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

CHAPTER 411
DIVISION 48

LONG TERM CARE COMMUNITY NURSING

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(Effective 11/01/2023)

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LONG TERM CARE COMMUNITY NURSING

411-048-0150 Purpose
(Amended 08/25/2021)

(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 services in a Medicaid-funded home and community-based setting.

(2) Long term care community nursing services provide the following:

(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, or the individual's caregiver or family, what is necessary to assure the individual's health and safety in a Medicaid-funded home and community-based setting as described in OAR 411-048-0180.

(c) Delegation of nursing tasks to an individual's caregiver as described in OAR 411-048-0180.

(d) Providing case managers and healthcare providers with the information needed to maintain an individual's health, safety, and community living situation while honoring the individual's autonomy and choices.

Stat. Auth.: ORS 409.050, 410.070
Stats. Implemented: ORS 409.010, 410.070

411-048-0160 Definitions
(Amended 11/01/2023)

Unless the context indicates otherwise, the following definitions apply to the rules in OAR chapter 411, division 048:

(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 and adults with disabilities in a designated planning and service area.

(2) "Abuse" means:

(a) "Abuse" as it applies to a "child" as those terms are defined in ORS 419B.005.

(b) "Abuse" as it applies to a "child in care" as those terms are defined in ORS 418.257.

(c) "Abuse" as it applies to an "adult" as those terms are defined in ORS 430.735.

(d) "Abuse" as defined in ORS 124.005 and OAR 411-020-0002 for older adults and adults with a physical disability who are 18 years of age or older.

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

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

(5) "Caregiver" means any person responsible for providing services to an eligible individual in a Medicaid-funded home and community-based setting. A caregiver may include an unlicensed person as a designated caregiver as described in OAR chapter 851, division 048.

(6) "Case Manager" means a person employed by the Department, CDDP, Support Services Brokerage, or AAA 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.

(7) "CDDP" means "Community Developmental Disability Program" as defined in OAR 411-317-0000.

(8) "Day Support Activities" as defined in OAR 411-317-0000.

(9) "Delegation Process" means the standards and processes described in OAR chapter 851, divisions 006, 045, and 047.

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

(11) "Department Approved Form" means the forms used by an RN and case manager to support these rules. The Department maintains these documents on the Department's website https://www.oregon.gov/odhs/providers-partners/ltccn/Pages/resources.aspx#forms

(12) "Direct Hands-on Nursing" means an RN providing 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 an RN as described in OAR 411-048-0200.

(14) "Employment Services" through the Office of Developmental Disabilities Services as defined in OAR 411-317-0000 or through Vocational Rehabilitation as described in OAR chapter 582.

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

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

(17) "Home" means a non-licensed setting where an individual is receiving Medicaid-funded home and community-based services.

(18) "Home and Community-Based Services" as defined in OAR 411-004-0010.

(19) "Home Health Agency" as defined in ORS 443.014.

(20) "Individual" means a person eligible for long term care community nursing services under these rules.

(21) "In-Home Care Agency" as defined in ORS 443.305.

(22) "Local Office" means the Department office, AAA, CDDP, or Support Services Brokerage, 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 long term care community nursing services are delivered.

(23) "Long Term Care Community Nursing Services" mean 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 includes assessments, 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.

(24) "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.

(25) "Nursing Assessment" for the purpose of payment under this program means an assessment defined in OAR chapter 851, division 006 and codified in OAR chapter 851, division 045 as a legal requirement of the RN practice and within the scope of the nurse's license.

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

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

(28) "Rate Schedule" means the rate schedule maintained by the Department in OAR 411-027-0170 and posted at http://www.dhs.state.or.us/spd/tools/program/osip/rateschedule.pdf.

(29) "RN" means a registered nurse licensed by the OSBN. 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. A Licensed Practical Nurse (LPN) or Certified Nursing Assistant (CNA) are not an RN under these rules.

(30) "Support Services Brokerage" means "Brokerage" as defined in OAR 411-317-0000.

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

(32) "Unregulated Assistive Person" or "UAP" is the same as caregiver as defined in (5) of these rules. CNAs and Certified Medication Aides (CMAs) are certified and not licensed.

Stat. Auth.: ORS 409.050, 410.070
Stats. Implemented: ORS 409.010, 410.070

411-048-0170 Eligibility and Limitations
(Amended 11/01/2023)

(1) ELIGIBILITY. Long term care 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 Medicaid-funded home and community-based services provided through the Department.

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

(A) A child who lives in the family home and receives children's intensive in-home services as described in OAR chapter 411, division 300.

(B) An adult foster home for:

(i) Individuals with intellectual or developmental disabilities as described in OAR chapter 411, division 360; or

(ii) Individuals found eligible for service in OAR chapter 411, division 015 residing in a Medicaid enrolled adult foster home as described in OAR chapter 411, divisions 049 through 052.

(C) A foster home for children with intellectual or developmental disabilities as described in OAR chapter 411, division 346.

(D) An adult or child who live in their own or family home as described in OAR chapter 411, division 030 or division 450.

(E) Independent Choices Program participants as described in OAR chapter 411, division 030.

(F) State Plan personal care participants as described in OAR chapter 411, division 034 or division 455.

(G) An adult who is eligible to receive day support activities as described in OAR chapter 411, division 450 or eligible to receive employment services as described in OAR chapter 411, division 345.

(H) Long term care community nursing services may be provided for individuals while receiving services in settings for employment services or day support activities regardless of their residential home and community-based setting.

(c) The individual must be referred by their case manager for long term care community nursing services. Individuals may request long term care 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, or residential care facility.

(B) An individual residing in a setting where nursing services are already provided and paid as part of a contract or agreement with the Department. The Department will not issue duplicate or unbundled payments for nursing services.

(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 409.050, 410.070
Stats. Implemented: ORS 409.010, 410.070

411-048-0180 Long Term Care Community Nursing Services
(Amended 11/01/2023)

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 OSBN 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 nursing assessment within 10 business days following the acceptance of a referral. The assessment is defined in OAR chapter 851, division 006 and regulated by OAR chapter 851, division 045.

(a) The RN must document the nursing assessment pursuant to OAR chapter 851, divisions 006 and 045.

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

(3) REASSESSMENT. For the purpose of this rule, the RN must perform a face-to-face reassessment and update the individual's Nursing Service Plan at a minimum annually. Based on the RN’s assessment of the individual, the RN may determine that an assessment needs to occur more frequently. Reasons for increased frequency may include, but are not limited to, a change of condition or change of environment.

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

(b) The RN must document the date, time and results of the reassessment and 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.

(c) Each reassessment requires the RN to update the nursing service plan and perform a medication review. The documentation must support the reason for the re-assessment, have a detailed description of the activities the RN provided to develop the new nursing service plan and include detailed information about the changes in the individual’s condition and the scope, duration, and frequency of all nursing interventions.

(4) NURSING SERVICE PLAN. Based on the initial assessment or reassessment, the RN develops or updates the individual's Nursing Service Plan and must:

(a) Prioritize actual or potential client needs, risk of both;

(b) Identify expected outcomes for needs and risks identified using quantitative and qualitative measures of effectiveness;

(c) Establish interventions and strategies designed to assist the client in attaining expected outcomes and the planned scope, duration and frequency of each intervention;

(d) Identify implementation, timelines, and documentation requirements for the plan of care;

(e) Utilize standardized language appropriate to the context of care;

(f) Complete and document Nursing Service Plan 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; and

(g) Attend a minimum of two Nursing Service Plan review meetings each year with an individual's case manager. This meeting can be held face-to-face, phone or other secure state approved conference technology.

(5) DELEGATION. The RN must follow the standards and documentation requirements for delegation of nursing tasks as required by OAR chapter 851, divisions 006, 045, and 047.

(a) The RN alone, based on professional judgment and the Oregon Nurse Practice Act regulations, makes the determination to delegate or not delegate a nursing procedure to a UAP, or to rescind a UAP's authorization to perform a nursing procedure.

(b) The RN must provide the case manager with:

(A) An estimate of the number of hours required for the delegation process;

(B) The individual delegation process needs identified in the Nursing Service Plan; and

(C) Keep the case manager informed of ongoing delegation activities on the Nursing Service Summary form (SDS 0752) and Nursing Service Plan form (SDS 0754).

(c) The RN must keep Medicaid funded home and community-based setting providers informed through completion of the Nursing Service Summary form (SDS 0754) for delegation at initial assessment and all subsequent delegation activities of the delegation decisions and activities provided to unregulated assistive person.

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

(a) The RN must develop and document a teaching plan that describes and communicates the reason the teaching is needed and the specific goals for the individual or the individual's caregiver.

(b) Teaching related to non-injectable medications must be provided by an RN in accordance with OAR chapter 851, division 045 and The Teaching of the Administration of Lifesaving Treatments specific to intramuscular injections identified in ORS 433.800 through 433.830 must be provided by the RN in accordance with Oregon Health Authority Training on Lifesaving Treatment Protocols. https://www.oregon.gov/oha/ph/providerpartnerresources/emstraumasystems/pages/epi-protocol-training.aspx

(7) MONITORING. The RN must provide monitoring visits at the individual's home, sufficient in frequency and duration to implement and keep current 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 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. The 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 needs of the individual or the individual's caregiver. Information collected and evaluated as part of a medication review may result in changes to an RN's nursing plan of care, subsequent Teaching Plan or care coordination activity.

(9) CARE COORDINATION. The RN provides care coordination in order to advocate for health care services that an individual needs and to gather the

information that is needed to complete the assessment, nursing service plan or reassessment process, and medication review. The 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, other nurses, healthcare providers, and non-caregiving family members or legal representatives.

(10) Time spent completing the services described in sections (3) through (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(2)(a)(b) and the Department's Long Term Care Community Nursing Procedure Codes and Payment Authorization Guidelines.

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

(a) The RN must use an individual's Nursing Service Plan to estimate the number of hours needed for long term care community nursing services within a six month time period. The RN must document the estimated number of long term care 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 five 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 long term care 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) The 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 409.050, 410.070
Stats. Implemented: ORS 409.010, 410.070

411-048-0190 Communication and Notification Practices
(Amended 11/01/2023)

(1) MANDATORY REPORTING. The RN must report suspected or known neglect or abuse of all older adults, adults, and children as required by ORS 124.050 to 095, ORS 418, ORS 430.735 to 765, ORS 441, ORS 419B.005 to 045, ORS 676.150 and OSBN's ORS 678.135.

(2) The RN or agency must notify the Department in writing of material changes in any status or condition that relates to their qualifications or eligibility to provide medical assistance services.

(3) CONFIDENTIALITY.

(a) The RN must protect client confidential information in a manner consistent with current laws, standards as described in OAR chapter 851 as well as the federal regulations adopted to implement the Health Insurance Portability and Accountability Act.

(b) The 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.

(4) NOTIFICATION.

(a) The RN must communicate any potential or actual life-threatening health and safety concerns immediately to:

(A) 911, police, or physician as appropriate to address emergent or urgent safety concerns; and

(B) The local office protective service worker, worker of the day, or case manager.

(b) If while performing long term care community nursing services under these rules the 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 UAP has reported this information to the physician or primary care provider.

(c) The RN must notify the individual's case manager or local office management within one business day the individual’s non-life threatening but high-risk concerns including:

(A) Changes in condition as described in subsection (b) of this section,

(B) Concerns about, or changes in, the client’s current place of residence, or

(C) Concerns about a UAP’s performance.

(d) The 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
(Amended 11/01/2023)

(1) The RN must meet the documentation, record keeping, and communication standards as required by the Department. The RN who meets the Department's standards remains responsible to also document in accordance with the Nurse Practice Act. This documentation shall include a record of all RN delegation as described in OAR 411-048-0180 and the RN's initial and assessment of the nursing procedures delegated to the individual's unregulated assistive person.

(2) The documentation standards in this rule and on the 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 006, 045, and 047;

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

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

(3) The 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) The RN must send completed 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 forms and documentation to pay a claim.

(b) The provider must submit true, accurate and complete information when billing the Department. Use of a billing provider does not overrule the performing provider's responsibility for the truth and accuracy of submitted information.

(c) Authorization or payment by the department does not restrict or limit the Department, Authority or any state or federal oversight entity's right to review or audit a claim before or after the payment.

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

(5) All electronic documentation must be sent 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 and as required by OAR 410-120-1280 for individuals served through a Medicaid program.

(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 and Medicaid provider rules.

(b) The documentation must be retained in an electronic or hard copy format until the RN or agency 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 in hard copy or electronic format for each individual following Department security and 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
(Amended 11/01/2023)

(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.

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

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

(a) Pass a background check as defined in OAR 407-007-0200 to 407-007-0370 and OAR 407-007-0600 to 407-007-0640; and

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

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

(B) Certification of professional liability insurance and commercial general liability insurance with coverage that meets Department requirements.

(C) Documentation supporting qualifications and expertise:

(i) A minimum of two years full time or equivalent verifiable experience practicing as an RN in an in-home, home health, skilled nursing, hospital, or Department licensed community setting. At least one of these two

years must have occurred within three years of the date the RN enrolls with the Department; and

(ii) One year experience with providing RN delegation service in the last two years or

(iii) A pass score on the Department's test on OSBN's OAR chapter 851, divisions 006, 045, and 047 to demonstrate satisfactory experience and the skills necessary to perform the duties as described under these rules.

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

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

(a) Have a current and unencumbered Oregon license pursuant to OAR chapter 333, division 027 or OAR chapter 333, division 536 and maintain compliance with existing in home or home health agency licensing rules;

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

(A) Policies and procedures for the in home or home health agency to credential RNs before hiring or contracting and recredential RNs at least every three years to ensure each RN has and maintains a current and unencumbered Oregon RN license at all times. The agency must maintain records of all credentialing and recredentialing activities.

(B) Certification of professional liability insurance and commercial general 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 with the RN delegation process in the community-based setting;

(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 407-007-0200 to 407-007-0370 and OAR 407-007-0600 to 407-007-0640.

(D) Evidence of policies and procedures ensuring that the agency and its employees follow the specific standards in OAR chapter 411, division 048 and OAR chapter 410, division 120 (as applicable) that may exceed OAR chapter 333, divisions 027 or 536.

Stat. Auth.: ORS 409.050, 410.070
Stats. Implemented: ORS 409.010, 410.070

411-048-0220 Medicaid Provider Disenrollment /Termination
(Amended 11/01/2023)

(1) Enrolled Medicaid providers of long term care community nursing services, or RN employees of an agency enrolled as a Medicaid provider delivering long term care community nursing services may be denied enrollment, terminated, or prohibited from providing long term care community nursing services for, but not limited to, any of the following:

(a) Violation of any part of these rules at any time.

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

(c) Violation of the applicable service rules in OAR chapter 410, division 120 or 173, or the provider rules in OAR chapter 333, division 027 or 536.

(d) Any sanction or action as a result of an OSBN investigation.

(e) Failure to keep required licensure or certifications current.

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

(g) Failure to participate in Nursing Service Plan review or care coordination meetings when requested by an individual's case manager.

(h) Failure to obtain a pass score on the Department's test on OSBN's OAR chapter 851, divisions 006, 045, and 047 as requested by the Department.

(i) Failure to provide services.

(j) Fraud or misrepresentation in the application for enrollment or for the provision of long-term care community nursing services.

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

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

(m) Exclusion by the Office of Inspector General from participating in publicly funded programs. Agencies listed in section (3)(b) and (c) of this rule are prohibited from employing or paying any excluded person or entity and must promptly notify the Authority's Health Systems Division's Provider Enrollment Unit or the Office of Inspector General in writing of any violation.

(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 047.

Stat. Auth.: ORS 409.050, 410.070
Stats. Implemented: ORS 409.010, 410.070

411-048-0230 Compensation and Billing
(Amended 11/01/2023)

(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, divisions 120 and 173 as applicable; and

(c) The Long Term Care Nursing Procedure Codes and Payment Authorization Guidelines posted at https://www.oregon.gov/odhs/providers-partners/ltccn/Pages/resources.aspx#billing

(3) Compensation for long term care community nursing services in OAR 411-048-0180 shall be defined in the Department's rate schedule. 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
(Amended 11/01/2023)

(1) A self-employed RN or agency administrator as described in OAR 411-048-0210 must complete an orientation with the Local Office for the area they intend to provide services. The orientation must be completed prior to accepting Referrals as described under OAR 411-048-0180.

(2) Local office management and RN or agency administrator shall review at a minimum the following:

(a) Local area practices that the RN should be aware of, schedules or best access times for case managers.

(b) Local CCO resources and practices that the RN or agency may need to know about.

(c) Communication, documentation and problem-solving activities that occur between the RN or agency and case managers.

(d) Develop expectation regarding when the RN or agency should contact management for concerns regarding the program, a client, a case manager or other providers.

(e) Review any questions the RN or agency may have from the program material and connect with LTCCN Contract Administrator for

any additional guidance.

(f) Other procedures as required by ODHS offices or designee.

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

411-048-0250 Variances
(Amended 11/01/2023)

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

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

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

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

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

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

(b) The variance 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 variance may not result in noncompliance with the Department's provider enrollment standards.

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