(d) Residing in the family or foster home; and

(e) Be capable of being safely served in the family or foster home, including, but not limited to, parents or foster parents demonstrating the willingness, skills, and ability to provide the direct care not paid for in the Comprehensive Plan of Care as determined by the service coordinator within the limitations of 411-350-0070.

(2) Children who reside in a hospital, school, sub-acute facility, nursing facility, ICF/MR, residential facility, or other institution are not eligible for MFC Services.

(3) Children who have sufficient family, government or community resources available to provide for their care are not eligible for MFC Services; also children not safely served in their homes as per OAR 411-350-0030(1)(e) are not eligible for MFC services. The services are not available to replace care provided by a parent or foster parent or to replace other governmental or community services.

(4) Children who meet the following criteria will be transitioned out of MFC services within three months and will no longer be eligible for MFC services:

- (a) Have been previously eligible for MFC services; and
- (b) The needs of the child have decreased; and
- (c) The score on the clinical criteria remains at 30 or less.

Stat. Auth.: ORS 409.050, 417.340 - 417.355 & 430.041

Stats. Implemented: ORS 430.215, 427.005 - 427.007 & 417.340 - 417.355

411-350-0040 Comprehensive Plan of Care

(Effective 6/1/2004)

(1) The MFC service coordinator shall perform the following duties:

(a) **Assessment:** The service coordinator will assess the service needs of the client by identifying the services for which the child is currently eligible, services currently being provided, and available family, community, private health insurance and government resources meeting any, some, or all of the child's needs. The service coordinator shall interview the parents or other caregivers and, when appropriate, other interested persons to assess the child's support needs.

(b) **Care Planning:** The service coordinator will prepare, with the input of the family and any person at family's request, a written Comprehensive Plan of Care that:

- (A) Defines the needs of the child and the family;
- (B) Identifies the methods, resources and strategies that address some or all of those needs;
- (C) Identifies the number of hours of MFC Services authorized for the child; and
- (D) Identifies other services authorized by the Department for the child.

(2) The Comprehensive Plan of Care will:

- (a) Note the maximum hours to be reimbursed for those services; and
- (b) Estimate the cost of the care.

(3) The plan will describe the estimated number of hours that a MFC aide will be authorized and the number of hours that a licensed nurse will be authorized.

(4) The Nursing Care Plan, when one exists, will be included in the Comprehensive Plan of Care.

(5) The plan will be reviewed with the family prior to implementation and a copy provided to the family.

(6) The plan will include the date of the next planned review that, at a minimum, will be every 6 months.

(7) Significant changes in the needs of the child shall be reflected in the revised Nursing Care Plan, if one exists, and the Comprehensive Plan of Care and a copy provided to the family.

Stat. Auth.: ORS 409.050, 417.340 - 417.355 & 430.041

Stats. Implemented: ORS 430.215, 427.005 - 427.007 & 417.340 - 417.355

411-350-0050 Scope and Limitations of MFC Services
(Effective 6/1/2004)

(1) Parents and foster parents are the primary caregiver(s) and the services are intended to support, not supplant the natural supports supplied by the family.

(2) MFC Services may include, for a child on the Hospital Model Waiver, a combination of the following based upon the needs of the child as determined by the service coordinator consistent with the child's Comprehensive Plan of Care:

- (a) In-Home Daily Care;
- (b) Minor Home Adaptations; or
- (c) Goods, services, and supplies.

(3) MFC Services for a child not on the Hospital Model Waiver are limited to In-Home Daily Care only.

(4) All services authorized by the Department must be included in a written Comprehensive Plan of Care in order to be eligible for payment.

(5) The Comprehensive Plan of Care will use the most cost-effective services for safely meeting that child's needs as determined by the MFC service coordinator.

(6) The average monthly payment for the MFC services authorized in the Comprehensive Plan of Care will not exceed the limits established for the child's service level as follows:

(a) Level I:

(A) Children that are eligible for Level I services:

- (i) Must be ventilator-dependent for 24 hours per day;
- (ii) Have a score on the Clinical Criteria of 70 or greater;
and
- (iii) Require awake staff or family for the full 24 hours.

(B) The average monthly cost for Level I shall be based on the Comprehensive Plan of Care and will not exceed \$18,000.

(b) Level II:

(A) Children that are eligible for Level II services:

(i) Must be ventilator-dependent for at least 6 hours per day; and

(ii) Have a score on the Clinical Criteria between 60 and 69; and

(iii) Require awake staff or family for the full 24 hours.

(B) The average monthly cost for Level II will be based on the Comprehensive Plan of Care and shall not exceed \$12,500.

(c) Level III:

(A) Children that are eligible for Level III services:

(i) Have a score on the Clinical Criteria between 50 and 59; and

(ii) Require awake staff or family for the full 24 hours.

(B) The average monthly cost of Level III will be based on the Comprehensive Plan of care and shall not exceed \$9,500.

(d) Level IV:

(A) Children that are eligible for Level IV services:

(i) Have a score on the Clinical Criteria of less than 50; and

(ii) Must meet the other eligibility criteria of OAR 411-350-0030; and

(iii) Have not been transitioned out of services.

(B) The average monthly cost of Level IV will be based on the Comprehensive Plan of Care and shall not exceed \$4,500.

(e) Exceptions by the Department to the above cost limitations in service may only be made in the following circumstances:

(A) In order to prevent a hospitalization, the service coordinator can authorize increased costs for a short, time-limited period.

(B) In order to provide initial teaching of new care needs, the service coordinator can authorize additional costs for a time-limited period, not to exceed 60 days.

(C) The service coordinator can authorize additional costs when the service coordinator determines that documentation of a significant medical condition in the primary caregiver indicates that the condition prevents or seriously impedes the primary caregiver from rendering services.

(7) MFC Services will only be authorized to enable the family to meet the needs of caring for the medically fragile child.

(8) Minor home adaptations will only be authorized that are necessary to ensure the health, welfare and safety of the child or that enable the child to function with greater independence in the home. Adaptations or improvements to the home that are of general utility and are not of direct medical or remedial benefit to the child are excluded. Adaptations that add to the total square footage of the home are excluded.

(9) All minor home adaptations must be provided in accordance with applicable state or local building codes by licensed contractors.

(10) For minor home adaptations that exceed \$5000, the Department may protect its interest through liens or other legally available means.

(11) Minor home adaptations that are provided in a rental structure must be authorized in writing by the owner of the structure prior to initiation of the work.

(12) Goods, services, and supplies may include any combination of the following:

(a) Homemaker. Homemaker Services consist of general household activities.

(b) Respite. Respite Services are furnished on a short-term basis because of the absence or need for relief for the primary caregiver.

(c) Transportation. Transportation is to gain access to community services, activities and resources as specified in the CPC. Family members cannot be paid to provide this transportation. This shall not replace medical transportation furnished by OHP in which family members can be paid.

(d) Specialized medical equipment and supplies. Items could include, among others, communication devices, adaptive clothing, adaptive eating equipment, or adaptive sensory or habilitation devices or supplies. Items furnished by the Oregon Health Plan are excluded.

(e) Chore. Chore services are those needed to maintain the home in a clean, sanitary, and safe manner. These services include heavy household chores such as window washing or carpet cleaning. These services shall be provided only in situations where no one else in the household or other persons capable of performing or providing these.

(f) Family training. Training and counseling services for the families of MFC children, that increase the family's capability to care for their child.

(g) Consultation by a physical therapist, occupational therapist, speech and language therapist, dietitian or other professional. Services covered by the Oregon Health Plan are excluded.

(h) Special diets. Special diets shall be ordered by a physician and periodically monitored as necessary by a dietitian. Special diets shall not constitute a full nutritional regime.

(i) Other goods, services, and supplies that are directly related to the child's disability included in an approved comprehensive Plan of Care, and required to help the family to continue to meet the needs of caring for the child.

(13) Goods, services and supplies paid for by the Department shall be documented by receipts and the receipts maintained by the Department for 5 years. If no receipt is available, the family shall submit to the Department in writing a statement that they obtained goods, service or supplies, the date that it was obtained, and the cost that was incurred.

(14) The Department may expend its funds for minor home adaptations or goods, services, and supplies through contract, purchase order, use of credit card, payment directly to the family or vendor, or any other legal payment mechanism.

Stat. Auth.: ORS 409.050, 417.340 - 417.355 & 430.041

Stats. Implemented: ORS 430.215, 427.005 - 427.007 & 417.340 - 417.355

411-350-0060 Denial of Services, Amount of Services, or Eligibility (Effective 6/1/2004)

(1) The Department must notify every applicant or recipient of services, unless the action is part of the CPC and the parent has agreed, in writing at the time of denial of a request for eligibility, or at the time of any action to terminate, suspend, or reduce MFCU eligibility or covered services, of the right to a hearing, of the method to obtain a hearing, and that the applicant may represent himself or herself, or use legal counsel, a relative, a friend, or other spokesperson. A notice concerning termination, suspension, or reduction of existing services shall be mailed to or served personally upon the child's parent or legal guardian not later than ten days before the effective date of action.

(2) The parent or legal guardian and foster parent may appeal a denial of a request for additional or different services only if the request has been

made in writing and submitted to MFCU, SPD, 500 Summer Street NE, First Floor, Salem, OR 97301. If the Department denies a written request for additional or different services, it must notify the parent or guardian in writing at the time of the denial of the information specified in paragraph (3) of this section.

(3) A notice required by paragraphs (1)(b) or (2) of this section shall be served upon the parent or legal guardian and foster parent personally or by certified mail. The notice shall state:

- (a) A statement of what action the Department intends to take;
- (b) The reasons for the intended action;
- (c) The specific regulations that support, or the change in Federal or State law that requires, the action;
- (d) A statement of the child's right to a contested case hearing;
- (e) A statement that the Department's files on the subject of the contested case automatically become part of the contested case record upon default for the purpose of making a prima facie case;
- (f) A statement that the notice becomes a final order upon default if the child fails to request a hearing within a specified time;
- (g) In cases of an action based upon a change in law, the circumstances under which a hearing will be granted; and
- (h) An explanation of the circumstances under which MFCU services will be continued if a hearing is requested.

(4) If the child or representative disagrees with the decision of the Department, the child or representative may request a contested case hearing as provided in ORS 183. The request for a hearing must be in writing on Form AFS 443 and signed by the parent or the child's representative. To be considered timely, the request must be received by the Department within 45 days from the date of the Department's notice of denial.

(5) The family will be offered an opportunity for informal review by the Department or the designee.

(6) If the family requests an expedited hearing to occur within 45 days of the request for a hearing, the Department will waive its right, once per family, to recovery of benefits expended if the Department's reduction or termination of services is sustained by the hearing decision.

(7) Expedited hearings are requested using AFS Form 443.

(8) The performing or billing provider shall submit relevant documentation to the Department within five working days at the request of the Department when a hearing has been requested.

Stat. Auth.: ORS 409.050, 417.340 - 417.355 & 430.041

Stats. Implemented: ORS 430.215, 427.005 - 427.007 & 417.340 - 417.355

411-350-0070 Scope and Limitations of In-Home Daily Care Services
(Effective 6/1/2004)

(1) MFC In-Home Daily Care services may include a combination of assistance with ADLs, nursing services, or other supportive services as determined by the MFCU service coordinator consistent with the child's Comprehensive Plan of Care. The extent of the services may vary, but the extent of service is limited as described in OAR 411-350-0050. The services include:

(a) Basic personal hygiene -- including assisting with bathing and grooming;

(b) Toileting/bowel and bladder care -- including assisting in the bathroom, diapering, external cleansing of perineal area, and care of catheters, ostomies and bags;

(c) Mobility -- including transfers, comfort, positioning, and assistance with range of motion exercises;

(d) Nutrition -- including preparing meals, special diets, gastrostomy feedings, monitoring intake and output, feeding;

- (e) Skin care -- including dressing changes and ostomy care;
- (f) Respiratory -- including monitoring and administering of oxygen, applying and adjusting ventilators and other respiratory equipment, providing inhalation therapies, monitoring and responding to apnea monitors and oximeters;
- (g) Cardiovascular -- including monitoring of vital signs and monitoring, and replacement and flushing of vascular access sites;
- (h) Neurological -- Monitoring of seizures, administering medication, observing status; and
- (i) Other Nursing or Personal Care Tasks or Services.

(2) When any of the services listed in Subsection (1)(a) through (l) of this section are essential to the health and welfare of the child, the following supportive services may also be provided:

- (a) Housekeeping tasks necessary to maintain the child in a healthy and safe environment;
- (b) Arranging for necessary medical equipment, supplies, and medications;
- (c) Arranging for necessary medical appointments;
- (d) Accompanying the child to appointments, outings, and community-based activities; and
- (e) Activities to enhance development or learning.

(3) The number of service hours will be based upon the projected amount of time to perform the specified assistance for the child. The hours may be spread throughout the time authorized in the voucher or used in large blocks as the family determines.

(4) Hours will be authorized only to support a family or foster family in their primary caregiving role.

(5) Hours will not be authorized that will supplant the services available from family, community, other government or public services, insurance plans, schools, philanthropic organizations, friends, or relatives. Hours will not be authorized solely to allow a parent to work, attend school, or attend any other activity.

(6) When two or more children in the same home or setting qualify for MFCU Services, the same provider will provide services to all qualified children if services can be safely delivered by a single provider, as determined by the MFCU service coordinator.

(7) The Comprehensive Plan of Care will not authorize RN hours when an LPN can safely perform the duties and RN or LPN hours when an aide can safely perform the duties.

Stat. Auth.: ORS 409.050, 417.340 - 417.355 & 430.041

Stats. Implemented: ORS 430.215, 427.005 - 427.007 & 417.340 - 417.355

411-350-0080 Provider Qualifications for In-Home Daily Care

(Effective 6/1/2004)

(1) A performing provider is an individual, 18 years or older, who provides evidence satisfactory to the Department or its designee that demonstrates, by background, education, references, skills, and abilities, that he/she is capable of safely and adequately providing the services authorized.

(2) A provider shall maintain a drug-free work place, pass a criminal history check as defined by OAR 407-007-0200 through 407-007-0380, and be free of convictions or founded allegations of abuse or neglect by the appropriate agency, including but not limited to, Children and Families, Child Welfare Services and Seniors and People with Disabilities.

(3) A prospective performing provider shall consent to a criminal record check by MFCU or the Department prior to enrolling as a provider. MFCU or the Department may require a criminal record check for any provider having regular unsupervised contact with children in the home. MFCU or the Department may require that the provider provide fingerprints and processing fees for the purpose of a criminal record check.

(4) A provider shall not be a parent, stepparent or foster parent of the child.

(5) A performing provider must sign a Medicaid provider agreement and be enrolled as a Medicaid provider prior to delivery of any In-Home Daily Care Services.

(6) A provider who is providing services as a nurse must have:

(a) A current Oregon Nursing license; and

(b) Be in good standing with appropriate professional associations and boards.

(7) A provider is not an employee of the Department or the State of Oregon and is not eligible for state benefits and immunities, including but not limited to, PERS or other state benefit programs.

(8) If the performing or billing provider is an independent contractor, during the terms of the contract, the performing or billing provider shall maintain in force at his/her own expense Professional Liability Insurance with a combined single limit of not less than \$1,000,000 each claim, incident or occurrence. The provider shall furnish evidence of insurance coverage to MFCU prior to beginning work. This insurance is to cover damages caused by error, omission, or negligent acts related to the professional services. There shall be no cancellation of insurance coverage(s) without 30 days written notice to MFCU.

(9) If the performing provider is an employee of the family, the provider shall submit to the Department documentation of immigration status required by Federal Statute. The Department will maintain documentation of immigration status required by Federal Statute, as a service to the family/employer.

(10) A Billing Provider that wishes to enroll with the Department must maintain and submit evidence upon initial application and upon request by the Department of the following:

(a) A current, valid, non-restricted Oregon Nurses' licenses for each employee who is providing services as a nurse;

(b) Current criminal history checks on each employee who will be providing services in a home or foster home showing that the employee has no disqualifying criminal convictions;

(c) Professional Liability Insurance that meets the requirements of OAR 411-350-0080(8) and

(d) Any licensure required of the agency by the State of Oregon or federal law or regulation.

(11) A provider shall immediately notify the family and MFCU of injury, illness, accidents, or any unusual circumstances that may have a serious effect on the health, safety, physical, emotional well being or level of service required by the child for whom services are being provided.

(12) Providers described in ORS Chapter 419 (Licensed Practical Nurses and Registered Nurses) are required to report suspected child abuse to their local office of the State Office of Children and Family Services or police in the manner described in ORS 419.

Stat. Auth.: ORS 409.050, 417.340 - 417.355 & 430.041

Stats. Implemented: ORS 430.215, 427.005 - 427.007 & 417.340 - 417.355

411-350-0090 Prior Authorization for In-Home Daily Care (Effective 6/1/2004)

(1) Except in cases of unforeseeable medical emergency, payment for services must be authorized by the Department before services begin. Payment will be based on these rules, the service needs of the child as documented in the Comprehensive Plan of Care and the cost effectiveness of the proposed services.

(2) Prior to authorization of services that are to be provided by a nurse, there shall be a physician's order for the nursing services. However, MFCU shall determine whether payment of nursing services or the hours of service as ordered by the physician will be authorized for payment according to these rules.

Stat. Auth.: ORS 409.050, 417.340 - 417.355 & 430.041

Stats. Implemented: ORS 430.215, 427.005 - 427.007 & 417.340 - 417.355

411-350-0100 Documentation Needs for In-Home Daily Care

(Effective 6/1/2004)

(1) Accurate timesheets signed by the individual provider of services shall be maintained and submitted to the MFCU with any request for payment for services.

(2) Requests for payment for services must:

(a) Include a copy of the voucher that prior authorized the services;

(b) Be signed by the parent or foster parent of the MFCU child, verifying that the services were delivered as billed; and

(c) Be signed by the provider or billing provider, acknowledging agreement upon request with the terms and condition of the voucher.

(3) Documentation of provided services must be provided to the service coordinator upon request and maintained in the child's place of residence or the place of business of the provider of services. Payment will not be made for services where the documentation of the duties provided does not support the level of service that was provided.

(4) If In-Home Daily Care is provided by a nurse, a Nursing Care Plan must be developed within seven days of the initiation of services and submitted to the MFCU for approval.

(5) The Nursing Care Plan must be reviewed, updated and resubmitted to the MFCU in the following instances:

(a) Every three months;

(b) Within seven working days of a change of the nurse who writes the Nursing Care Plan;

(c) With any request for authorization of an increase in hours of service; or

(d) After any significant change of condition. Examples of significant changes of condition include, but are not limited to, hospital admission or change in health status.

(6) The Nursing Care Plan must be shared with the family by the provider.

(7) If In-Home Daily Care is provided by a nurse, documentation of the child's status and services provided must be maintained in a format acceptable to the MFCU, contain information required by the MFCU, and submitted to MFCU upon request.

(8) Delegation, teaching and assignment of nursing tasks and performance of nursing care must be in accordance with the Oregon Board of Nursing regulations.

(9) MFCU must be notified by the provider within one working day of the death of any MFCU child.

(10) Vouchers and timesheets will be retained by the Department for at least five years from the date of service.

(11) Documentation of provided services will be maintained by the billing provider for at least seven years from the date of service. If a performing provider is a nurse and does not use a billing provider, that performing provider will either maintain for at least five years documentation of provided services or will send the documentation to the Department.

(12) Upon written request from the Department, the Oregon Department of Justice Medicaid Fraud Unit or Health Care Financing Administration or their authorized representatives, providers or billing providers will furnish requested documentation immediately or within the timeframe specified in the written request. Failure to comply with the request may be deemed by the Department as reason to deny or recover payments.

(13) Access to records by the Department inclusive of medical/nursing records and financial records, does not require authorization or release by the MFC child or family.

Stat. Auth.: ORS 409.050, 417.340 - 417.355 & 430.041

Stats. Implemented: ORS 430.215, 427.005 - 427.007 & 417.340 - 417.355

411-350-0110 Payment for In-Home Daily Care

(Effective 6/1/2004)

- (1) Payment will be made after services are delivered as authorized by the service coordinator.
- (2) Rates will be individually negotiated by the Department, based on the individual needs of the child.
- (3) Authorization must be obtained prior to the delivery of any services for those services to be eligible for reimbursement.
- (4) Providers must request payment authorization for services provided for an unforeseeable medical emergency on the first business day following the emergency service. The service coordinator will determine if the service is eligible for payment.
- (5) The Department will make payment to the employee of the family on behalf of the parent. The following will be ancillary contributions:
 - (a) The Department will pay the employer's share of FICA and withhold the employee's share of FICA as a service to the family/employer.
 - (b) The Department will cover real and actual costs to the Employment Department, in lieu of the family/employer paying unemployment tax.
- (6) The delivery of authorized services must occur so that any individual employee of the parent shall not exceed forty hours per workweek. Services will not be authorized that require the payment of overtime, without written prior authorization by the supervisor of the Medically Fragile Children's Unit.
- (7) Holidays are paid at the same rate as non-holidays.

(8) Travel time to reach the job site is not reimbursable.

(9) Requests for payments must be submitted to the Department within 6 months of the delivery of services in order to be eligible for payment.

(10) Payment by the Department for In-Home Daily Care will be considered full payment for the services rendered under Title XIX or Title XXI. Under no circumstances shall the performing provider or billing providers demand or receive additional payment for these services from the family or any other source unless the payment is the financial responsibility (spend-down) of the child under the Medically Needy Program.

(11) Medicaid funds are the payor of last resort. The provider or billing provider must bill all third party resources before Medicaid unless another arrangement is agreed upon by the Department in the Comprehensive Plan of Care.

(12) The Department reserves the right to make a claim against any third party payer before or after making payment to the provider of service.

(13) Prior authorizations that have been issued may be voided in the event of any of the following:

(a) Change in the status of the child. Examples include, but are not limited to, death, hospitalization, and improvement in health status;

(b) Decision of the family to change providers;

(c) Inadequate services, inadequate documentation, or other failure to perform expected duties;

(d) Any situation, as determined by the MFC service coordinator that puts the child's health or safety at risk.

(14) Upon submission of the voucher for payment, the provider agrees that it has complied with:

(a) All rules of the Department; and

(b) 45 CFR Part 84 that implements Title V, Section 504 of the Rehabilitation Act of 1973; and

(c) Title II and Title III of the Americans with Disabilities Act of 1991; and

(d) Title VI of the Civil Rights Act of 1964.

(15) All billings must be for services provided within the provider's licensure.

(16) It is the responsibility of the provider to submit true and accurate information on the voucher. Use of a billing provider does not abrogate the performing provider's responsibility for the truth and accuracy of submitted information.

(17) No person will submit to the Department:

(a) A false voucher for payment;

(b) A voucher for payment that has been or is expected to be paid by another source; or

(c) Any voucher for services that have not been provided.

(18) The Department will make payment only to the enrolled provider who actually performs the service or the provider's enrolled billing provider. Federal regulations prohibit the Department from making payment to collection agencies.

(19) Payments may be denied if any provisions of 411-350-0010-411-350-0120 are not complied with.

(20) Overpayments shall be recouped. The amount to be recovered:

(a) Will be the entire amount determined or agreed to by the Department; and

(b) Is not limited to amount(s) determined by criminal or civil proceedings.

(c) Will include interest to be charged at allowable State rates.

(21) The Department will deliver to the provider by registered or certified mail or in person a request for repayment of the overpayment or notification of recoupment of future payments.

(22) Payment schedules with the interest may be negotiated at the discretion of the Department.

(23) If recoupment is sought from a family who received services, contested hearing rights in OAR 411-350-0060 shall apply.

(24) Payment for services provided to more than one child in the same setting at the same time will not exceed the maximum hourly rate for one child.

Stat. Auth.: ORS 409.050, 417.340 - 417.355 & 430.041

Stats. Implemented: ORS 430.215, 427.005 - 427.007 & 417.340 - 417.355

411-350-0120 Provider Sanctions for MFC Services

(Effective 6/1/2004)

(1) Sanction(s) may be imposed on a provider when a following condition is determined by the Department to have occurred:

(a) Convicted of any crime that would have resulted in an unacceptable criminal history check upon hiring or issuance of a provider number;

(b) Convicted of unlawfully manufacturing, distributing, prescribing, or dispensing a controlled substance;

(c) Had his/her health care license suspended, revoked, or otherwise limited, or surrendered his/her license;

(d) Has failed to safely and adequately provide the services authorized;

(e) Has had an allegation of abuse or neglect substantiated against them;

(f) Failed to cooperate with any investigation or grant access to or furnish, as requested, records or documentation;

(g) Billed excessive or fraudulent charges or convicted of fraud;

(h) Has made a false statement concerning conviction of crime or substantiation of abuse;

(i) Falsified required documentation; or

(j) Been suspended or terminated as a provider by another agency within the Department of Human Services (DHS).

(2) The following sanctions may be imposed on a provider by the Department:

(a) The provider may be terminated from participation in the MFC program;

(b) The provider may be suspended from participation for a specified length of time or until specified conditions for reinstatement are met and approved by the state; and

(c) The Department may withhold payments to the provider.

(3) If the Department makes a decision to sanction a provider, the provider will be notified by mail of the intent to sanction. The provider may appeal this action within 45 days of the date of the notice. The provider must appeal this action separately from any appeal of audit findings and overpayments.

(4) For an appeal to be valid, written notice of the appeal must be received by the Department within 45 days of the date the sanction notice was mailed to the provider.

(5) At the discretion of the Department, providers who have previously been terminated or suspended by any agency within DHR may not be re-enrolled as providers of Medicaid services.

(6) The provider may appeal a sanction by requesting an administrative review by the Administrator of the Department or a contested case hearing.

Stat. Auth.: ORS 409.050, 417.340 - 417.355 & 430.041

Stats. Implemented: ORS 430.215, 427.005 - 427.007 & 417.340 - 417.355