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

CHAPTER 411
DIVISION 70

NURSING FACILITIES/MEDICAID - GENERALLY

411-070-0000 Purpose
(Effective 10/4/1990)

The purpose of these rules is to control payment for Nursing Facility services provided to Medicaid clients.

Stat. Auth.: ORS 410.070 & 414.065
Stats. Implemented: ORS 410.070 & 414.065

411-070-0005 Definitions
(Effective 3/1/2008)

As used in OAR chapter 411, division 070, the definitions in OAR 411-085-0005 and the following definitions apply:

(1) "Accrual Method of Accounting" means a method of accounting in which 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/behavior.

(4) "Alternative Services" means individuals or organizations offering services to persons living in a community other than a nursing facility or hospital.

(5) “AMHD” means the Department of Human Services, Addictions and Mental Health Division

(6) "Area Agency on Aging (AAA)" means an established public agency designated under the Older Americans Act, 42 USC 3025, and which has a responsibility for local administration of senior and disability programs as described in ORS chapter 410.

(7) "Basic Flat Rate Payment" and "Basic Rate" mean 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).

(8) "Case Manager” means a Seniors and People with Disabilities or Area Agency on Aging employee who assesses the service needs of an applicant or eligible individual, determines eligibility and offers service choices to eligible individuals. The case manager authorizes and implements the service plan and monitors the services delivered.

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

(10) "Categorical Determinations" means the provision 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 PASRR Level II evaluation if criteria of a categorical determination are met as described in OAR 411-070-0043(2)(a)-(2)(c).

(11) “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.

(12) "Certified Program" means a hospital, private agency or an Area Agency on Aging certified by the Department to conduct Private Admission Assessments in accordance with ORS 410.505 through 410.530.

(13) "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 but are not limited to 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.

(14) "Client" means a resident for whom payment is made under the Medicaid Program.

(15) "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. They include but are not necessarily limited to the following:

(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.

(16) "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.

(17) "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.

(18) "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. They include, for example, costs 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.

(19) "Costs Related to Resident Services" means 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.

(20) "CPI" means the Consumer Price Index for all items and all urban consumers.

(21) "Department" or “DHS” means the Department of Human Services.

(22) "Developmental Disabilities" means a disability that originates in childhood that is likely to continue and significantly impacts adaptive behavior. 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 attains the age of 22 years, except that in the case of mental retardation, the condition must be manifested before the age of 18; and

(b) Originates in the brain and has continued, or can be expected to continue, indefinitely; and

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

(d) The condition or impairment must not be primarily attributed to mental illness, substance abuse, an emotional disorder, Attention Deficit Hyperactivity Disorder, a learning disability, personality disorder or sensory impairment.

(23) "Direct Costs" means costs incurred to provide services required to directly meet all the resident nursing and activity of daily living service needs. These costs are further defined in these rules. 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.

(24) "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.”

(25) "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).

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

(27) "Facility Financial Statement" 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 for reimbursement.

(28) "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.

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

(30) "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.

(31) "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. It does not include "start-up costs" as defined in this rule.

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

(33) "Indirect Costs" means the costs associated with property, administration and other operating support (real property taxes, insurance, utilities, maintenance, dietary (excluding food), laundry and housekeeping). These costs are further described in OAR 411-070-0359, OAR 411-070-0428, and OAR 411-070-0465.

(34) "Interrupted-Service Facility" means an established facility recertified by the Department following decertification.

(35) "Level I" means a component of the Federal PASRR requirement. It 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)}.

(36) "Level II" means a component of the Federal PASRR requirement. It 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}.

(37) "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.

(38) "Medical Add-On" or "Complex Medical Add-On Payment" has the meaning provided in section (16) of this rule.

(39) "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.

(40) "Mental Retardation" means significantly sub-average general intellectual function defined as IQ's under 70 existing concurrently with significant impairments 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. The adaptive behavior must be primarily 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. Levels of Mental Retardation are:

(a) Mild Mental Retardation is used to describe the degree of retardation when intelligence test scores are 50-69. Individuals with IQ's in the 70-75 range can 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 35-49.

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

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

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

(42) "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)}.

(43) "New Facility" means a nursing facility commencing to provide services to Seniors and People with Disabilities Division recipients.

(44) "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.

(45) "Ordinary Costs" means costs incurred that are customary for the normal operation.

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

(47) "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.

(48) "Perquisites" means privileges incidental to regular wages.

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

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

(51) "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 or Developmental Disabilities.

(52) "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.

(53) "Prior-Authorization" means the local Seniors and People with Disabilities Division/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.

(54) “Private Admission Assessment (PAA)” means the assessment that is conducted for non-Medicaid individuals as established by ORS 410.505-410.545 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 PAA is the Federal PASRR Level I requirement, {42 CFR, Part 483.128(a)}, to identify individuals with Mental Illness or Developmental Disabilities.

(55) "Provider" means an organization that has entered into an agreement with the Department to provide services for individuals served by the Department.

(56) "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.

(57) "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 five 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.

(58) "Resident" or "Individual" means those for whom payment is made under the Medicaid program.

(59) "Resident Review" means a review conducted by the Addictions and Mental Health Division for individuals with Mental Illness or by the Seniors 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}.

(60) "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.

(61) “SPD” means the Department of Human Services, Seniors and People with Disabilities Division.

(62) "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.

(63) "Specialized Services for Mental Retardation/Developmental Disabilities" means:

(a) For individuals with Mental Retardation/Developmental Disabilities under age 21, specialized services are equal to school services; and

(b) For individuals with Mental Retardation/Developmental Disabilities over age 21, specialized services means:

(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; and

(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.

(64) "Start-Up Costs" means one-time costs incurred prior to the first resident being admitted. Start-up costs include administrative and nursing salaries, utility costs, taxes, insurance, mortgage and other interest, repairs and maintenance, training costs, etc. They 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.

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

(66) "Title XVIII" and "Medicare" mean Title XVIII of the Social Security Act.

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

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

Stat. Auth.: ORS 410.070
Stats. Implemented: ORS 410.070 & 414.065

411-070-0010 Conditions for Payment
(Effective 2/1/2006)

Nursing Facilities must meet the following conditions in order to receive payment under Title XIX (Medicaid):

(1) Certification:

(a) Compliance with Federal Regulations. The facility must be in compliance with Title XIX Federal certification requirements;

(b) All Beds Certified. Except as provided in subsection (1)(c) of this rule, all beds in the nursing facility must be certified as nursing facility beds;

(c) Gradual Withdrawal. A facility choosing to discontinue compliance with subsection (1)(b) of this rule, may elect to gradually withdraw from Medicaid certification, but must comply with all of the following:

(A) Notify the Department in writing within 30 days of the certification survey that it elects to gradually withdraw from the Medicaid Program;

(B) Request Medicaid reimbursement for any resident who resided in the facility, or who was eligible for right of return or right of readmission under OAR 411-088-0050 or 411-088-0060, on the date of the notice required by subsection (1)(c) of this rule. If it appears the resident may be eligible within 90 days, such request may be initiated;

(C) Retain certification for any bed occupied by or held for any resident who is found eligible for Medicaid, until the bed is vacated by:

(i) The death of the resident; or

(ii) The transfer or discharge of the resident, pursuant to the Transfer Rules (OAR chapter 411, division 088).

(D) All Medicaid recipients exercising rights of return or readmission under the transfer rules must be permitted to occupy a Medicaid certified bed; and

(E) Notify in writing all persons applying for admission subsequent to notification of gradual withdrawal that, should the person later become eligible for Medicaid assistance, that reimbursement would not be available in that facility.

(2) Civil Rights, Medicaid Discrimination:

(a) The facility must meet the requirements of Title VI of the Civil Rights Act of 1964 and Section 504 of the Rehabilitation Act of 1973;

(b) The facility must not discriminate based on source of payment. The facility must not have different standards of transfer or discharge for Medicaid residents except as required to comply with this rule;

(c) The facility must accept Medicaid payment as payment in full. The facility must not require, solicit or accept payment, the promise of payment, a period of residence as a private pay resident, or any other consideration as a condition of admission, continued stay, or provision of care or service from the resident, relatives, or any one designated as a "responsible party";

(d) No applicant may be denied admission to a facility solely because no family member, relative or friend is willing to accept personal financial liability for any of the facility's charges;

(e) The facility may not request or require a resident, relative or "responsible party" to waive or forego any rights or remedies provided under state or federal law, rule or regulation.

(3) Provider Agreement, Facility Payment:

(a) The facility must sign a formal provider agreement with the Department;

(b) The facility must file a Facility Financial Statement with the Department within 90 days after the end of its fiscal year;

(c) The facility must bill the Department in accordance with established rules and guidelines.

Stat. Auth.: ORS 410.070 & 414.065
Stats. Implemented: ORS 410.070 & 414.065

411-070-0015 Denial, Termination or Non-Renewal of Provider Agreement
(Effective 2/1/2006)

(1) Failure to Comply. The Department reserves the right to deny, terminate or not renew contracts with providers who fail to comply with OAR 411-070-0000 through 411-070-0470 relating to nursing facility services.

(2) Notice. The Department will give the provider 30 day's written notice, by Certified Mail, before the effective date of the denial, termination or non-renewal. The notice will include the basis of the Department decision, advise the provider of the right to an informal conference to give the opportunity to refute the Department findings in writing.

(3) Information Conference:

> (a) A request for an informal conference must be received by the Department prior to the effective date of the denial, termination or non-renewal;
>
> (b) A written notice of the Department's decision reached in an informal conference will be sent to the provider by Certified Mail. This notice will also advise the provider of his or her right to a hearing, if requested within 30 days of mailing the notice.

(4) Hearing. When a hearing is requested, it will be conducted in accordance with OAR chapter 461, division 025.

Stat. Auth.: ORS 410.070 & 414.065
Stats. Implemented: ORS 410.070 & 414.065

411-070-0020 On-Site Reviews
(Effective 2/1/2006)

The facility must allow periodic on-site reviews of Medicaid residents as required by federal regulations.

Stat. Auth.: ORS 410.070 & 414.065
Stats. Implemented: ORS 410.070 & 414.065

411-070-0025 Basic Flat Rate Payment (Basic Rate)
(Effective 2/1/2006)

(1) PAYMENT. The Department may authorize payment at the basic rate if a Medicaid client requires daily, intermittent licensed nurse observation and continuous nursing care and has a physician's order for nursing facility care. When determining the payment rate, the Department will consider the stability of the medical condition, the health care needs of the client, and the client's ability to maintain themselves in a less restrictive setting. A client who qualifies for reimbursement at the basic rate will:

(a) Have chronic medical problems that are stabilized but not cured and have a need for supervision in a structured environment to maintain or restore stability and prevent deterioration; or

(b) Require assistance for a combination of health care needs either because of a physical or psycho-social disabling condition; or

(c) Have insufficient personal and community resources available to provide for either subsection (1)(a) or (b) of this rule.

(2) DOCUMENTATION. The professional nursing staff of the nursing facility must keep sufficient documentation in the resident's clinic record to justify the basic rate payment determination in accordance with these rules and must make it available to the Department upon request.

Stat. Auth.: ORS 410.070
Stats. Implemented: ORS 410.070 & 414.065

411-070-0027 Complex Medical Add-On Payment Authorization
(Effective 3/1/2008)

(1) PAYMENT. SPD may authorize payment for a 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 medical add-on criteria listed in OAR 411-070-0091, the medical add-on may be effective from the date the resident’s condition or

service needs meets the medical add-on criteria to the last date the resident's condition or service needs continues to meet the 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 add-on, using SPD's Complex Medical Add-On Procedure Code(s), to provide justification that the residents' service needs meet add-on criteria.

(b) Continued Payment -- SPD may continue to pay the 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 procedure code(s) in the resident's clinical record to justify the medical add-on payment determination in accordance with these rules (refer to OAR 411-070-0091) and must make it available to SPD upon request.

(4) MEDICAL ADD-ONS PROHIBITED. SPD will not provide 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 & 414.065

411-070-0029 Pediatric Rate
(Effective 2/1/2006)

(1) This rate will be for those facilities meeting the criteria established in OAR 411-070-0452 as Pediatric Nursing Facilities or as self-contained pediatric units.

(2) The pediatric rate will constitute the total rate payable by the Department on behalf of its client.

Stat. Auth.: ORS 410.070
Stats. Implemented: ORS 410.070 & 414.065

411-070-0033 Post Hospital Extended Care Benefit
(Effective 4/19/2005)

(1) The Post Hospital Extended Care Benefit (OAR 410-120-1210(3)(a)(G)) is an Oregon Health Plan benefit that consists of a stay of up to twenty days in a nursing facility to allow discharge from hospitals.

(2) This benefit must be prior authorized by Pre-Admission Screening for clients not enrolled in managed care.

(3) To be eligible for the Post Hospital Extended Care Benefit, the client must meet all of the following:

(a) Be receiving Oregon Health Plan Plus or Standard, Fee-for-Service benefits;

(b) Not be Medicare eligible;

(c) Have a medically-necessary, qualifying hospital stay consisting of:

(A) A DMAP-paid admission to an acute-care hospital bed, not including a hold bed, observation bed or emergency room bed;

(B) The stay must consist of three or more consecutive days, not counting the day of discharge.

(d) Transfer to a nursing facility within 30 days of discharge from the hospital;

(e) Needs skilled nursing or rehabilitation services for hospitalized condition, meeting Medicare skilled criteria;

(f) These skilled services are needed on a daily basis;

(g) The daily services can be provided only in a nursing facility, meaning:

(A) The client would be at risk of further injury from falls, dehydration or nutrition because of insufficient supervision or assistance at home; or

(B) The client's condition would require daily transportation to hospital or rehabilitation facility by ambulance; or

(C) It is too far to travel to provide daily nursing or rehabilitation services in the client's home.

(4) The client may qualify for another twenty day Post-Hospital Extended Care Benefit only if the client has been out of a hospital and has not received skilled nursing care for 60 consecutive days in a row and meets all the criteria in OAR 411-070-0032(3).

(5) Clients eligible for the twenty day Post-Hospital Extended Care Benefit are not eligible for long term care nursing facility or Home and Community Based waiver services unless the client meets the eligibility criteria in OAR 411-015-0100 or 411-320-0010(21, 22, or 23).

Stat. Auth.: ORS 409, 410.070 & 414.065
Stats. Implemented: 410.070 & 414.065

411-070-0035 Complex Medical Add-On Notification, Effective Dates and Administrative Review
(Effective 3/1/2008)

(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 will 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 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 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 will adjust the requested effective add-on date and pay the medical add-on from the date of notification only.

(D) For a resident whose condition or service needs meet a medical add-on procedure code(s), the medical add-on is effective only until the last date the resident's condition or need continues to meet 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 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 will adjust the requested effective add-on date and pay the medical add-on from the date of notification only.

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

(3) ADMINISTRATIVE REVIEW. If a provider disagrees with the decision of SPD's Complex Medical Add-On Coordinator to make or deny an adjustment in the medical add-on payment for a Medicaid resident, the provider may request from SPD 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 SPD, to substantiate its position. SPD will notify the provider in writing of its informal decision within 45 days of SPD's receipt of the provider's request for review. SPD's informal decision will be an order in other than a contested case and subject to review pursuant to ORS 183.484.

(4) OVERPAYMENT FOR MEDICAL ADD-ONS. SPD will collect monies that were overpaid to a facility for any period SPD determines the resident's condition or service needs did not meet the criteria for the medical add-on, or determines the facility did not maintain the required documentation.

Stat. Auth.: ORS 414.070
Stats. Implemented: ORS 410.070 & 414.065

411-070-0040 Client Screening, Assessment and Review
(Effective 9/1/2007)

(1) INTRODUCTION. All individuals who are candidates for admission to a Medicaid-certified nursing facility must be assessed to evaluate their service needs, preferences and must receive information about community based, alternative services and resources that can meet the individual's service needs and are safe, least restrictive and potentially less costly than comparable nursing facility services.

(2) PRE-ADMISSION SCREENING. A Pre-Admission Screening (PAS) as described in OAR 411-070-0005 is required for potentially Medicaid eligible individuals who are at risk for nursing facility services.

(a) PAS includes:

(A) An assessment;

(B) The determination of an individual's service eligibility for Medicaid-paid long term care or post-hospital extended care services in a nursing facility;

(C) The identification of individuals who can transition to community based service settings;

(D) The provision of information about community based services and resources to meet the individual's needs; and

(E) Transition planning assistance as needed.

(b) PAS is conducted in conjunction with the individual and any representative designated by the individual.

(c) The PAS assessment will be conducted by a case manager or other qualified SPD or AAA representative using SPD's Client Assessment and Planning System (CA/PS) tool, and other standardized assessment tools and forms approved by SPD.

(d) A PAS may be completed based on information obtained by phone or fax only to authorize Title XIX post-hospital benefits in a nursing facility when short-term nursing facility services are needed. A face-to-face assessment including the discussion of alternative community based services and resources shall be completed within seven days of the initial, short term nursing facility service approval.

(e) Payment for nursing facility services will not be authorized by SPD until PAS has established that nursing facility services are required based on the individual's service needs and Medicaid financial eligibility has been established.

(3) PRIVATE ADMISSION ASSESSMENT. A Private Admission Assessment (PAA) is required for individuals with private funding who are referred to Medicaid-certified nursing facilities established by ORS 410.505 through ORS 410.545 and OAR chapter 411, division 071.

(4) PRE-ADMISSION SCREENING AND RESIDENT REVIEW. A Pre-Admission Screening and Resident Review (PASRR) as described in OAR 411-070-0043 is required for individuals regardless of payment source, with

either Mental Illness or Developmental Disabilities who need nursing facility services.

(5) CLIENT REVIEW. Title XIX regulations require utilization review and quality assurance reviews of Medicaid residents in nursing facilities. The reviews carried out by the authorized utilization review organization must meet these requirements:

(a) Staff associated with SPD are required to maintain service plans on all SPD clients in nursing facilities. The frequency of their service plan update will vary depending on such factors as the resident's potential for transition to home or community based care and federal or state requirements for Resident Review;

(b) Authorized representatives of SPD or the authorized utilization review organization must have immediate access to SPD residents and to facility records. "Access" to facility records means the right to personally read charts and records to document continuing eligibility for payment, quality of care or alleged abuse. The SPD or the authorized utilization review organization representative must be able to make and remove copies of charts and records from the facility's property as required to carry out the above responsibilities;

(c) SPD or the authorized utilization review organization representatives must have the right to privately interview any SPD residents and any facility staff in carrying out the above responsibilities; and

(d) SPD or the authorized utilization review organization representatives must have the right to participate in facility staffings on SPD residents.

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

411-070-0043 Pre-Admission Screening and Resident Review (PASRR)
(Effective 9/1/2007)

(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 Retardation 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 sections (2)(a) through (2)(c) 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 patient; 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. This 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 or Developmental Disabilities that may require further evaluation {42 CFR 483.128} or if categorical determinations, as described in sections (2)(a) through (2)(c) 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 the Department.

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

(C) If there are no indicators of Mental Illness or Mental Retardation 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) Mental Illness Indicators. 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 the Addictions and Mental Health Division (AMHD) and request a PASRR Level II evaluation.

(E) Mental Retardation or Developmental Disabilities Indicators. If PASRR Level I screening determines that an individual has indicators of Mental Retardation 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) PASRR Level I Screening Form Requirement. 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 client 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 individual's clinical record and must accompany the individual if he or she transfers to another nursing facility.

(b) PASRR LEVEL II. This 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 Retardation or Developmental Disabilities who does not meet categorical determination criteria {42 CFR 483.128}.

(A) PASRR Level II Referral. Individual’s identified with indicators or Mental Illness or Mental Retardation 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. PASRR Level II evaluations and determinations are conducted by AMHD for individuals with Mental Illness or by SPD for individuals with Mental Retardation or Developmental Disabilities.

(C) PASRR Level II Determination. PASRR Level II evaluation will 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 will 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 Retardation 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) Mental Illness. 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 will 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 Form specified by the AMHD, in accordance with OAR 411-086-0060.

(B) Mental Retardation or Developmental Disabilities. All individuals identified as having Mental Retardation 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 the Department.

(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 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 or Developmental Disabilities over age 21 are not provided in nursing facilities. Individuals with Mental Retardation 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 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 or Developmental Disabilities, a nursing facility admission for respite care must be authorized by SPD Central Office; and

(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; and

(c) Nursing facility level of service must be required to meet a severe medical condition that excludes care needs due to Mental Illness, Mental Retardation 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, 410.535 & 414.065
Stats. Implemented: ORS 410.070, 410.535 & 414.065

411-070-0045 Facility Payments
(Effective 3/1/2008)

(1) PRIOR AUTHORIZATION. The Department may reimburse a nursing facility for services provided to a Department resident only if prior authorized after the Department has participated in development of the placement plan and is satisfied that the placement is justified and most suitable for the person according to the Department care plan. The Department may not reimburse a nursing facility for services rendered prior to the date of referral to the Department. A nursing facility must verify that the local SPD/Type B AAA where the facility is located is involved in the placement.

(2) The facility must confirm an individual's financial eligibility for Medicaid payment of any nursing facility service with the local office. Medicaid eligibility is based on the requirements outlined in OAR chapter 461. The facility is responsible for collecting resident liability from the resident or their responsible party.

(3) PAYMENT TO PROVIDER. Provider payments will be made following the month of service. For billing, the Department will mail Form SDS 483, Invoice and Payment Authorization, to each facility.

(4) RESIDENT'S INCOME. A resident's income, exclusive of the authorized allowance for personal incidental needs and other prior authorized special needs, will be offset as a credit against the established Department rate paid to that facility.

(5) REDUCED PAYMENT FOR ABUSE.

> (a) If abuse of a resident, according to the provisions of ORS 441.630 to ORS 441.685, is substantiated by the Department, the Department may reduce the payment for the resident(s) for the month the abuse occurred, and until such time as the Department determines the conditions leading to the abuse have been corrected.

(A) The facility will receive payment for services provided for the resident as determined by the Department. This determination will be based on the absence of appropriate services that resulted in the substantiated abuse of a resident.

(B) The reduced payment may not be considered a reduction in benefits for the resident.

(b) The Department will notify the facility by certified mail at least 15 days prior to taking action to reduce payment.

(A) The notice will include the basis of the Department decision, the effective date of the reduced payment, the amount of the reduced payment, and will advise the facility of their right to request review by the Assistant Director if such request is made in writing within 30 days of the receipt of the notice.

(B) If a request for review is made, the Assistant Director will include the basis of the Department decision, the effective date of the reduced review and all material relating to the allegation of resident abuse and to the reduction in payment. The Assistant Director will include the basis of the Department decision, the effective date of the reduced determination, based upon review of the material, whether or not to sustain the decision to reduce payments to the facility and will notify the facility of the decision within 20 days of receiving the request for review.

(C) If the Assistant Director determines not to sustain the decision to reduce payments, the reduction will be lifted immediately. Otherwise, the reduction in payment will remain in effect until the Department determines the conditions leading to the abuse have been corrected.

(D) If the decision to reduce payment is sustained, the payment reduction will not be recovered in the year end settlement.

Stat. Auth.: ORS 410.070 & 414.065
Stats. Implemented: ORS 410.070 & 414.065

411-070-0050 Days Chargeable

(Effective 2/1/2006)

The Department will pay for the day of admission but not for the day of discharge, transfer, or death except as provided for in OAR 411-070-0110. When the day of admission is the same as the day of discharge, the Department will only pay for one day.

Stat. Auth.: ORS 410.070 & 414.065
Stats. Implemented: ORS 410.070 & 414.065

411-070-0075 Rates -- Facilities in Oregon

(Effective 7/1/1997)

The daily rate of payment for Oregon facilities will be the basic rate plus the medical add-on, if determined to be appropriate, or the pediatric rate, if warranted.

Stat. Auth.: ORS 414.070
Stats. Implemented: ORS 410.070 & 414.065

411-070-0080 Out-of-State Rates

(Effective 2/1/2006)

Out-of-state facilities in areas contiguous to Oregon will be paid for Department clients who are receiving temporary care while alternative placement in Oregon is being located. Payment will be made at the facility's Medicaid rate established by the state in which the facility is located or the maximum rate paid to Oregon nursing facilities for a comparable payment level, whichever is less. The maximum rate for out-of-state purposes is Oregon's basic rate plus the medical add-on, if determined to be appropriate, or the pediatric rate, if warranted. The facility must submit a copy of the Assurance and Compliance (HHS 690), certifying its compliance with the Civil Rights Act of 1964. The facility must also submit their current approved nursing facility Medicaid rate to the Department. An Oregon resident will be returned to Oregon when proper placement can be made and it is feasible to do so.

[ED. NOTE: Forms referenced are available from the agency.]

Stat. Auth.: ORS 414.070
Stats. Implemented: ORS 410.070 & 414.065

411-070-0085 Bundled Rate
(Effective 3/1/2008)

(1) PURPOSE. The nursing facility rate established for a facility is a bundled rate and includes all services, supplies and facility equipment required for services.

(2) SERVICES AND SUPPLIES.

(a) The following services and supplies required to provide services in accordance with each resident's care plan are included in the bundled rate:

(A) All nursing services defined in OAR 411-086-0110 through OAR 411-086-0160;

(B) All support services and supplies associated with the required nursing services;

(C) All activity services, supplies and staffing as defined in OAR 411-086-0230;

(D) All social services, supplies and staffing as defined in OAR 411-086-0240;

(E) All dietary services, supplies and staffing as defined in OAR 411-086-0250;

(F) All professional consultant services;

(G) All services of the facility medical director;

(H) Management of resident funds, including purchase of items;

(I) Room and board, including:

(i) Special diets and non-pumped food supplements; and

(ii) Laundry, whether performed by the facility staff or an outside provider, including laundering and marking of resident's personal clothing and bedding;

(J) Miscellaneous services and supplies, including:

(i) Items stocked by the facility in gross supply and administered individually on physician's order;

(ii) Items owned or rented by the facility that are utilized by individual residents but are reusable and are routinely expected to be available in a nursing facility;

(iii) Shaves, haircuts, supplies and shampoos as required for grooming and cleanliness, whether performed by facility staff or by an outside provider; and

(iv) Transportation provided in vehicles that are owned or leased by the facility or by any person who holds an ownership interest in the facility.

(b) Items included within the bundled rate must meet all of the following criteria:

(A) Item(s) are medically appropriate;

(B) Item(s) are most effective and least costly means to meet the individuals' needs; and

(C) Item(s) are allowed in the state plan.

(c) The Oregon Health Plan will continue to provide coverage for specified items and equipment in accordance with OAR chapter 410, division 122. No entitlement to any item is created for any resident in a nursing facility based solely on the listing of an item in OAR chapter

410, division 122, as potentially included in the nursing facility bundled rate. Oregon Health Plan limits on duration, scope and/or frequency of provision of the item(s) may not apply to the bundled rate if the facility needs to provide the item(s) in excess of the limits in order to meet resident needs. Nursing facilities are not required to purchase all specified codes, forms, sizes or varieties of the items listed in OAR chapter 410, division 122, so long as the residents' service needs are met. Nursing facilities are not required to honor individual preferences for specific types of equipment and supplies.

(d) The bundled rate pays for all equipment and supplies, unless the item(s) is specified as not paid for by the bundled rate. Equipment and supplies paid for in the bundled rate include:

(A) Oxygen and oxygen equipment, including concentrators, unless the oxygen provided exceeds 1,000 liters in a 24-hour period;

(B) Glucose monitors and diabetic equipment;

(C) Nebulizers and nebulizer supplies;

(D) Ostomy supplies;

(E) Urological supplies;

(F) Resident lifts except as specified in Appendix A to this rule;

(G) Toilet supplies, except as specified in Appendix A to this rule;

(H) Miscellaneous supplies;

(I) Surgical dressings;

(J) Incontinence supplies;

(K) All medically necessary wheelchairs and wheelchair accessories except:

(i) As specified in Appendix A to this rule; or

(ii) If at the time of admission, the individual's expected length of stay in the nursing facility is 30 days or less as confirmed on a written statement from the individual's attending physician, and the individual has a physician's order for the same wheelchair for on-going use in the individual's home and meets Department of Medical Assistance Programs (DMAP) criteria for a tilt-in-space wheelchair;

(L) Suction pumps and supplies;

(M) Tracheostomy supplies;

(N) Canes and crutches;

(O) Standing and positioning aides;

(P) Walkers;

(Q) Hospital beds, except as specified in Appendix A to this rule or if an exception need exists as determined by the DMAP prior authorization process;

(R) Pressure reducing support services, except as specified in Appendix A to this rule;

(S) Hospital bed accessories, except as specified in Appendix A to this rule;

(T) Bath supplies; and

(U) Over the counter medications as defined in Appendix B to this rule.

(e) The following services and supplies are NOT included in the bundled rate:

(A) Therapy services provided to residents by outside providers;

(B) Medical services by physicians or other practitioners other than the services required by OAR 411-086-0200;

(C) Radiology services, laboratory services and podiatry services;

(D) Transportation for residents to and from medical services in vehicles that are not owned or leased by the facility or by any person who holds an ownership interest in the facility;

(E) Biologicals (e.g., immunization vaccines);

(F) Hyperalimentation ;

(G) Prescription pharmaceuticals; or

(H) Ventilators.

Stat. Auth.: ORS 414.065 & 410.070
Stats. Implemented: ORS 410.070 & 414.065

411-070-0091 Complex Medical Add-On Services
(Effective 3/1/2008)

(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 sections (1)(a) to (2) of this rule, and the nursing facility maintains documentation per OAR 411-070-0027, SPD 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 does not include routine medications, 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/Wound.

(A) S-1 – Is limited to Stage III or IV pressure ulcers that require aggressive treatment and are expected to resolve. The facility must maintain a weekly wound assessment and a weekly nursing note. 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; and

(ii) Requires nursing or medical interventions such as extra feeding, glucagon or additional insulin, 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 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.

(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 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

411-070-0095 Resident Funds
(Effective 3/1/2008)

(1) Each Medicaid resident is allowed a monthly amount for personal incidental needs. For purposes of this rule, personal incidental funds (PIFs) include monthly payments as allowed and previously accumulated resident savings.

(2) FACILITY RESPONSIBILITY.

(a) The facility must not charge for items included in the bundled rate or for other items or services for which funding can be provided through the Medicaid agency or another non-resident source.

(b) The facility must hold, safeguard and account for a resident's funds if he or she requests such management; or if the case manager requests on Form SDS 0542 that the facility perform such management.

(c) The facility must maintain a record of the request by the resident, case manager or resident representative on Form SDS 0542, covering all funds it holds or manages for residents.

(d) The facility must manage resident funds in a manner in the resident's best interest.

(A) The facility must not charge the resident for holding, disbursing, safeguarding, accounting for, or purchasing from resident funds. Charges for these services are included in the Nursing Facility Financial Statement, Form SPD 35 or 35A and are considered allowable costs reimbursable through the bundled rate.

(B) The cost for items charged to resident funds must not be more than the actual purchase price charged by an unrelated supplier.

(C) The facility may not charge SPD residents or other sources for items or services furnished if all residents receiving such items or services are not charged. Charges must be for direct, identifiable services or supplies furnished to individual residents. A periodic "flat" charge for routine items, such as beverages, cigarettes, etc., is not allowed. Charges must be made only after services are performed or items are delivered.

(D) The facility must keep any funds received from a resident for holding, safeguarding and accounting separate from the facility's funds.

(E) The nursing facility may request technical assistance from SPD/Type B AAA staff, however, responsibility for managing resident funds in the resident's best interest remains with the facility.

(F) When a facility is a resident's representative payee, it must fulfill its duties as representative payee in accordance with applicable federal regulations and state regulations that define those duties.

(G) Facilities holding resident funds must be insured to cover all amounts held in trust.

(3) DELEGATION OF AUTHORITY.

(a) The resident may manage his or her personal financial resources, including PIFs, and may authorize another person or the facility to manage them. If appropriate, the facility must, upon written authorization by the resident, resident representative, or case manager on the resident's behalf, accept responsibility for holding, safeguarding, spending and accounting of the resident's funds.

(b) At the time of admission, the facility must assure that the resident, or representative delegating such responsibility to the facility, completes Form SDS 0542, Designation of Management of Personal Incidental Funds. The facility must sign the form acknowledging

responsibility. The facility must retain the original in the resident's account records, with copies to the resident and SPD.

(c) The resident wishing to change delegation must do so by completing a new Form SDS 0542 that must be available at the facility.

(d) SPD cannot be delegated to account for the resident's funds.

(4) RESIDENT ADMISSION.

(a) The facility must provide each resident or resident representative with a written statement at the time of admission that:

(A) States the facility's responsibility to pay for all services, supplies and facility equipment required for services (basic rate);

(B) Lists all services provided by the facility that are not included in the facility's basic rate;

(C) States that there is no obligation for the resident to deposit funds with the facility;

(D) Describes the resident's right to select how personal funds will be handled. The following alternatives must be included:

(i) The resident's right to receive, retain, and manage his or her personal funds or have this done by a legal guardian, or conservator;

(ii) The resident's right to delegate on the SDS 0542 another person to act for the purpose of managing his or her personal funds; and

(iii) The facility's obligation, upon written authorization by the resident or representative, to hold, safeguard and account for the resident's personal funds in accordance with these rules;

(E) States that any facility charge for this service is included in the facility's basic rate, and that the facility cannot charge for resident fund management or charge residents more than the actual purchase price of items at an unrelated supplier;

(F) States that the facility is permitted to accept a resident's funds to hold, safeguard and account for, only upon the written authorization of the resident or representative, or if the facility is appointed as the resident's representative payee; and

(G) States that if the resident becomes incapable of managing his or her personal funds and does not have a representative, the facility is required to manage his or her personal funds if requested on the Form SDS 0542 by the case manager.

(b) The facility must obtain documentation on the Form SDS 0542 of:

(A) Resident intention to manage own funds; or

(B) Resident, resident representative, or case manager delegation to another individual or the facility to manage the resident's funds.

(5) RESIDENT ACCOUNT RECORDS.

(a) The facility must maintain a Resident Account Record (Form SDS 713), on an ongoing, day-to-day basis, for each resident for whom the facility is holding funds. Each receipt or disbursement of funds must be posted to the resident's account. Posting from supporting documentation must be done within seven days after the transaction date.

(b) The resident account record must show, in detail with supporting documentation, all monies received on behalf of the resident and the disposition of all funds so received. Persons shopping for residents must provide a list showing description and price of items purchased, along with payment receipts for these items.

(c) Individual resident accounts must be reconciled and listed by the facility at the end of each calendar month.

(d) Petty cash accounts must be reconciled within ten days of receipt of the bank statement.

(e) The facility must maintain a monthly list that separately lists the petty cash and savings account balances for each resident for whom the facility is managing funds.

(f) Records and supporting documentation must be retained for at least three years following the death or discharge of the resident.

(g) Accumulations of $50 or more.

(A) The facility must, within 15 days of receipt of the money, deposit in an individual interest-bearing account any funds held in excess of $50 for an individual resident, unless this money is being managed in a Trust and Agency Account by SPD.

(B) The account must be individual to the resident, must be in a form that clearly indicates that the facility does not have an ownership interest in the funds, and must be insured under federal or state law.

(h) Accumulations of Under $50.

(A) The facility may accumulate no more than $50 of a resident's funds in a pooled bank account or petty cash fund that must be separate from facility funds.

(B) The interest earned on any pooled interest-bearing account containing residents' petty cash must be either prorated to each resident on an actual interest-earned basis, or prorated to each resident on the basis of his or her end-of-quarter balance.

(6) RESIDENT RIGHTS.

(a) The resident must be allowed to manage his or her own funds, or to delegate their management to another, unless the resident has been determined to be incompetent by a court of law. A resident who

was not adjudicated incompetent may always decide how to spend his or her own funds.

(b) Facility staff delegated to manage resident funds must follow guidelines outlined in this rule and other state and federal laws and regulations that may apply in order to assure that decisions not made by the resident are made in his or her best interest.

(c) The resident, family or friends has the right to be free from solicitation from the facility to purchase items that are included in the facilities daily rate.

(d) The resident must not be charged for any item included in the facility's daily rate unless the facility can show at least one of the following:

(A) The resident made an informed decision to purchase the item, understanding that a similar and appropriate item is included in the daily rate;

(B) The family requested that the facility purchase the item, understanding that a similar and appropriate item is included in the daily rate; or

(C) The resident is not currently able to make an informed decision to purchase the item, but did so prior to current incapacity.

(e) The resident, family or friends must not be charged for any drug designated by the Food and Drug Administration as less-than-effective unless it can show that both the physician and the resident made an informed decision to continue use of the drug.

(f) Prior to purchasing an item that is included in the facility's daily rate or is over $50, the facility must consult with the SPD/Type B AAA case manager.

(g) The facility must not charge resident funds for any item or service that benefits the facility, facility staff or relatives or friends of facility

staff, unless it can show that the resident made an informed decision to purchase the item or service.

(h) When the facility or SPD is of the opinion that a resident is incapable of managing personal funds and the resident has no representative, the facility must refer the resident to the case manager in the local SPD/Type B AAA, who will consult with the resident regarding resident preference. If the attending physician agrees, as documented on the Form SDS 544, Physician's Statement of Resident's Capacity to Manage Funds, that the resident is incapable of handling funds, the case manager will attempt to find a suitable delegate to manage the resident's funds. If no delegate can be found, the facility must assume the responsibility. If the resident disagrees with the designation of a delegate, the designation cannot be made, and the resident retains the right to manage, delegate, and direct use of his own money, if not adjudicated incompetent.

(7) ACCESS TO FUNDS, RECORDS.

(a) The facility must provide each resident or delegate reasonable access to his or her own financial records and funds. Reasonable access is defined as seven business days for records and one business day for funds.

(b) The facility must provide a written statement, at least quarterly, to each resident, delegate, or a person chosen by the resident to receive the statement. The quarterly statement must reflect separately all of the resident's funds that the facility has deposited in an interest-bearing account plus the resident funds held by the facility in a petty cash account or other account. The statement must include at least the following:

(A) Identification number and location of any account in which that resident's personal funds have been deposited;

(B) Balances at the beginning of the statement period;

(C) Total deposits with source and withdrawals with identification;

(D) Interest earned, if any;

(E) Ending balances; and

(F) Reconciliation.

(c) The facility must provide a quarterly Resident Account Record on Form SDS 713 to the local SPD/Type B AAA within 15 days following the end of the calendar quarter and provide a copy to the resident or an individual delegated by the resident to receive the copy.

(d) The resident or delegate must have access to funds in accordance with OAR 411-085-0350.

(e) Within ten business days of the resident's transfer or discharge, or appointment of a new delegate as documented on the Form SDS 0542, the facility must provide a final accounting and return to the resident, or the delegate, all of the resident's funds that the facility has received for holding, safeguarding, and accounting, and that are maintained in a petty cash fund or individual account.

(8) CHANGE OF OWNERSHIP.

(a) The facility must give each resident or delegate a written accounting of any personal funds held by the facility before any transfer of facility ownership occurs, with a copy to the local SPD/Type B AAA.

(b) The facility must provide the new owner and the local SPD/Type B AAA with a written accounting of all resident funds being transferred and must obtain a written receipt for those funds from the new owner.

(9) LOCAL SPD/TYPE B AAA RESPONSIBILITY. The local SPD/Type B AAA must:

(a) Monitor receipt of SDS 713 forms and review them quarterly for appropriateness of expenditures;

(b) Monitor resident resources for resources over the current Medicaid limit;

(c) For residents incapable of managing their own funds and having no one to delegate to do so, attempt to determine resident wishes, seek physician input on the physician statement, and find a delegate, delegating the facility if necessary and not in conflict with resident wishes;

(d) Notify the facility of inappropriate expenditures and report uncorrected problems to SPD Central Office and assist residents in obtaining legal counsel; and

(e) Track expensive or reusable items purchased for residents through resident funds or by SPD and assure their appropriate use after resident death.

(10) DEATH OF RESIDENT.

(a) Within five business days following a resident's death, the facility must send a written accounting of the resident's funds to the executor or administrator of the resident's estate. If a deceased resident has no executor or administrator, the facility must provide the accounting to:

(A) The resident's next of kin;

(B) The resident's representative;

(C) The clerk of probate court of the county in which the resident died; and

(D) Estate Administration Unit, Seniors and People with Disabilities, P.O. Box 14021, Salem, OR 97309-5024.

(b) Within five business days following a resident's death, the facility must:

(A) Send a written accounting of the resident's funds and a listing of resident personal property, including wheelchairs, television sets, walkers, jewelry, etc., to the local SPD Estate Administration Unit;

(B) Hold personal property for 90 days, unless otherwise instructed by the SPD Estate Administration Unit; and

(C) Comply with the laws of Oregon regarding disbursal of resident funds, and any advance payments, or contact the Estate Administration Unit, SPD, for more detailed instructions.

Stat. Auth.: ORS 410.070 & 414.065
Stats. Implemented: ORS 410.070 & 414.065

411-070-0100 Audit of Personal Incidental Funds
(Effective 2/1/2006)

(1) Records Available to Department. All account records and expenditure receipts for the resident's personal incidental funds must be available in the facility for audit and inspection by representatives of the Department of Human Services.

(2) Department Audits. Audits of a provider's cost reports, financial records and other pertinent documents may be made by the Department to verify that the provider is complying with Federal regulations and State Administrative Rules regarding protection of residents' funds. Copies of the provider's records may be removed from the facility.

(3) Discrepancies. Any discrepancies in the utilization of personal incidental funds brought to the attention of the case manager will be discussed with the facility. If the discrepancy cannot be resolved, the Department will assist the resident in finding an attorney to represent them or bring the situation to the attention of the local district attorney.

(4) Abuse of Funds. Abuse of resident's personal incidental funds or failure to comply with SPD personal incidental funds policy will be considered by the Department in deciding if a provider's agreement will be continued or renewed.

Stat. Auth.: ORS 410.070 & 414.065
Stats. Implemented: ORS 410.070 & 414.065

411-070-0105 Resident Property Records
(Effective 2/1/2006)

(1) Current Records. The facility must maintain a current, written record for each resident that includes written receipts for all personal possessions deposited with the facility.

(2) Availability. The property record must be available to the resident and the resident's representative.

(3) Personal Property. The resident's private property must be clearly marked with his or her name.

(4) Department Audit. These records are subject to the same audit criteria as all personal incidental funds in OAR 411-070-0100.

(5) Removal from Facility. The Department may remove copies of these records from the facility.

Stat. Auth.: ORS 410.070 & 414.065
Stats. Implemented: ORS 410.070 & 414.065

411-070-0110 Temporary Absence from Facility (Bedhold)
(Effective 2/1/2006)

(1) Payment by Department. The Department does not pay for holding a client's bed when the client is absent from the facility.

(2) Private Payment for Bedhold. Personal incidental funds or payment from a resident's family may be used to hold a facility bed if there are no vacancies in the facility to which other residents of the same sex could be admitted and if there is no duplicate payment from the Department. Personal incidental funds may only be used if the resident so chooses.

Stat. Auth.: ORS 410.070 & 414.065
Stats. Implemented: ORS 410.070 & 414.065

411-070-0115 Transfer of Residents
(Effective 2/1/2006)

(1) Prior Approval Required. A resident must not be transferred to another facility without prior approval by the resident, the attending physician, branch worker, and the facility's director of nursing services. Reassignment of rooms within the facility requires prior notice to the case manager. All transfers, both inter- and intra-facility, must be conducted in accordance with resident's rights as described in OAR chapter 411, division 085 and the transfer rules in OAR chapter 411, division 088.

(2) Emergency Transfer. In an emergency, consultation with the branch worker is waived. However, the branch worker must be notified by the facility of the resident's transfer at the earliest possible opportunity.

(3) Noncompliance. Failure on the part of the facility administration to comply with this rule can constitute a basis for withholding payment for care of the resident involved.

Stat. Auth.: ORS 410.070, 414.065 & 441.357
Stats. Implemented: ORS 410.070 & 414.065

411-070-0120 Discharge of Residents
(Effective 2/1/2006)

When the attending physician indicates that the resident does not, or in the future will not, require long-term care, facility authorities must report this fact to the branch office no later than the first branch office working day following the physician's notification. Upon request, the branch office will assist the resident, facility, relatives, or guardian in developing plans and arrangements for discharge placement. Resident's refusal to be discharged will relieve the Department of responsibility for payment.

Stat. Auth.: ORS 410.070 & 414.065
Stats. Implemented: ORS 410.070 & 414.065

411-070-0125 Medicare, (Title XVIII)
(Effective 2/1/2006)

The Department will pay on behalf of eligible clients the coinsurance rate established under Medicare, Part A, Hospital Care, for care rendered from the 21st day through the 100th day of care in a Medicare certified nursing facility. The Department will pay the appropriate rate as defined in OAR 411, Division 070, for care beyond the 100th day. Payment will be subject to documentation required for the rate.

Stat. Auth.: ORS 410.070
Stats. Implemented: ORS 410.070 & 414.065

411-070-0130 Medicaid Payment in Hospitals
(Effective 3/13/2007)

(1) SWING BED ELIGIBILITY. To be eligible to receive a Medicaid payment under this rule, a hospital must:

(a) Have approval from the Centers for Medicare and Medicaid Services (CMS) to furnish skilled nursing facility services as a Medicare swing-bed hospital;

(b) Have a Medicare provider agreement for acute care; and

(c) Have a current signed provider agreement with the Seniors and People with Disabilities Division to receive Medicaid payment for swing-bed services.

(2) NUMBER OF BEDS.

(a) A Critical Access Hospital (CAH) not located within a 30 mile geographic radius of a licensed nursing facility as of March 13, 2007 may receive Medicaid payment for up to 20 residents at one time. The CAH must maintain at least five beds or twice the average acute care daily census, whichever is greater, for exclusive acute care use.

(b) Other hospitals receiving payment for Medicaid services under this rule may not receive Medicaid payment for more than a total of five residents at one time. In addition, the residents must have a

documented need for and receive services that meet the complex medical add-on requirements outlined in OAR 411-070-0091.

(c) If circumstances change so that a CAH receiving payment for Medicaid services pursuant to section (2)(b) of this rule meets the criteria set out in section (2)(a) of this rule after March 13, 2007, the CAH may petition the Division for authorization to receive such payment pursuant to section (2)(a) of this rule. The Division will evaluate all available long-term care resources within a 30 mile geographic radius of the CAH and the amount of unmet long-term care need in the same area and determine if the CAH will be authorized to receive payment pursuant to section (2)(a) of this rule.

(3) PAYMENT.

(a) Daily Rate. Medicaid payment for swing-beds will be equal to the rate paid to Oregon's Medicaid certified nursing facilities during the current six-month period.

(b) Medicare Co-payment. Medicaid payment for Medicare co-insurance for Division clients will be made at a rate which is the difference, if any, between the Medicare partial payment and the facility rate as established in section (3) of this rule.

(4) SERVICES PROVIDED. The daily Medicaid rate will be for the services outlined in OAR 411-070-0085 (All-Inclusive Rate).

(5) COMPLIANCE WITH MEDICAID REQUIREMENTS. Hospitals receiving Medicaid payment for swing-bed services must comply with federal and Division rules and statutes that affect long-term care facilities as outlined in the facility's provider agreement with the Division.

(6) ADMISSION OF CLIENTS. Prior to determination of Medicaid payment eligibility in the swing bed, the case manager must determine there is no nursing facility bed available to the client within a 30 mile geographic radius of the hospital. For the purpose of this rule, "available bed" means a bed in a nursing facility that is available to the client at the time the placement decision is made.

Stat. Auth.: ORS 410.070
Stats. Implemented: ORS 410.070 & 414.065

411-070-0140 Hospice Services
(Effective 2/1/2006)

(1) Contract. The Department may enter into a contract (provider agreement) to reimburse Medicare certified hospice providers in Oregon for services provided in Medicaid certified nursing facilities under the following conditions:

(a) The Medicare-certified hospice provider must have a written contract with the nursing facility;

(b) A copy of the completed contract must be submitted to the Department; and

(c) The hospice provider must have a completed, written contract (provider agreement) with the Department for nursing facility-based hospice services prior to being determined eligible for reimbursement.

(2) Reimbursement:

(a) The Department will pay the hospice provider a rate equal to 95 percent of the rate that the nursing facility would otherwise receive;

(b) The hospice provider is solely responsible for reimbursing the nursing facility; and

(c) Reimbursement for services provided under this rule is available only if the recipient of such services is Medicaid-eligible, Medicare hospice eligible, and been found to need nursing facility care through the Pre-Admission Screening process.

Stat. Auth.: ORS 410.070 & 414.065
Stats. Implemented: ORS 410.070 & 414.065

Bundled Rate
Table OAR 411-070-0085
(Appendix A)
See OAR chapter 410, division 122 for complete information regarding coverage requirements.

HCPCS Code	Narrative Description
E0302	Hospital bed, extra heavy duty, extra wide, with weight capacity greater than 600 pounds, with any type siderails, without mattress (weight or need based)
E0304	Hospital bed, extra heavy duty, extra wide, with weight capacity greater than 600 pounds, with any type siderails, with mattress (weight or need based)
E0635	Patient lift, electric, with seat or sling only when client weighs 450 pounds or more (capped rental only)
E1226	Wheelchair accessory, manual fully reclining back, (recline greater than 80 degrees), each
E1399	Durable medical equipment, misc. - Includes pressure reducing support surface, Group 2 bariatric only - Includes bariatric trapeze bar - Includes bariatric commode
E2609	Custom fabricated wheelchair seat cushion, any size
E2617	Custom fabricated wheelchair back cushion, any size, including any type mounting hardware
K0007	Extra heavy-duty wheelchair only when client weighs more than 350 pounds
K0009	Other manual wheelchair/base
K0108	Wheelchair component or accessory, not otherwise specified

Bundled Rate
Table OAR 411-070-0085
(Appendix B)

OTC ANALGESICS		
Code	Drug/Class Name	Comments
HSN 001820	Aspirin - 325 mg	80 mg form will be covered by OHP
HSN 000186	Acetaminophen	
HSN 003723	Ibuprofen	Dosages that require a prescription for dispensing will be covered by OHP
HSN 003726	Naproxen Sodium	Dosages that require a prescription for dispensing will be covered by OHP
OTC TOPICALS		
Code	Drug/Class Name	Comments
STC 92	Topical Coal Tar Shampoo	
STC 93	Emollients/Protectants	OHP covers Dextranomer (HSN=002363).
HIC3 Q5P	Topical Steroid Cream	Such as Hydrocortisone
HIC3 Q5W	Topical First Aid Cream	Such as Bacitracin or Neosporin
OTC LAXATIVES, ANTI DIARRHEA, ANTACIDS		
Code	Drug/Class Name	Comments
STC 06	Laxatives	Docusate will be covered by OHP
HIC3 D4B	Antacids	
HSN 001228 etc.	Anti diarrhea OTC medication	Such as Kaopectate

OTC COUGH & COLD PREPS		
Code	Drug/Class Name	Comments
STC 16	Cough Medication	
STC 17	Cold Medication	
OTC VITAMINS		
Code	Drug/Class Name	Comments
STC 80-83	Multivitamin	Calcium and Vitamin D preparations prescribed for treatment and prevention of osteoporosis will be covered by OHP
THICKENERS		
Code	Drug/Class Name	Comments
HIC3 U6C	Oral Thickener	Such as Starch, Corn Starch, Xanthan Gum
HIC3 Q5R	Scabacides/Pediculicides	Any product in this class that does not require a prescription for dispensing