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MICHAEL KAPLAN
DEPUTY SECRETARY OF STATE

ARCHIVES DIVISION
STEPHANIE CLARK
DIRECTOR

800 SUMMER STREET NE
SALEM, OR 97310
503-373-0701

NOTICE OF PROPOSED RULEMAKING

INCLUDING STATEMENT OF NEED & FISCAL IMPACT

CHAPTER 410
OREGON HEALTH AUTHORITY
HEALTH SYSTEMS DIVISION: MEDICAL ASSISTANCE PROGRAMS

FILED: 10/21/2026 6:20 PM
ARCHIVES DIVISION SECRETARY OF STATE

FILING CAPTION: Transitioning defined term “Client” to “Member”, “CCO Member”, or “Open Card Member” where appropriate.

LAST DAY AND TIME TO OFFER COMMENT TO AGENCY: 11/21/2026 5:00 PM
The Agency requests public comment on whether other options should be considered for achieving the rule's substantive goals while reducing negative economic impact of the rule on business.

CONTACT:
Kelsey Gleeson
503-979-4579
medicaid.rules@oha.oregon.gov
500 Summer Street NE
Salem, OR 97301

Filed By:
Kelsey Gleeson
Rules Coordinator

HEARING(S)
Auxiliary aids for persons with disabilities are available upon advance request. Notify the contact listed above.

DATE: 11/17/2026
TIME: 9:00 AM - 9:45 AM
OFFICER: Kelsey Gleeson

REMOTE HEARING DETAILS
MEETING URL: Click here to join the meeting
PHONE NUMBER: 669-254-5252
CONFERENCE ID: 1658671365
SPECIAL INSTRUCTIONS:
Meeting ID: 165 867 1365
Passcode: 215425

NEED FOR THE RULE(S):

In the Oregon Health Authority’s (OHA) external communications, the agency has referred to individuals receiving

services from the Oregon Health Plan (Medicaid) as a “Member” for many years. This rule language change aligns rule language with external communications.

DOCUMENTS RELIED UPON, AND WHERE THEY ARE AVAILABLE:

None

STATEMENT IDENTIFYING HOW ADOPTION OF RULE(S) WILL AFFECT RACIAL EQUITY IN THIS STATE:

The purpose of this rule change is to improve plain language and grammar. These changes are consistently applied to all rules within chapter 410 (Medical Assistance Programs). The Oregon Health Authority does not expect a disproportional impact to racial equity within any specific community as a result of this rulemaking.

FISCAL AND ECONOMIC IMPACT:

The purpose of this rule change is to improve clarity, plain language, and grammar. These changes do not effect policy, operations, or service delivery. The Oregon Health Authority does not expect any fiscal or economic impact to any entity or individual as a result of this rulemaking.

COST OF COMPLIANCE:
(1) Identify any state agencies, units of local government, and members of the public likely to be economically affected by the rule(s). (2) Effect on Small Businesses: (a) Estimate the number and type of small businesses subject to the rule(s); (b) Describe the expected reporting, recordkeeping and administrative activities and cost required to comply with the rule(s); (c) Estimate the cost of professional services, equipment supplies, labor and increased administration required to comply with the rule(s).

(1) Identify any state agencies, units of local government, and members of the public likely to be economically affected by the rule(s).
There is no expected economic impact.

(2) Effect on Small Businesses:
None.

(a) Estimate the number and type of small businesses subject to the rule(s);
None.

(b) Describe the expected reporting, recordkeeping and administrative activities and cost required to comply with the rule(s);
None.

(c) Estimate the cost of professional services, equipment supplies, labor and increased administration required to comply with the rule(s).
None.

DESCRIBE HOW SMALL BUSINESSES WERE INVOLVED IN THE DEVELOPMENT OF THESE RULE(S):

Small businesses were invited with the general public to participate in the rules advisory committee.

WAS AN ADMINISTRATIVE RULE ADVISORY COMMITTEE CONSULTED? YES

RULES PROPOSED:
410-127-0020, 410-127-0045, 410-127-0065, 410-127-0080, 410-132-0020, 410-132-0030, 410-132-0060, 410-132-0070, 410-132-0080, 410-132-0100, 410-132-0120, 410-142-0020, 410-142-0040, 410-142-0060, 410-142-0225, 410-142-0280, 410-142-0290, 410-142-0300, 410-142-0380

AMEND: 410-127-0020

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

410-127-0020
Definitions ¶

(1) "Acquisition Cost" means the net invoice price of the item, supply, or equipment plus shipping or postage for the item.¶
(2) "Assessment" means procedures by which a ~~client~~Member's health strengths, weaknesses, problems, and needs are identified.¶
(3) "Custodial Care" means provision of services and supplies that can safely be provided by non-medical or unlicensed personnel.¶
(4) "Division-" means the Health Systems Division within the Oregon Health Authority (Authority). The Division is responsible for coordinating medical assistance programs within the State of Oregon including the Oregon Health Plan (OHP), the State Children's Health Insurance Program (SCHIP-Title XXI), and several other programs.¶
(5) "Electronic Visit Verification (EVV)" means a technological solution used to electronically verify home health ~~p~~Providers delivered or rendered ~~h~~Home ~~h~~Health ~~s~~Services. EVV data to be collected in real time for each visit includes:¶
(a) Provider number of agency;¶
(b) Individual name of ~~p~~Provider rendering the service;¶
(c) Client prime number;¶
(d) Service date;¶
(e) Start and end time (to the minute);¶
(f) Location (geo location) of service delivery;¶
(g) Type of service performed.¶
(6) "Evaluation" means a systematic objective ~~a~~Assessment of the ~~client~~Member for the purpose of forming a plan of treatment and a judgment of the effectiveness of care and measurement of treatment progress. The evaluation of direct care and effectiveness of care plans and interventions is an ongoing activity.¶
(7) "Home" as it relates to ~~h~~Home ~~h~~Health ~~s~~Services, means a place of temporary or permanent residence used as an individual's home including assisted living facilities, residential care facilities and foster homes. This does not include a ~~h~~Hospital, ~~n~~Nursing ~~f~~Facility, intermediate care facility for individuals with intellectual disabilities, any setting that exists primarily for the purpose of providing medical/nursing care, or any setting in which payment is or could be made under Medicaid for inpatient services that include room and board.¶
(8) "Home Health Agency" means a public or private agency or organization that meets requirements for participation in Medicare, including the capitalization requirements under 42 CFR 489.28, and is licensed by the Authority as a ~~h~~Home ~~h~~Health ~~a~~Agency in Oregon. Home ~~h~~Health ~~a~~Agency does not include:¶
(a) Any visiting nurse service or ~~h~~Home ~~h~~Health ~~s~~Service conducted by and for those who rely upon spiritual means through prayer alone for healing in accordance with tenets and practices of a recognized church or religious denomination;¶
(b) Health services offered by county health departments that are not formally designated and funded as ~~h~~Home ~~h~~Health ~~a~~Agencies within the individual departments;¶
(c) Personal care services that do not pertain to the curative, rehabilitative, or preventive aspect of nursing.¶
(9) "Home Health Aide" means an individual who meets all requirements for home health aide as defined in the Medicare Conditions of Participation at 42 CFR 484.80 and who is certified as a nursing assistant by the Oregon State Board of Nursing in accordance with OAR chapter 851, division 062.¶
(10) "Home Health Aide Services" means services provided by a ~~h~~Home ~~h~~Health ~~a~~Aide on a part-time or intermittent basis, under the direction and supervision of a registered nurse or licensed therapist familiar with the ~~client, the client~~Member, the Member's plan of care, and the written care instructions. The focus of care shall be to provide personal care services or other services under the ~~h~~Home ~~h~~Health ~~s~~Services plan of care needed to

maintain the ~~client~~Member's health or to facilitate treatment of the ~~client~~Member's illness or injury. These services must not duplicate other Medicaid-paid personal care services.¶
(11) "Home Health Services" means the following items and services furnished to a ~~client~~Member who is under the care of a ~~p~~Physician, by a ~~h~~Home ~~h~~Health ~~a~~Agency, under a plan established and periodically reviewed by a ~~p~~Physician, on a visiting basis:¶
(a) Part-time or intermittent nursing care provided by or under the supervision of a registered nurse;¶
(b) Physical, occupational, or speech-language pathology services;¶
(c) Part-time or intermittent ~~h~~Home ~~h~~Health ~~a~~Aide ~~s~~Services provided by a ~~h~~Home ~~h~~Health ~~a~~Aide who has successfully completed the required training and certification; and¶
(d) Medical supplies and ~~d~~Durable ~~m~~Medical ~~e~~Equipment.¶
(12) "Medicaid Home Health Provider" means a ~~h~~Home ~~h~~Health ~~a~~Agency licensed by Health Services, Health Care Licensure and Certification certified for Medicare and enrolled with the Division as a Medicaid ~~p~~Provider.¶
(13) "Medical Supplies" means supplies prescribed by a ~~p~~Physician as a necessary part of the plan of care being provided by the ~~h~~Home ~~h~~Health ~~a~~Agency.¶
(14) "Outcome and Assessment Information Set (OASIS)" means a ~~client~~Member specific comprehensive ~~a~~Assessment that identifies the ~~client~~Member's need for ~~h~~Home ~~h~~Health ~~s~~Services that meet the ~~client~~Member's medical, nursing, rehabilitative, social, and discharge planning needs.¶
(15) "Occupational Therapy Services" means services provided by a registered ~~o~~Occupational ~~t~~Therapist or certified ~~o~~Occupational ~~t~~Therapy assistant supervised by a registered ~~o~~Occupational ~~t~~Therapist, due to the complexity of the service and ~~client~~Member's condition. The focus of these services shall be curative, rehabilitative, or preventive and must be considered specific and effective treatments for a ~~client~~Member's condition under accepted standards of medical practice. Teaching the ~~client~~Member, family, and caregiver task-oriented therapeutic activities designed to restore function and independence in the activities of daily living is included in this skilled service. Occupational Therapy Licensing Board ORS 675.210-675.340 and the Uniform Terminology for Occupational Therapy established by the American Occupational Therapy Association, Inc. govern the practice of occupational therapy.¶
(16) "Physical Therapy Services" means services provided by a licensed ~~p~~Physical ~~t~~Therapist or licensed ~~p~~Physical ~~t~~Therapy assistant under the supervision of a licensed ~~p~~Physical ~~t~~Therapist, due to the inherent complexity of the service and the ~~client~~Member's condition. The focus of these services shall be curative, rehabilitative, or preventive and must be considered specific and effective treatments for a patient's condition under accepted standards of medical practice. Teaching the ~~client~~Member, family, and caregiver the necessary techniques, exercises, or precautions for treatment and prevention of illness or injury is included in this skilled service. Physical Therapy Licensing Board ORS 688.010 to 688.235 and Standards for Physical Therapy as well as the Standards of Ethical Conduct for the Physical Therapy Assistant established by the American Physical Therapy Association govern the practice of physical therapy. Physical therapy shall not include radiology or electrosurgery.¶
(17) "Plan of Care" means written instructions describing how care is to be provided. The plan is initiated by the admitting registered nurse, ~~p~~Physical ~~t~~Therapist, ~~o~~Occupational ~~t~~Therapist, or speech therapist and certified by the prescribing ~~p~~Physician. The ~~p~~Plan of ~~c~~Care must include the ~~client~~Member's condition, rationale for the care plan including justification for the skill level of care, and the summary of care for additional certification periods. This includes but is not limited to:¶
(a) All pertinent diagnoses;¶
(b) Mental, psychosocial, and cognitive status;¶
(c) Types of services;¶
(d) Specific therapy services;¶
(e) Frequency and duration of visits to be made;¶
(f) Supplies and equipment needed;¶
(g) Prognosis;¶
(h) Rehabilitation potential;¶
(i) Functional limitations;¶
(j) Activities permitted;¶
(k) Nutritional requirements;¶
(~~l~~l) All medications and treatments;¶
(m) Safety measures to protect against injury;¶
(n) Discharge plans including patient and caregiver education and training to facilitate timely discharge;¶
(o) Patient-specific measurable outcomes/goals;¶
(p) If ~~h~~Home ~~h~~Health ~~s~~Services are initiated following a ~~h~~Hospital discharge, an ~~a~~Assessment of ~~client~~Member's level of risk for hospital ~~e~~Emergency ~~d~~Department visits or ~~h~~Hospital readmission;¶
(q) Additional interventions/orders the ~~h~~Home ~~h~~Health ~~a~~Agency or ~~p~~Physician chooses to include.¶
(18) "Practitioner" means an individual licensed pursuant to federal and state law to engage in the provision of

health care services within the scope of the ~~p~~Practitioner's license and certification.¶
(19) "Responsible Unit" means the agency responsible for approving or denying payment authorization.¶
(20) "Skilled Nursing Services" means the ~~client~~Member care services pertaining to the curative, restorative, or preventive aspects of nursing performed by a registered nurse or under the supervision of a registered nurse, pursuant to the ~~p~~Plan of ~~c~~Care established by the prescribing ~~p~~Physician in consultation with the ~~h~~Home ~~h~~Health ~~a~~Agency staff. Skilled nursing emphasizes a high level of nursing direction, observation, and skill. The focus of these services shall be the use of the nursing process to diagnose and treat human responses to actual or potential health care problems, health teaching, and health counseling. Skilled ~~n~~Nursing ~~s~~Services include the provision of direct ~~client~~Member care and the teaching, delegation, and supervision of others who provide tasks of nursing care to ~~client~~Members, as well as phlebotomy services. Such services shall comply with the Nurse Practice Act and administrative rules of the Oregon State Board of Nursing and Health Division, chapter 410 division 127, Home Health Agencies.¶
(21) "Speech-Language Pathology Services" means services provided by a licensed ~~s~~Speech-~~l~~Language ~~p~~Pathologist due to the inherent complexity of the service and the patient's condition. The focus of these services shall be curative, rehabilitative, or preventive and must be considered specific and effective treatment for a patient's condition under accepted standards of medical practice. Teaching the ~~client~~Member, family, and caregiver task-oriented therapeutic activities designed to restore function and compensatory techniques to improve the level of functional communication ability is included in this skilled service. Speech-Language Pathology and Audiologist Licensing Board ORS 681.205 to 681.991 and the Standards of Ethics established by the American Speech and Hearing Association govern the practice of speech-language pathology.¶
(22) "Title XVIII (Medicare)" means Title XVIII of the Social Security Act.¶
(23) "Title XIX (Medicaid)" means Title XIX of the Social Security Act.¶
[Note: Publications referenced are available from the agency.]
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.065

AMEND: 410-127-0045

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

410-127-0045
Face-to-Face Encounter Requirements for Home Health Services ¶

(1) The Division requires that for the initial ordering of ~~h~~Home ~~h~~Health ~~s~~Services, an in-person face-to-face encounter that is related to the primary reason the ~~client~~Member requires the ~~h~~Home ~~h~~Health ~~s~~Services must occur within not more than 90 days before or 30 days after the start of services.¶
(2) The face-to-face encounter shall be conducted by:¶
(a) The certifying ~~p~~Physician (MD or DO); or¶
(b) An authorized non-physician ~~p~~Practitioner (NPP); or¶
(c) An attending or post-acute ~~p~~Physician for ~~client~~Members admitted to home health immediately after an ~~a~~Acute or post-acute stay.¶
(3) Authorized NPP's for ~~h~~Home ~~h~~Health ~~s~~Services are ~~n~~Nurse ~~p~~Practitioners, a ~~c~~Clinical ~~n~~Nurse ~~s~~Specialist working in collaboration with the ~~p~~Physician, or a ~~p~~Physician ~~a~~Associate under the supervision of a ~~p~~Physician.~~-~~¶
(4) If an authorized NPP performs the face-to-face encounter, they shall communicate the clinical findings to the certifying ~~p~~Physician. Those clinical findings must be incorporated into a written or electronic document included in the ~~client~~Member's medical record.~~-~~¶
(5) The certifying ~~p~~Physician shall document that the ~~client~~Member was evaluated or treated for a condition that supports the need for the ~~h~~Home ~~h~~Health ~~s~~Services ordered within no more than 90 days before or 30 days after the start of services. The certifying ~~p~~Physician shall also document the name of the ~~p~~Practitioner who conducted the encounter and the date of the encounter.¶
(6) The documentation of the face-to-face encounter must be a separate and distinct section of or an addendum to the certification and must be clearly titled, dated, and signed by the certifying ~~p~~Physician.¶
(7) A face-to-face encounter must occur for certification any time a new start of care ~~a~~Assessment is completed to initiate care for the ~~h~~Home ~~h~~Health ~~s~~Services.~~-~~¶
(8) If a dually eligible ~~client~~Member begins home health under Medicare and transitions to Medicaid, the Medicare face-to-face encounter documentation shall meet the Medicaid face-to-face requirement.¶
(9) The ~~h~~Home ~~h~~Health ~~a~~Agency shall maintain documentation of the qualifying face-to-face encounter and provide this documentation to the Division with the ~~p~~Prior ~~a~~Authorization request for services.
Statutory/Other Authority: 411.404, 414.065
Statutes/Other Implemented: 414.065

AMEND: 410-127-0065

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

410-127-0065
Signature Requirements ¶

(1) Physicians shall sign for services they order. This signature shall be handwritten or electronic, and it must be in the ~~client~~Member's medical record.¶
(2) The ordering ~~p~~Physician shall ensure the authenticity of the signature.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.065

AMEND: 410-127-0080

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

410-127-0080
Prior Authorization ¶

(1) Home health ~~p~~Providers must obtain ~~p~~Prior ~~a~~Authorization (PA) for services as specified in rule.¶
(2) Providers must request PA as follows (see the Home Health Supplemental Information booklet for contact information) and include the documentation requirements from the supplemental (e.g., face-to-face encounter, ~~p~~Plan of ~~c~~Care, primary diagnosis, initial assessment, evaluation, etc.):¶
(a) For ~~client~~Members enrolled in a Coordinated Care Organization (CCO) or a Prepaid Health Plan (PHP), from the CCO or the PHP;¶
(b) For all other ~~client~~Members, from the Division.¶
(3) For services requiring authorization, ~~p~~Providers must contact the responsible unit for authorization within five working days following initiation or continuation of services. The ~~FAX~~fax or postmark date on the request shall be honored as the request date. The ~~p~~Provider shall obtain ~~p~~Payment ~~a~~Authorization. Authorization shall be given based on ~~m~~Medical ~~a~~Appropriateness and appropriate level of care, cost, and effectiveness as supported by submitted documentation. The ~~p~~Plan of ~~c~~Care submitted must include the ~~client~~Member's condition, the rationale for the care plan including justification for the required skill level of care, and the summary of care for additional certification periods.¶
(4) Payment ~~a~~Authorization does not guarantee reimbursement (e.g., eligibility changes, incorrect identification number, ~~p~~Provider contract ends).¶
(5) For rules related to authorization of payment including retroactive eligibility, see ~~General Rules~~ OAR 410-120-1320.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.065

AMEND: 410-132-0020

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

410-132-0020
Private Duty Nursing Services ¶

(1) The practice of nursing is governed by the following: Oregon State Board of Nursing, ORS 678.010 to 678.410, and Oregon State Board of Nursing, chapter 851, divisions 031, 045, and 047.¶
(2) Private ~~d~~Duty ~~n~~Nursing ~~is~~Services are considered supportive to the care provided to a ~~client~~Member by the ~~client~~Member's family, foster parents, and delegated caregivers, as applicable. Nursing ~~s~~Services shall be ~~m~~Medically ~~a~~Appropriate. Medically ~~a~~Appropriate for private duty nursing shift care is determined by qualifying for services based on the Private Duty Nursing Acuity Grid (DMAP 591). Increases or decreases in the level of care and number of hours or visits authorized shall be based on a change in the ~~client~~Member's condition, program limitations, and the family, foster parents, or delegated caregiver's ability to provide care.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.065

AMEND: 410-132-0030

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

410-132-0030
Definitions ¶

(1) "Activities of ~~d~~Daily ~~l~~Living ~~or~~ (ADL~~'~~)" means activities usually performed in the course of a normal day in an individual's life including:¶
(a) Eating: Assisting the individual in feeding or fluid intake by any means from a receptacle into the body, including monitoring to prevent choking or aspiration;¶
(b) Bathing: Assisting the individual with cleansing the body, washing hair, shaving, nail care, and using assistive devices when necessary to get in and out of the bathtub or shower;¶
(c) Dressing: Assisting the individual with putting on, fastening, and taking off all items of clothing, braces, and artificial limbs, including obtaining and replacing items from their storage area in the immediate environment;¶
(d) Toileting: Assisting the individual in getting to and from, on and off, the toilet, commode, or bedpan for elimination of feces and urine. This includes cleansing after elimination and adjusting clothing as necessary;¶
(e) Maintaining Continence: Including external cleansing of Foley catheter, emptying catheter drainage bag, maintenance bowel care, changing and replacing incontinence products, including colostomy or ileostomy bags;¶
(f) Transferring: Assisting the individual with mobility, transfers, and repositioning by any means including use of an assistive device and includes turning or adjusting padding for physical comfort or pressure relief and encouraging or assisting with range of motion exercises.¶
(2) "Admission" means acceptance of the ~~client~~Member into the ~~p~~Private ~~d~~Duty ~~n~~Nursing Services program contingent upon meeting the criteria as stated in rule.¶
(3) "Basic ~~t~~Tasks of ~~client/n~~Member/Nursing ~~c~~Care" means procedures that do not require the education or training of a registered nurse or licensed practical nurse that cannot be performed by the ~~client~~Member independently. Basic ~~t~~Tasks of ~~client/n~~Member/Nursing ~~c~~Care also means procedures that may be directed by the ~~client~~Member. These basic tasks include, but are not limited to, ~~a~~Activities of ~~d~~Daily ~~l~~Living. Basic tasks may vary from setting to setting depending on the ~~client~~Member population served in that setting and the acuity and complexity of the ~~client~~Member's care needs. Basic tasks may require the assignment and supervision of a licensed nurse. The need for supervision is at the discretion of the registered nurse. See State Board of Nursing rules that govern the practice of nursing.¶
(4) "Critical/~~f~~Fluctuating ~~c~~Condition" means a situation where the ~~client~~Member's clinical and behavioral state is of a serious nature expected to rapidly change and be in need of continuous reassessment and evaluation.¶
(5) "Delegation" means that a registered nurse authorizes an unlicensed person to perform tasks of nursing care in selected situations and indicates that authorization in writing. The delegation process includes nursing ~~a~~Assessment of a ~~client~~Member in a specific situation, evaluation of the ability of the unlicensed persons, teaching the task, ensuring supervision of the unlicensed persons, and re-evaluating the task at regular intervals. For the purpose of these rules, the unlicensed person, caregiver, or certified nursing assistant performs tasks of nursing care under the Registered Nurse's delegated authority.¶
(6) "Discharge" means the ~~client~~Member no longer meets the Division rules and criteria of the ~~p~~Private ~~d~~Duty ~~n~~Nursing Services program.¶
(7) "Habilitation" means services that are provided in order to assist an individual to acquire a variety of skills including self-help, socialization, and adaptive skills. Habilitation is aimed at raising the level of physical, mental, and social functioning of an individual. Habilitation is contrasted to rehabilitation, which involves the restoration of function an individual lost.¶
(8) "Home" means a place of temporary or permanent residence, not including a ~~h~~Hospital, intermediate care facility for individuals with intellectual disabilities (ICF/ID), ~~n~~Nursing ~~f~~Facility, or licensed residential care facility.¶
(9) "Instrumental ~~a~~Activities of ~~d~~Daily ~~l~~Living ~~or~~ (IADL~~'~~)" means activities usually performed in the course of a normal day in an individual's life and include:¶
(a) Personal Hygiene: Perform or assist with activities required to keep one's appearance neat, secure clothing, comb/brush hair, nail care, foot care, skin care, mouth care, and oral hygiene, etc.;¶
(b) Light Housework: Perform or assist with housekeeping tasks necessary to maintain the individual in a healthy and safe living environment;¶
(c) Laundry: Perform or assist with laundering or cleaning of clothing, bedding, and other linens;¶
(d) Meal Preparation: Perform or assist with healthy meal planning and preparation, ~~i~~ensuring special diets are

followed;¶
(e) Transportation: Assist the individual in getting to and from necessary appointments and community activities through available means of transportation;¶
(f) Grocery Shopping: Perform or assist the individual in planning for and purchasing basic needs and household items;¶
(g) Using the Telephone: Perform or assist the individual in arranging necessary appointments and making desired phone calls;¶
(h) Medication Management: Assist with medications that are ordinarily self-administered, including administering medication and observing to ~~i~~ensure the individual is taking medication as ordered, documenting and monitoring any notable side effects, and refilling prescriptions in a timely manner. Assist with use, maintenance, and cleaning of in-home equipment, monitoring ~~client~~Member's condition, and ordering and maintaining necessary supplies;¶
(i) Money Management: Perform or assist with budgeting, making payments for monthly expenses, and use of personal funds for desired items and activities.¶
(10) "Maintenance ~~c~~Care" means the level of care needed when the goals and objectives of the care plan are reached, the condition of the ~~client~~Member is stable or predictable, the ~~p~~Plan of ~~c~~Care does not require the skills of a licensed nurse in continuous attendance, or the ~~client~~Member, family, foster parents, or caregivers have been taught and have demonstrated the skills and abilities to carry out the ~~p~~Plan of ~~c~~Care.¶
(11) "Medically Fragile Children's (MFC) ~~p~~Program" means an Oregon Department of Human Services (Department) organizational unit that coordinates and funds appropriate services for children ages 0 to 18 years with intensive medical needs that require in-home and technological supports and meet MFC clinical criteria.¶
(12) "Member of the ~~h~~Household" means any individual sharing a common home as part of a single family unit, including domestic employees and others who live together as part of a family unit, but not including a roomer or boarder.¶
(13) "Plan of ~~c~~Care" means written instructions detailing how the ~~client~~Member is to be cared for. The plan is initiated by the private duty nurse or nursing agency with input from the prescribing ~~p~~Physician. See the ~~"D~~documentation ~~R~~requirements~~"~~ section of the Private Duty Nursing Services administrative rules.¶
(14) "Private ~~d~~Duty ~~n~~Nursing ~~s~~Shift ~~c~~Care" means an RN or LPN nursing service for the ~~client~~Member's ~~c~~Critical/~~f~~Fluctuating ~~c~~Conditions requiring the need for reassessment and evaluation with a high probability that complications would arise without skilled nursing management of the treatment program supplied in a specified block of time.¶
(15) "Practice of ~~n~~Nursing" means using the nursing process under doctor's orders to diagnose and treat human response to actual or potential health care problems, health teaching and health counseling, the provision of direct ~~client~~Member care, and the teaching, delegation, and supervision of others who provide tasks of nursing care to ~~client~~Members. See State Board of Nursing rules that govern the ~~p~~Practice of ~~n~~Nursing.¶
(16) "Private ~~d~~Duty ~~n~~Nursing ~~v~~Visit" means RN or LPN skilled nursing services for non-critical/stable conditions requiring reassessment and evaluation with a moderate probability that complications would arise without skilled nursing management of the treatment program supplied on an intermittent per visit basis.¶
(17) "Respite" means short-term or intermittent care and supervision in order to provide an interval of rest or relief to family or caregivers.¶
(18) "Responsible ~~u~~Unit" means the agency responsible for approving or denying ~~p~~Prior ~~a~~Authorization.¶
(19) "Shift" means four to twelve hours of ~~p~~Private ~~d~~Duty ~~n~~Nursing Services.¶
(20) "Skilled ~~n~~Nursing ~~s~~Services" means ~~client~~Member care services pertaining to the curative, restorative, or preventive aspects of nursing performed by or under the supervision of a registered nurse pursuant to the plan of care established by the ~~p~~Physician in consultation with the registered nurse. Skilled nursing emphasizes a high level of nursing direction, observation, and skill. The focus of these services shall be the use of the nursing process to diagnose and treat human responses to actual or potential health care problems, health teaching, and health counseling. Skilled ~~n~~Nursing ~~s~~Services include the provision of direct care and the teaching, delegation, and supervision of others who provide tasks of nursing care to ~~client~~Members. These services shall comply with the Nurse Practice Act and administrative rules of the Oregon State Board of Nursing.¶
(21) "Special ~~t~~Tasks of ~~client/n~~Member/Nursing ~~c~~Care" means tasks that require the education and training of a registered nurse or licensed practical nurse to perform. Special tasks may vary from setting to setting depending on the ~~client~~Member population served in that setting and the acuity/complexity of the ~~client~~Member's care needs. Examples of special tasks include, but are not limited to, administration of injectable medications, suctioning, and complex wound care.¶
(22) "Stable/~~p~~Predictable ~~c~~Condition" means a situation in which the ~~client~~Member's clinical and behavioral status is known and does not require the regularly scheduled presence and evaluation of a licensed nurse. See State Board of Nursing rules that govern the ~~p~~Practice of ~~n~~Nursing.¶
(23) "Teaching" means the registered nurse instructs an unlicensed person in the correct method of performing a selected task of ~~client~~Member/nursing care. See State Board of Nursing rules that govern the practice of nursing.¶

(24) "Unlicensed Person" means an individual who is not licensed to practice nursing, medicine, or any other health occupation requiring a license in Oregon, but who provides tasks of nursing care or is taught to administer non-injectable medications. A certified nursing assistant, as defined by these rules, is an unlicensed person. For the purpose of these delegation rules, unlicensed persons do not include members of the ~~client~~Member's immediate family. Family members may perform tasks of nursing care without specific delegation from a Registered Nurse. The terms "~~u~~Unlicensed ~~p~~Person" and "caregiver" may be used interchangeably.¶
(25) "Visit" means nursing service supplied on an intermittent basis in the ~~h~~Home.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.065

AMEND: 410-132-0060

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

410-132-0060
Private Duty Nursing Transition into Maintenance ¶

(1) Private ~~d~~Duty ~~n~~Nursing ~~s~~Services become maintenance care when any one of the following situations occurs:¶
(a) Medical and nursing documentation supports that the condition of the ~~client~~Member is stable/predictable;¶
(b) The ~~p~~Plan of ~~c~~Care does not require a licensed nurse to be in continuous attendance;¶
(c) The ~~client~~Member, family, foster parents, or caregivers have been taught the ~~n~~Nursing ~~s~~Services and have demonstrated the skills and ability to carry out the ~~p~~Plan of ~~c~~Care;¶
(d) The combined score on the Acuity Grid and Psychosocial Grid is less than 54.¶
(2) This rule does not apply to individuals in the MFC program.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.065

AMEND: 410-132-0070

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

410-132-0070
Documentation Requirements ¶

(1) Documentation of services provided shall be maintained in the ~~client~~Member's place of residence by the private duty nurse until ~~d~~Discharged from service. Payment may not be made for services where the documentation does not support the definition of skilled nursing. Documentation shall meet the standards of the Oregon State Board of Nursing.¶
(2) The private duty nurse shall ensure completion and documentation of a comprehensive assessment of the ~~client~~Member's capabilities and needs for nursing services within seven days of admission. Comprehensive assessments shall be updated and submitted to the ~~r~~Responsible ~~u~~Unit by the next work day after any significant change of condition and reviewed by the ~~r~~Responsible ~~u~~Unit within the Oregon Health Authority at least every 60 days. Some examples of significant change in condition are ~~h~~Hospital admission, emergency room visit, and change in status, death, or ~~d~~Discharge from care.¶
(3) The nursing care plan shall document that the private duty nurse, through case management and coordination with all interdisciplinary staff and agencies, provides services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each ~~client~~Member in accordance with a written, dated, nursing care plan. The nursing care plan shall:¶
(a) Be completed within seven days after admission for children and adolescents with short-term needs who are served through the Division. The nursing care plan shall be reviewed, updated, and submitted whenever the ~~client~~Member's needs change, but at least every 60 days;¶
(b) Describe the medical, nursing, and psychosocial needs of the ~~client~~Member and how the private duty nurse will actively coordinate and facilitate meeting those needs. This description of needs shall include interventions, measurable objectives, goals, and time frames in which the goals and objectives will be met and by whom;¶
(c) Include the rehabilitation potential including functional limitations related to Activities of Daily Living (ADL), types and frequency of therapies, and activity limitations per ~~p~~Physician order;¶
(d) Include services related to school-based care according to the IEP and the Individualized Family Service Plan, if applicable;¶
(e) Show coordination of all services being provided including, but not limited to, the ~~client~~Member or ~~r~~Representative, registered nurse (RN) case manager, Department case worker, ~~p~~Physician, other disciplines involved, and all other care ~~p~~Providers involved in the ~~client~~Member's treatment plan;¶
(f) Include a statement of the ~~client~~Member's potential toward ~~d~~Discharge. Timelines shall be included in the plan outline;¶
(g) Be available to and followed by all caregivers involved with the ~~client~~Member's care.¶
(4) Documentation of private duty shift care and responses to care shall be written in an accurate, timely, thorough, and clear manner on the narrative or flow sheet. Documentation shall comply with the requirements of the Oregon State Board of Nursing in OAR chapter 851 and shall include:¶
(a) The name of the ~~client~~Member on each page of documentation;¶
(b) The date of service;¶
(c) Time of start and end of service delivery by each caregiver;¶
(d) Anything unusual from the standard plan of care shall be expanded on the narrative;¶
(e) Interventions;¶
(f) Outcomes including the ~~client~~Member's response to services delivered;¶
(g) Nursing assessment of the ~~client~~Member's status and any changes in that status per each working shift; and¶
(h) Full signature of ~~p~~Provider.¶
(5) Documentation of delegation, teaching, and assignment shall be in accordance with the Oregon State Board of Nursing Rules.¶
(6) For documentation to be submitted with ~~p~~Prior ~~a~~Authorization, see OAR 410-132-0100.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.065

AMEND: 410-132-0080

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

410-132-0080
Limitations ¶

(1) General pertains to both shift care and ~~v~~Visits:¶
(a) Private ~~d~~Duty ~~n~~Nursing ~~is~~Services are not covered if the ~~client~~Member is:¶
(A) Twenty-one years of age or older;¶
(B) A resident of a ~~n~~Nursing ~~f~~Facility;¶
(C) A resident of a licensed intermediate care facility for individuals with intellectual disabilities (ICF/ID);¶
(D) In a ~~h~~Hospital;¶
(E) In a licensed residential care facility;¶
(b) Private ~~d~~Duty ~~n~~Nursing ~~is~~Services are not covered solely to allow the ~~client~~Member's family or caregiver to work or go to school;¶
(c) Private ~~d~~Duty ~~n~~Nursing ~~is~~Services are not covered solely to allow respite for caregivers or the ~~client~~Member's family;¶
(d) Payment for ~~p~~Private ~~d~~Duty ~~n~~Nursing Services may not be authorized for parents, siblings, grandparents, foster care parents, significant others, ~~m~~Members of the ~~client's h~~Household, or individuals paid by other agencies to provide caregiving services;¶
(e) Costs of ~~p~~Private ~~d~~Duty ~~n~~Nursing ~~s~~Services are not reimbursable if they are provided concurrently with care being provided under ~~h~~Home ~~h~~Health Services or ~~h~~Hospice program rules;¶
(f) Home nursing visits as defined in the Home Enteral/Parenteral Nutrition and IV Services rules are not covered in conjunction with ~~p~~Private ~~d~~Duty ~~n~~Nursing ~~s~~Services;¶
(g) These services are provided for individuals aged 0 to 21 who need PDN or the same or similar ~~n~~Nursing ~~s~~Services during school hours. These services are provided through the ~~s~~School-~~b~~Based ~~h~~Health ~~s~~Services program in conjunction with the individual's Individual Education Plan (IEP) or Individualized Family Service Plan (IFSP) under the Individuals with Disabilities Education Act (IDEA);¶
(h) Holidays are paid at the same rate as non-holidays;¶
(i) Hours nurses spend in training are not reimbursable;¶
(j) Travel time to reach the job site is not reimbursable;¶
(k) Maintenance ~~c~~Care is not reimbursable, except for those individuals in the MFC program.¶
(2) Private ~~d~~Duty ~~n~~Nursing ~~v~~Visit:¶
(a) The nursing care plan and documentation supporting the ~~m~~Medical ~~a~~Appropriateness for ~~p~~Private ~~d~~Duty ~~n~~Nursing Services shall be reviewed every 60 days to continue the service for children and adolescents with short-term needs who are served by the Division. Reviews shall be conducted by the ~~r~~Responsible ~~u~~Unit;¶
(b) Private ~~d~~Duty ~~n~~Nursing ~~v~~Visits are limited to two per day.¶
(3) Private ~~d~~Duty ~~n~~Nursing ~~s~~Shift ~~c~~Care:¶
(a) Medically ~~a~~Appropriate ~~p~~Private ~~d~~Duty ~~n~~Nursing ~~s~~Shift ~~c~~Care for ~~client~~Members up to 21-years old may be covered for ~~a~~Acute episodes of illness, injury, or medical condition up to 60 continuous days in cases where it has been determined that skilled management by a licensed nurse is required;¶
(b) A ~~client~~Member may be referred to the MFC program to determine if they meet the criteria for program admission at the time of the initial request for services if any of the following are determined to exist:¶
(A) The ~~client~~Member's medical needs are for habilitation or maintenance; or¶
(B) The ~~client~~Member's medical needs are long term.¶
(c) Individuals who no longer qualify for ~~p~~Private ~~d~~Duty ~~n~~Nursing ~~s~~Shift ~~c~~Care shall be referred to the Department for determination of their ~~l~~Long-~~t~~Term ~~c~~Care needs;¶
(d) The number of hours of ~~p~~Private ~~d~~Duty ~~n~~Nursing ~~s~~Services that a ~~client~~Member may receive is determined by the score on the Private Duty Nursing Acuity Grid (DMAP 591):¶
(A) The ~~client~~Member shall score greater than 60 points on the Acuity Grid to receive up to 24-hours per day immediately after discharge from a ~~h~~Hospital or if there is a significant worsening or decline of condition; or¶
(B) The ~~client~~Member shall score 50 to 60 points on the Acuity Grid to receive up to 16 hours per day immediately after discharge from a ~~h~~Hospital or if there is a significant worsening or decline of condition; or¶
(C) The ~~client~~Member shall score 40 to 49 points on the Acuity Grid to receive up to 84 hours per week immediately after discharge from a ~~h~~Hospital or if there is a significant worsening or decline of condition; or¶

(D) If the score is 30 to 39 on the Acuity Grid, then the Private Duty Nursing Psychosocial Grid (DMAP 590) shall be used to determine eligibility. If the score is 24 or above, the ~~client~~Member may receive up to 84 hours per week of shift care.¶
(e) The banking, saving, or accumulating unused ~~p~~Prior ~~a~~Authorized hours used for the convenience of the family or caregiver is not covered.
Statutory/Other Authority: 413.042
Statutes/Other Implemented: ORS 414.065

AMEND: 410-132-0100

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

410-132-0100
Prior Authorization ¶

(1) Private ~~d~~Duty ~~n~~Nursing ~~p~~Services Providers shall obtain ~~p~~Prior ~~a~~Authorization (PA) for all services.¶
(2) Providers shall request PA as follows (see the Private Duty Nursing Services Supplemental Information booklet for contact information):¶
(a) For individuals served by the MFC~~)~~, from the Departments MFC Program;¶
(b) For ~~client~~Open Card Members enrolled in the fee-for-service (FFS) Medical Case Management (MCM) program, from the MCM contractor;¶
(c) For ~~m~~CCO Members enrolled in a ~~c~~Coordinated ~~c~~Care ~~o~~Organization (CCO) or ~~p~~Prepaid ~~h~~Health ~~p~~Plan (PHP), from the CCO or the PHP;¶
(d) For all other ~~client~~Members, from the Division.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.065

AMEND: 410-132-0120

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

410-132-0120
Billing Information ¶

(1) If the ~~client~~Member has not enrolled in a CCO or PHP, bill with the appropriate Division unique procedure codes and follow the instructions on how to complete the CMS-1500.¶
(2) ~~Client~~Member copayments may be required for certain services.~~ See OAR 410-120-1230 for specific details.~~¶
(3) Claims shall be submitted on a CMS-1500, electronically or on paper. Paper claims shall be sent to the Division.¶
(4) Contact the Division's Electronic Billing Representative for information about electronic billing.¶
(5) Bill on a CMS-1500 and enter the appropriate TPR Explanation Code in Field 9 when billing for ~~client~~Members with Medicare.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.065

AMEND: 410-142-0020

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

410-142-0020
Definitions ¶

(1) "Accredited/Accreditation~~: A~~" means a designation by an accrediting organization that a ~~h~~Hospice program has met standards that have been developed to indicate a quality program.¶
(2) "Ancillary ~~s~~Staff~~: S~~" means staff that provide~~s~~ additional services to support or supplement ~~h~~Hospice care.¶
(3) "Assessment~~: P~~" means procedures by which strengths, weaknesses, problems, and needs are identified and addressed.¶
(4) "Attending ~~p~~Physician~~: A p~~" means a Physician who is a doctor of medicine or osteopathy and is identified by the ~~client~~Member, at the time the ~~or she~~ elect~~s~~ to receive ~~h~~Hospice care, as having the most significant role in the determination and delivery of the ~~client~~Member's medical care.¶
(5) "Bereavement counseling~~: C~~" means counseling services provided to the ~~client~~Member's family before and after the ~~client~~Member's death. Bereavement counseling is required to be offered per the ~~C~~conditions of ~~P~~participation and is a non-reimbursable ~~h~~Hospice service.¶
(6) "Bundled Rate~~:~~" means the Nursing Facility (NF) rate as defined in 411-070-0085.¶
(7) ~~Client f~~"Member-Family ~~u~~Unit" includes a ~~client~~Member who has a life threatening disease with a limited prognosis and all others sharing housing, common ancestry or a common personal commitment with the ~~client~~Member.¶
(8) "Conditions of Participation (CoPs)~~: T~~" means the applicable federal regulations that ~~h~~Hospice programs are required to comply with in order to participate in the federal Medicare and Medicaid programs.¶
(9) "Coordinated~~: W~~" when used in conjunction with the phrase "hospice program," means the integration of the interdisciplinary services provided by ~~client~~Member-family care staff, other ~~p~~Providers and volunteers directed toward meeting the ~~h~~Hospice needs of the ~~client~~Member.¶
(10) "Coordination of Care (COC)~~: T~~" means the federal regulations for coordination of ~~client~~Member care between the ~~h~~Hospice and the ~~n~~Nursing ~~f~~Facility that hospice programs are required to comply with in order to serve ~~h~~Hospice ~~client~~Members in a ~~n~~Nursing ~~f~~Facility and participate in the federal Medicare and Medicaid programs.¶
(11) "Coordinator~~: A~~" means a registered nurse designated to coordinate and implement the care plan for each ~~h~~Hospice ~~client~~Member.¶
(12) "Counseling~~: A~~" means a relationship in which a person endeavors to help another understand and cope with problems as a part of the ~~h~~Hospice plan of care.¶
(13) "Curative~~: M~~" means medical intervention used to ameliorate the disease.¶
(14) "Dying~~: T~~" means the progressive failure of the body systems to retain normal functioning, thereby limiting the remaining life span.¶
(15) "Family~~: T~~" means the relatives ~~and/~~or other significantly important persons who provide psychological, emotional, and spiritual support of the ~~client~~Member. The "family" need not be blood relatives to be an integral part of the ~~h~~Hospice care plan.¶
(16) "Hospice~~: A~~" means a public agency or private organization or subdivision of either that is primarily engaged in providing care to terminally ill ~~client~~individuals, and is certified by the federal Centers for Medicare and Medicaid Services as a program of hospice services meeting current standards for Medicare and Medicaid reimbursement and Medicare Conditions of Participation; and currently licensed by the Oregon Health Authority (Authority), Public Health Division.¶
(17) "Hospice ~~c~~Continuity of ~~c~~Care~~: S~~" means services that are organized, coordinated and provided in a way that is responsive at all times to ~~client~~Member/family needs, and which are structured to assure that the ~~h~~Hospice is accountable for its care and services in all settings according to the ~~h~~Hospice plan of care.¶
(18) "Hospice ~~r~~Routine ~~h~~Home ~~c~~Care~~: F~~" means formally organized services designed to provide and coordinate ~~h~~Hospice interdisciplinary team services to ~~client~~Member/family in the place of residence. The ~~h~~Hospice will deliver at least 80 percent of the care in the place of residence.¶
(19) "Hospice ~~p~~Philosophy~~: Hospice~~" means the philosophy that recognizes dying as part of the normal process of living and focuses on maintaining the quality of life. Hospice exists in the hope and belief that through appropriate care and the promotion of a caring community sensitive to their needs, ~~client~~Members and their families may be free to attain a degree of mental and spiritual preparation for death that is satisfactory to them.¶

(20) "Hospice Program~~: A~~" means a coordinated program of home and inpatient care, available 24 hours a day, that uses an interdisciplinary team of personnel trained to provide palliative and supportive services to a ~~client-f~~Member-Family unit experiencing a life threatening disease with a limited prognosis. A ~~h~~Hospice ~~p~~Program is an institution for purposes of ORS.¶
(21) "Hospice Program ~~r~~Registry~~: A~~" means a registry of all licensed ~~h~~Hospice ~~p~~Programs maintained by the Authority, Public Health Division.¶
(22) "Hospice ~~s~~Services~~: I~~" means items and services provided to a ~~client/f~~Member-Family ~~u~~Unit by a ~~h~~Hospice ~~p~~Program or by other ~~client~~Members or community agencies under a consulting or contractual arrangement with a ~~h~~Hospice ~~p~~Program. Hospice ~~s~~Services include home care, inpatient care for ~~a~~Acute pain and symptom management or respite, and bereavement services provided to meet the physical, psychosocial, emotional, spiritual and other special needs of the ~~client/f~~Member-Family ~~u~~Unit during the final stages of illness, dying and the bereavement period.¶
(23) "Illness~~: T~~" means the condition of being sick, diseased or with injury.¶
(24) "Interdisciplinary team~~: A~~" means a group of individuals working together in a coordinated manner to provide ~~h~~Hospice care. An interdisciplinary team includes, but is not limited to, the ~~client-f~~Member-Family ~~u~~Unit, the ~~client~~Member's attending ~~p~~Physician or clinician and one or more of the following ~~h~~Hospice ~~p~~Program personnel: Physician, ~~n~~Nurse ~~p~~Practitioner, nurse, hospice aide (nurse's aide), ~~o~~Occupational ~~t~~Therapist, ~~p~~Physical ~~t~~Therapist, trained lay volunteer, clergy or spiritual counselor, and credentialed mental health professional such as psychiatrist, psychologist, psychiatric nurse or social worker.¶
(25) "Medical ~~d~~Director~~: T~~" means the medical director must be a ~~h~~Hospice employee who is a doctor of medicine or osteopathy who assumes overall responsibility for the medical component of the ~~h~~Hospice's ~~client~~Member care program.¶
(26) "Medicare ~~c~~Certification~~: L~~" means licensed and certified by the Authority, Public Health Division as a program of services eligible for reimbursement.¶
(27) "Nursing ~~f~~Facility~~: A~~" means a facility licensed and certified by the Oregon Department of Human Services (Department) as a ~~n~~Nursing ~~f~~Facility and defined in OAR 411-070.¶
(28) "Nursing ~~f~~Facility ~~s~~Services~~: T~~" means the bundled rate of services which incorporates all services, including room and board, for which the ~~n~~Nursing ~~f~~Facility is paid per OAR 411-070.¶
(29) "Pain and Symptom Management~~: F~~" for the ~~h~~Hospice ~~p~~Program means, the focus of intervention is to maximize the quality of the remaining life through the provision of palliative services that control pain and symptoms. Hospice ~~p~~Programs recognize that when a ~~client/family~~Member-Family Unit is faced with terminal illness, stress and concerns may arise in many aspects of their lives. Symptom management includes assessing and responding to the physical, emotional, social and spiritual needs of the ~~client/family~~Member-Family Unit.¶
(30) "Palliative ~~s~~Services~~: C~~" means comfort services of intervention that focus primarily on reduction or abatement of the physical, psychosocial and spiritual symptoms of terminal illness. Palliative therapy:¶
(a) Active: Is treatment to prolong survival, arrest the growth or progression of disease. The person is willing to accept moderate side-effects and psychologically is fighting the disease. This person is not likely to be a ~~client~~Member for ~~h~~Hospice;¶
(b) Symptomatic: Is treatment for comfort, symptom control of the disease and improves the quality of life. The person is willing to accept minor side-effects and psychologically wants to live with the disease in comfort. This person would have requested and been admitted to a ~~h~~Hospice.¶
(31) "Period of ~~c~~Crisis~~: A~~" means a period in which the ~~client~~Member requires continuous care to achieve palliation or management of ~~a~~Acute medical symptoms.¶
(32) "Physician ~~d~~Designee~~: M~~" means a doctor of medicine or osteopathy designated by the ~~h~~Hospice who assumes the same responsibilities and obligations as the ~~m~~Medical ~~d~~Director when the ~~m~~Medical ~~d~~Director is not available.¶
(33) "Primary ~~c~~Caregiver~~: T~~" means the person designated by the ~~client~~Member or ~~r~~Representative. This person may be family, a client who has personal significance to the ~~client~~Member but no blood or legal relationship (e.g., significant other), such as a neighbor, friend or other person. The ~~p~~Primary ~~c~~Caregiver assumes responsibility for care of the ~~client~~Member as needed. If the ~~client~~Member has no designated ~~p~~Primary ~~c~~Caregiver the ~~h~~Hospice may, according to ~~client~~Member program policy, make an effort to designate a ~~p~~Primary ~~c~~Caregiver.¶
(34) "Prognosis~~: T~~" means the amount of time set for the prediction of a probable outcome of a disease.¶
(35) "Representative~~: A~~" means an individual who has been authorized under state law to terminate medical care or to elect or revoke the election of ~~h~~Hospice care on behalf of a terminally ill ~~client~~Member who is mentally or physically incapacitated.¶
(36) "Terminal ~~i~~Illness~~: A~~" means an illness or injury which is forecast to result in the death of the ~~client~~Member, for which treatment directed toward cure is no longer believed appropriate or effective.¶
(37) "Terminally Ill" means that the ~~client~~Member has a medical prognosis that ~~his or he~~their life expectancy is six months or less if the illness runs its normal course.¶

(38) "Volunteer~~: A~~" means an individual who agrees to provide services to a ~~h~~Hospice ~~p~~Program without monetary compensation.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.065

AMEND: 410-142-0040

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

410-142-0040
Eligibility for the Hospice Services ¶

(1) Hospice ~~s~~Services are covered for ~~client~~Members who have:¶
(a) Been certified as ~~t~~Terminally ~~i~~Ill in accordance with OAR 410-142-0060; and¶
(b) Have Oregon Health Plan (OHP) Plus ~~b~~Benefit ~~p~~Package coverage.¶
(2) Providers must bill Medicare for ~~h~~Hospice ~~s~~Services for ~~client~~Members with Medicare Part A coverage. Medicare's payment is considered payment in full.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.065

AMEND: 410-142-0060

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

410-142-0060
Certification of Terminal Illness ¶

(1) In order to receive reimbursement from the Division ~~of Medical Assistance Programs (Division)~~, the ~~h~~Hospice must obtain and retain a ~~p~~Physician's written certification of a ~~client~~Member's ~~t~~Terminal ~~i~~Illness in accordance with the following procedures. The Division ~~will~~must not pay for services provided prior to certification.¶
(2) The attending ~~p~~Physician is a doctor of medicine or osteopathy or a ~~n~~Nurse ~~p~~Practitioner and is identified by the ~~client~~Member at the time the ~~or she~~y elect~~s~~ to receive ~~h~~Hospice care, as having the most significant role in the determination and delivery of the ~~client~~Member's medical care. A ~~n~~Nurse ~~p~~Practitioner serving as the attending ~~p~~Physician may not certify or re-certify the ~~t~~Terminal ~~i~~Illness.¶
(3) Certifications may be completed up to two weeks before ~~h~~Hospice care is elected.¶
(4) The certification of a ~~client~~Member who elects ~~h~~Hospice is based on the ~~p~~Physician's or medical director's clinical judgment regarding the normal course of the ~~client~~Member's illness and must include:¶
(a) The statement that the ~~client~~Member's medical ~~p~~Prognosis indicates a life expectancy of six months or less if the ~~t~~Terminal ~~i~~Illness runs its normal course; and¶
(b) Clinical information and other documentation which support the medical ~~p~~Prognosis must accompany the certification and be filed in the medical record with the certification.¶
(5) A written certification signed by the ~~p~~Physician(s) must be on file in the ~~h~~Hospice ~~client~~Member's record prior to submission of a claim to Division for all benefit periods.¶
(6) For the initial period of ~~h~~Hospice coverage, the ~~h~~Hospice must obtain, no later than two calendar days after ~~h~~Hospice care is initiated (that is, by the end of the third day), oral or written certification of the ~~t~~Terminal ~~i~~Illness by the medical director of the ~~h~~Hospice or the ~~p~~Physician member of the ~~h~~Hospice ~~i~~Interdisciplinary ~~group~~Team and the ~~client~~Member's attending ~~p~~Physician (if the ~~client~~Member has an attending ~~p~~Physician). If the written certification is not dated, a notarized statement or some other acceptable documentation may be obtained to verify the actual certification date.¶
(7) For any subsequent periods, the ~~h~~Hospice must obtain, no later than two calendar days after the first date of each period, a written certification from the ~~m~~Medical ~~d~~Director of the ~~h~~Hospice or the ~~p~~Physician member of the ~~h~~Hospice's ~~i~~Interdisciplinary ~~group~~Team. If the ~~h~~Hospice cannot obtain written certification within two calendar days, it must obtain oral certification within two calendar days.¶
(8) The requirements specified in this rule also apply to ~~client~~Members who had been previously discharged during a benefit period and are again being certified for ~~h~~Hospice care.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.065

AMEND: 410-142-0225

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

410-142-0225
Signature Requirements ¶

(1) The Division ~~of Medical Assistance Programs (Division)~~ requires ~~p~~Practitioners to sign for services they order. This signature shall be handwritten or electronic, (or facsimiles of original written or electronic signatures for ~~t~~Terminal ~~i~~Illness for ~~h~~Hospice) and it must be in the ~~client~~Member's medical record.¶
(2) The ordering ~~p~~Practitioner is responsible for the authenticity of the signature.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.065

AMEND: 410-142-0280

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

410-142-0280
~~Recipient~~Member Benefits ¶

An individual who has elected to receive ~~h~~Hospice care remains entitled to receive other services not included in the ~~h~~Hospice benefit. These services are subject to the same rules as for non-hospice ~~client~~Members. Typical services used that are not covered by the ~~h~~Hospice benefit include:¶
(1) Attending ~~p~~Physician care (e.g. office visits, hospital visits, etc.);¶
(2) Medical ~~t~~Transportation;¶
(3) Any services, drugs or supplies for a condition other than the ~~recipient~~Member's ~~t~~Terminal ~~i~~Illness or a related condition (e.g. broken leg, pre-existing diabetes).
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.065

AMEND: 410-142-0290

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

410-142-0290
Hospice Services in a Nursing Facility ¶

(1) Pursuant to Title XIX, Section 1902 and 1905, federal statute prohibits the state from paying ~~n~~Nursing ~~f~~Facility (NF) ~~p~~Providers directly for NF services when their Medicaid residents elect ~~h~~Hospice care. In these instances, the Centers for Medicare and Medicaid Services (CMS) require the state to pay the ~~h~~Hospice ~~p~~Provider the additional amount equal to at least 95~~%~~ percent of the per diem rate the state would have paid to the NF for NF services for that ~~client~~Member in that facility.¶
(2) When a ~~client~~Member resides in a NF and elects ~~h~~Hospice care, the ~~h~~Hospice ~~p~~Provider and the NF must have a written contract which addresses the provision of ~~h~~Hospice care and the method upon which the ~~h~~Hospice will pay the NF. The ~~h~~Hospice and the NF must maintain a copy of the completed and signed contract on file and it must be available upon request.¶
(3) Reimbursement when a ~~client~~Member resides in a NF and elects ~~h~~Hospice care:¶
(a) In accordance with CMS 4308.2, "when hospice care is furnished to an individual residing in a NF, the state will pay hospice an additional amount on routine home care or continuous home care days to take into account the room and board furnished by the NF. In this context, the term room and board' includes performance of personal care services, including assistance in the activities of daily living, in socializing activities, administration of medication, maintaining the cleanliness of a residents' room, and supervision and assisting in the use of durable medical equipment and prescribed therapies," as well as any other services considered under the bundled rate for which the NF is paid pursuant to OAR 411-070.¶
(b) The ~~h~~Hospice shall bill the Division ~~of Medical Assistance Programs (Division)~~ directly for the ~~h~~Hospice care provided (under routine home care, Revenue code 651, or continuous home care, Revenue code 652) and for the cost of NF services at their usual and customary rate for NF services delivered in that NF for that ~~client~~Member;¶
(c) The Division shall pay the ~~h~~Hospice ~~p~~Provider for the ~~h~~Hospice care provided and not to exceed 100~~%~~ percent of the current NF basic, complex medical, pediatric, or special contract rate according to the rate schedule for NF services delivered in that NF for that ~~client~~Member;¶
(d) The ~~h~~Hospice ~~p~~Provider must reimburse the ~~n~~Nursing ~~f~~Facility according to their contract and after the ~~h~~Hospice receives payment from the Division for that NF for that ~~client~~Member; and¶
(e) Reimbursement for services provided under this rule is available only if the recipient of the services is Medicaid-eligible, ~~h~~Hospice-eligible, and been found to need NF care through the ~~P~~pre-~~A~~admission ~~S~~screening process under OAR 411-070-0040.¶
(4) NF Services Overpayment: Any payment received from the Division by a NF for services delivered after a ~~client~~Member has elected ~~h~~Hospice care shall adjust their claims from the day the ~~client~~Member first elected hospice care. Failure to submit an adjustment subjects the NF to potential ~~s~~Sanctions and all means of ~~o~~Overpayment recovery authorized under OAR chapter 410, division 120.¶
(5) Coordination of Care (COC) must be provided according to CMS Conditions of Participation (CoPs), 42CFR418.112 for ~~h~~Hospice and ~~n~~Nursing ~~f~~Facilities.¶
(6) C~~oordinated Care Organization (CCO) and Prepaid Health Plan (PHP) client~~CO Members who reside in a NF and elect ~~h~~Hospice care shall remain in the CCO ~~and PHP~~ for all care other than ~~h~~Hospice ~~s~~Services in the NF. Hospice ~~s~~Services for a resident in a NF shall be excluded from CCO ~~and PHP~~ capitation and the ~~h~~Hospice must bill the Division directly for payment of ~~h~~Hospice and NF services.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.065

AMEND: 410-142-0300

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

410-142-0300
Hospice Reimbursement and Limitations ¶

(1) The Division recalculates its ~~h~~Hospice rates annually. When billing for ~~h~~Hospice ~~s~~Services, the ~~p~~Provider must bill the ~~u~~Usual ~~c~~Charge or the rate based upon the geographic location in which the care is furnished, whichever is lower. See ~~h~~Hospice rates on the Oregon Health Authority (Authority) website at: http://www.oregon.gov/OHA/HSD/OHP/Pages/Policy-Hospice.aspx.¶
(2) Rates:¶
(a) The Division bases its rates on the methodology used in setting Medicare rates, adjusted to disregard cost offsets attributable to Medicare coinsurance amounts;¶
(b) Under the Medicaid ~~h~~Hospice benefit regulations, the Division cannot impose cost sharing for ~~h~~Hospice ~~s~~Services rendered to Medicaid ~~recipient~~Members;¶
(c) The Division sets rates no lower than the rates used under Part A of Title XVIII of the Social Security Act (Medicare);¶
(d) The Division uses prospective ~~h~~Hospice rates;¶
(e) The Division makes no retroactive adjustments other than the optional application of the cap on overall payments and the limitation on payments for inpatient care, if applicable.¶
(3) With the exception of payment for ~~p~~Physician services, the Division reimburses ~~p~~Providers of ~~h~~Hospice ~~s~~Services for each day of care at one of five predetermined rates. Rates are based on intensity and type of care, which the Division defines as:¶
(a) Routine home care. The Division pays the ~~h~~Hospice the routine home care rate for each day that the ~~client~~Member is under the care of the ~~h~~Hospice and that the Division does not reimburse at another rate. The Division pays this rate without regard to the volume or intensity of services provided on any given day;¶
(b) Continuous home care. The Hospice must provide a minimum of eight hours of continuous home care per day to receive the continuous home care rate:¶
(A) The continuous home care rate is divided by 24 hours in order to arrive at an hourly rate;¶
(B) The Division pays the ~~h~~Hospice for every hour or part of an hour of continuous care furnished up to a maximum of 24 hours a day.¶
(c) Inpatient respite care. The Division pays the ~~h~~Hospice at the ~~i~~inpatient ~~R~~respite ~~C~~care rate for each day on which the ~~client~~Member is in an approved inpatient facility and is receiving respite care:¶
(A) The Division pays for inpatient respite care for a maximum of five days at a time, including the date of admission but not counting the date of discharge;¶
(B) The Division pays for the sixth and any subsequent days at the routine home care rate.¶
(d) General inpatient care. The Division pays ~~p~~Providers at the general inpatient rate when general inpatient care is provided;¶
(e) In-home respite care. An in-home respite care day is a day on which short-term in-home care is provided to the ~~client~~Member only when necessary to relieve the family members or other persons caring for the ~~client~~Member at home. Respite care may be provided only on an occasional basis and may not be reimbursed for more than five consecutive days at a time. In-home respite care will be provided at the level necessary to meet the ~~client~~Member's need, with a minimum of eight hours of care provided in a 24-hour day, which begins and ends at midnight. Hospice aide/CNA or homemaker services or both may be utilized for providing in-home respite care.¶
(4) On the day of discharge from an inpatient unit, the Division pays the appropriate home care rate unless the ~~client~~Member dies as an inpatient. When the ~~client~~Member is discharged deceased, the Division pays the appropriate inpatient rate (general or respite) for the discharge date.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.065

AMEND: 410-142-0380

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

410-142-0380
Death With Dignity ¶

(1) Death with dignity services are defined in the Division ~~of Medical Assistance Programs (Division)~~ Medical-Surgical Services and Pharmaceutical Services program rules.¶
(2) All death with dignity services must be billed directly to Division, even if the ~~client~~Member is in a ~~p~~Prepaid ~~h~~Health ~~p~~Plan (PHP).¶
(3) Death with dignity services are not included in the ~~h~~Hospice care per diem payment.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.065