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

CHAPTER 411
DIVISION 48

LONG TERM CARE COMMUNITY NURSING

411-048-0150 Purpose
(Temporary Effective 7/1/2013 - 12/28/2013)

(1) The rules in OAR chapter 411, division 048 establish standards and procedures for Medicaid enrolled providers who provide long term care community nursing services. Long term care community nursing services provide ongoing registered nurse (RN) services to eligible individuals who are receiving Medicaid funded home and community-based waivered or state plan services in a home based or foster home setting.

(2) Long term care community nursing services provide:

(a) Evaluation and identification of supports that help an individual maintain maximum functioning and minimize health risks, while promoting the individual's autonomy and self management of healthcare;

(b) Teaching an individual's caregiver or family that is necessary to assure the individual's health and safety in a home based or foster home setting;

(c) Delegation of nursing tasks to an individual’s caregiver; and

(d) Case managers and health professionals with the information needed to maintain the individual’s health, safety, and community living situation while honoring the individual's autonomy and choices.

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

411-048-0160 Definitions
(Temporary Effective 7/1/2013 - 12/28/2013)

(1) "AAA" means the Area Agency on Aging designated by the Department that is responsible for providing a comprehensive and coordinated system of services to older adults or adults with disabilities in a designated planning and service area.

(2) "Abuse" means:

(a) Abuse of a child:

(A) As defined in ORS 419B.005; and

(B) As defined in OAR 407-045-0260, when a child resides in a foster home licensed by the Department to provide residential services to a child with developmental disabilities.

(b) Abuse of an adult or older adult:

(A) As defined in ORS 124.050-095 and ORS 430.735-765; and

(B) As defined in OAR 407-045-0260 for individuals 18 years or older with developmental disabilities that reside in a Department licensed adult foster home; or

(C) As defined in OAR 411-020-0002 for older adults and adults with a physical disability who are 18 years of age or older that reside in a Department licensed adult foster home.

(3) "Acute Care Nursing" means, for the purpose of these rules, nursing services provided on an intermittent or time limited basis such as those provided by a hospice agency as defined in ORS 443.850, or a home health agency as defined in ORS 443.005. Acute care nursing may include direct service and is designed to address a specific task of nursing or a short term health condition.

(4) "Business Day" means the day that the "Local Office" is open for business.

(5) "Care Coordination" means the email, faxes, phone calls, meetings and other types of information exchange, consultation, and advocacy provided by a registered nurse on behalf of an individual that is necessary for the registered nurse to conduct assessments, complete medication reviews, provide for individual safety needs, and implement an individual's Nursing Service Plan.

(6) "Caregiver" means any person responsible for providing services to an eligible individual in a home based or foster home setting. For the purpose of these rules, a caregiver may include an unlicensed person defined as a designated caregiver in OAR chapter 851, division 48 (Standards for Provision of Nursing Care by a Designated Caregiver).

(7) "Case Manager" means a person employed by the Department, Community Developmental Disability Program, or Area Agency on Aging who assesses the service needs of an applicant, determines eligibility, and offers service choices to the eligible individual. The case manager authorizes and implements an individual's plan for services and monitors the services delivered.

(8) "CDDP" means the Community Developmental Disability Program responsible for the planning and delivery of services for individuals with developmental disabilities according to OAR chapter 411, division 320. A CDDP operates in a specific geographic service area of the state under a contract with the Department, local mental health authority, or other entity as contracted by the Department.

(9) "Delegation" means, for the purpose of these rules, the standards and processes described in OAR chapter 851, division 047 (Standards for Community Based Care Registered Nurse Delegation).

(10) "Department" means the Department of Human Services or the Department's designee.

(11) "Department Approved Form" means forms used by registered nurses and case managers to support these rules. The Department maintains these documents on the Department's website (http://www.oregon.gov/dhs/spd/pages/provtools/nursing/forms.aspx). Printed copies may be obtained by contacting the Department of Human

Services, ATTN: Rule Coordinator, 500 Summer Street NE, E10, Salem, OR 97301.

(12) "Direct Hands-on Nursing" means a registered nurse provides treatment or therapies directly to an individual instead of teaching or delegating the tasks of nursing to the individual's caregiver. Payment for direct hands-on nursing services is not reimbursed unless an exception has been granted by the Department as described in OAR 411-048-0170.

(13) "Documentation" means a written record of all services provided to, and for, an individual and an individual's caregiver that is maintained by the registered nurse as described in OAR 411-048-0200.

(14) "Enrolled Medicaid Provider" means an entity or individual that meets and completes all the requirements in these rules, OAR 407-120-0300 to 0400 (Medicaid Provider Enrollment and Claiming), and OAR chapter 410, division 120 (Medicaid General Rules) as applicable.

(15) "Foster Home" means any Department licensed or certified family home in which residential services are provided as described in:

(a) OAR chapter 411, division 050 for adult foster homes for older adults and adults with physical disabilities;

(b) OAR chapter 411, division 346 for foster homes for children with developmental disabilities; and

(c) OAR chapter 411, division 360 for adult foster homes for individuals with developmental disabilities.

(16) "Healthcare Provider" means a licensed provider providing services such as but not limited to home health, hospice, mental health, primary care, specialty care, durable medical equipment, pharmacy, or hospitalization to an eligible individual.

(17) "Home" means a non-licensed setting where an individual is receiving home and community-based waivered or state plan services.

(18) "Home Health Agency" has the meaning given that term in ORS 443.005.

(19) "Individual" means a person eligible for community nursing services under these rules.

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

(21) "Local Office" means the Department office, Area Agency on Aging, or Community Developmental Disability Program responsible for Medicaid services including case management, referral, authorization, and oversight of long term care community nursing services in the region where the individual lives and where the community nursing services are delivered.

(22) "Long Term Care Community Nursing Services (Community Nursing Service)" mean, for the purpose of these rules, the nursing services provided under these rules to individuals living in a home based or foster home setting where the monthly home and community-based waivered or state plan services rate does not include nursing services. Long term care community nursing services are a distinct set of services that focus on an individual’s chronic and ongoing health and activity of daily living needs. Long term care community nursing services include an assessment, monitoring, delegation, teaching, and coordination of services that addresses an individual’s health and safety needs in a Nursing Service Plan that supports individual choice and autonomy. The requirements in these rules are provided in addition to any nursing related requirements stipulated in the licensing rules governing the individual's place of residence.

(23) "Medication Review" means a review focused on an individual's medication regime that includes examination of the prescriber's orders and related administration records, consultation with a pharmacist or the prescriber, clarification of PRN (as needed) parameters, and the development of a teaching plan based upon the needs of the individual or the individual's caregiver. In an unlicensed setting, the medication review may include observation and teaching related to administration methods and storage systems.

(24) "Nursing Assessment" means one of the following assessments selected by the registered nurse based on an individual's need and situation:

(a) A "nursing assessment" as defined in OAR 851-047-0010 (Standards for Community Based Care Registered Nurse Delegation); or

(b) A "comprehensive assessment" or "focused assessment" as defined in OAR 851-045-0030 (Standards and Scope of Practice for the Licensed Practical Nurse and Registered Nurse).

(25) "Nursing Service Plan" means the plan that is developed by the registered nurse based on an individual's initial nursing assessment, reassessment, or updates made to a nursing assessment as a result of monitoring visits.

(a) The Nursing Service Plan is specific to the individual and identifies the individual's diagnoses and health needs, the caregiver's teaching needs, and any care coordination, teaching, or delegation activities.

(b) The Nursing Service Plan is separate from the case manager's service plan, the foster home provider’s service plan, and any service plans developed by other health professionals.

(c) Nursing service plans must meet the standards in OAR chapter 851, division 045 (Standards and Scope of Practice for the Licensed Practical Nurse and Registered Nurse).

(26) "OSBN" means the Oregon State Board of Nursing. OSBN is the agency responsible for regulating nursing practice and education for the purpose of protecting the public's health, safety, and well-being.

(27) "Rate Schedule" means the communication tool issued by the Department to transmit rate changes to partners, subcontractors, and stakeholders. The Department maintains this document on the Department's website (http://www.oregon.gov/dhs/spd/provtools/rateschedule.pdf). Printed copies may be obtained by contacting the Department of Human Services, ATTN: Rule Coordinator, 500 Summer Street NE, E10, Salem, OR 97301.

(28) "RN" means a registered nurse licensed by the Oregon State Board of Nursing. An RN providing long term care community nursing services under

these rules is either an independent contractor who is an enrolled Medicaid provider or an employee of an organization that is an enrolled Medicaid provider.

(29) "These Rules" mean the rules in OAR chapter 411, division 048.

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

411-048-0170 Eligibility and Limitations
(Temporary Effective 7/1/2013 - 12/28/2013)

(1) ELIGIBILITY. Community nursing services may be provided by an RN to an individual if the individual meets the following requirements:

(a) The individual must be determined eligible for home and community-based waivered or state plan services provided through the Department;

(b) The individual must be receiving services through one of the following:

(A) Long term supports for children with developmental disabilities as described in OAR chapter 411, division 308;

(B) Adult foster homes for individuals with developmental disabilities as described in OAR chapter 411, division 360;

(C) Foster homes for children with developmental disabilities as described in OAR chapter 411, division 346;

(D) Comprehensive in home support for adults with developmental disabilities as described in OAR chapter 411, division 330;

(E) Adult foster homes for older adults and adults with physical disabilities as described in OAR chapter 411, division 050;

(F) Independent Choices Program participants as described in OAR chapter 411, division 030;

(G) 1915C Nursing Facility Waiver; or

(H) State Plan K Community First Choice;

(c) The individual must live in a home or a foster home as defined in OAR 411-048-0160;

(d) The individual must be referred by their case manager for long term care community nursing services. Individuals may request long term community nursing services through their case manager.

(2) LIMITATIONS.

(a) Long term care community nursing services may not be provided to:

(A) A resident of a nursing facility, assisted living facility, residential care facility, 24 hour developmental disability group home, or intermediate care facility for individuals with developmental disabilities;

(B) An individual enrolled in a brokerage, Independent Choices, or other support services not funded by home and community-based waivered or state plan services; or

(C) An individual enrolled in a program or residing in a setting where nursing services are provided under a monthly service rate.

(b) Case managers may not prior authorize long term care community nursing services that duplicate nursing services provided by Medicare or other Medicaid programs.

(c) Long term care community nursing services do not include nursing activities used for administrative functions such as protective service investigations, pre-admission screenings, eligibility determinations, licensing inspections, case manager assessments, or corrective action activities. This limitation does not include authorized care coordination as defined in OAR 411-048-0160.

(d) Long term care community nursing services do not include reimbursement for direct hands-on nursing as defined in OAR 411-048-0160.

(3) EXCEPTIONS. An exception to sections (2)(c) and (2)(d) of this rule may be requested as described in OAR 411-048-0250.

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

411-048-0180 Long Term Care Community Nursing Services
(Adopted 4/15/2013)

When authorized by an individual's case manager, the following long term care community nursing services must be provided by an RN in accordance with these rules and the scope of practice as stated in the Oregon State Board of Nursing rules in OAR chapter 851.

(1) REVIEW OF REFERRAL. An RN must screen a referral and notify the individual's case manager of their decision to accept or refuse the referral within two business days of receiving the referral on the Department approved form. The RN may refuse any referral.

(2) INITIAL ASSESSMENT. The RN must perform a face-to-face comprehensive nursing assessment as defined in OAR 851-045-0030 within 10 business days following the acceptance of the individual's referral.

(a) The RN must conduct and document the comprehensive nursing assessment as specified in OAR chapter 851, division 045.

(b) The RN must send copies of the comprehensive nursing assessment to the individual's case manager. If the RN recommends ongoing long term care community nursing services, the RN must send a Nursing Service Plan as described in section (4) of this rule with the individual's comprehensive nursing assessment.

(3) REASSESSMENT. The RN must perform a face-to-face reassessment and update the individual's Nursing Service Plan at least annually and

more frequently at the RN's discretion if the individual experiences a change of condition or change of environment. Based on individual need, the RN must determine if this reassessment is a focused or comprehensive assessment as defined in OAR 851-045-0030.

(a) The RN must conduct and document the comprehensive or focused assessment as specified in OAR chapter 851, division 045.

(b) The RN must complete the reassessment within 10 business days of the date the reassessment started.

(c) The RN must send copies of the reassessment to the individual's case manager and include an updated Nursing Service Plan as described in section (4) of this rule.

(4) NURSING SERVICE PLAN. Based on the initial assessment or reassessment, the RN must develop or update the individual's Nursing Service Plan.

(a) The Nursing Service Plan must describe the needs of the individual and the individual's caregiver and the specific interventions the RN intends to provide to meet those needs including scope, duration, and frequency.

(b) An RN must complete and document Nursing Service Plans on the Department approved form and provide the Nursing Service Plan to an individual's case manager within 10 business days of the date that an initial assessment or a reassessment is initiated.

(c) An RN must attend a minimum of two Nursing Service Plan review meetings each year with a case manager. The RN and the case manager may agree to conduct the Nursing Service Plan review meeting by phone.

(5) DELEGATION. An RN must follow the standards and documentation requirements for delegation of nursing tasks as required by OAR chapter 851, division 047 (Standards for Community Based Care Registered RN Delegation).

(a) The RN alone, based on professional judgment and regulation, makes the determination to delegate or not delegate a nursing task, or to rescind a delegation.

(b) The RN must provide the case manager with an estimate of the number of hours of delegation the individual needs on the Nursing Service Plan and keep the case manager informed of ongoing delegation activities on the Service Summary form.

(c) The RN must keep the adult foster home provider informed of the delegation decisions and activities provided to caregivers in their home.

(6) TEACHING. An RN must follow the standards and documentation requirements for teaching health promotion as described in OAR 851-045-0060.

(a) In an overall teaching plan, the RN must describe and document the reason the teaching is needed and the specific goals for the individual or the individual's caregiver.

(b) An RN must follow the standards for community based care RN delegation in OAR chapter 851, division 047 and the standards for provision of nursing care by a designated caregiver in OAR chapter 851, division 048 when teaching an individual and the individual's caregiver the nursing tasks needed to meet the individual's health care needs.

(c) Teaching related to non-injectable medications or anticipated emergencies must be provided by an RN in accordance with OAR chapter 851, division 047 (Standards for Community Based Care RN Delegation).

(7) MONITORING. An RN must provide home based monitoring visits as needed to oversee and implement an individual's Nursing Service Plan.

(a) The RN must document the projected frequency of monitoring visits in an individual's Nursing Service Plan and may adjust the frequency based on the complexity of the Nursing Service Plan and the individual's needs.

(b) Calls with adult foster home providers, caregivers, or an individual to review health status, follow up on instructions, or exchange information related to care coordination are considered a monitoring visit.

(8) MEDICATION REVIEW. An RN must provide a medication review during each monitoring visit and as part of an initial assessment or reassessment. The scope of a medication review shall be based on the RN's judgment and the needs of the individual or the individual's caregiver. Information gathered as part of a medication review may result in changes to an RN's Teaching Plan or care coordination activity.

(9) CARE COORDINATION. An RN provides care coordination in order to advocate for health care services that an individual needs and to gather the information that is needed in the assessment or reassessment process, medication review, or Nursing Service Plan implementation. An RN uses care coordination to provide updated information to people involved in an individual’s health care via phone calls, faxes, electronic mediums, or meetings. Care coordination is provided but not limited to case managers, RNs who provide acute care community nursing services, health care providers, and non-caregiving family members or legal representatives.

(10) Time spent completing the services described in sections (3) to (9) of this rule may be included in the claim for the respective service but must meet documentation standards specified in OAR 410-120-1360(1)(a)(b).

(11) PRIOR AUTHORIZATION. All long term care community nursing services in sections (2) to (9) of this rule must be prior authorized by an individual’s case manager.

(a) An RN must use an individual's Nursing Service Plan to estimate the number of hours needed for community nursing services within a six month time period. The RN must document the estimated number of community nursing service hours on the Department approved form for authorization and send the Department approved form for authorization to the individual's case manager.

(b) The case manager must authorize the proposed hours after reviewing the individual's completed Nursing Service Plan. The case

manager must complete the prior authorization within 5 business days of receiving the Department approved form for authorization and the individual's completed Nursing Service Plan.

(12) Prior authorization for the initial assessment and delegation of services described in sections (2) and (5) of this rule is granted once the Department approved form for referral is signed by the RN and the individual's case manager. The payment received by an RN for initial assessment shall include compensation for all community nursing services excluding delegation, provided by the RN to the individual and the individual's caregiver. Payment is not provided until prior authorization as described in section (11) of this rule has been provided to the RN by the individual's case manager.

(13) An RN must use the Department approved Service Summary form as the communication tool for case managers and caregivers to document the monitoring, care coordination, teaching, delegation, or other services as noted in these rules provided to each individual.

(14) A local office manager may grant an exception to the timeframes required in this rule on a case specific basis.

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

411-048-0190 Communication and Notification Practices
(Adopted 4/15/2013)

(1) MANDATORY REPORTING. An RN must report suspected or known neglect or abuse of all older adults, adults, and children as required by OSBN and ORS 124.050 to 095, ORS 430.735 to 765, and ORS 419B.005 to 045.

(2) CONFIDENTIALITY.

(a) An RN must adhere to the OSBN confidentiality standards as described in OAR chapter 851 as well as the federal regulations adopted to implement the Health Insurance Portability and Accountability Act.

(b) An RN must provide all written, verbal, digital, video, and electronic information regarding an individual in accordance with the Department's confidentiality parameters as described in OAR chapter 407, division 014 and the federal regulations adopted to implement the Health Insurance Portability and Accountability Act.

(3) NOTIFICATION.

(a) An RN must immediately communicate possible life-threatening health and safety concerns to:

(A) The local office protective service worker, worker of the day, or case manager; and

(B) 911, police, or physician if needed to address emergent or urgent safety concerns.

(b) If while performing long term care community nursing services under these rules an RN determines that an individual's health condition is unstable or a significant change of condition is noted, the RN must either notify the individual's physician or primary care provider directly or ensure that the individual's caregiver has reported this information to them.

(c) An RN must notify the individual's case manager or local office management within one business day of non life threatening but high risk concerns including changes in condition as described in subsection (b) of this section, concerns about placement, or concerns about a caregiver's performance.

(d) An RN must notify the individual's case manager if the RN becomes aware that an individual has recently received a significant healthcare intervention such as an emergency room visit, hospitalization, a change in physician, referral to a specialist, home health, or hospice.

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

411-048-0200 Additional Documentation Requirements

(Adopted 4/15/2013)

(1) An RN must meet the documentation, record keeping, and communication standards as required by the Department in addition to the documentation, record keeping, and communication standards as required by the OSBN in OAR chapter 851. Compliance with these standards ensures communication between an RN and an individual's case manager and caregiver.

(2) The documentation standards in this rule and on Department approved forms provided by the Department do not replace or substitute for the documentation requirements in the:

(a) Rules for professional nursing standards as prescribed by the OSBN in OAR chapter 851, divisions 045, 047, and 48;

(b) Medicaid provider rules governing provider requirements as described in OAR chapter 407, division 120; and

(c) As applicable, the Medicaid General Rules described in OAR chapter 410, division 120.

(3) An RN is expected to complete the Department approved forms specified by the Department to support the long term care community nursing services in these rules. The Department may approve the use of alternative but equivalent forms.

(4) An RN must send copies of the completed Department approved forms to the case manager prior to or at the time of invoice submission. Documentation must support the long term care community nursing services billed and adhere to the timeframes noted in these rules.

(a) An individual's case manager must receive the required Department approved forms and documentation to pay a claim.

(b) Failure to comply with the documentation standards in this rule may result in the determination of overpayment for which restitution may be sought.

(5) All documentation must be provided in HIPAA secured format.

(6) The self-employed RN that is enrolled as a Medicaid provider or an agency enrolled as a Medicaid provider as described in OAR 411-048-0210 must maintain a record of all long term care community nursing services provided to each assigned individual and the individual's caregiver.

(a) The record must include copies of all documentation provided to the local office as well as any additional documentation the RN or agency maintained to meet OSBN or Medicaid provider rules.

(b) The RN must retain the record until the RN no longer provides long term care community nursing services to the individual, at which time the RN or agency must provide the individual's case manager a copy of any part of the record not previously provided.

(c) The RN or agency must retain original records for each individual following HIPAA practices for a period of seven years.

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

411-048-0210 Qualifications for Enrolled Medicaid Providers
(Adopted 4/15/2013)

(1) The Department may determine the number and type of enrolled Medicaid providers in a geographic area to assure that there is an appropriate number of qualified enrolled Medicaid providers to meet the needs of individuals eligible for long term care community nursing services.

(2) The Department shall select qualified enrolled Medicaid providers for long term care community nursing services according to the standards in these rules, OAR 407-120-0320, and OAR chapter 410, division 120 as applicable.

(3) The long term care community nursing services provided under these rules may be delivered by the following enrolled Medicaid providers:

(a) An RN who is a self-employed provider;

(b) Home health agencies meeting the requirements in OAR chapter 333, division 027; or

(c) In-home care agencies meeting the requirements in OAR chapter 333, division 536.

(4) A self-employed RN who contracts with the Department to provide long term care community nursing services under these rules must:

(a) Pass a background check as defined in OAR 407-007-0210; and

(b) Provide and have available verification of the following:

(A) A current and unencumbered Oregon Registered RN license;

(B) Certification of professional liability insurance with coverage that meets Department requirements;

(C) Documentation supporting qualifications and expertise:

(i) A minimum of three years experience practicing as an RN in an in-home, home health, skilled nursing, hospital, or Department licensed community setting. At least one of these three years must have occurred within three years of the date the RN contracted with the Department to provide long term care community nursing services.

(ii) Experience providing nursing delegation or a pass score on the Department's nursing delegation self study test.

(D) Contact information for people or entities that verify the qualifications and expertise documented pursuant to this section.

(c) The RN must attend a contract briefing session with the local office management to review contract expectations.

(5) Agencies listed in section (3)(b) and (c) of this rule who contract with the Department to provide long term care community nursing services under these rules must:

(a) Maintain compliance with existing in home or home health agency licensing rules;

(b) Maintain a separate contract with the Department to provide Medicaid funded in home care agency services;

(c) Provide and have available verification of the following:

(A) A current and unencumbered Oregon Registered RN license;

(B) Certification of professional liability insurance with coverage that meets Department requirements;

(C) Documentation verifying the qualification and expertise of the RNs hired by the agency to provide long term care community nursing services including:

(i) Experience providing nursing delegation or a pass score on the Department's nursing delegation self study test;

(ii) Contact information for people or entities that verify the qualifications and experience documented pursuant to this section; and

(iii) A background check as defined in OAR 407-007-0210.

(D) Evidence of policies and procedures ensuring that the agency and its employees follow the specific standards in OAR chapter 411, division 048 that may exceed OAR chapter 333, division 536.

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

411-048-0220 Medicaid Provider Disenrollment /Termination
(Adopted 4/15/2013)

(1) Enrolled Medicaid providers of long term care community nursing services, or RN employees of an agency enrolled as a Medicaid provider providing these long term care community nursing services may be denied enrollment, terminated, or prohibited from providing long term care community nursing services for any of the following:

(a) Violation of any part of these rules;

(b) Violation of the protective service and abuse rules in OAR chapter 411, division 020 and OAR chapter 407, division 045;

(c) Any sanction or action as a result of an OSBN investigation;

(d) Failure to keep required licensure or certifications current;

(e) Failure to provide copies of the records described in these rules to designated Department or Oregon Health Authority entities;

(f) Repeated failure to participate in Nursing Service Plan review or care coordination meetings when requested by an individual's case manager;

(g) Failure to obtain a pass score on the Department's delegation self study test if requested by the Department;

(h) Failure to provide services;

(i) Fraud or misrepresentation in the provision of long term care community nursing services;

(j) Evidence of conduct derogatory to the standards of nursing as described in OAR 851-045-0070 that results in referral to OSBN; or

(k) A demonstrated pattern of repeated unsubstantiated complaints of neglect or abuse per OAR chapter 411, division 020 and OAR chapter 407, division 045.

(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) Enrolled Medicaid providers of long term care community nursing services must provide advance written notice to the Department at least 30 days prior to no longer providing long term care community nursing services.

(4) An RN ending long term care community nursing services must comply with the OSBN's standards regarding transition of care and transfer or rescinding of delegations per OAR chapter 851, division 47.

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

411-048-0230 Compensation and Billing
(Adopted 4/15/2013)

(1) All long term care community nursing services must be authorized by an individual's case manager using Department approved forms provided by the Department prior to the delivery of long term care community nursing services.

(2) All billing and claims must comply with:

(a) OAR 407-120-0330 and 407-120-0340;

(b) OAR chapter 410, division 120 as applicable; and

(c) The Long Term Care Nursing Procedure Codes and Payment Authorization Guidelines posted at http://www.oregon.gov/dhs/spd/pages/provtools/nursing/forms.aspx.

(3) Compensation for long term care community nursing services in OAR 411-048-0180 shall be defined in the Department's rate schedule or

through a contract with the Department. The Department may adjust rates in underserved areas to assure that individuals have access to long term care community nursing services.

(4) Payment for non-Medicaid covered services must be prior authorized by the Department and billed on Department approved invoices.

(a) Rates for non-Medicaid services shall be determined by the Department but may not exceed the rate noted on the Department's rate schedule.

(b) The Department makes payment for non-Medicaid covered services within 45 days of receipt of the completed invoice.

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

411-048-0240 Orientation Requirements
(Adopted 4/15/2013)

(1) Self-employed RN providers as described in OAR 411-048-0210 must attend a total of 12 hours of office or field based orientation. Field based orientation must be provided by an experienced RN prior approved by the local office.

(2) Local office management may authorize additional orientation or field mentorship hours if mutually agreed upon by the newly contracted RN and the local office manager

(3) Each RN providing long term care community nursing services as an employee of an agency as described in OAR 411-048-0210 must attend a total of 12 hours of office or field based orientation approved by the local office.

(4) Local office managers may exempt an RN employed by an agency or a self-employed RN provider from all or part of orientation activities based on written request from the agency or self-employed RN provider describing an alternative orientation plan. The agreed upon alternative orientation plan must be signed by either the agency or self-employed provider and local

office management. The local office must provide a copy of the signed alternative orientation plan to the Department.

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

411-048-0250 Exceptions
(Adopted 4/15/2013)

(1) The Department may grant an exception to these rules. Implementation of an exception may not occur without the Department's written approval.

(2) A request for an exception to these rules must include but not be limited to the following standards:

(a) A written exception request must be provided to central office Department management for prior approval. The exception request must include;

(A) Local office management support for the exception request;

(B) A description of the benefit to the individual served by the Department that may occur as result of the exception; and

(C) Details regarding the specific rule for which the exception may be granted, the rationale for why the exception is needed, the proposed duration of the exception, identification of alternatives (including rule compliance), and costs of the exception if any.

(b) The exception may not impact compliance with any rules other than these rules for long term care community nursing services in OAR chapter 411, division 048.

(c) The exception may not result in non compliance with the Department's contract standards.

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