

Secretary of State
NOTICE OF PROPOSED RULEMAKING HEARING*

A Statement of Need and Fiscal Impact accompanies this form.

Department of Human Services, Aging and People with Disabilities

411

Agency and Division

Administrative Rules Chapter Number

Kimberly Colkitt-Hallman

500 Summer Street NE, E-48
Salem, OR 97301-1074

(503) 945-6398

Rules Coordinator

Address

Telephone

RULE CAPTION

Nursing Facilities - Complex Medical Add-On

Not more than 15 words that reasonably identifies the subject matter of the agency's intended action.

February 19, 2015

3:00 p.m.

Human Services Building
500 Summer Street NE, ROOM 160
Salem, Oregon 97301

Staff

Hearing Date

Time

Location

Hearings Officer

Auxiliary aids for persons with disabilities are available upon advance request.

RULEMAKING ACTION

Secure approval of new rule numbers (Adopted or Renumbered rules) with the Administrative Rules Unit prior to filing.

ADOPT:

AMEND:

411-070-0005; 411-070-0027; 411-070-0035; 411-070-0043; 411-070-0091

REPEAL:

RENUMBER:

AMEND & RENUMBER:

Stat. Auth.: ORS 410.070

Other Auth.:

Stats. Implemented: ORS 410.070; 414.065

RULE SUMMARY

The Department of Human Services (Department), Aging and People with Disabilities (APD) is proposing to amend the rules for Nursing Facilities located in OAR chapter 411, division 070 to update the process in regards to complex medical add-on documentation. Definitions, along with all of the rules, were updated to reflect current Department terminology. The amendments also fix minor grammar, formatting, punctuation, and housekeeping issues in the rules.

The Agency requests public comment on whether other options should be considered for achieving the rule's substantive goals while reducing the negative economic impact of the rule on business.

Written comments may be submitted via e-mail to Kimberly.Colkitt-Hallman@state.or.us or mailed to 500 Summer Street NE, E48 Salem, Oregon, 97301-1064. All comments received will be given equal consideration before the Department proceeds with the permanent rulemaking.

February 24, 2015 2014 at 5 p.m.

Last Day for Public Comment (Last day to submit written comments to the Rules Coordinator)

Signed Michael R. McCormick, Director, Aging and People with Disabilities

1/7/2015

Signature

Date

Secretary of State

STATEMENT OF NEED AND FISCAL IMPACT

A Notice of Proposed Rulemaking Hearing or a Notice of Proposed Rulemaking accompanies this form.

Department of Human Services, Aging and People with Disabilities

411

Agency and Division

Administrative Rules Chapter Number

Nursing Facilities - Complex Medical Add-On

Rule Caption (Not more than 15 words that reasonably identifies the subject matter of the agency's intended action.)

In the Matter of: **The amendment of OAR 411-070-0005; 411-070-0027; 411-070-0035; 411-070-0043; 411-070-0091 relating to nursing facilities.**

Statutory Authority: **ORS 410.070**

Other Authority:

Stats. Implemented: **ORS 410.070; 414.065**

Need for the Rule(s):

The Department needs to amend the rules in OAR 411-070 to improve the process for complex medical add-on. The purpose of the improvement process was to minimize and eliminate duplicate or unnecessary steps to ensure nursing facilities received timely payment while maintaining program integrity.

The requirements for the facility to notify APD's complex medical add-on coordinator, by completing the weekly add-on reports and initial documentation to request authorization for complex medical add-on, was removed from the initial authorization process.

The nursing facilities are required to maintain sufficient documentation for complex medical add-on payment and must be available to the Department upon request.

The proposed rules do this by eliminating the requirements for the facility to notify APD's complex medical add-on coordinator, by completing the weekly add-on reports, and initial documentation to request authorization for complex medical add-on.

All of the rules, including definitions, were updated to reflect current Department terminology. Changes were also made to fix minor grammar, formatting, punctuation, and housekeeping issues in the rules.

Documents Relied Upon, and where they are available:

Fiscal and Economic Impact:

Statement of Cost of Compliance:

1. Impact on state agencies, units of local government and the public (ORS 183.335(2)(b)(E)):

The Department estimates that amending Chapter 411, Division 070 will have the following fiscal and economic impact:

State Agencies: The Department estimates there will be no fiscal or economic impact on state agencies.

Units of Local Government: The Department estimates there will be no fiscal or economic impact on units of local government.

Consumers: The Department estimates there will be no fiscal or economic impact on consumers.

Providers: The Department estimates there will be positive fiscal or economic impact on providers in terms of costs being reduced in regards to documentation requirements.

Public: The Department estimates there will be no fiscal or economic impact on the public.

2. Cost of compliance effect on small business (ORS 183.336):

a. Estimate the number of small businesses and types of business and industries with small businesses subject to the rule:

There are currently 139 licensed nursing facilities. Of these, 18 may be considered a small business as defined by ORS 183.310.

Projected reporting, recordkeeping and other administrative activities required for compliance, including costs of professional services:

The proposed changes impact nursing facilities as described above in the Department's statement of cost of compliance.

c. Equipment, supplies, labor and increased administration required for compliance:

The proposed changes impact nursing facilities as described above in the Department's statement of cost of compliance.

How were small businesses involved in the development of this rule?

A small business as defined in ORS 183.310 participated on the Administrative Rule Advisory Committee. Small businesses will also be included in the public review and comment period.

Administrative Rule Advisory Committee consulted?:

Yes. The Administrative Rule Advisory Committee included representation from Oregon Health Care Association, LeadingAge Oregon, Oregon Association of Area Agencies on Aging & Disabilities, Long Term Care Ombudsman, SEIU, Governor's Commission on Senior Services and Oregon Disabilities Commission.

Signed Michael R. McCormick, Director, Aging and People with Disabilities

1/7/2015

Signature

Date

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

**CHAPTER 411
DIVISION 70**

**NURSING FACILITIES/MEDICAID – GENERALLY AND
REIMBURSEMENT**

Nursing Facilities/Medicaid – Generally

411-070-0005 Definitions

Unless the context indicates otherwise, the following definitions and the definitions in OAR 411-085-0005 apply to the rules in OAR chapter 411, division 070:

(1) "Accrual Method of Accounting" means a method of accounting ~~in~~ which/where revenues are reported in the period ~~when~~ they are earned, regardless of when they are collected, and expenses are reported in the period ~~in which~~ they are incurred, regardless of when they are paid.

(2) "Active Treatment" means the implementation of an individualized care plan developed under and supervised by a physician and other qualified mental health professionals that prescribes specific therapies and activities.

(3) "Activities of Daily Living" means activities usually performed in the course of a normal day in an individual's life such as eating, dressing, ~~grooming~~, ~~bathing~~, ~~personal hygiene~~, mobility (ambulation and transfer), elimination (toileting, bowel, and bladder management), and cognition and ~~behavior~~.

(4) "Addictions and Mental Health (AMH) Division" means the Division, within the Oregon Health Authority, responsible for addictions and mental health services.

(5) "Aging and People with Disabilities" means the program area of Aging and People with Disabilities, within the Department of Human Services.

| [\(6\) "APD" means "Aging and People with Disabilities."](#)

| [\(75\)](#) "Alternative Services" mean individuals or organizations offering services to persons living in a community other than a nursing facility or hospital.

| [\(86\)](#) "Area Agency on Aging (AAA)" means the Department of Human Services designated agency charged with the responsibility to provide a comprehensive and coordinated system of services to seniors and individuals with disabilities in a planning and service area. For the purpose of these rules, the term Area Agency on Aging is inclusive of both Type A and Type B Area Agencies on Aging as defined in ORS 410.040 and described in ORS 410.210 to 410.300.

| [\(97\)](#) "Augmented Rate" means the additional compensation to a nursing facility who qualifies for the Quality and Efficiency Incentive Program described in OAR 411-070-0437. The augmented rate is a daily rate of \$9.75 and is in addition to the rate ~~that~~ a nursing facility would otherwise receive. The Department may pay the augmented rate to a qualifying facility for a period not to exceed four years from the date ~~that~~ the facility purchases bed capacity under the Quality and Efficiency Incentive Program.

| [\(108\)](#) "Basic Flat Rate Payment" and "Basic Rate" means the statewide standard payment rate for all long term services provided to a Medicaid resident of a nursing facility, except for services reimbursed through another Medicaid payment source. The "Basic Rate" is the bundled payment rate, unless the resident qualifies for the complex medical add-on rate (in addition to the basic rate) or the bundled pediatric rate (instead of the basic rate).

| [\(19\)](#) "Capacity" means licensed nursing beds multiplied by number of days in operation.

| [\(129\)](#) "Case Manager" means a Department of Human Services or Area Agency on Aging employee who assesses the service needs of an applicant, determines eligibility, and offers service choices to the eligible individual. The case manager authorizes and implements the service plan and monitors the services delivered.

(134) "Cash Method of Accounting" means a method of accounting ~~in~~ which/where revenues are recognized only when cash is received, and expenditures for expense and asset items are not recorded until cash is disbursed for them.

(142) "Categorical Determinations" mean the provisions in the Code of Federal Regulations ~~{(42 CFR 483.130)}~~ for creating categories that describe certain diagnoses, severity of illness, or the need for a particular service that clearly indicates that admission to a nursing facility is normally needed or that the provision of specialized services is not normally needed.

(a) Membership in a category may be made by the evaluator only if existing data on the individual is current, accurate, and of sufficient scope.

(b) An individual with mental illness or developmental disabilities may enter a nursing facility without a PASRR Level II evaluation if criteria of a categorical determination are met as described in OAR 411-070-0043(2)(a)-(2)(c).

(153) "Certification" and "Certification for the Categorical Determination of Exempted Hospital Discharge" means ~~that~~ the attending physician has written orders for the individual to receive skilled services at the nursing facility.

(164) "Certified Program" means a hospital, private agency, or an Area Agency on Aging certified by the Department of Human Services to conduct private admission assessments in accordance with ORS 410.505 through 410.530.

(175) "Change of Ownership" means a change in the individual or legal organization that is responsible for the operation of a nursing facility. Change of ownership does not include ~~changes that are merely~~ changes in personnel, e.g., a change of administrators. Events that change ownership include 1, but are not limited to 1 the following:

(a) The form of legal organization of the owner is changed (e.g., a sole proprietor forms a partnership or corporation);

(b) The title to the nursing facility enterprise is transferred to another party;

(c) The nursing facility enterprise is leased or an existing lease is terminated;

(d) Where the owner is a partnership, any event occurs which dissolves the partnership;

(e) Where the owner is a corporation, it is dissolved, merges with another corporation that is the survivor, or consolidates with one or more other corporations to form a new corporation; or

(f) The facility changes management via a management contract.

| (186) "Compensation" means the total of all benefits and remuneration, exclusive of payroll taxes and regardless of the form, provided to or claimed by an owner, administrator, or other employee. Compensation includes, but is not necessarily limited to:

(a) Salaries paid or accrued;

(b) Supplies and services provided for personal use;

(c) Compensation paid by the facility to employees for the sole benefit of the owner;

(d) Fees for consultants, directors, or any other fees paid regardless of the label;

(e) Key man life insurance;

(f) Living expenses, including those paid for related persons; or

(g) Gifts for employees in excess of federal Internal Revenue Service reporting guidelines.

| (197) "Complex Medical Add-On Payment" and "Medical Add-On" means the statewide standard supplemental payment rate for a Medicaid resident of a nursing facility whose service is reimbursed at the basic rate if the

resident needs one or more of the medication procedures, treatment procedures, or rehabilitation services listed in OAR 411-070-0091, for the additional licensed nursing services needed to meet the resident's increased needs.

(2018) "Continuous" means more than once per day, seven days per week. Exception: If only skilled rehabilitative services and no skilled nursing services are required, "continuous" means at least once per day, five days per week.

(219) "Costs Not Related to Resident Services" means costs that are not appropriate or necessary and proper in developing and maintaining the operation of a nursing facility. Such costs are not allowable in computing reimbursable costs. Costs not related to resident services include, for example, cost of meals sold to visitors, cost of drugs sold to individuals who are not residents, cost of operation of a gift shop, and similar items.

(229) "Costs Related to Resident Services" mean all necessary costs incurred in furnishing nursing facility services, subject to the specific provisions and limitations set out in these rules. Examples of costs related to resident services include nursing costs, administrative costs, costs of employee pension plans, and interest expenses.

(234) "CPI" means the consumer price index for all items and all urban consumers.

(242) "Day of Admission" means an individual being admitted, determined as of 12:01 a.m. of each day, for all days in the calendar period for which an assessment is being reported and paid. If an individual is admitted and discharged on the same day, the individual is deemed present on 12:01 a.m. of that day.

(253) "Department" or "DHS" means the Department of Human Services.

(264) "Developmental Disability" means "developmental disability" as defined in OAR 411-320-0020 and described in OAR 411-320-0080. ~~"Developmental Disability" means a disability that originates in the developmental years, that is likely to continue, and significantly impacts adaptive behavior as diagnosed and measured by a qualified professional. Developmental disabilities include mental retardation, autism, cerebral~~

~~palsy, epilepsy, or other neurological disabling conditions that require training or support similar to that required by individuals with mental retardation, and the disability:~~

~~(a) Originates before the individual reaches the age of 22 years, except that in the case of mental retardation, the condition must be manifested before the age of 18;~~

~~(b) Originates and directly affects the brain and has continued, or must be expected to continue, indefinitely;~~

~~(c) Constitutes a significant impairment in adaptive behavior; and~~

~~(d) Is not primarily attributed to a mental or emotional disorder, sensory impairment, substance abuse, personality disorder, learning disability, or Attention Deficit Hyperactivity Disorder (ADHD).~~

(275) "Direct Costs" mean costs incurred to provide services required to directly meet all the resident nursing and activity of daily living service needs. Direct costs are further defined in OAR 411-070-0359 and OAR 411-070-0465. Examples: The person who feeds food to the resident is directly meeting the resident's needs, but the person who cooks the food is not. The person who is trained to meet the resident's needs incurs direct costs whereas the person providing the training is not. Costs for items that are capitalized or depreciated are excluded from this definition.

(286) "Division of Medical Assistance Programs (DMAP)" means a Division, within the Oregon Health Authority, responsible for coordinating the medical assistance programs within the State of Oregon including the Oregon Health Plan Medicaid demonstration, the State Children's Health Insurance Program, and several other programs.

(297) "DRI Index" means the "HCFA or CMS Nursing Home Without Capital Market Basket" index, which is published quarterly by DRI/McGraw - Hill in the publication, "Global Insight Health Care Cost Review".

(3028) "Essential Nursing Facility" means a nursing facility that serves predominantly rural and frontier communities as designated by the Office of Rural Health that is located more than 32 miles from another nursing facility or from a hospital that has received a formal notice of Critical Access

Hospital (CAH) designation from the Centers for Medicare and Medicaid Services and that is currently contracted to provide swing bed services for Medicaid-eligible individuals.

(3129) "Exempted Hospital Discharge" for PASRR means an individual seeking temporary admission to a nursing facility from a hospital as described in OAR 411-070-0043(2)(a).

(320) "Facility" or "Nursing Facility" means an establishment that is licensed and certified by the Department of Human Services as a nursing facility. A nursing facility also means a Medicaid certified nursing facility only if identified as such.

(334) "Fair Market Value" means the price for which an asset would have been purchased on the date of acquisition in an arms-length transaction between a well-informed buyer and seller, neither being under any compulsion to buy or sell.

(342) "Generally Accepted Accounting Principles" mean the accounting principles approved by the American Institute of Certified Public Accountants.

(353) "Goodwill" means the excess of the price paid for a business over the fair market value of all other identifiable, tangible, and intangible assets acquired, or the excess of the price paid for an asset over its fair market value.

(364) "Historical Cost" means the actual cost incurred in acquiring and preparing a fixed asset for use. Historical cost includes such planning costs as feasibility studies, architects' fees, and engineering studies. Historical cost does not include "start-up costs" as defined in this rule.

(375) "Hospital-Based Facility" means a nursing facility that is physically connected and operated by a licensed general hospital.

(386) "Indirect Costs" mean the costs associated with property, administration, and other operating support (real property taxes, insurance, utilities, maintenance, dietary (excluding food), laundry, and housekeeping). Indirect costs are further described in OAR 411-070-0359 and OAR 411-070-0465.

(397) "Individual" means a person who receives or expected to receive nursing facility services.

(40) "Intellectual Disability" means "intellectual disability" as defined in OAR 411-320-0020 and described in OAR 411-320-0080.

(3841) "Interrupted-Service Facility" means an established facility recertified by the Department of Human Services following decertification.

(3942) "Level I" means a component of the federal PASRR requirement. Level I refers to the identification of individuals who are potential nursing facility admissions who have indicators of mental illness or developmental disabilities ~~{{42 CFR 483.128(a)}}~~.

(439) "Level II" means a component of the federal PASRR requirement. Level II refers to the evaluation and determination of whether nursing facility services and specialized services are needed for individuals with mental illness or developmental disability who are potential nursing facility admissions, regardless of the source of payment for the nursing facility service ~~{{42 CFR 483.128(a)}}~~. Level II evaluations include assessment of the individual's physical, mental, and functional status ~~{{42 CFR 483.132}}~~.

(444) "Level of Care Determination" means an evaluation of the intensity of a person's health service needs. The level of care determination may not be used to require that the person receive services in a nursing facility.

(452) "Medicaid Occupancy Percentage" means the total Medicaid bed days divided by total resident days.

(463) "Medical Add-On" or "Complex Medical Add-On Payment" has the meaning provided in section (1976) of this rule.

(474) "Mental Illness" means a major mental disorder as defined in the Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (DSM IV-TR) limited to schizophrenic, paranoid and schizoaffective disorders, bipolar (manic-depressive), and atypical psychosis. "Mental Illness" for pre-admission screening means having both a primary diagnosis of a major mental disorder (schizophrenic, paranoid, major affective and schizoaffective disorders, or atypical psychosis) and treatment related to

the diagnosis in the past two years. Diagnoses of dementia or Alzheimers are excluded.

~~(45) "Mental Retardation" means significantly sub-average general intellectual functioning defined as IQ's under 70 as measured by a qualified professional and existing concurrently with significant impairment in adaptive behavior that are manifested during the developmental period, prior to 18 years of age. Individuals of borderline intelligence, IQ's 70-75, may be considered to have mental retardation if there is also significant impairment of adaptive behavior as diagnosed and measured by a qualified professional. The adaptive behavior must be directly related to the issues of mental retardation. Definitions and classifications must be consistent with the "Manual of Terminology and Classification in Mental Retardation" by the American Association on Mental Deficiency, 1977 Revision.~~

~~(a) Mild mental retardation is used to describe the degree of retardation when intelligence test scores are 50 to 69. Individuals with IQ's in the 70 to 75 range may be considered as having mental retardation if there is significant impairment in adaptive behavior as defined in OAR 411-320-0020.~~

~~(b) Moderate mental retardation is used to describe the degree of retardation when intelligence test scores are 35 to 49.~~

~~(c) Severe mental retardation is used to describe the degree of retardation when intelligence test scores are 20 to 34.~~

~~(d) Profound mental retardation is used to describe the degree of retardation when intelligence test scores are below 20.~~

(486) "Necessary Costs" mean costs that are appropriate and helpful in developing and maintaining the operation of resident facilities and activities. Necessary costs are usually costs that are common and accepted occurrences in the field of long term nursing services.

(497) "New Admission" for PASRR purposes means an individual admitted to any nursing facility for the first time. It does not include individuals moving within a nursing facility, transferring to a different nursing facility, or individuals who have returned to a hospital for treatment and are being

admitted back to the nursing facility. New admissions are subject to the PASRR process ~~{(42 CFR 483.106(b)(1), (3), (4))}~~.

(4850) "New Facility" means a nursing facility commencing to provide services to individuals.

(4951) "Nursing Aide Training and Competency Evaluation Program (NATCEP)" means a nursing assistant training and competency evaluation program approved by the Oregon State Board of Nursing pursuant to ORS chapter 678 and the rules adopted pursuant thereto.

(529) "Nursing Facility Financial Statement (NFFS)" means Form SPD 35, or Form SPD 35A (for hospital-based facilities), and includes an account number listing of all costs to be used by all nursing facility providers in reporting to the Department of Human Services for reimbursement.

(534) "Occupancy Rate" means total resident days divided by capacity.

(542) "Official Bed Count Measurement" means the number of licensed nursing facility beds as of October 7, 2013 and the beds being developed by facilities that either applied to the Oregon Health Authority for a certificate of need between August 1, 2011 and December 1, 2012 or submitted a letter of intent under ORS 442.315(7) between January 15, 2013 and January 31, 2013.

(553) "Ordinary Costs" mean costs incurred that are customary for the normal operation.

(564) "Oregon Medical Professional Review Organization (OMPRO)" means the organization that determines level of services, need for services, and quality of services.

(575) "Pediatric Rate" means the statewide standard payment rate for all long term services provided to a Medicaid resident under the age of 21 who is served in a pediatric nursing facility or a self-contained pediatric unit.

(586) "Perquisites" mean privileges incidental to regular wages.

(597) "Personal Incidental Funds" mean resident funds held or managed by the licensee or other person designated by the resident on behalf of a resident.

(5860) "Placement" means the location of a specific place where health services can be adequately provided to meet the service needs.

(5961) "Pre-Admission Screening (PAS)" means the assessment and determination of a potential Medicaid-eligible individual's need for nursing facility services, including the identification of individuals who can transition to community-based service settings and the provision of information about community-based alternatives. This assessment and determination is required when potentially Medicaid-eligible individuals are at risk for admission to nursing facility services. PAS may include the completion of the federal PASRR Level I requirement ~~{{(42 CFR, Part 483, (C)-(E))}}~~, to identify individuals with mental illness or ~~mental-retardation~~ intellectual or developmental disabilities.

(629) "Pre-Admission Screening and Resident Review (PASRR)" means the federal requirement, ~~{{(42 CFR, Part 483, (C)-(E))}}~~, to identify individuals who have mental illness or developmental disabilities and determine if nursing facility service is required and if specialized services are required. PASRR includes Level I and Level II functions.

(634) "Prior Authorization" means the local Seniors Aging and People with Disabilities Division/ or Area Agency on Aging office participates in the development of proposed nursing facility care plans to assure ~~that~~ the facility is the most suitable service setting for the individual. Nursing facility reimbursement is contingent upon prior-authorization.

(642) "Private Admission Assessment (PAA)" means the assessment that is conducted for non-Medicaid residents as established by ORS 410.505 to 410.545 and OAR chapter 411, division 071, who are potential admissions to a Medicaid-certified nursing facility. Service needs are evaluated and information is provided about long-term service choices. A component of private admission assessment is the federal PASRR Level I requirement, ~~{{(42 CFR, Part 483.128(a))}}~~, to identify individuals with mental illness or developmental disabilities.

(653) "Provider" means an entity, licensed by ~~the Seniors Aging~~ and People with Disabilities ~~Division~~, responsible for the direct delivery of nursing facility services.

(664) "Provider Preventable Condition (PPC)" means a condition listed below caused by the provider:

- (a) Foreign object retained after treatment;
- (b) Stage III and IV pressure ulcers;
- (c) Falls and trauma;
- (d) Manifestations of poor glycemic control;
- (e) Catheter-associated urinary tract infection;
- (f) Medication error; or
- (g) Surgical site or wound site infection.

(675) "Quality and Efficiency Incentive Program" means the program described in OAR 411-070-0437 designed to reimburse quality nursing facilities that voluntarily reduce bed capacity that increases occupancy levels and enhances efficiency with the goal of slowing the growth of system-wide costs.

(686) "Reasonable Consideration" means an inducement that is equivalent to the amount that would ordinarily be paid for comparable goods and services in an arms-length transaction.

(697) "Related Organization" means an entity that is under common ownership or control with, or has control of, or is controlled by the contractor. An entity is deemed to be related if it has 5 percent or more ownership interest in the other. An entity is deemed to be related if it has capacity derived from any financial or other relationship, whether or not exercised, to influence directly or indirectly the activities of the other.

(6870) "Resident" means a person who receives nursing facility services.

(6971) "Resident Days" mean the number of occupied bed days.

(729) "Resident Review" means a review conducted by the Addictions and Mental Health Division for individuals with mental illness or by the [Seniors Aging](#) and People with Disabilities Division for individuals with developmental disabilities who are residents of nursing facilities. The findings of the resident review may result in referral to PASRR Level II ~~{(42 CFR 483.114)}~~.

(734) "Restricted Fund" means a fund in which the use of the principal or principal and income is restricted by agreement with, or direction by, the donor to a specific purpose. Restricted fund does not include a fund over which the owner has complete control. The owner is deemed to have complete control over a fund that is to be used for general operating or building purposes.

~~(72) "Seniors and People with Disabilities (SPD) Division" means the Department.~~

(743) "Specialized Services for Mental Illness" means mental health services delivered by an interdisciplinary team in an inpatient psychiatric hospital for treatment of acute mental illness.

(754) "Specialized Services for ~~Mental Retardation~~[Intellectual](#) or Developmental Disabilities" means:

(a) For individuals with ~~mental retardation~~[intellectual](#) or developmental disabilities under age 21, specialized services are equal to school services; and

(b) For individuals with ~~mental retardation~~[intellectual](#) or developmental disabilities over age 21, specialized services mean:

(A) A consistent and ongoing program that includes participation by the individual in continuous, aggressive training and support to prevent loss of current optimal function;

(B) Promotes the acquisition of function, skills, and behaviors necessary to increase independence and productivity; and

(C) Is delivered in community-based or vocational settings at a minimum of 25 hours a week.

(765) "Start-Up Costs" mean one-time costs incurred prior to the first resident being admitted. Start-up costs include, but are not limited to, administrative and nursing salaries, utility costs, taxes, insurance, mortgage and other interest, repairs and maintenance, training costs, ~~etc.~~ Start-up costs do not include such costs as feasibility studies, engineering studies, architect's fees, or other fees that are part of the historical cost of the facility.

(776) "Supervision" means initial direction and periodic monitoring of performance. Supervision does not mean ~~that~~ the supervisor is physically present when the work is performed.

(787) "These Rules" mean the rules in OAR chapter 411, division 070.

(798) "Title XVIII" and "Medicare" means Title XVIII of the Social Security Act.

(7980) "Title XIX," "Medicaid," and "Medical Assistance" means Title XIX of the Social Security Act.

(810) "Uniform Chart of Accounts (Form SPD 35)" means a list of account titles identified by code numbers established by the Department of Human Services for providers to use in reporting their costs.

Stat. Auth.: ORS 410.070

Stats. Implemented: ORS 410.070; ~~&~~ ORS 414.065

411-070-0027 Complex Medical Add-On Payment Authorization

(1) PAYMENT. SAPD may authorize-provide payment for a complex medical add-on (in addition to the basic rate) when the resident requires one or more of the treatments, procedures, and services listed in OAR 411-070-0091, for the additional licensed nursing services needed to meet the resident's increased needs.

~~(2) AUTHORIZATION. For a Medicaid resident whose condition or service needs meet the complex medical add-on criteria listed in OAR 411-070-~~

~~0091, the complex medical add-on may be effective from the date the resident's condition or service needs meets the complex medical add-on criteria to the last date the resident's condition or service needs continues to meet the complex medical add-on criteria.~~

~~(a) Initial Authorization -- The facility must submit documentation to SPD's Complex Medical Add-On Coordinator for initial authorization of the complex medical add-on, using SPD's Complex Medical Add-On Procedure Code(s), to provide justification that the resident's service needs meet complex medical add-on criteria.~~

~~(2b) Continued Payment -- SAPD may continue to pay the complex medical add-on only as long as the resident's needs meet one or more of the treatments, procedures, and services listed in OAR 411-070-0091 and the facility maintains the required documentation.~~

(3) DOCUMENTATION. The licensed nursing staff of the nursing facility must keep sufficient documentation pertinent to the qualified complex medical add-on procedure code(s) in the resident's clinical record to justify the complex medical add-on payment determination in accordance with these rules (refer to OAR 411-070-0091) and must make it available to SAPD upon request.

(4) COMPLEX MEDICAL ADD-ONS PROHIBITED. SAPD may not provide complex medical add-on payments for a facility with a waiver that allows a reduction of eight or more hours per week from required licensed nurse staffing hours.

Stat. Auth.: ORS 410.070

Stats. Implemented: ORS 410.070; & ORS 414.065

411-070-0035 Complex Medical Add-On Notification, Effective Start and End Dates, and Administrative Review

~~(1) NOTIFICATION. The nursing facility must notify SPD's Complex Medical Add-On Coordinator by completing SPD's Weekly Add-On Report to request authorization for complex medical add-on procedure code(s) (Refer to OAR 411-070-0091). SPD shall assign the facility a weekly report due date. The facility must accurately report, on a weekly basis, all of the following complex medical activity for the seven days prior to the report's~~

~~due date (excluding weekends, state holidays, and any business day the offices of the state of Oregon are closed by the Governor or the Governor's designee):~~

~~(a) Admission of any Medicaid resident whose condition or service needs meet the criteria for a complex medical add-on procedure code(s). This includes a readmission or return of a Medicaid resident following a leave of absence from the nursing facility whose needs meet add-on criteria.~~

~~(A) The nursing facility must add these residents to the "new" section of the next weekly report filed after the resident's condition or service needs meets the complex medical add-on criteria.~~

~~(B) Following a resident's return from a leave of absence, the nursing facility must add these residents to the "new" section of the next weekly report filed after the resident's return if their condition or service needs meet a complex medical add-on procedure code(s).~~

~~(C) If the nursing facility fails to add the resident to the next weekly report filed, or files the report more than two working days after it is due, SPD shall adjust the requested effective add-on date and pay the complex medical add-on from the date of notification only.~~

(1) Effective Complex Medical Add-On Start and End Dates

(a) Complex Medical Add-On Start Date:

(A) Admission of any Medicaid resident whose condition or service needs meet the criteria for a complex medical add-on procedure code; or

(B) A current Medicaid resident whose condition or service needs change and now meets the criteria for a complex medical add-on procedure code. This includes a readmission or return of a Medicaid resident following a leave of absence from the nursing facility whose needs meet add-on criteria.

(b) Complex Medical Add-On End date :- For a resident whose condition or service needs meet a complex medical add-on procedure code(s), the complex medical add-on is effective only until the last date the resident's condition or need continues to meet complex medical add-on procedure code(s) criteria.

~~(D) For a resident whose condition or service needs meet a complex medical add-on procedure code(s), the complex medical add-on is effective only until the last date the resident's condition or need continues to meet complex medical add-on procedure code(s) criteria.~~

~~(b) A Medicaid resident whose condition or service needs change and now meets the criteria for a complex medical add-on procedure code(s).~~

~~(A) The nursing facility must add these residents to the "new" section of the next weekly report filed after the resident's condition or service needs meets the complex medical add-on criteria.~~

~~(B) If the nursing facility fails to add the resident to the next weekly report filed, or files the report more than two working days after it is due, SPD shall adjust the requested effective add-on date and pay the complex medical add-on from the date of notification only.~~

~~(C) For a resident whose condition or service needs meet a complex medical add-on procedure code(s), the complex medical add-on is effective only until the last date the resident's condition or need continues to meet complex medical add-on procedure code(s) criteria.~~

~~(c) A Medicaid resident whose condition or service needs continue to meet the criteria for a complex medical add-on procedure code(s), only if that same complex medical add-on procedure code(s) has been approved or is pending approval by SPD's Complex Medical Add-On Coordinator. The facility must add these residents to the~~

~~“existing” section of the next weekly report filed after the resident’s condition or service needs has been approved or is pending approval.~~

~~(d) Discontinuation of a complex medical add-on procedure code(s) for a resident whose condition or service needs no longer meet the criteria for the complex medical add-on procedure code(s). This includes residents on a leave of absence from the nursing facility. The nursing facility must add these residents to the “discontinued” section of the next weekly report filed after the last date the resident’s condition or service needs continues to meet the complex medical add-on procedure code(s) criteria.~~

~~(2) NOTIFICATION FOR EMERGENT MEDICAL OR SURGICAL PROBLEMS AND EMERGENT BEHAVIOR PROBLEMS.~~

~~(a) For a resident with an emergent medical or surgical problem or an emergent behavior problem, the nursing facility must contact SPD’s Complex Medical Add-On Coordinator the next working day following the emergent medical, surgical, or behavior problem for pre-authorization of complex medical add-on.~~

~~(b) If the nursing facility fails to contact SPD in a timely manner, SPD shall pay the complex medical add-on from the date of notification only.~~

~~(c) For a resident whose condition or service needs change by an emergent medical, surgical, or behavior problem, the complex medical add-on is effective only until the last date the resident’s condition or need continues to meet complex medical add-on procedure code(s) criteria.~~

(23) ADMINISTRATIVE REVIEW. If a provider disagrees with the decision of SAPD’s Complex Medical Add-On Coordinator to make or deny an adjustment in the complex medical add-on payment for a Medicaid resident, the provider may request from SAPD an administrative review of the decision. The provider must submit its request for review in writing within 30 days of receipt of the notice to make or deny the adjustment. The provider must submit documentation, as requested by SAPD, to substantiate its position. SAPD shall notify the provider in writing of its informal decision within 45 days of SAPD’s receipt of the provider’s request

for review. [SAPD](#)'s informal decision shall be an order in other than a contested case and subject to review pursuant to ORS 183.484.

(34) OVERPAYMENT FOR COMPLEX MEDICAL ADD-ONS. [SAPD](#) shall collect monies that were overpaid to a facility for any period [SAPD](#) determines the resident's condition or service needs did not meet the criteria for the complex medical add-on, or determines the facility did not maintain the required documentation.

Stat. Auth.: ORS 410.070

Stats. Implemented: ORS 410.070 & ORS 414.065

411-070-0043 Pre-Admission Screening and Resident Review (PASRR)

(1) INTRODUCTION. PASRR was mandated by Congress as part of the Omnibus Budget Reconciliation Act of 1987 and is codified in Section 1919(e)(7) of the Social Security Act. Final regulations are contained in 42 CFR, Part 483, subparts C through E. The purpose of PASRR is to prevent the placement of individuals with mental illness or [mental retardationintellectual](#) or developmental disabilities in a nursing facility unless their medical needs clearly indicate that they require the level of service provided by a nursing facility. Categorical determination, as described in section (2) of this rule, are groupings of individuals with mental illness or developmental disabilities who may be admitted to a nursing facility without a PASRR Level II evaluation.

(2) CATEGORICAL DETERMINATIONS.

(a) Exempted hospital discharge:

(A) The individual is admitted to the nursing facility directly from a hospital after receiving acute inpatient care at the hospital; or

(B) The individual is admitted to the nursing facility directly from a hospital after receiving care as an observation-status; and

(C) The individual requires nursing facility services for the condition for which he or she received care in the hospital; and

(D) The individual's attending physician has certified before admission to the facility that the individual is likely to require nursing facility services for 30 days or less.

(b) End of life care for terminal illness. The individual is admitted to the nursing facility to receive end of life care and the individual has a life expectancy of six months or less.

(c) Emergency situations with nursing facility admission not to exceed seven days unless authorized by AAA or SPD staff.

(A) The individual requires nursing facility level of service; and

(B) The emergency is due to unscheduled absence or illness of the regular caregiver; or

(C) Nursing facility admission is the result of protective services action.

(3) PASRR includes three components.

(a) PASRR LEVEL I. PASRR Level I is a screening process that is conducted prior to nursing facility admission for all individuals applying as new admissions to a Medicaid certified nursing facility regardless of the individual's source of payment. The purpose of the screening is to identify indicators of mental illness or [mental retardation-intellectual](#) or developmental disabilities that may require further evaluation {42 CFR 483.128} or if categorical determinations, as described in section (2) of this rule, which verify that the nursing facility service is required.

(A) PASRR Level I screening is performed by AAA/SPD authorized staff, private admission assessment (PAA) programs, professional medical staff working directly under the supervision of the attending physician, or by organizations designated by DHS.

(B) Documentation of PASRR Level I screening is completed using a SPD-designated form.

(C) If there are no indicators of mental illness or ~~mental retardation~~ intellectual or developmental disabilities or if the individual belongs to a categorically determined group, the individual may be admitted to a nursing facility subject to all other relevant rules and requirements.

(D) If PASRR Level I screening determines that an individual has indicators of mental illness and no categorical determinations are met, then the individual cannot be admitted to a nursing facility. The Level I assessor must contact AMHD and request a PASRR Level II evaluation.

(E) If PASRR Level I screening determines that an individual has indicators of ~~mental retardation~~ intellectual or developmental disabilities and no categorical determinations are met, then the individual cannot be admitted to a nursing facility. The Level I assessor must contact SPD and request a PASRR Level II evaluation.

(F) Except as provided in section (3)(a)(F)(ii) of this rule, nursing facilities must not admit an individual without a completed and signed PASRR Level I screening form in the individual's resident record.

(i) Completion of the PASRR Level I form under sections (3)(a)(A) through (3)(a)(F) of this rule does not constitute prior authorization of payment. Nursing facilities must still obtain prior authorization from the local AAA or SPD office as required in OAR 411-070-0035.

(ii) A nursing facility may admit an individual without a completed and signed PASRR Level I form in the resident record provided the facility has received verbal confirmation from the Level I assessor that the screening has been completed and a copy of the PASRR Level I form will be sent to the facility as soon as is reasonably possible.

(iii) The original or a copy of the PASRR Level I form must be retained as a permanent part of the resident's clinical

record and must accompany the individual if he or she transfers to another nursing facility.

(b) PASRR LEVEL II. PASRR Level II is an evaluation and determination of whether nursing facility service and specialized services are needed for an individual who has been identified through the PASRR Level I screening process with indicators of mental illness or [mental retardationintellectual](#) or developmental disabilities who does not meet categorical determination criteria {42 CFR 483.128}.

(A) Individual's identified with indicators or mental illness or [mental retardationintellectual](#) or developmental disabilities as a result of PASRR Level I screening are referred for PASRR Level II evaluation and determination.

(B) PASRR Level II evaluations and determinations are conducted by AMHD for individuals with mental illness or by SPD for individuals with [mental retardationintellectual](#) or developmental disabilities.

(C) PASRR Level II evaluations result in a determination of an individual's need for nursing facility services and specialized services {42 CFR 483.128-136} consistent with federal regulations established by the Social Security Act, Section 1919(e)(7)(C).

(D) Pursuant to 42 CFR 483.130(l), the written determination must include the following findings:

- (i) Whether a nursing facility level of services is needed;
- (ii) Whether specialized services are needed;
- (iii) The placement options that are available to the individual consistent with these determinations; and
- (iv) The rights of the individual to appeal the determination.

(E) The PASRR Level II evaluation report must be sent to the individual or their legal representative, the individuals attending physician, and the admitting or retaining nursing facility. In the case of an individual being discharged from the hospital, the discharging hospital must receive a copy of the PASRR evaluation report as well {42 CFR 483.128 (l)(1)-(3)}.

(F) Denials of nursing facility service are subject to appeal {OAR 137-003, OAR 461-025 & 42 CFR Subpart E}.

(c) RESIDENT REVIEW. Resident reviews are conducted by AMHD for individuals with indicators of mental illness or SPD for individuals with [mental retardationintellectual](#) or developmental disabilities who are residents of nursing facilities. Based on the findings of the resident review, a PASRR Level II may be requested. {42 CFR 483.114}.

(A) All residents of a Medicaid certified nursing facility may be referred for resident review when symptoms of mental illness develop.

(i) Resident review for individuals with indicators of mental illness that require further evaluation must be referred to the local Community Mental Health Program who shall determine eligibility for PASRR Level II evaluations.

(ii) The resident review form, part A, must be completed by the nursing facility. The resident review must be performed in conjunction with the comprehensive assessment specified by the AMHD, in accordance with OAR 411-086-0060.

(B) All individuals identified as having [mental retardationintellectual](#) or developmental disabilities through the PASRR Level I screening process that are admitted to a nursing facility must receive a resident review. A resident review must be conducted within seven days if the nursing facility admission is due to an emergency situation {OAR 411-070-0043(2)(c)(A)-(C)}, within 20 days if the nursing facility admission is due to other categorical determinations {OAR 411-

070-0043(2)(a)-(b)}, and annually, or as dictated by changes in resident's needs or desires.

(i) The resident review must be completed by SPD or designee.

(ii) The resident review must be completed using forms designated by SPD.

(4) SPECIALIZED SERVICES.

(a) Specialized services for individuals with mental illness are not provided in nursing facilities. Individuals with mental illness who are determined to need specialized services as a result of PASRR Level II evaluation and determination must be referred to another setting.

(b) Specialized services for individuals with ~~mental retardation~~intellectual or developmental disabilities under age 21 are equal to school services and must be based on the Individualized Education Plan.

(c) Specialized services for individuals with ~~mental retardation~~intellectual or developmental disabilities over age 21 are not provided in nursing facilities. Individuals with ~~mental retardation~~intellectual or developmental disabilities over age 21 that are determined to need specialized services as a result of PASRR Level II evaluation and determination must be referred to another setting.

(5) RESPITE CARE. Respite care in nursing facilities for individuals with mental illness, ~~mental retardation~~intellectual, or developmental disabilities is approved under the following conditions:

(a) For individuals with mental illness, a nursing facility admission for respite care must be authorized by AMHD and for individuals with ~~mental retardation~~intellectual or developmental disabilities, a nursing facility admission for respite care must be authorized by SPD Central Office;

(b) Nursing facility respite stay must be limited to no more than a total of 56 respite days within a calendar year although SPD may grant exceptions to this limit at its discretion;

(c) Nursing facility level of service must be required to meet a severe medical condition that excludes care needs due to mental illness or, ~~mental retardation~~ intellectual, or developmental disabilities; and

(d) There must not be a viable community care setting available that is appropriate to meet the individual's respite care needs as determined by section (5)(a) of this rule.

Stat. Auth.: ORS 410.070, ORS 410.535, & ORS 414.065

Stats. Implemented: ORS 410.070, ORS 410.535, & ORS 414.065

411-070-0091 Complex Medical Add-On Services

(1) LICENSED NURSING SERVICES. If a Medicaid resident qualifies for payment at the basic rate and if the resident's condition or service needs are determined to meet one or more of the procedures, routines, or services listed in this rule, and the nursing facility maintains documentation per OAR 411-070-0027, SAPD may pay a complex medical add-on payment (in addition to the basic rate) for the additional licensed nursing services needed to meet the resident's increased needs.

(a) Medication Procedures.

(A) M-1 -- Administration of medication ~~(s)~~, at least daily, requiring skilled observation and judgment for necessity, dosage, and effect, for example new anticoagulants, ~~etc.~~ (This category is limited to non-routine subcutaneous injections and does not include ~~routine medications, insulin, any oral medications~~ or the infrequent adjustments of current medications). The facility must maintain a daily nursing note.

(B) M-2 -- Intravenous injections or infusions, heparin locks used daily or continuously for hydration or medication. The facility must maintain a daily nursing note. For total parenteral nutrition (TPN) the facility must maintain daily documentation on a flow sheet and must maintain a weekly nursing note.

(C) M-4 -- Intramuscular medications for unstable condition used at least daily. The facility must maintain a daily nursing note.

(D) M-5 -- External infusion pumps used at least daily. This does not include external infusion pumps when the resident is able to self bolus. The facility must maintain a daily nursing note.

(E) M-6 -- Hypodermoclysis - daily or continuous use. The facility must maintain a daily nursing note.

(F) M-7 -- Peritoneal dialysis, daily. This does not include residents who can do their own exchanges. The facility must maintain a daily nursing note.

(b) Treatment Procedures.

(A) T-1 -- Nasogastric, Gastrostomy or Jejunostomy tubes used daily for feedings. The facility must maintain daily information on a flow sheet and ~~must maintain~~ a weekly nursing note.

(B) T-2 -- Nasopharyngeal suctioning, twice a day or more. Tracheal suctioning, as required, for a resident who is dependent on nursing staff to maintain airway. The facility must maintain a daily nursing note.

(C) T-3 -- Percussion, postural drainage, and aerosol treatment when all three are performed twice per day or more. The facility must maintain a daily nursing note.

(D) T-4 -- Ventilator dependence. Services for a resident who is dependent on nursing staff for initiation, monitoring, and maintenance. The facility must maintain a daily nursing note.

(c) Skin ~~or~~ Wound.

(A) S-1 -- Is limited to visible Stage III or IV pressure ulcers that require aggressive treatment ~~and~~ with documented

~~expectation of ulcer resolution. are expected to resolve.~~ The facility must maintain a weekly wound assessment and a weekly nursing note. A healing Stage III or IV pressure ulcer that has the visual appearance of a Stage II pressure ulcer cannot be considered eligible for purposes of complex medical criteria.

The pressure ulcer is eligible for add-on until the last day the ulcer is visibly a Stage III pressure ulcer. For complex medical add-on, facilities must stage the ulcer as it is visualized in appearance in accordance to the below definitions for determining if a resident's needs meet or continue to meet complex medical add-on criteria.

(i) Pressure ulcer means any skin ulcer caused by pressure resulting in damage of underlying tissues. Other terms used to indicate this condition include decubitus ulcers.

(ii) Stage II means a partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater.

(iii) Stage III means a full thickness of skin is lost, exposing the subcutaneous tissues. Presents as a deep crater with or without undermining adjacent tissue.

(iv) Stage IV means a full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone.

~~(v) A healing Stage III or IV pressure ulcer that has the visual appearance of a Stage II pressure ulcer cannot be considered eligible for purposes of complex medical criteria.~~

(B) S-2 -- Open wound(s) as defined by dehisced surgical wounds or surgical wounds not closed primarily that require aggressive treatment and are expected to resolve. The facility must maintain a weekly wound assessment and a weekly nursing note.

(C) S-3 -- Deep or infected stasis ulcers with tissue destruction equivalent to at least a Stage III. The facility must maintain a weekly wound assessment and a weekly nursing note. The stasis ulcer is eligible for add-on until the last day the ulcer is visually equivalent to a Stage III, or if the stasis ulcer is an infected, chronic Stage III or IV, it is eligible for add-on until it is no longer infected and returns to previous chronic Stage III or IV state. For complex medical add-on, facilities must stage the ulcer as it is visualized in appearance in accordance to the below definitions for determining if a resident's needs meet or continue to meet complex medical add-on criteria.

(i) Stasis ulcer means a skin ulcer, usually in the lower extremities, caused by altered blood flow from chronic vascular insufficiency, also referred to as venous insufficiency, lymphedema, arterial insufficiency, or peripheral vascular disease.

(ii) Stage II means a partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater.

(iii) Stage III means a full thickness of skin is lost, exposing the subcutaneous tissues. Presents as a deep crater with or without undermining adjacent tissue.

(iv) Stage IV means a full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone.

(v) A healing Stage III or IV stasis ulcer that has the visual appearance of a Stage II stasis ulcer cannot be considered eligible for purposes of complex medical criteria.

(vi) A chronic Stage III or IV stasis ulcer that is no longer infected and has returned to previous chronic Stage III or IV status cannot be considered eligible for purposes of complex medical criteria.

(d) O-4 – Insulin Dependent Diabetes Mellitus (IDDM).

(A) Unstable IDDM in a resident who requires sliding scale insulin; and

(i) Exhibits signs or symptoms of hypoglycemia ~~and/or~~ hyperglycemia, or both; and

(ii) Requires nursing or medical interventions such as extra feeding, glucagon, or additional insulin, and transfer to emergency room; and

(iii) Is having insulin dosage adjustments.

(B) The facility must maintain a daily nursing note. A Medication Administration Record is required when sliding scale insulin or other medication related to the IDDM has been administered. While all three criteria do not need to be present on a daily basis, the resident must be considered unstable. A resident with erratic blood sugars, without a need for further interventions, does not meet this criteria.

(e) Other.

(A) O-1 -- Professional Teaching. Short term, daily teaching pursuant to discharge or a self-care plan. The facility must maintain a teaching plan and a weekly nursing note.

(B) O-2 -- Emergent medical or surgical problems, requiring short term licensed nursing observation and assessment. ~~This criteria requires pre-authorization from SPD's Complex Medical Add-On Coordinator (Refer to OAR 411-070-0035).~~ Eligibility for the add-on will be until the resident no longer requires additional licensed nursing observation and assessment for this medical or surgical problem. The facility must maintain a nursing note every shift.

(C) O-3 -- Emergent Behavior Problems -- Emergent behavior is a sudden, generally unexpected change or escalation in behavior of a resident that poses a serious threat to the safety

of self or others and requires immediate intervention, consultation, and a care plan. ~~This criteria requires pre-authorization from SPD's Complex Medical Add-On Coordinator (Refer to OAR 411-070-0035).~~ Eligibility for the add-on will be until the resident no longer requires additional licensed nursing observation and assessment for this medical problem. The facility must maintain a nursing note every shift.

(f) Effective September 1, 2012, the Department shall no longer provide the complex medical add-on for Provider Preventable Conditions (PPC).

(A) Nursing facilities may not receive complex medical add-on if the need for the complex medical add-on was caused by a PPC and the need for complex medical add-on did not exist prior to treatment or intervention.

(B) No reduction in payment for a PPC shall be imposed on a provider when the condition defined as a PPC for a particular individual occurred outside of the nursing facility or prior to admission.

(C) Regardless of payment requests, a nursing facility must report each PPC event to the Department through a Department approved reporting system.

(2) R-1 -- REHABILITATION SERVICES.

(a) Physical Therapy -- At least five days every week. The facility must maintain the therapist's notes and a weekly nursing progress note related to the rehabilitation service(s) being provided.

(b) Speech Therapy -- At least five days every week. The facility must maintain the therapist's notes and a weekly nursing progress note related to the rehabilitation service(s) being provided.

(c) Occupational Therapy -- At least five days every week. The facility must maintain the therapist's notes and a weekly nursing progress note related to the rehabilitation service(s) being provided.

(d) Any combination of physical therapy, occupational therapy, and speech therapy at least five days every week qualifies. The facility must maintain the therapist's notes and a weekly nursing progress note related to the rehabilitation service(s) being provided.

(e) Respiratory Therapy -- At least five days every week by a respiratory therapist. These services must be authorized by Medicare, Medicaid Oregon Health Plan, or a third party payor. The facility must maintain the therapist's notes and a weekly nursing progress note.

Stat. Auth.: ORS 410.070

Stats. Implemented: ORS 410.070 & 414.065