DEPARTMENT OF HUMAN SERVICES
DEVELOPMENTAL DISABILITIES
OREGON ADMINISTRATIVE RULES

CHAPTER 411
DIVISION 380

Direct Nursing Services for Adults with Intellectual or Developmental Disabilities

411-380-0010 Statement of Purpose
(Adopted 06/29/2016)

(1) The rules in OAR chapter 411, division 380 establish standards and procedures for the provision of direct nursing services for adults with intellectual or developmental disabilities and complex health management support needs. These rules define eligibility for services, prescribe Medicaid provider enrollment conditions, and enact service and documentation requirements.

(2) Direct nursing services provide medical tasks to adults with intellectual or developmental disabilities and complex health management support needs in order to live as independently as possible in their home and community.

Stat. Auth.: ORS 409.050, 413.085
Stats. Implemented: ORS 409.050, 413.085

411-380-0020 Definitions and Acronyms
(Adopted 06/29/2016)

(1) "Acuity Level" means the amount of the medically related support needs of an individual as measured by an assessment.

(2) "Authorization" means the approval of the case management entity for planning, provision, and payment of direct nursing services.

(3) "Case Management Entity" means the Community Developmental Disability Program or Support Services Brokerage contracted to deliver the functions of case management.

(4) "Complex Health Management Support Needs" mean those medical or nursing tasks, activities, or duties in response to a health condition or series of conditions that impacts all aspects of the care of an individual, requiring oversight by a nurse and physician.

(5) "Direct Nursing Services" mean the services described in OAR 411-380-0050 (Direct Nursing Service Requirements) that are determined medically necessary to support an individual with complex health management support needs in their home and community. Direct nursing services are provided on a shift staffing basis.

(6) "Direct Nursing Services Criteria" means the assessment to measure the acuity and support level of nursing tasks to determine eligibility for direct nursing services.

(7) "Enrolled Medicaid Provider" means an RN or LPN that meets and completes all the requirements in these rules, OAR 407-120-0300 to 0400 (Medicaid Provider Enrollment and Claiming), and OAR chapter 410, division 120 (OHA, Medicaid General Rules), as applicable.

(8) "Home Health Agency" has the meaning given that term in ORS 443.005.

(9) "Individual" means an adult applying for, or determined eligible for, Department-funded developmental disabilities services.

(10) "In-Home Care Agency" has the meaning given that term in ORS 443.305.

(11) "ISP" means "Individual Support Plan".

(12) "LPN" means a licensed practical nurse who holds a current license from the Oregon State Board of Nursing pursuant to ORS chapter 678 and OAR chapter 851, division 045 (Standards and Scope of Practice for the LPN and RN). An LPN providing direct nursing services under these rules is either an independent contractor who is an enrolled Medicaid provider or an employee of an in-home care or home health agency that is an enrolled Medicaid provider.

(13) "MMIS" means "Medicaid Management Information System". MMIS is the automated claims processing and information retrieval system for handling all Medicaid transactions. The objectives of the system include verifying provider enrollment and individual eligibility, managing health care provider claims and benefit package maintenance, and addressing a variety of Medicaid business needs.

(14) "Medicaid Provider Enrollment Agreement" means an agreement between the Department and a provider for the provision of covered services to covered individuals for payment.

(15) "National Provider Index Number" means a federally directed provider number mandated for use on Health Insurance Portability and Accountability Act (HIPAA) covered transactions by individuals, provider organizations, and subparts of provider organizations that meet the definition of health care provider (45 CFR 160.103) and who conduct HIPAA covered transactions electronically.

(16) "Nursing Intervention" means the actions deliberately designed, selected, and performed by a nurse to implement the Nursing Service Plan.

(17) "Nursing Service Plan" means the written guidelines developed by an RN as described in OAR 411-380-0050 (Direct Nursing Service Requirements) that identifies the specific needs of an individual and the intervention or regiment to assist the individual to achieve optimal health potential. Developing the Nursing Service Plan includes a comprehensive and focused nursing assessment of the health status of the individual as part of the standards outlined in OAR 851-045-0040(2) (Scope of Practice Standards for Registered Nurses), establishing individual and nursing goals, and determining nursing interventions to meet care objectives.

> (a) The Nursing Service Plan is specific to an individual and identifies the diagnoses and health needs of the individual and all direct nursing service needs.
>
> (b) The Nursing Service Plan is separate from the ISP as well as any service plans developed by other health professionals.

(18) "OHA" means "Oregon Health Authority".

(19) "OSIPM" means "Oregon Supplemental Income Program-Medical".

(20) "Prior Authorization for Services" means payment authorization for direct nursing services given by the Department or contracted agencies of the Department prior to provision of the service. A physician referral is not a prior authorization for services.

(21) "Provider" means an enrolled Medicaid provider who holds a current license from the Oregon State Board of Nursing as an RN or LPN pursuant to ORS chapter 678.

(22) "RN" means a registered nurse who holds a current license from the Oregon State Board of Nursing pursuant to ORS chapter 678 and OAR chapter 851, division 045 (Standards and Scope of Practice for the LPN and RN). An RN providing direct nursing services under these rules is either an independent contractor who is an enrolled Medicaid provider or an employee of an in-home care or home health agency that is an enrolled Medicaid provider.

(23) "These Rules" mean the rules in OAR chapter 411, division 380.

(24) "Third Party Resources" means a medical or financial resource that, under law, is available and applicable to pay for medical services and items for an individual.

Stat. Auth.: ORS 409.050, 413.085
Stats. Implemented: ORS 409.050, 413.085

411-380-0030 Eligibility and Limitations for Direct Nursing Services
(Adopted 06/29/2016)

(1) ELIGIBILITY. To be eligible for direct nursing services, an individual must:

(a) Be 21 years of age or older;

(b) Be determined eligible for developmental disabilities services by a Community Developmental Disabilities Program in the county of origin as described in OAR 411-320-0080;

(c) Be OSIPM eligible;

(d) Meet the level of care as defined in OAR 411-320-0020;

(e) Based on a functional needs assessment, require oversight for complex health management support needs;

(f) Based on a Direct Nursing Services Criteria completed by the Department, score 45 or higher; and

(g) Have health impairments requiring long term direct nursing services determined medically necessary and appropriate based on the order of a physician.

(2) ACUITY LEVELS. The amount of hours available for direct nursing services is based on the following acuity levels as measured by the Direct Nursing Services Criteria:

(a) Level 1: Score of 75 or above and on a ventilator for 20 hours or more per day = up to a maximum of 554 hours per month for direct nursing services.

(b) Level 2: Score of 70 or above = up to a maximum of 462 hours per month for direct nursing services.

(c) Level 3: Score of 65 to 69 = up to a maximum of 385 hours per month for direct nursing services.

(d) Level 4: Score of 60 to 64 = up to a maximum of 339 hours per month for direct nursing services.

(e) Level 5: Score of 50 to 59 or if an individual requires ventilation for sleeping hours = up to a maximum of 293 hours per month for direct nursing services.

(f) Level 6: Score of 45 to 49 = up to a maximum of 140 hours per month for direct nursing services.

(3) SERVICE DELIVERY.

(a) Except as limited under section (4)(a) of this rule, direct nursing services may be delivered in the home of an individual, in an adult foster home, at an employment or day service site, or in the community.

(b) The hours for direct nursing services for individuals accessing other attendant care services at an employment setting or in the community, are prorated based on the acuity level of the individual between the employment setting and the home or adult foster home of the individual.

(4) LIMITATIONS.

(a) Direct nursing services are excluded for:

(A) An individual residing in a licensed 24-hour residential setting as described in OAR chapter 411, division 325;

(B) An individual while in a medical or psychiatric hospital; or

(C) An individual residing in a school, nursing facility, assisted living facility, or residential care facility.

(b) Direct nursing services may not substitute for or duplicate other direct or private duty nursing services provided by State Plan or third party resources.

(c) Direct nursing services provided concurrently with care being provided under OAR 410-142-0240 (OHA, Hospice Services) or OAR 410-127-0040 (OHA, Home Health Care Services) are not reimbursable under these rules.

(d) Direct nursing services are not covered in conjunction with any intravenous, enteral, or parenteral related skilled nursing services as described in OAR 410-148-0300 (OHA, Home Enteral/Parenteral Nutrition and IV Services).

(e) Direct nursing services may not duplicate school-based nursing services covered under the provision of the Individuals with Disabilities Education Act (IDEA).

(f) Direct nursing services do not include:

(A) Hours spent receiving professional training or career development;

(B) Administrative functions such as non-individual-specific services, quality assurance reviews, authoring health related agency policies and procedures, or providing general training for caregivers;

(C) Travel time spent in transit to or from the residence of the provider; or

(D) Nursing services as defined under OAR chapter 411, division 048 (Long Term Care Community Nursing). This includes nurse delegation.

Stat. Auth.: ORS 409.050, 413.085
Stats. Implemented: ORS 409.050, 413.085

411-380-0040 Complaints, Notifications of Planned Actions, and Hearings
(Adopted 06/29/2016)

(1) INDIVIDUAL COMPLAINTS.

(a) Complaints by or on behalf of individuals must be addressed in accordance with OAR 411-318-0015 (Complaints).

(b) The case management entity must have and implement written policies and procedures for individual complaints in accordance with OAR 411-318-0015 (Complaints).

(c) Upon entry and request and annually thereafter, the policy and procedures for complaints must be explained and provided to an individual and the legal or designated representative of the individual (as applicable).

(2) NOTIFICATION OF PLANNED ACTION. In the event that direct nursing services are denied, reduced, suspended, or terminated or voluntarily reduced, suspended, or terminated, a written advance Notification of Planned Action (form SDS 0947) must be provided as described in OAR 411-318-0020 (Notification of Planned Action).

(3) HEARINGS.

(a) Hearings must be addressed in accordance with ORS chapter 183 and OAR 411-318-0025 (Contested Case Hearings for Reductions, Suspensions, Terminations, or Denials).

(b) An individual may request a hearing as provided in ORS chapter 183 and OAR 411-318-0025 (Contested Case Hearings for Reductions, Suspensions, Terminations, or Denials) for a denial, reduction, suspension, or termination of direct nursing services.

(c) Upon entry, individual request, and annually thereafter, a notice of hearing rights and the policy and procedures for hearings must be explained and provided to an individual and the legal or designated representative of the individual (as applicable).

Stat. Auth.: ORS 409.050, 413.085
Stats. Implemented: ORS 409.050, 413.085

411-380-0050 Direct Nursing Service Requirements
(Adopted 06/29/2016)

(1) DIRECT NURSING SERVICES CRITERIA. The Department completes an assessment using the Direct Nursing Services Criteria at the following times:

(a) For initial eligibility of direct nursing services;

(b) As part of annual ISP planning, but no longer than 12 months from the last assessment; and

(c) After any significant change of condition, such as hospitalization, emergency visits, or significant changes in the health status of the individual, reported by the case management entity or provider.

(2) NURSING SERVICE PLAN. Each individual must have a written Nursing Service Plan that meets the standards in OAR chapter 851, division 045 (Standards and Scope of Practice for the LPN and RN).

(a) An RN must develop a Nursing Service Plan within seven days of the initiation of direct nursing services and submit the Nursing Service Plan to the case management entity and Department for review.

(b) The RN must review, update, and resubmit the Nursing Service Plan to the case management entity and the Department in the following instances:

(A) Every six months;

(B) Within seven working days of a change of RN;

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

(D) After any significant change of condition, such as hospitalization, emergency visits, or significant change in the health status of the individual.

(c) The RN must share the Nursing Service Plan with the individual and if applicable, the legal representative, designated representative, foster care provider, or agency providers.

(3) Direct nursing services must be documented as part of the ISP. The maximum number of eligible hours based on the Direct Nursing Services Criteria must be authorized in the ISP.

(4) Direct nursing services may not duplicate or occur at the same time as attendant care services, except when the delivery of attendant care is provided by a personal support worker or provider agency as defined in OAR 411-317-0000, and the individual --

(a) Has been assessed needing Department approved 2:1 attendant care supports based on the results of a functional needs assessment;

(b) Is attending employment or day service activities; or

(c) Needs 2:1 staffing in the community.

(5) Direct nursing services include, but are not limited to:

(a) Continuous assessment and reassessment of the medical condition of the individual, as part of each shift;

(b) Skilled nursing tasks;

(c) Nursing interventions;

(d) Implementation of treatment and therapies;

(e) Data collection;

(f) Documentation;

(g) Written and oral communication with individuals, physicians and other health professionals, other caregivers, case management entities, ISP teams, foster care providers, and agency providers; and

(h) Other nursing responsibilities under OAR 851-045-0040 (Oregon State Board of Nursing Scope of Practice Standards for All Licensed Nurses) approved by the Department.

(6) Direct nursing services must be provided on a shift staffing basis. Shifts are from a minimum of four hours to a maximum of 16 hours.

Stat. Auth.: ORS 409.050, 413.085
Stats. Implemented: ORS 409.050, 413.085

411-380-0060 Qualifications for Providers of Direct Nursing Services
(Adopted 06/29/2016)

(1) The direct nursing services provided under these rules may be delivered by the following enrolled Medicaid providers:

(a) Self-employed LPNs or RNS licensed under ORS 678.021;

(b) Home health agencies licensed under ORS 443.015 and meeting the requirements in OAR chapter 333, division 027 (Home Health Agencies);

(c) In-home care agencies licensed under ORS 443.315 and meeting the requirements in OAR chapter 333, division 536 (In-Home Care Agencies);

(d) An adult foster home provider as described in OAR 411-360-0140 (Standards and Practices for Health Care) and section (2) of this rule; and

(e) A family member as described in section (2) of this rule.

(2) The decision to have an adult foster home provider or family member deliver direct nursing services must be made by the individual and the ISP team and may not be for the convenience of the adult foster home provider or family member.

(3) The legal representative of an individual is prohibited from providing direct nursing services.

(4) A provider of direct nursing services must --

(a) Be a licensed RN or LPN with a current and unencumbered license; and

(b) Meet and maintain provider enrollment requirements under OAR 407-120-0320 (Provider Enrollment) as follows:

(A) Providers delivering services prior to January 1, 2016 must meet the provider enrollment requirements under OAR 407-120-0320 (Provider Enrollment) no later than June 28, 2016.

(B) Provider applicants enrolling on or after January 1, 2016 must meet the provider enrollment requirements under OAR 407-120-0320 (Provider Enrollment) upon enrollment.

(5) Providers must submit a resume to the case management entity indicating the education, skills, and abilities necessary to provide nursing services in accordance with Oregon law. At least one year of experience working with individuals with intellectual or developmental disabilities is recommended, but not required.

(6) The provider must maintain in force, at the expense of the provider, professional liability insurance with a combined single limit of not less than $1,000,000 for each claim, incident, or occurrence. Professional liability insurance is to cover damages caused by error, omission, or negligent acts related to the professional services.

(a) The provider must provide written evidence of insurance coverage to the Department prior to beginning work and at any time upon the request of the Department.

(b) There must be no cancellation of insurance coverage without 30 days prior written notice to the Department.

(7) PROVIDER ENROLLMENT.

(a) Providers must enroll through the MMIS system by:

(A) Completing and submitting the Medicaid Provider Enrollment Application that includes the Provider Enrollment Agreement;

(B) Completing a Criminal Background Check as described in OAR 407-007-0200 to 0370 (Criminal History Checks); and

(C) Enrolling, receiving, and submitting a National Provider Index Number.

(b) An applicant listed in the exclusions database of the Office of the Inspector General is not eligible to become an enrolled Medicaid provider per OAR 410-120-1400(3)(b) (OHA, Provider Sanctions).

(8) All enrolled Medicaid providers must comply with federal, state, and Department conflict of interest regulations or policy.

Stat. Auth.: ORS 409.050, 413.085
Stats. Implemented: ORS 409.050, 413.085

411-380-0070 Provider Disenrollment and Termination
(Adopted 06/29/2016)

(1) Enrolled Medicaid providers may be denied enrollment, terminated, or prohibited from providing direct nursing services for any of the following:

(a) Violation of any part of these rules;

(b) A substantiation of a violation of the protective service and abuse rules in OAR chapter 411, division 020 (Adult Protective Services - General) or OAR chapter 407, division 045 (Office of Investigations and Training);

(c) Any sanction or action as a result of an investigation of the Oregon State Board of Nursing;

(d) Failure to keep required licensure or certifications current;

(e) Failure to provide copies of the records described in these rules to OHA, the Department, or case management entity;

(f) Failure to participate in the review of the Nursing Service Plan or care coordination meetings when requested by the case management entity;

(g) Failure to provide services;

(h) Fraud or misrepresentation in the provision of direct nursing services;

(i) Evidence of conduct derogatory to the standards of nursing as described in OAR 851-045-0070 (Conduct Derogatory to the Standards of Nursing Defined) that results in referral to the Oregon State Board of Nursing;

(j) A demonstrated pattern of repeated unsubstantiated complaints of neglect or abuse per OAR chapter 411, division 020 (Adult Protective

Services - General) or OAR chapter 407, division 045 (Office of Investigations and Training); or

(k) The provider is listed in the exclusions database of the Office of the Inspector General.

(2) Enrolled Medicaid providers may appeal a termination of their Medicaid provider number based on OAR 407-120-0360(8)(g) (Consequences of Non-Compliance and Provider Sanctions) and OAR chapter 410, division 120 (OHA, Medical Assistance Programs), as applicable.

(3) An enrolled Medicaid provider of direct nursing services must provide advance written notice to the Department and any individuals the provider is delivering direct nursing services to at least 30 days prior to no longer providing direct nursing services.

Stat. Auth.: ORS 409.050, 413.085
Stats. Implemented: ORS 409.050, 413.085

411-380-0080 Provider Documentation and Records
(Adopted 06/29/2016)

(1) Documentation of direct nursing services must be written in an accurate, timely, thorough, and clear manner.

(2) Documentation must comply with OAR chapter 851 (Oregon State Board of Nursing) and must include:

(a) The name of the individual on each page of documentation;

(b) The date of service;

(c) Time of start and end of service delivery by each provider;

(d) Anything unusual from the standard plan of care expanded in the narrative;

(e) Interventions;

(f) Outcomes, including the response of the individual to services delivered;

(g) Nursing assessment of the status of the individual and any changes in that status per each working shift; and

(h) Full signature of the provider.

(3) Documentation of provided direct nursing services must be sent to the case management entity upon request or as outlined in the ISP and maintained in the home, foster home, or the place of business of the provider of services.

(4) Providers must furnish requested documentation immediately upon the written request from the Department, the Oregon Department of Justice Medicaid Fraud Unit, OHA, Centers for Medicare and Medicaid Services, or their authorized representatives, or within the timeframe specified in the written request. Failure to comply with the request may be considered by the Department as reason to deny or recover payments.

(5) Access to records by the Department including, but not limited to, medical, nursing, behavior, psychiatric, or financial records, to include providers and vendors providing goods and services, does not require authorization or release by the individual or the legal representative of the individual.

(6) Per OAR 410-120-1360(2)(e) (OHA, Requirements for Financial, Clinical and Other Records), providers must --

(a) Retain billing forms, timesheets, and financial records for at least five years from the date of service; and

(b) Retain clinical record documentation of provided services for at least seven years from the date of service.

Stat. Auth.: ORS 409.050, 413.085
Stats. Implemented: ORS 409.050, 413.085

411-380-0090 Provider Billing and Payment
(Adopted 06/29/2016)

(1) AUTHORIZATION OF HOURS. Authorization for direct nursing service hours are:

(a) Based on acuity levels from the Direct Nursing Services Criteria; and

(b) Authorized in the ISP by the case management entity.

(2) PRIOR AUTHORIZATION.

(a) Providers must request electronic authorization for direct nursing service hours through MMIS and have hours prior authorized by the Department.

(b) The Department may withdraw, modify, or deny prior authorizations in the event of any of the following:

(A) Change in the status of the individual, such as eligibility for direct nursing services, hospitalization, improvement in health status, or death;

(B) Decision of the individual, family, or legal representative, to change providers;

(C) Failure to comply with the delivery of direct nursing services and documentation; or

(D) Failure to perform other expected duties.

(3) CLAIMS.

(a) A provider must comply with the rules for authorization of claims as written in OAR 410-120-1300 (OHA, Timely Submission of Claims) and OAR 410-120-1320 (OHA, Authorization of Payment).

(b) A provider must follow all Department required documentation procedures for timesheets, invoices, and signatures and submit true and accurate information.

(c) Medicaid funds are the payer of last resort. A provider must bill all third party resources until all resources are exhausted.

(d) A provider may not submit the following to the Department or case management entity:

(A) A false billing form for payment;

(B) A billing form for payment that has been, or is expected to be, paid by another source; or

(C) Any billing form for services that have not been provided.

(e) The billing form used to submit a claim must include the prior authorization number.

(f) A provider must sign the billing form acknowledging agreement with the terms and conditions of the claim and attesting that the hours were delivered as billed.

(g) Timely submission of claims is required per OAR 410-120-1300(1) (OHA, Timely Submission of Claims). A provider must submit a claim for payment to the case management entity within 12 months of the date of service.

(h) The case management entity must review the claim and match the number of hours claimed by the provider against the number of hours prior authorized. The case management entity must review, approve, and forward the claim to the Department in a timely manner.

(4) PAYMENT.

(a) Payment for direct nursing services is made in accordance with --

(A) These rules;

(B) OAR 410-120-1300 (OHA, Timely Submission of Claims);

(C) OAR 411-120-1320 (OHA, Authorization of Payment);

(D) OAR 411-120-1340 (OHA, Payment);

(E) OAR 411-120-1380 (OHA, Compliance with Federal and State Statutes);

(F) OAR 407-120-300 to 400 (Provider Enrollment and Claiming); and

(G) OAR 407-120-1505 (Provider and Contractor Audits, Appeals, and Post Payment Recoveries).

(b) Funds may not be used to support, in whole or in part, a provider in any capacity who has been convicted of any of the disqualifying crimes listed in OAR 407-007-0275 (Convictions under ORS 443.004 Resulting in Ineligibility for Aging and People with Disabilities Program and Developmental Disabilities Program).

(c) Payment for direct nursing services are fee for service with payment made subsequent to the delivery of the services.

(d) The Department does not pay for services that are not authorized in the ISP.

(e) Providers must be present with an individual in the delivery of direct nursing services in order to claim payments.

(f) Holidays are paid at the same rate as non-holidays.

(g) Hours will not be authorized for overtime.

(h) Payment by the Department for direct nursing services is considered payment in full for the services rendered under Medicaid. A provider may not demand or receive additional payment for direct nursing services from an individual, family member, foster care provider, agency provider, or any other source, under any circumstances.

(i) Payment may be denied based on the provisions of OAR 410-120-1320 (OHA, Authorization of Payment) and the provisions of these rules.

(5) OVERPAYMENT. An overpayment occurs when a provider submits a claim or encounter, or received payment to which the provider is not properly entitled. The determination of overpayment is based on OAR 410-120-1397(5)(a)-(h) (OHA, Recovery of Overpayments to Providers - Recoupment). The Department and OHA recoup all overpayments under OAR 410-120-1397 (OHA, Recovery of Overpayments to Providers - Recoupment).

Stat. Auth.: ORS 409.050, 413.085
Stats. Implemented: ORS 409.050, 413.085