

**OREGON DEPARTMENT OF HUMAN SERVICES
OFFICE OF DEVELOPMENTAL DISABILITIES SERVICES
OREGON ADMINISTRATIVE RULES**

**CHAPTER 411
DIVISION 380**

**DIRECT NURSING SERVICES FOR ADULTS WITH INTELLECTUAL OR
DEVELOPMENTAL DISABILITIES**

EFFECTIVE JUNE 1, 2021

411-380-0010 Statement of Purpose

(Adopted 06/29/2016)

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

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

Stat. Auth.: ORS 409.050, 413.085

Stats. Implemented: ORS 409.050, 413.085

411-380-0020 Definitions and Acronyms

(Amended 06/01/2021)

In addition to the following definitions, OAR 411-317-0000 includes general definitions for words and terms frequently used in OAR chapter 411, division 380. If a word or term is defined differently in OAR 411-317-0000, the definition in this rule applies.

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

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

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

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

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

(6) "Direct Nursing Services Agency" means an agency certified under OAR chapter 411, division 323 and endorsed to deliver direct nursing services under these rules.

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

(8) "Enrolled Medicaid Provider" means a provider that meets and completes all the requirements in these rules, OAR 407-120-0300 through 407-120-0400, and OAR chapter 410, division 120, as applicable.

(9) "Home Health Agency" has the meaning given that term in ORS 443.014.

(10) "HSD" means Health Systems Division, Medical Assistance Programs under OHA.

(11) "Individual" means an adult, 21 years of age or older, eligible for direct nursing services according to OAR 411-380-0030.

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

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

(14) "LPN" means a licensed practical nurse who holds a current license from the Oregon State Board of Nursing according to ORS chapter 678 and OAR chapter 851, division 045. An LPN providing direct nursing services under these rules is either one of the following:

(a) An independent contractor who is an enrolled Medicaid provider.

(b) An employee of an in-home care agency, home health agency, or direct nursing services agency.

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

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

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

(18) "Nurse" means an "LPN" or "RN".

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

(20) "Nursing Service Plan" means the written guidelines developed by an RN as described in OAR 411-380-0050 that identifies the specific needs of

an individual and the intervention or regimen to assist the individual to achieve optimal health potential. Developing the Nursing Service Plan includes a comprehensive and focused nursing assessment of the health status of the individual as part of the standards outlined in OAR 851-045-0060(3), establishing individual and nursing goals, and determining nursing interventions to meet care objectives.

(a) The Nursing Service Plan is specific to an individual and identifies the diagnoses and health needs of the individual and all direct nursing service needs.

(b) The Nursing Service Plan is separate from the ISP as well as any service plans developed by other health professionals.

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

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

(23) "Prior Authorization" means payment authorization for direct nursing services given by the Department or case management entity prior to the delivery of the service. A physician referral is not a prior authorization for services.

(24) "Provider" means an enrolled Medicaid provider who is qualified to deliver direct nursing services according to OAR 411-380-0060 and is either one of the following:

(a) A nurse.

(b) An in-home care agency, home health agency, or direct nursing services agency.

(25) "RN" means a registered nurse who holds a current license from the Oregon State Board of Nursing according to ORS chapter 678 and OAR chapter 851, division 045. An RN providing direct nursing services under these rules is either one of the following:

(a) An independent contractor who is an enrolled Medicaid provider.

(b) An employee of an in-home care agency, home health agency, or direct nursing services agency that is an enrolled Medicaid provider.

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

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

Stat. Auth.: ORS 409.050, 413.085, 427.104

Stats. Implemented: ORS 409.010, 413.085, 427.007, 427.104

411-380-0030 Eligibility and Limitations for Direct Nursing Services
(Amended 06/01/2021)

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

(a) Be 21 years of age or older.

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

(c) Be receiving a Medicaid Title XIX benefit package through OSIPM or the HSD Medical Program. Individuals receiving Medicaid Title XIX under the HSD Medical Program for services in a nonstandard living arrangement as defined in OAR 461-001-0000 are subject to the requirements in the same manner as if the individual requested these services under OSIPM, including the rules regarding:

(A) The transfer of assets as set forth in OAR 461-140-0210 to 461-140-0300; and

(B) The equity value of a home which exceeds the limits as set forth in OAR 461-145-0220.

(d) Be determined to meet the ICF/IID Level of Care as defined in OAR 411-317-0000.

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

(f) Score 45 or higher on the Direct Nursing Services Criteria completed by the Department.

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

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

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

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

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

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

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

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

(3) SERVICE DELIVERY.

(a) Except as limited under section (4)(a) of this rule, direct nursing services may be delivered at the following:

(A) An individual's home.

(B) An adult foster home as described in OAR chapter 411, division 360.

(C) A licensed 24-hour residential setting as described in OAR chapter 411, division 325.

(D) An employment setting as described in OAR chapter 411, division 345.

(E) A day service site.

(F) In the community.

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

(4) LIMITATIONS.

(a) Direct nursing services are excluded for the following:

(A) An individual while in a medical or psychiatric hospital.

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

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

(c) Direct nursing services provided concurrently with hospice services provided under OAR 410-142-0240 or home health care services provided under OAR 410-127-0040 are not reimbursable under these rules.

(d) Direct nursing services are not covered in conjunction with any intravenous, enteral, or parenteral related skilled nursing services as described in OAR 410-148-0300.

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

(f) Direct nursing services do not include any of the following:

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

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

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

(D) Long-term care community nursing services, including nurse delegations, as described in OAR chapter 411, division 048.

Stat. Auth.: ORS 409.050, 413.085, 427.104

Stats. Implemented: ORS 409.010, 413.085, 427.007, 427.104

411-380-0040 Complaints, Notifications of Planned Actions, and Hearings

(Amended 06/01/2021)

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

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

(3) HEARINGS.

(a) Hearings must be addressed in accordance with ORS chapter 183 and OAR 411-318-0025.

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

Stat. Auth.: ORS 409.050, 413.085, 427.104

Stats. Implemented: ORS 409.010, 413.085, 427.007, 427.104

411-380-0050 Direct Nursing Service Requirements

(Amended 06/01/2021)

(1) DIRECT NURSING SERVICES CRITERIA. The Department uses the Direct Nursing Services Criteria at the following times:

(a) For initial eligibility of direct nursing services.

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

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

(2) NURSING SERVICE PLAN. Each individual must have a written Nursing Service Plan that meets the standards in OAR chapter 851, division 045.

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

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

(A) Every six months.

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

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

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

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

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

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

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

(b) Is attending employment or day service activities;

(c) Needs 2:1 staffing in the community; or

(d) Has authorized direct nursing services with a nursing ratio other than 1:1 as described in section (7) of this rule.

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

(6) Direct nursing services include, but are not limited to the following:

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

(b) Skilled nursing tasks.

- (c) Nursing interventions.
- (d) Implementation of treatment and therapies.
- (e) Data collection, including ventilator, medication, or seizure logs.
- (f) Documentation, including shift notes and flow sheets.
- (g) Written and oral communication with individuals, physicians and other health professionals, other caregivers, case management entities, ISP teams, foster care providers, and agency providers.
- (h) Other nursing responsibilities under OAR 851-045-0040 approved by the Department.

(7) NURSING RATIOS.

- (a) Direct nursing services must be provided exclusively unless direct nursing services are authorized for an individual with a nursing ratio other than 1:1 as described in subsection (c) of this section.
- (b) Individuals determined eligible at an acuity level 1 based on the Direct Nursing Services Criteria in OAR 411-380-0030(2) are not eligible for a nursing ratio other than 1:1.
- (c) Individuals determined eligible at acuity levels 2 through 6 based on the Direct Nursing Services Criteria in OAR 411-380-0030(2) may have a nursing ratio no higher than 1:2 or one nurse for two individuals per shift. The nursing ratio may be determined by the provider using their professional judgement at the beginning of each shift:
 - (A) After reviewing any previous shift documentation; and
 - (B) After an initial assessment of the medical condition of each individual.
- (d) The decision to have an alternative nursing ratio must be documented as described in OAR 411-380-0080.

Stat. Auth.: ORS 409.050, 413.085, 427.104

Stats. Implemented: ORS 409.010, 413.085, 427.007, 427.104

411-380-0060 Qualifications for Providers of Direct Nursing Services
(Amended 06/01/2021)

(1) Direct nursing services may be delivered by the following enrolled Medicaid providers:

(a) A self-employed LPN or RN licensed under ORS 678.021 that may also be an adult foster home provider or family member.

(A) An adult foster home provider must also be licensed under OAR 411-360-0040.

(B) The decision to have an adult foster home provider or family member deliver direct nursing services must:

(i) Be made by the individual and the ISP team;

(ii) Be documented; and

(iii) Not be for the convenience of the adult foster home provider or family member.

(b) Home health agency licensed under ORS 443.015 and meeting the requirements in OAR chapter 333, division 027.

(c) In-home care agency licensed under ORS 443.315 and meeting the requirements in OAR chapter 333, division 536.

(d) A direct nursing services agency meeting the requirements in OAR 411-380-0065.

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

(3) A provider of direct nursing services must:

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

(b) Meet and maintain the provider enrollment requirements under OAR 407-120-0320 and section (5) of this rule. .

(4) At least one year of experience working with individuals with intellectual or developmental disabilities is recommended, but not required.

(5) PROVIDER ENROLLMENT.

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

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

(B) Completing a Background Check as described in OAR 407-007-0200 through 407-007-0370. Background check approval is effective for two years from the initial fitness determination; and

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

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

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

Stat. Auth.: ORS 409.050, 413.085, 427.104

Stats. Implemented: ORS 409.010, 413.085, 427.007, 427.104

411-380-0065 Standards for Direct Nursing Services Agencies
(Adopted 06/01/2021)

(1) CERTIFICATION, ENDORSEMENT, AND ENROLLMENT. In addition to completing the provider enrollment requirements in OAR 411-380-0060, a direct nursing services agency must also have the following:

(a) A certificate and endorsement to deliver direct nursing services according to OAR chapter 411, division 323.

(b) A Medicaid Agency Identification Number assigned by the Department as described in OAR chapter 411, division 370.

(2) POLICIES AND PROCEDURES. A direct nursing services agency must develop and implement written policies and procedures required for administration and operation in compliance with these rules including, but not limited to, all of the following:

(a) Assuring each RN and LPN employed by the agency has a current and unencumbered license from the Oregon State Board of Nursing.

(b) Protecting individual rights according to OAR 411-318-0010.

(c) Addressing individual complaints according to OAR 411-380-0040.

(d) Complying with all of the following:

(A) Management and personnel practices described in OAR 411-323-0050.

(B) Confidentiality of records according to OAR 411-323-0060.

(C) Inspections and investigations according to OAR 411-323-0040.

(D) Complaints of abuse and serious incidents must be treated as described in OAR 411-323-0063.

Stat. Auth.: ORS 409.050, 413.085, 427.104

Stats. Implemented: ORS 409.010, 413.085, 427.007, 427.104

411-380-0070 Provider Disenrollment and Termination
(Amended 06/01/2021)

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

- (a) Violation of any part of these rules.
- (b) A founded report of child abuse or substantiation of a violation of the protective service and abuse rules in OAR chapter 411, division 020 or OAR chapter 407, division 045.
- (c) Any sanction or action as a result of an investigation of the Oregon State Board of Nursing.
- (d) Failure to keep required licensure or certifications current.
- (e) Failure to provide copies of the records described in these rules to OHA, the Department, or case management entity.
- (f) Failure to participate in the review of the Nursing Service Plan or care coordination meetings when requested by the case management entity.
- (g) Failure to provide services.
- (h) Fraud or misrepresentation in the provision of direct nursing services.
- (i) Evidence of conduct derogatory to the standards of nursing as described in OAR 851-045-0070 that results in referral to the Oregon State Board of Nursing.
- (j) A demonstrated pattern of repeated unsubstantiated complaints of neglect or abuse per OAR chapter 411, division 020 or OAR chapter 407, division 045.
- (k) The provider is listed in the exclusions database of the Office of the Inspector General.

(2) Enrolled Medicaid providers may appeal a termination of their Medicaid provider number based on OAR 407-120-0360(8)(g) and OAR chapter 410, division 120, as applicable.

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

Stat. Auth.: ORS 409.050, 413.085, 427.104

Stats. Implemented: ORS 409.010, 413.085, 427.007, 427.104

411-380-0080 Provider Documentation and Records

(Amended 06/01/2021)

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

(2) Documentation must comply with OAR chapter 851 and must include all of the following:

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

(b) The date of service.

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

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

(e) Interventions.

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

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

(h) Full signature of the provider.

(3) Documentation of provided direct nursing services must be sent to the case management entity upon request or as outlined in the ISP and maintained in the home, foster home, 24-hour residential setting, or the place of business of the provider of services.

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

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

(6) Per OAR 410-120-1360(2)(e), providers must:

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

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

Stat. Auth.: ORS 409.050, 413.085, 427.104

Stats. Implemented: ORS 409.010, 413.085, 427.007, 427.104

411-380-0090 Provider Billing and Payment

(Amended 06/01/2021)

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

(a) Based on acuity levels from the Direct Nursing Services Criteria and documented on an individual's Direct Nursing Service Criteria Memo.

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

(2) PRIOR AUTHORIZATION.

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

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

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

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

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

(D) Failure to perform other expected duties.

(3) CLAIMS.

(a) A provider must comply with the rules for timely submission of claims as written in OAR 410-120-1300 and authorization of payment in OAR 410-120-1320. A provider must submit a claim for payment to the case management entity within 12 months of the date of service.

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

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

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

(A) A false billing form for payment.

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

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

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

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

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

(h) Claims for direct nursing services may be paid for nursing ratio other than 1:1 as long as each individual's case does not overlap with another individual's case. Only time spent with each individual may be billed. Claims must be billed in 15 minute units.

(4) PAYMENT.

(a) Payment for direct nursing services is made in accordance with the following:

(A) These rules.

(B) OAR 410-120-1300 for timely submission of claims.

(C) OAR 410-120-1320 for authorization of payment.

(D) OAR 410-120-1340 for payment.

(E) OAR 410-120-1380 for compliance with federal and state statutes.

(F) OAR 407-120-0300 to 407-120-0400 for provider enrollment and claiming.

(G) OAR 407-120-1505 for provider and contractor audits, appeals, and post payment recoveries.

(b) Funds may not be used to support, in whole or in part, a provider in any capacity who has been convicted of any of the disqualifying crimes listed in ORS 443.004.

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

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

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

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

(g) Overtime hours are not authorized.

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

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

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

Stat. Auth.: ORS 409.050, 413.085, 427.104

Stats. Implemented: ORS 409.010, 413.085, 427.007, 427.104