DEPARTMENT OF HUMAN SERVICES
DEVELOPMENTAL DISABILITIES
OREGON ADMINISTRATIVE RULES

CHAPTER 411
DIVISION 375

INDEPENDENT PROVIDERS DELIVERING DEVELOPMENTAL DISABILITIES SERVICES

EFFECTIVE JANUARY 25, 2019

411-375-0000 Purpose
(Amended 06/29/2016)

(1) The rules in OAR chapter 411, division 375 establish the standards and procedures governing independent providers and the fiscal services provided on behalf of individuals who employ or contract with an independent provider.

(2) Independent providers provide home and community-based waiver, state plan, and general fund services to individuals eligible for developmental disabilities services and receiving supports authorized by a case management entity.

Stat. Auth.: ORS 409.050
Stats. Implemented: ORS 410.600, 410.606-410.619, 427.007

411-375-0010 Definitions and Acronyms
(Amended 01/25/2019)

In addition to the following definitions, OAR 411-317-0000 includes general definitions for words and terms frequently used in OAR chapter 411, division 375. If a word or term is defined differently in OAR 411-317-0000, the definition in this rule applies.

(1) "Active Provider Number" means an identifying number issued by the Department to an independent provider who has completed the qualification and enrollment conditions described in OAR 411-375-0020. An

active provider number is a provider number not currently in inactivated or terminated status.

(2) "ADL" means "activities of daily living".

(3) "Base Pay Rate" means the hourly wage to be paid to personal support workers, without any differentials, established in the Collective Bargaining Agreement.

(4) "Behaviorally-Driven Services and Supports" means the behavioral treatments an individual requires in addition to routine assessed ADL and IADL supports as identified in a functional needs assessment.

(5) "Burden of Proof" means the existence or nonexistence of a fact is established by a preponderance of the evidence.

(6) "CDDP" means "Community Developmental Disabilities Program".

(7) "CIIS" means "Children's Intensive In-Home Services".

(8) "Collective Bargaining Agreement" means the ratified agreement between the Home Care Commission and the Service Employees International Union, Local 503, Oregon Public Employees Union regarding wages, hours, rules, and working conditions for personal support workers.

(9) "Common Law Employer" means the employer of record (EOR) responsible for the duties described in OAR 411-375-0055.

(10) "Community Transportation" means the non-medical transportation provided to an individual. "Community Transportation" is further defined in OAR 411-435-0020 and described in OAR 411-435-0050.

(11) "Confidentiality" means the conditions for use and disclosure of specific information governed by other laws and rules including, but not limited to, OAR 407-014-0000 to 407-014-0070.

(12) "Department Funds" means state public funds or Medicaid funds used to purchase developmental disabilities services and supports for individuals enrolled in developmental disabilities services.

(13) "Enhanced Personal Support Worker" means a personal support worker certified by the Home Care Commission to deliver services to individuals who require advanced medically-driven services and supports or behaviorally-driven services and supports, as identified in a functional needs assessment.

(14) "Evidence" means the testimony, writings, material objects, or other things presented to the senses, offered to prove the existence or nonexistence of a fact.

(15) "Exceptional Personal Support Worker" means a personal support worker certified by the Home Care Commission to deliver services to individuals who require extensive medically-driven services and supports or behaviorally-driven services and supports, as identified in a functional needs assessment and whose service needs also require staff to be awake more than 20 hours in a 24-hour period.

(16) "eXPRS" means "Express Payment and Reporting System". eXPRS is the information system used by the Department to track and document service delivery of claims funded by the Department.

(17) "FICA" means "Federal Insurance Contributions Act".

(18) "Fiscal Improprieties" means financial misconduct involving the money, property, or benefits of an individual.

(a) Fiscal improprieties include, but are not limited to, financial exploitation, borrowing money from an individual, taking property or money from an individual, having an individual purchase items for the independent provider, forging the signature of an individual, falsifying payment records, claiming payment for hours not worked, claiming payment for hours not prior authorized, claiming payment for hours that exceed limitations, or similar acts intentionally committed for financial gain.

(b) Fiscal improprieties do not include the exchange of money, gifts, or property between a personal support worker and an individual with whom the personal support worker is related unless an allegation of financial exploitation, as defined in OAR 411-020-0002 or OAR 407-

045-0260, has been substantiated based on an adult protective services investigation.

(19) "Fiscal Intermediary" means a person or entity that receives and distributes Department funds on behalf of an individual who employs or contracts with a personal support worker to deliver services.

(20) "IADL" means "instrumental activities of daily living".

(21) "Imminent Danger" means there is reasonable cause to believe the life or physical, emotional, or financial well-being of an individual is in danger if no intervention is immediately initiated.

(22) "Inactivation" means an independent provider has a Department issued provider number that has been inactivated in accordance with OAR 411-375-0070.

(23) "Independent Provider" means a personal support worker, a person who is paid as a contractor, or a self-employed person. An agency or the employee of an agency is not an independent provider.

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

(25) "Lack of Skills, Knowledge, or Ability to Adequately or Safely Provide Services" means an independent provider does not possess the physical, mental, or emotional skills or abilities necessary to deliver services and the lack of skills or abilities puts an individual at risk because the independent provider fails to perform, or learn to perform, the duties needed to adequately meet the needs of the individual.

(26) "Medically-Driven Services and Supports" means the medical treatments an individual requires in addition to routine assessed ADL and IADL supports as identified in a functional needs assessment.

(27) "Non-Motorized Transportation" means traveling on foot, riding a bicycle, traveling in a wheelchair or scooter, or other similar means of transportation.

(28) "ODDS" means the Department of Human Services, Office of Developmental Disabilities Services.

(29) "Office of Administrative Hearings" means the office described in ORS 183.605 established within the Employment Department to conduct contested case proceedings on behalf of designated state agencies.

(30) "Personal Support Worker":

(a) Means a person:

(A) Who has a Medicaid provider number.

(B) Who is hired or selected by an individual, their designated common law employer, or proxy.

(C) Who receives money from the Department for the purpose of delivering services to the individual in the home or community of the individual.

(D) Whose compensation for providing services is provided in whole or in part through the Department.

(b) This definition of personal support worker is intended to be interpreted consistently with ORS 410.600.

(31) "Preponderance of the Evidence" in a contested case hearing means, the evidence of one party is more convincing than the evidence of the other party.

(32) "Protective Service and Abuse Rules" means any of the rules described in:

(a) OAR chapter 411, division 020.

(b) OAR chapter 407, division 045.

(c) OAR chapter 413, division 015.

(d) OAR chapter 943, division 045.

(33) "Proxy" means the common law employer proxy. The common law employer proxy is the person delegated specific tasks to assist a common law employer in the duties described in OAR 411-375-0055.

(34) "Provider Enrollment" means the process for enrolling an independent provider for the purpose of receiving payment for authorized services delivered to an individual. Provider enrollment includes the completion and submission of a Provider Enrollment Agreement before receiving a provider number.

(35) "Provider Number" means the identifying number issued to each qualified independent provider enrolled through the Department as a provider.

(36) "Restricted Personal Support Worker" means the Department, or the designee of the Department, has placed restrictions on the provider enrollment of a personal support worker as described in OAR 411-375-0020.

(37) "Termination" means an independent provider has a Department issued provider number that has been terminated in accordance with OAR 411-375-0070.

(38) "Travel Directly" means the travel time for a personal support worker from one worksite to another worksite is not interrupted for any of the following reasons:

(a) Eat a meal.

(b) Purchase fuel for the vehicle being used for the travel.

(c) Use a restroom.

(d) Change buses, trains, or other modes of public transit.

(39) "These Rules" mean the rules in OAR chapter 411, division 375.

(40) "Violation of Protective Service and Abuse Rules" means a substantiated allegation of abuse or finding of abuse under the protective

service and abuse rules or the violation of reporting or other requirements in the protective service and abuse rules.

(41) "Workday" means 12:00 AM through 11:59 PM.

(42) "Worksite" means the physical location where a personal support worker is authorized to deliver services to an individual. A worksite may be the home of an individual, the community of the individual, or a home and community-based setting.

(43) "Workweek" means 12:00 AM Sunday through 11:59 PM Saturday.

Stat. Auth.: ORS 409.050
Stats. Implemented: ORS 410.600, 410.606-410.619, 427.007

411-375-0020 Qualifications, Exclusions, and Enrollment Responsibilities for Independent Providers
(Amended 01/25/2019)

(1) QUALIFICATIONS. An independent provider who is qualified to provide services must meet the following requirements:

(a) Be at least 18 years of age.

(b) Have approval to work based on a background check and final fitness determination completed by the Department as described in OAR 407-007-0200 through 407-007-0370 and section (3) of this rule.

(c) Not have been convicted of any of the disqualifying crimes listed in ORS 443.004, unless hired or contracted with prior to July 28, 2009 and remaining in the original position for which the independent provider was hired or contracted.

(d) Be legally eligible to work in the United States.

(e) Demonstrate by background, education, references, skills, and abilities, the independent provider is capable of safely and adequately performing the tasks specified in an ISP or Service Agreement, with

such demonstration of the following confirmed in writing by the individual, or as applicable their legal or designated representative:

(A) Ability and sufficient education to follow oral and written instructions and keep any required records.

(B) Possess the physical health, mental health, good judgment, and good personal character determined necessary to deliver services.

(C) Ability to communicate with the individual.

(D) Training of a nature and type sufficient to ensure the independent provider has knowledge of emergency procedures specific to the individual.

(f) Maintain confidentiality and safeguard individual information. An independent provider may not share any personal information about the individual, including medical, social service, financial, public assistance, legal, or other personal details, unless given specific permission by the individual or as applicable their legal representative.

(g) Not be on the list of excluded or debarred providers maintained by the Office of the Inspector General (http://exclusions.oig.hhs.gov/).

(h) Complete and submit a Provider Enrollment Agreement to the Department and possess a current provider number issued by the Department. A Provider Enrollment Agreement must be renewed 70 calendar days prior to the end date of the current Provider Enrollment Agreement unless the provider enrollment is terminated or inactivated by the Department.

(i) Have a Taxpayer Identification Number or Social Security number that matches the legal name of the independent provider as verified by the Internal Revenue Service or Social Security Administration.

(j) Possess a current and unencumbered license if providing services requiring specific professional education, training, and skill. The individual, or as applicable their designated or legal representative or

the case management entity, must check the status of the professional license to verify the license is current and unencumbered.

(k) If transporting an individual, have a valid driver's license and proof of insurance, as well as any other license or certification required under state and local law depending on the nature and scope of the transportation. Copies of a valid driver's license and proof of insurance, as well as any other license or certification (if applicable), must be provided to a case management entity upon authorization of community transportation and as requested.

(l) Additional qualifications required by applicable program rules relevant to the services being delivered.

(2) EXCLUSIONS.

(a) An employee of the State of Oregon may not be authorized to deliver services as a personal support worker.

(b) An independent provider may not be authorized to deliver services to an individual in any of the following circumstances:

(A) The individual is less than 18 years of age and the independent provider is the parent of the individual.

(B) The independent provider is the legal representative of the individual and has not appointed a designated representative to plan supports for the individual.

(C) The independent provider is the designated representative of the individual.

(D) The independent provider is the spouse of the individual.

(E) The independent provider is the common law employer or the proxy of the common law employer.

(F) The independent provider is or has been the case manager for the individual in the previous 12 months.

(3) BACKGROUND CHECKS.

(a) A subject individual as defined in OAR 407-007-0210 may be approved for one position to work statewide when the subject individual is working in the same employment role with the same population. The Background Check Request Form must be completed by the subject individual to show intent to work statewide.

(b) When an independent provider is approved without restrictions following a background check final fitness determination, the approval must meet the provider enrollment requirements for the employment role of the independent provider.

(c) Background check approval is effective for two years from the date of fitness determination to provide services except in one or more of the following circumstances:

(A) A new fitness determination is conducted resulting in a change in approval status.

(B) The Department has terminated the provider enrollment for the independent provider.

(d) A case management entity may conduct a background recheck if additional information about an independent provider, such as possible criminal activity or other allegations, is discovered or reported to the case management entity or the Department.

(e) An independent provider must self-report any potentially disqualifying crimes under OAR 125-007-0270 and potentially disqualifying conditions under OAR 407-007-0290 to the case management entity within 24 hours.

(4) ENROLLMENT RESPONSIBILITIES.

(a) The Department may deny provider enrollment in any of the following circumstances:

(A) The applicant has been suspended or terminated as a provider by another division within the Department or by the Oregon Health Authority.

(B) The applicant has a history of violating the protective service and abuse rules or has a founded report of child abuse or substantiated adult abuse.

(C) The applicant has committed fiscal improprieties.

(D) The applicant has demonstrated a lack of skills, knowledge, or ability to adequately or safely provide services.

(E) The applicant has an unacceptable background check or the background check results in a closed case pursuant to OAR 407-007-0320.

(F) The applicant is on the list of excluded or debarred providers maintained by the Office of the Inspector General (http://exclusions.oig.hhs.gov/).

(G) The case management entity has documentation that the applicant is not capable of performing required services in a professionally competent, safe, legal, or ethical manner.

(H) The Taxpayer Identification Number or Social Security number for the applicant does not match the legal name of the applicant as verified by the Internal Revenue Service or Social Security Administration.

(b) CONTINUED ENROLLMENT.

(A) An independent provider is responsible for maintaining an active provider number by:

(i) Completing and submitting a new Provider Enrollment Agreement to the Department at least 70 calendar days prior to the end date of the Provider Enrollment Agreement.

(ii) Completing and submitting a Background Check Request Form and receiving approval to work by the Department at least 70 calendar days prior to the end of the background check approval period.

(iii) Completing and submitting properly completed paperwork at the request of the Department that is required to receive payment.

(iv) Maintaining valid contact information with the Department including current address, email address, and telephone number.

(v) Completing and submitting required paperwork at the request of the Department.

(B) An independent provider is responsible to attend trainings and maintain certifications as required by applicable program rules.

(5) An individual, or as applicable their legal or designated representative, has the right to choose any independent provider who meets all additional program qualifications for the services to be delivered and is enrolled as a provider as described in this rule.

(6) PERSONAL SUPPORT WORKERS.

(a) ORIENTATION. A personal support worker must attend a personal support worker orientation consistent with the Collective Bargaining Agreement.

(b) RESTRICTED PERSONAL SUPPORT WORKER PROVIDER ENROLLMENT.

(A) The Department may enroll an applicant as a restricted personal support worker. A restricted personal support worker may only provide services to a specific individual who is a family member, neighbor, or friend.

(i) After conducting a weighing test as described in OAR 407-007-0200 through 407-007-0370, the Department may approve a restricted enrollment for an applicant with a prior criminal record, unless according to OAR 407-007-0275 the applicant has been found ineligible due to ORS 443.004.

(ii) The Department may approve a restricted enrollment for an applicant based on their lack of skills, knowledge, or ability to adequately or safely provide services.

(B) To remove restricted personal support worker status, the applicant must complete a new application and background check and be approved by the Department.

(c) ENHANCED AND EXCEPTIONAL PERSONAL SUPPORT WORKERS.

(A) ENHANCED PERSONAL SUPPORT WORKERS.

(i) A personal support worker must be certified by the Home Care Commission as an enhanced personal support worker to deliver services to individuals who require advanced medically-driven services and supports or behaviorally-driven services and supports, as identified by a functional needs assessment.

(ii) Enhanced personal support workers are paid for providing ADL and IADL services at the enhanced personal support worker rate set forth in the Collective Bargaining Agreement. The enhanced personal support worker rate is effective the first day of the month following the month in which both:

(I) The personal support worker is certified by the Home Care Commission to deliver services.

(II) The outcome of the functional needs assessment for an individual indicates the need for assistance with advanced medically-driven services

and supports or behaviorally-driven services and supports.

(B) EXCEPTIONAL PERSONAL SUPPORT WORKER.

(i) A personal support worker must be certified by the Home Care Commission as an exceptional personal support worker to deliver services to individuals who require assistance with extensive medically-driven services and supports or behaviorally-driven services and supports, as identified by a functional needs assessment.

(ii) Exceptional personal support workers are paid for providing ADL and IADL services at the exceptional personal support worker rate set forth in the Collective Bargaining Agreement. The exceptional personal support worker rate is effective the first day of the month following the month in which both:

(I) The personal support worker is certified by the Home Care Commission to deliver services.

(II) The outcome of the functional needs assessment for an individual indicates the need for assistance with extensive medically-driven services and supports or behaviorally-driven services and supports, and at least 20 hours per day of attendant care support excluding 2:1 support hours.

(C) A personal support worker who has been certified by the Home Care Commission to provide enhanced or exceptional supports may not receive the enhanced or exceptional rate when providing services to an individual whose functional needs assessment does not indicate the need for assistance with advanced or extensive medically-driven services and supports or behaviorally-driven services and supports, except as required by the Collective Bargaining Agreement.

Stat. Auth.: ORS 409.050
Stats. Implemented: ORS 410.600, 410.606-410.619, 427.007

411-375-0030 Personal Support Worker-Individual Relationship
(Repealed 06/29/2016)

411-375-0035 Documentation and Reporting Requirements
(Amended 01/25/2019)

(1) SERVICE AGREEMENT.

(a) An independent provider may not provide services to an individual without a completed and authorized Service Agreement. For independent providers who are not personal support workers, the signature of the independent provider on an individual's ISP may serve as the Service Agreement.

(b) An independent provider must maintain a copy of the authorized Service Agreement for the authorized service period.

(2) SAFEGUARDING INTERVENTIONS AND SAFEGUARDING EQUIPMENT.

(a) An independent provider must only utilize a safeguarding intervention or safeguarding equipment when:

(A) BEHAVIOR. Used to address an individual's challenging behavior, the safeguarding intervention or safeguarding equipment is included in the individual's Positive Behavior Support Plan written by a qualified behavior professional as described in OAR 411-304-0150 and implemented consistent with the individual's Positive Behavior Support Plan.

(B) MEDICAL. Used to address an individual's medical condition or medical support need, the safeguarding intervention or safeguarding equipment is included in a medical order written by the individual's licensed health care provider and implemented consistent with the medical order.

(b) The individual, or as applicable their legal representative, must provide consent for the safeguarding intervention or safeguarding

equipment through an individually-based limitation in accordance with OAR 411-415-0070.

(c) Prior to utilizing a safeguarding intervention or safeguarding equipment, an independent provider must be trained.

(A) For a safeguarding intervention, the independent provider must be trained in intervention techniques using an ODDS-approved behavior intervention curriculum and trained to the individual's specific needs. Training must be conducted by a person who is appropriately certified in an ODDS-approved behavior intervention curriculum.

(B) For safeguarding equipment, the independent provider must be trained on the use of the identified safeguarding equipment.

(d) An independent provider must not utilize any safeguarding intervention or safeguarding equipment not meeting the standards set forth in this rule even when the use is directed by the individual or their legal or designated representative, regardless of the individual's age.

(3) EMERGENCY PHYSICAL RESTRAINTS.

(a) The use of an emergency physical restraint when not written into a Positive Behavior Support Plan, not authorized in an individual's ISP, and not consented to by the individual in an individually-based limitation, must only be employed when all of the following conditions are met:

(A) In situations when there is imminent risk of harm to the individual or others or when the individual's behavior has a probability of leading to engagement with the legal or justice system;

(B) Only as a measure of last resort; and

(C) Only for as long as the situation presents imminent danger to the health or safety of the individual or others.

(b) The use of an emergency physical restraint must not include any of the following characteristics:

(A) Abusive.

(B) Aversive.

(C) Coercive.

(D) For convenience.

(E) Disciplinary.

(F) Demeaning.

(G) Mechanical.

(H) Prone or supine restraint.

(I) Pain compliance.

(J) Punishment.

(K) Retaliatory.

(4) PROGRESS NOTES.

(a) An independent provider must maintain regular progress notes. The progress note must include, at minimum, the following information regarding the service rendered:

(A) Date and time the service was delivered.

(B) Information regarding progress towards achieving the intended ISP goal identified in the Service Agreement for which the service was delivered.

(C) Documentation of incident reporting made to a case management entity during the time period covered by the

progress note, including the date the incident was reported and the nature of the incident.

(b) For a personal support worker, progress notes must be submitted to the case management entity with their timesheet as part of their claim for payment, and additionally upon request from the case management entity. The completed timesheet fulfills the requirement for date and time the service was delivered.

(c) For an independent provider who is not a personal support worker, progress notes must be submitted as required by applicable program rules.

(5) ABUSE REPORTING.

(a) An independent provider must immediately notify an individual's case management entity of any reasonable suspicion an individual is the victim of abuse.

(b) Independent providers who are mandatory reporters must also make reports of suspected abuse consistent with the following:

(A) ORS 419B.010 and 419B.015 for abuse of a child.

(B) ORS 124.060 and 124.065 for abuse of an older adult 65 years of age or older.

(C) ORS 430.737 and 430.743 for abuse of an adult with an intellectual or developmental disability or mental illness.

(D) ORS 441.640 and 441.645 for abuse of a resident of a long-term care facility as defined in ORS 442.015.

(6) INCIDENT REPORTING. An independent provider must notify an individual's case management entity of the following:

(a) Death, serious illness, injury, accident, or unusual incident involving an individual.

(b) Use of an emergency physical restraint, safeguarding intervention, or safeguarding equipment not as prescribed, in accordance with the following timelines.

(A) EMERGENCY PHYSICAL RESTRAINT. A report documenting the use of an emergency physical restraint must be submitted within one business day from the date of the incident.

(B) TEMPORARY EMERGENCY SAFETY PLANS. If an individual has a Temporary Emergency Safety Plan, a report documenting the use of an emergency crisis strategy or physical restraint must be completed in accordance with the requirements outlined in the individual's Temporary Emergency Safety Plan.

(C) INJURY. A report documenting the use of a safeguarding intervention or safeguarding equipment, resulting in an injury, must be provided within one business day from the date of the incident.

(D) NO INJURY. A report documenting the use of a safeguarding intervention or safeguarding equipment, not resulting in an injury, must be provided within five business days from the date of the incident.

(c) The report must include all of the following information:

(A) Name of the individual who is the subject of the incident.

(B) Date, time, duration, type, and location of the incident.

(C) Conditions prior to, or leading to, the incident.

(D) Detailed description of the incident, including the independent provider's response.

(E) Description of injury, if injury occurred.

(F) Name of the independent provider and witnesses to the incident.

(G) Follow-up to be taken to prevent a recurrence of the incident.

Stat. Auth.: ORS 409.050
Stats. Implemented: ORS 410.600, 410.606-410.619, 427.007

411-375-0040 Fiscal and Accountability Responsibility
(Amended 02/28/2017)

(1) DIRECT SERVICE PAYMENTS. The Department, case management entity, or contracted fiscal intermediary makes payment to an independent provider on behalf of an individual for all services.

(a) Payment is considered full payment for the services rendered. The independent provider may not, under any circumstances, demand or receive additional payment for Department-funded services from the individual or any other source.

(b) The Department only makes payment for services authorized in an ISP, included in a Service Agreement, and delivered by a provider authorized in eXPRS to deliver the service.

(c) The Department does not make Department funds available to an individual or common law employer to pay an independent provider.

(d) The Department only makes payment to an enrolled provider who actually performs the authorized services. Federal regulations prohibit the Department from making payment to a collection agency.

(e) All Department funds paid to a personal support worker must come through a fiscal intermediary.

(f) Department funds may only be paid to a personal support worker who has properly completed all Department required paperwork for fiscal intermediary payments.

(2) TIMELY SUBMISSION OF CLAIMS. In accordance with 42 CFR 447.45, all claims for services must be submitted within 12 months from the date of services in order to be considered for payment. A claim submitted after 12 months from the date of services may not be considered for payment.

(3) CLAIM OR ENCOUNTER SUBMISSION.

(a) Submission of a claim, encounter, or other payment request document constitutes the agreement of an independent provider to all of the following:

(A) The services were delivered in compliance with the Service Agreement in effect on the date of service.

(B) The information on the claim, encounter, or other payment request document, regardless of the format, is true, accurate, and complete.

(C) The independent provider understands payment of the claim, encounter, or other payment request document is from Department funds and any falsification or concealment of a material fact may result in prosecution under federal and state laws.

(b) The independent provider must submit a claim for payment directly into eXPRS, unless an exception has been granted by the case management entity.

(A) Claims for payment submitted by independent providers who are not personal support workers must include documentation from the provider of services delivered.

(B) Claims for payment submitted by personal support workers must meet the requirements of a properly completed timesheet as defined by the Collective Bargaining Agreement including submission of progress notes as required by OAR 411-375-0035.

(4) CLAIM OR ENCOUNTER AUTHORIZATION. Authorization of a submitted claim, encounter, or other payment request document by the employer, constitutes agreement the independent provider delivered services in accordance with the claim.

(5) PAYMENT LIMITATIONS.

(a) Department funds may not pay for services delivered by an independent provider who does not possess an active provider number issued by the Department on the date services are delivered.

(b) An active provider number with the Department is not a guarantee that an independent provider shall receive any minimum amount of work or payment from the case management entity.

(c) Payment is not made for services delivered to any individual prior to the following:

(A) The return of a signed Service Agreement, specific to the individual, to the case manager of the individual.

(i) When the provider is a personal support worker, a completed Service Agreement must include a dated signature from the common law employer and the personal support worker.

(ii) When the provider is an independent provider, but not a personal support worker, a completed Service Agreement must include the name and dated signature of the individual or as applicable their legal or designated representative.

(B) Authorization of the services in eXPRS.

(d) A personal support worker may not work more than 40 hours in a workweek, inclusive of travel time and time worked with other Department programs, as a personal support worker or homecare worker unless the personal support worker meets the criteria in subsection (A) or (B) of this section.

(A) A personal support worker may work 50 hours per workweek, inclusive of travel time and time worked with other Department programs, if the personal support worker was paid for more than an average of 40 hours per workweek during the months of March, April, and May of 2016.

(B) A personal support worker may work more than 40 hours in a workweek if an exception has been granted by the case management entity or the Department. All determinations regarding exceptions to the limitation on workweek hours are final.

(6) ANCILLARY CONTRIBUTIONS FOR PERSONAL SUPPORT WORKERS.

(a) FICA. The case management entity or contracted fiscal intermediary applies applicable FICA regulations on behalf of the individual, including the following:

(A) Withholding the FICA contribution of the personal support worker from the payment to the personal support worker.

(B) Submitting the FICA contribution of the individual and the amounts withheld from the payment to the personal support worker to the Social Security Administration.

(b) BENEFIT FUND ASSESSMENT. The Workers' Benefit Fund pays for programs that provide direct benefits to an injured worker and the beneficiary of the injured worker and also assists an employer in helping an injured worker return to work. The Department of Consumer and Business Services sets the Workers' Benefit Fund assessment rate for each calendar year. The case management entity or contracted fiscal intermediary calculates the hours rounded up to the nearest whole hour and deducts an amount rounded up to the nearest cent. The case management entity or contracted fiscal intermediary performs the following duties on behalf of the individual:

(A) Deducts the share of the Benefit Fund assessment rate for the personal support worker for each hour or partial hour worked.

(B) Collects the share of the Benefit Fund assessment rate for the individual for each hour or partial hour of paid services received.

(C) Submits the contributions of the personal support worker and the individual to the Workers' Benefit Fund.

(c) The case management entity or contracted fiscal intermediary submits the unemployment tax.

(7) STATE AND FEDERAL INCOME TAX WITHHOLDING.

(a) The case management entity or contracted fiscal intermediary withholds state and federal income taxes on all payments to personal support workers, as indicated in the Collective Bargaining Agreement.

(b) Personal support workers must complete and return all applicable Internal Revenue Service (IRS) forms.

(A) Personal support workers working with individuals receiving services through a CDDP, Brokerage, or CIIS must return all applicable fiscal intermediary forms to the fiscal intermediary for the Department.

(B) The fiscal intermediary must apply standard income tax withholding practices in accordance with 26 CFR 31.

Stat. Auth.: ORS 409.050
Stats. Implemented: ORS 410.600, 410.606-410.619, 427.007

411-375-0045 Overpayments
(Amended 06/29/2016)

(1) An overpayment is any payment made by the Department or case management entity to an independent provider that is more than the independent provider is permitted to receive under DHS rules. An independent provider may only receive payment for a number of hours that are actually provided and do not exceed the amount stated in a Service Agreement.

(2) Overpayments are categorized as follows:

(a) ADMINISTRATIVE ERROR. The case management entity failed to authorize, compute, or process the correct amount of service hours or wage rate.

(b) INDEPENDENT PROVIDER ERROR. The Department overpays the independent provider due to a misunderstanding or unintentional error.

(c) FRAUD. "Fraud" means taking actions that may result in the independent provider receiving a benefit in excess of the correct amount whether by intentional deception, misrepresentation, or failure to account for payments or money received. "Fraud" also means spending payments or money the independent provider was not entitled to and any act that constitutes fraud under applicable federal or state law (including 42 CFR 455.2). The Department of Justice, Medicaid Fraud Unit determines when a Medicaid fraud allegation is pursued for prosecution.

(3) The Department may recover an overpayment established by a judgment in a state or federal court, by the Department or another administrative agency in a contested case proceeding, or by a signed document in which the person acknowledges the overpayment and waives the right to a contested case hearing.

(4) Overpayments for personal support workers are recovered as follows:

(a) Overpayments are collected prior to garnishments, such as child support, Internal Revenue Service back taxes, or educational loans.

(b) Overpayments due to administrative error or personal support worker error are recouped at no more than five percent of the total for the hours paid until repaid in full.

(c) When a fraud overpayment has occurred, the Department shall determine the manner and the amount to be recovered.

(d) When a provider is no longer employed as a personal support worker, any remaining overpayment is deducted from the final check to the provider. The provider is responsible for repaying the amount in full when the final check is insufficient to cover the remaining overpayment.

(3) Overpayments for independent providers who are not personal support workers are recovered as described in OAR chapter 407, division 120.

Stat. Auth.: ORS 409.050
Stats. Implemented: ORS 410.600, 410.606-410.619, 427.007

411-375-0050 Benefits and Secondary Expenses for Personal Support Workers
(Amended 01/25/2019)

(1) The only benefits available to personal support workers are negotiated in the Collective Bargaining Agreement and provided in Oregon Revised Statute. The Collective Bargaining Agreement does not include participation in the Public Employees Retirement System or the Oregon Public Service Retirement Plan. Personal support workers are not employees of a case management entity.

(2) Workers' compensation, as defined in Oregon Revised Statute, is available to eligible personal support workers as described in the Collective Bargaining Agreement. In order to receive services delivered by a personal support worker, an individual, the designated common law employer, or the proxy must provide written authorization and consent to the Department for the provision of workers' compensation insurance for the personal support worker.

(3) TRANSPORTATION REIMBURSEMENT.

(a) COMMUNITY TRANSPORTATION.

(A) A personal support worker may be reimbursed for providing community transportation related to services if the community transportation is prior authorized by a case manager and reflected in the ISP for an individual in accordance with OAR 411-435-0050. A personal support worker providing community

transportation must have a valid driver's license, a good driving record, and proof of insurance for the vehicle used to transport the individual, as well as any other license or certificate that may be required under state and local law depending on the nature and scope of the transportation. Copies of a valid driver's license and proof of insurance, as well as any other license or certification that may be required, must be provided to any case management entity upon authorization of community transportation and as requested.

(B) Community transportation services exclude medical transportation. Medical transportation is provided through the Health Systems Division of the Oregon Health Authority.

(C) The Department is not responsible for vehicle damage or personal injury sustained while using a personal motor vehicle for ISP-related transportation, except as may be covered by workers' compensation.

(D) Reimbursement for transporting an individual to accomplish ADL, IADL, or a health-related task within the community in which the individual lives or an employment goal identified in an ISP, is on a per-mile basis as outlined in the Collective Bargaining Agreement.

(b) TRAVEL BETWEEN WORKSITES.

(A) A personal support worker who travels directly between one worksite to another worksite is paid at the base pay rate, as defined in the Collective Bargaining Agreement, for the time spent traveling directly between the worksites.

(B) Unless otherwise specified in statute or rule, the amount of time a personal support worker may take to travel directly from one worksite to another worksite may not exceed one hour.

(C) The total time spent traveling directly between worksites for all individuals a personal support worker is authorized to deliver services to, may not total more than 10 percent of the total

wages the personal support worker claims during a pay period, as described in the Collective Bargaining Agreement.

(D) The time claimed by a personal support worker for travel directly between worksites contributes to the limitation of hours a personal support worker may work in a workweek as described in OAR 411-375-0040(5)(d).

(E) The Department determines the time needed for a personal support worker to travel directly between worksites.

(i) When a personal support worker uses their own vehicle to travel directly between worksites, payment for travel time is based on a time estimate published in a common, publicly-available, web-based mapping program.

(ii) When a personal support worker uses public transportation to travel directly between worksites, payment for travel time is based on the scheduled pick-up and drop-off times for the stops nearest the worksites.

(iii) When a personal support worker uses non-motorized transportation to travel directly between worksites, payment for travel time is based on a time estimate published in a common, publicly-available, web-based mapping program.

(c) Claims for travel time exceeding the travel time estimated by the Department require a written explanation from the personal support worker. Travel time claimed in excess of the time estimated by the Department may not be paid.

(d) Under no circumstances may a personal support worker be paid for time spent in transit to or from their own residence.

(e) Personal support workers receive mileage reimbursement only as set forth in subsection (a) of this section.

(4) GLOVES AND MASKS. Once all public and private resources have been exhausted and in response to a documented change or newly identified individual need, an emergency supply of protective gloves and masks must be made available to a personal support worker for the safety of the personal support worker, as outlined in the Collective Bargaining Agreement.

Stat. Auth.: ORS 409.050
Stats. Implemented: ORS 410.600, 410.606-410.619, 427.007

411-375-0055 Standards for Common Law Employers for Personal Support Workers
(Amended 01/25/2019)

(1) A common law employer is required when a personal support worker is selected by an individual, or as applicable their legal or designated representative, to deliver supports. Only one common law employer is permitted to be the employer for all personal support workers delivering services to an individual.

(2) The Department, provider agencies, or case management entities may not act as the common law employer for a personal support worker.

(3) The relationship between a personal support worker and an individual, or their designated common law employer, is an employee and employer relationship.

(4) Common law employers do not qualify for any benefits including, but not limited to, financial compensation.

(5) COMMON LAW EMPLOYER REQUIREMENTS.

(a) Common law employers may be one of the following:

(A) The individual.

(B) The legal or designated representative of the individual.

(C) A person who is designated by the individual, or as applicable their legal or designated representative, to act as the designated common law employer on behalf of the individual.

(i) As of December 1, 2016, a designated common law employer or proxy must sign a Department-approved form affirming the designated common law employer or proxy is able to fulfill the responsibilities, or responsibilities delegated to them, as outlined in subsection (b) of this section.

(ii) A designated common law employer must not have any of the following:

(I) A history of substantiated abuse of an adult as described in OAR 407-045-0250 through 407-045-0370.

(II) A history of substantiated abuse of an adult as described in OAR chapter 411, division 020.

(III) A history of founded abuse of a child as described in ORS 419B.005.

(IV) A conviction of any crime in ORS 443.004.

(iii) A common law employer must not currently be employed as a provider in any capacity for the individual receiving services.

(iv) A common law employer must meet federal and state requirements to enter into an employment relationship.

(v) A common law employer may not have an indictment or conviction of fraud according to 42 CFR 455.23.

(b) Common law employers have the following responsibilities:

(A) Locating, screening, and hiring a qualified personal support worker.

(B) Assisting in developing a Service Agreement with the case management entity as needed.

(C) Ensuring services are delivered in accordance with the Service Agreement.

(D) Supervising and training the personal support worker.

(E) Scheduling work, leave, and coverage.

(F) Tracking the hours worked and verifying the authorized hours completed by the personal support worker.

(G) Recognizing, discussing, and attempting to correct, with the personal support worker, any performance deficiencies and provide appropriate and progressive disciplinary action as needed.

(H) Notifying the case management entity of any suspected fraud or abuse by the personal support worker.

(I) Discharging an unsatisfactory personal support worker.

(J) Understanding and acting upon correspondence from the Department or the Department's contractors related to their role as the employer.

(c) A common law employer must meet all of the employer responsibilities described in subsection (b) of this section.

(d) The Department or case management entity may be required to intervene as described in section (6) of this rule when a common law employer, proxy, or a designated common law employer has demonstrated an inability to meet one or more of the employer responsibilities described in subsection (b) of this section. Indicators that a common law employer, proxy, or a designated common law employer may not be meeting one or more of the responsibilities include, but are not limited to the following:

(A) Complaints to the case management entity or Department from the personal support worker.

(B) Scheduling personal support workers for more time than authorized in the Service Agreement.

(C) Scheduling multiple personal support workers for the same time period without authorization.

(D) Approving time worked without verifying services were delivered as described in the Service Agreement.

(E) Verifying time not actually worked by a personal support worker.

(F) Refusal to verify time worked by a personal support worker for services delivered as described in the Service Agreement.

(G) Complaints to Medicaid fraud involving the common law employer, proxy, or designated common law employer.

(H) Documented observation by the case management entity or Department services are not being delivered as identified in a Service Agreement.

(e) In the event an individual is unable or unwilling to perform the duties of a common law employer and has not already designated a common law employer, the individual, or as applicable their legal or designated representative, must either:

(A) Designate a proxy meeting the requirements of a designated common law employer described in subsection (a)(C) of this section.

(i) A proxy may not be delegated all of the responsibilities of the common law employer.

(ii) The proxy may not perform any common law employer tasks not delegated to the proxy on a Department approved form.

(B) Select a designated common law employer as outlined in subsection (a)(C) of this section.

(f) A designated common law employer must be able to fulfill all of the duties outlined in subsection (b) of this section and may not utilize a proxy.

(g) If an individual is unable to fulfill the responsibilities of a common law employer and is unable to select a proxy or designated common law employer who meets the requirements outlined in subsection (a)(C) of this section, the individual may only select services from providers who are not personal support workers.

(6) INTERVENTION.

(a) For the purposes of this rule, "intervention" means the action the Department or the case management entity requires when a common law employer fails to meet the responsibilities described in section (5)(b) of this rule.

(b) Interventions may include any of the following:

(A) A review of the employer responsibilities described in section (5)(b) of this rule.

(B) Training related to employer responsibilities or referral to a Department approved resource for training.

(C) Corrective action taken as a result of a personal support worker filing a complaint with the Department or the case management entity.

(D) Recommending alternative designation of common law employer responsibilities, such as a new designated common law employer or proxy.

(c) Any intervention initiated by the Department or the case management entity against a common law employer designated prior to October 1, 2016 must include the common law employer

accepting, on a Department approved form, the responsibilities outlined in section (5)(b) of this rule.

(7) REMOVAL OF COMMON LAW AND DESIGNATED COMMON LAW EMPLOYERS AND PROXIES.

(a) The individual, or their legal or designated representative, may remove a designated common law employer or proxy at any time, for any reason. Such an action by the individual, or their legal or designated representative, is not subject to sections (7)(b) through (8) of this rule.

(b) Prior to the removal of any common law employer, designated common law employer, or proxy by the Department or case management entity, the Department or case management entity must intervene at least once, as described in section (6) of this rule, unless:

(A) There is an imminent danger to the health and safety of the individual receiving services, including any of the following:

(i) Pending charges against or conviction of the designated common law employer or proxy for any crime in ORS 443.004.

(ii) An open protective services case for an allegation of abuse as defined in OAR 407-045-0260 against the designated common law employer or proxy.

(iii) Finding of substantiated abuse of an adult as described in OAR 407-045-0250 through 407-045-0370.

(iv) Finding of substantiated abuse of an adult as described in OAR chapter 411, division 020.

(v) Finding of abuse of a child as described in ORS 419B.005.

(B) There is a credible allegation, indictment, or conviction of fraud according to 42 CFR 455.23.

(C) The common law employer has committed fiscal improprieties.

(c) The Department or case management entity shall remove any designated common law employer or proxy for any violation of section (5)(a)(C)(ii) or subsection (b) of this section.

(d) Any common law employer, designated common law employer, or proxy may be removed by the case management entity or Department for failure to meet the responsibilities of a common law employer as referenced in section (5)(b) after a documented intervention as outlined in section (6) of this rule.

(e) A common law employer, designated common law employer, or proxy, who is removed by the case management entity or Department may not act in any capacity as a common law employer or proxy for any individual receiving Department-funded services effective:

(A) 30 calendar days from the date of removal; or

(B) Immediately if removed for reasons listed under section (5)(b) of this rule.

(f) If a designated common law employer or proxy is removed, the individual, or their legal or designated representative, may select another designated common law employer or proxy. If a designated common law employer or proxy is not selected and the individual is unable or unwilling to serve as their own common law employer, the individual may only select providers who are not personal support workers.

(8) NOTIFICATION OF DESIGNATED COMMON LAW EMPLOYER OR PROXY REMOVAL. The Department or case management entity shall notify the designated common law employer or proxy, the individual and their legal or designated representative (as applicable), and any personal support workers currently employed by the designated common law employer or proxy of the removal of the designated common law employer or proxy.

(9) REQUEST FOR REINSTATEMENT OF COMMON LAW EMPLOYER, DESIGNATED COMMON LAW EMPLOYER, OR PROXY STATUS.

(a) An individual, designated common law employer, or proxy, is eligible to request reinstatement of their previous common law employer status if:

(A) The common law employer was the individual; or

(B) The designated common law employer or proxy no longer meets the criteria in section (7)(b) of this rule or is removed under section (7)(c) of this rule and the individual or their legal or designated representative agrees to the reinstatement.

(b) Requests for reinstatement:

(A) Must be submitted to the case management entity.

(B) Must include evidence of improvement in the areas for which they were removed. Evidence may include, but is not limited to:

(i) Improvements in health and cognitive functioning; or

(ii) Participation in a Department or case management entity approved training plan.

(C) May be approved by the case management entity when there is evidence of improvement in the ability to perform the responsibilities of being a designated common law employer and the individual agrees with the reinstatement.

(c) A request for reinstatement may not be submitted more than once in a six-month period unless approved by the case management entity.

Stat. Auth.: ORS 409.050
Stats. Implemented: ORS 410.600, 410.606-410.619, 427.007

411-375-0060 Overpayments

(06/26/2016 Renumbered to 411-375-0045)

411-375-0070 Inactivation and Termination of Independent Providers
(Amended 01/25/2019)

(1) An independent provider is not paid for work performed while their provider number is inactivated, inactivated in an emergency, or terminated.

(2) STANDARD INACTIVATION. The Department may inactivate a provider number for an independent provider for any of the following reasons until the independent provider takes action to reinstate their provider enrollment:

(a) The independent provider informs the case management entity the independent provider is no longer providing services in Oregon.

(b) For a personal support worker, the personal support worker fails to participate in a required orientation for personal support workers as described in the Collective Bargaining Agreement.

(c) The background check for an independent provider results in a closed case pursuant to OAR 407-007-0320.

(d) More than two years have passed since the date on the most recent background check final fitness determination for an independent provider.

(e) More than two years have passed since the signature date on the most recent Provider Enrollment Application and Agreement for an independent provider.

(f) The independent provider fails to participate in training required by the Department.

(g) The independent provider does not request a hearing within 10 business days of a notice of proposed termination.

(3) EMERGENCY INACTIVATION.

(a) The Department may immediately inactivate the provider number for an independent provider for any of the following reasons:

(A) The independent provider, whether or not providing any paid services to an individual, is being investigated for any alleged violation of the protective service and abuse rules for suspected abuse that poses imminent danger to current or future individuals.

(B) The independent provider, whether or not providing any paid services to an individual, is being investigated by law enforcement for a crime listed in ORS 443.004.

(C) The independent provider has a credible allegation of fraud according to 42 CFR 455.23.

(b) EMERGENCY INACTIVATION ORDER. The Department shall issue a written order of emergency inactivation of a provider number to the independent provider when the emergency inactivation is based on subsection (a) of this section.

(A) The Department-issued emergency inactivation order must include the following:

(i) Findings of the specific act or omission of the independent provider that violates applicable laws or rules and is the grounds for emergency inactivation.

(ii) The reasons the specified act or omission presents imminent danger to individuals.

(iii) A reference to the law or rule involved, including specific sections and subsections.

(iv) The hearing rights as described in OAR 411-375-0080, including the right to legal representation, if applicable, where to file a hearing request, and the right of the independent provider to request that a hearing be held as soon as practicable to contest the emergency inactivation order. The request for a hearing must be

received by the Department within 90 calendar days of the date of the emergency inactivation order or the independent provider shall waive the right to a hearing regarding the emergency inactivation order.

(v) The effective date of the emergency inactivation.

(B) Service of the emergency inactivation order must be accomplished either by personal service, or service by registered or certified mail.

(4) TERMINATION.

(a) The Department may terminate the provider number for an independent provider for any of the following reasons:

(A) The independent provider violates the requirement to maintain a drug-free work place by either of the following:

(i) Being intoxicated by alcohol, inhalants, prescription drugs, or other drugs, including over-the-counter medications, while responsible for the care of an individual, while in the home of the individual, or while transporting the individual; or

(ii) Manufacturing, possessing, selling, offering to sell, trading, or using illegal drugs while providing authorized services to an individual or while in the home of the individual.

(B) The independent provider has an unacceptable background check and the background check results in a closed case pursuant to OAR 407-007-0320.

(C) The independent provider demonstrates a lack of skills, knowledge, or ability to adequately or safely provide services as defined in OAR 411-375-0010.

(D) The independent provider has a violation of the protective service and abuse rules as defined in OAR 411-375-0010.

(E) Notwithstanding abuse as defined in OAR 411-317-0000, OAR 407-045-0260, OAR 411-020-0002, or child abuse as defined in OAR 413-015-0115, the independent provider fails to safely and adequately provide authorized services.

(F) The independent provider commits fiscal improprieties including, but not limited to, billing excessive or fraudulent charges or has a conviction for fraud according to 42 CFR 455.23.

(G) The independent provider fails to provide services to an individual as described in the individual's Service Agreement or ISP.

(H) The independent provider lacks the ability or willingness to maintain individual confidentiality.

(I) The independent provider engages in repeated unacceptable conduct at work, such as the following:

(i) Delay in arriving to work or absences from work not scheduled in advance with the individual, or as applicable their legal or designated representative, that are either unsatisfactory to the individual, or as applicable their legal or designated representative, or that neglect the service needs of the individual; or

(ii) Inviting unwelcome guests or pets into the home or community with the individual resulting in the dissatisfaction of the individual, or as applicable their legal or designated representative, or inattention to the service needs of the individual.

(J) The independent provider has been excluded or debarred by the Office of the Inspector General.

(K) The independent provider fails to perform the applicable duties as a mandatory reporter as required by any of the following:

(i) ORS 419B.010 and 419B.015 for abuse of a child.

(ii) ORS 124.060 and 124.065 for abuse of an older adult 65 years of age or older.

(iii) ORS 430.737 and 430.743 for abuse of an adult with an intellectual or developmental disability or mental illness.

(iv) ORS 441.640 and 441.645 for abuse of a resident of a long-term care facility as defined in ORS 442.015.

(L) The independent provider fails to provide a Taxpayer Identification Number or Social Security number that matches the legal name of the independent provider as verified by the Internal Revenue Service or Social Security Administration.

(M) The independent provider fails to complete training required by the Department as a condition of retaining their provider number due to a violation of these rules.

(N) The independent provider has been suspended or terminated as a provider by another division within the Department or by the Oregon Health Authority.

(O) Notwithstanding abuse as defined in OAR 411-317-0000, OAR 407-045-0260, OAR 411-020-0002, or child abuse as defined in OAR 413-015-0115, the independent provider either:

(i) Uses a safeguarding intervention or safeguarding equipment as a restraint without training in an ODDS-approved behavior intervention system.

(ii) Uses a safeguarding intervention or safeguarding equipment as a restraint not meeting the standards in OAR 411-375-0035.

(b) NOTIFICATION OF PROPOSED TERMINATION. The Department must issue a written notice of the proposed termination of

a provider number to the independent provider when the termination is based on subsection (a) of this section.

(A) For terminations based on a violation of the protective service and abuse rules, the written notice of termination may only contain the information allowed by law. In accordance with ORS 430.753, 430.763, and OAR 411-020-0030, the name of a complainant, witness, or alleged victim, and protected health information may not be disclosed.

(B) The Department-issued written notice of the proposed termination must include the following:

(i) Findings of the specific act or omission of the independent provider that violates applicable laws or rules and is the grounds for termination.

(ii) A reference to the law or rule involved, including specific sections and subsections.

(iii) The hearing rights, if any, of the independent provider as described in OAR 411-375-0080, including the right to legal representation, if applicable, and where to file a request for hearing.

(iv) The effective date of the termination.

(C) Service of the notification of proposed termination must be accomplished either by personal service, or service by registered or certified mail.

(c) RETENTION OF PROVIDER NUMBER PENDING TERMINATION HEARING OUTCOME.

(A) Unless an independent provider is immediately inactivated as described in section (3) of this rule, the provider number of an independent provider may not be inactivated during the first 10 business days after a notice of proposed termination to provide the opportunity for the independent provider to file a request for hearing.

(i) The independent provider must file a request for hearing within 10 business days from the date of the notice of proposed termination if the independent provider wishes to continue to work during the hearing process as described in OAR 411-375-0080.

(ii) If the independent provider files a written request for a hearing prior to the deadline, the provider number of the independent provider may not be terminated until the hearing process is concluded.

(B) EXCLUSIONS. An independent provider may be terminated immediately by the Department for any of the following reasons and the independent provider may not continue to work during the hearing process as described in OAR 411-375-0080 when termination is based on the following:

(i) A background check. The independent provider has the right to a hearing in accordance with OAR 407-007-0200 to 407-007-0370.

(ii) Being excluded or debarred by the Office of the Inspector General.

(iii) A conviction for fraud according to 42 CFR 455.23.

(iv) An alleged violation listed in subsection (a) of this section and the alleged violation presents imminent danger to current or future individuals.

(d) TERMINATION IF NO HEARING REQUEST FILED.

(A) An independent provider must file a request for hearing as described in OAR 411-375-0080 within 30 calendar days from the date of the notice of proposed termination.

(B) The decision of the Department becomes final if an independent provider does not request a hearing within 30

calendar days from the date of the notice of proposed termination.

(C) The Department shall issue a final order by default to the independent provider in accordance with OAR 137-003-0670. The provider enrollment for the independent provider is terminated once the time period for the independent provider to request a hearing has expired.

Stat. Auth.: ORS 409.050
Stats. Implemented: ORS 410.600, 410.606-410.619, 427.007

411-375-0080 Hearing Rights
(Amended 01/25/2019)

(1) EXCLUSIONS. The following are excluded from the hearings process described in this rule:

(a) Terminations based on a background check. The independent provider has the right to a hearing in accordance with OAR 407-007-0200 through 407-007-0370.

(b) Termination based on being excluded or debarred by the Office of the Inspector General.

(c) Termination based on a conviction for fraud according to 42 CFR 455.23.

(d) Standard inactivation as described in OAR 411-375-0070.

(e) Independent providers that are denied a provider enrollment number at the time of initial application.

(2) EMERGENCY INACTIVATION.

(a) If an independent provider files a timely hearing request as described in OAR 411-375-0070, the matter shall be referred to the Office of Administrative Hearings, a hearing on the emergency inactivation shall be held, and a final order shall be issued in

accordance with the following timelines, unless a delay is explained in the final order as required by subsection (e) of this section:

(A) Within seven calendar days of receiving a timely request for hearing, the Department shall refer the matter to the Office of Administrative Hearings to hold a hearing on the emergency inactivation order.

(B) Within 30 calendar days of receiving a referral for a hearing on an emergency inactivation order, the Office of Administrative Hearings shall complete the hearing and close the evidentiary record.

(C) Within 15 calendar days of the close of the evidentiary record in the hearing, the Office of Administrative Hearings shall issue a proposed order or a final order, if the Department has delegated authority to issue a final order.

(D) Within 15 calendar days of receiving a proposed order from the Office of Administrative Hearings, the Department shall issue a final order.

(b) The time limits established in subsection (a) of this section may be waived or extended with the agreement of the Department and the independent provider.

(c) The hearing on an emergency inactivation order may be combined with any related agency proceeding affecting the provider number only with the agreement of the independent provider.

(d) At the hearing regarding the emergency inactivation order, the administrative law judge shall consider the facts and circumstances including, but not limited to the following:

(A) Whether the acts or omissions of the independent provider pose imminent danger to individuals; and

(B) Whether circumstances at the time of the hearing justify confirmation, alteration, or revocation of the order.

(e) The administrative law judge shall issue a proposed order consistent with OAR 137-003-0645 unless the administrative law judge has authority to issue a final order without first issuing a proposed order. A proposed order shall contain a recommendation whether the emergency inactivation order is confirmed, altered, or revoked. The final order shall be consistent with OAR 137-003-0665 and shall be based upon the criteria in subsection (d) of this section. If any of the deadlines specified in subsection (a) of this section are not met, the final order shall state the reason.

(3) TERMINATIONS.

(a) An independent provider may file a request for a hearing with the Department if the independent provider disputes the decision to terminate the provider number of the independent provider except when excluded under section (1) of this rule. If an independent provider decides to file a request for hearing, the independent provider must specify in the request, the issues or decisions being disputed and the reason for the request.

(b) The request for a hearing must be filed in writing on the Department approved form with the Department within 30 calendar days from the effective date of the termination included on the notification of proposed termination.

(c) INFORMAL CONFERENCE. The Department offers an informal conference for proposed terminations, as described in OAR 461-025-0325, to an independent provider within five business days from the receipt of a request for hearing.

(A) The independent provider has 10 business days to respond to the offer for an informal conference with the Department.

(B) If the independent provider accepts the offer of an informal conference, the informal conference must be scheduled with the independent provider and, if requested, a legal representative. The informal conference must involve the independent provider and the Department to review the facts, and explain the decision to terminate the provider enrollment. The informal conference may be held by telephone. At the

discretion of the Department representative, the Department representative may grant an additional informal conference to facilitate the hearing process.

(C) Participation in an informal conference by the independent provider is not required.

(4) The referral of a hearing request by the Department to the Office of Administrative Hearings is subject to OAR 137-003-0515.

(5) BURDEN OF PROOF. The Department has the burden of proving the decision to emergency inactivation or termination of the provider enrollment of an independent provider by a preponderance of the evidence. Evidence submitted for a hearing is governed by OAR 137-003-0610.

Stat. Auth.: ORS 409.050
Stats. Implemented: ORS 410.600, 410.606-410.619, 427.007