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CHAPTER 410
OREGON HEALTH AUTHORITY
HEALTH SYSTEMS DIVISION: MEDICAL ASSISTANCE PROGRAMS

FILING CAPTION: Amending, Repealing Home Health Care Services Rules; Adding New Rule, Meets Medicaid Regulations 42CFR440.70

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RULES:
410-127-0020, 410-127-0040, 410-127-0045, 410-127-0050, 410-127-0060, 410-127-0065, 410-127-0080, 410-127-0200

AMEND: 410-127-0020

REPEAL: Temporary 410-127-0020 from DMAP 29-2017(TEMP)

RULE TITLE: Definitions

NOTICE FILED DATE: 11/17/2017

RULE SUMMARY: Medicaid regulations at 42 CFR 440.70 were revised consistent with section 6407 of the Affordable Care Act of 2010 and section 504 of the Medicare Access and CHIP Reauthorization Act of 2015 to add requirements that, for home health services and certain medical equipment, a face-to-face encounter with the OHP fee-for-service client must be conducted within established timeframes. This aligns timeframes with similar regulatory requirements for Medicare home health services. Repealing OAR 410-127-0050 as copayments are no longer required.

RULE TEXT:
(1) “Acquisition Cost” means the net invoice price of the item, supply, or equipment plus shipping or postage for the item.
(2) “Assessment” means procedures by which a client’s health strengths, weaknesses, problems, and needs are identified.
(3) “Custodial Care” means provision of services and supplies that can safely be provided by non-medical or unlicensed personnel.
(4) “Division (Division)” means the Health Systems Division within the Oregon Health Authority (Authority). The Division is responsible for coordinating medical assistance programs within the State of Oregon including the Oregon Health Plan (OHP), the State Children’s Health Insurance Program (SCHIP-Title XXI), and several other programs.
(5) “Evaluation” means a systematic objective assessment of the client for the purpose of forming a plan of treatment and a judgment of the effectiveness of care and measurement of treatment progress. The evaluation of direct care and effectiveness of care plans and interventions is an ongoing activity.

(6) “Home” means a place of temporary or permanent residence used as an individual’s home. This does not include a hospital, nursing facility, or intermediate care facility, but does include assisted living facilities, residential care facilities, and adult foster care homes.
(7) “Home Health Agency” means a public or private agency or organization that has been certified by Medicare as a Medicare home health agency and that is licensed by the Authority as a home health agency in Oregon and meets the capitalization requirements as outlined in the Balanced Budget Act (BBA) of 1997. Home health agency does not include:
(a) Any visiting nurse service or home health service conducted by and for those who rely upon spiritual means through prayer alone for healing in accordance with tenets and practices of a recognized church or religious denomination;
(b) Health services offered by county health departments that are not formally designated and funded as home health agencies within the individual departments;
(c) Personal care services that do not pertain to the curative, rehabilitative, or preventive aspect of nursing.
(8) “Home Health Aide” means an individual who meets the criteria for Home Health Aide defined in the Medicare Conditions of Participation 42 CFR 484.36, 42 CFR 484.80, and certified by the Oregon Board of Nursing.
(9) “Home Health Aide Services” means services of a home health aide must be provided under the direction and supervision of a registered nurse or licensed therapist familiar with the client, the client’s plan of care, and the written care instructions. The focus of care shall be to provide personal care and other services under the plan of care that supports curative, rehabilitative, or preventive aspects of nursing. These services are provided only in support of skilled nursing, physical therapy, occupational therapy, or speech therapy services. These services do not include custodial care.
(10) “Home Health Services” means only the services described in the Division’s Home Health Services provider guide.
(11) “Medicaid Home Health Provider” means a home health agency licensed by Health Services, Health Care Licensure and Certification certified for Medicare and enrolled with the Division as a Medicaid provider.
(12) “Medical Supplies” means supplies prescribed by a physician as a necessary part of the plan of care being provided by the home health agency.
(13) “OASIS (Outcome and Assessment Information Set)” means a client specific comprehensive assessment that identifies the client's need for home care and that meets the client's medical, nursing, rehabilitative, social, and discharge planning needs.
(14) “Occupational Therapy Services” means services provided by a registered occupational therapist or certified occupational therapy assistant supervised by a registered occupational therapist, due to the complexity of the service and client's condition. The focus of these services shall be curative, rehabilitative, or preventive and must be considered specific and effective treatments for a client's condition under accepted standards of medical practice. Teaching the client, family, and caregiver task-oriented therapeutic activities designed to restore function and independence in the activities of daily living is included in this skilled service. Occupational Therapy Licensing Board ORS 675.210-675.340 and the Uniform Terminology for Occupational Therapy established by the American Occupational Therapy Association, Inc. govern the practice of occupational therapy.
(15) “Physical Therapy Services” means services provided by a licensed physical therapist or licensed physical therapy assistant under the supervision of a licensed physical therapist, due to the inherent complexity of the service and the client's condition. The focus of these services shall be curative, rehabilitative, or preventive and must be considered specific and effective treatments for a patient's condition under accepted standards of medical practice. Teaching the client, family, and caregiver the necessary techniques, exercises, or precautions for treatment and prevention of illness or injury is included in this skilled service. Physical Therapy Licensing Board ORS 688.010 to 688.235 and Standards for Physical Therapy as well as the Standards of Ethical Conduct for the Physical Therapy Assistant established by the American Physical Therapy Association govern the practice of physical therapy. Physical therapy shall not include radiology or electrosurgery.
(16) “Plan of Care” means written instructions describing how care is to be provided. The plan is initiated by the admitting registered nurse, physical therapist, occupational therapist, or speech therapist and certified by the

prescribing physician. The plan of care must include the client's condition, rationale for the care plan including justification for the skill level of care, and the summary of care for additional certification periods. This includes but is not limited to:
(a) All pertinent diagnoses;
(b) Mental status;
(c) Types of services;
(d) Specific therapy services;
(e) Frequency and duration of service delivery;
(f) Supplies and equipment needed;
(g) Prognosis;
(h) Rehabilitation potential;
(i) Functional limitations;
(j) Activities permitted;
(k) Nutritional requirements;
(L) Medications and treatments;
(m) Safety measures;
(n) Discharge plans;
(o) Teaching requirements;
(p) Individualized, measurably objective short-term and long-term functional goals;
(q) Other items as indicated.
(17) "Practitioner" means an individual licensed pursuant to federal and state law to engage in the provision of health care services within the scope of the practitioner's license and certification.
(18) "Responsible Unit" means the agency responsible for approving or denying payment authorization.
(19) "Skilled Nursing Services" means the client care services pertaining to the curative, restorative, or preventive aspects of nursing performed by a registered nurse or under the supervision of a registered nurse, pursuant to the plan of care established by the prescribing physician in consultation with the home health agency staff. Skilled nursing emphasizes a high level of nursing direction, observation, and skill. The focus of these services shall be the use of the nursing process to diagnose and treat human responses to actual or potential health care problems, health teaching, and health counseling. Skilled nursing services include the provision of direct client care and the teaching, delegation, and supervision of others who provide tasks of nursing care to clients, as well as phlebotomy services. Such services will comply with the Nurse Practice Act and administrative rules of the Oregon State Board of Nursing and Health Division, chapter 410 division 27, Home Health Agencies.
(20) "Speech-Language Pathology Services" means services provided by a licensed speech-language pathologist due to the inherent complexity of the service and the patient's condition. The focus of these services shall be curative, rehabilitative, or preventive and must be considered specific and effective treatment for a patient's condition under accepted standards of medical practice. Teaching the client, family, and caregiver task-oriented therapeutic activities designed to restore function and compensatory techniques to improve the level of functional communication ability is included in this skilled service. Speech-Language Pathology and Audiologist Licensing Board ORS 681.205 to 681.991 and the Standards of Ethics established by the American Speech and Hearing Association govern the practice of speech-language pathology.
(21) "Title XVIII (Medicare)" means Title XVIII of the Social Security Act.
(22) "Title XIX (Medicaid)" means Title XIX of the Social Security Act.
[Note: Publications referenced are available from the agency.]

STATUTORY/OTHER AUTHORITY: ORS 413.042

STATUTES/OTHER IMPLEMENTED: ORS 414.065

AMEND: 410-127-0040

REPEAL: Temporary 410-127-0040 from DMAP 29-2017(TEMP)

RULE TITLE: Coverage

NOTICE FILED DATE: 11/17/2017

RULE SUMMARY: Medicaid regulations at 42 CFR 440.70 were revised consistent with section 6407 of the Affordable Care Act of 2010 and section 504 of the Medicare Access and CHIP Reauthorization Act of 2015 to add requirements that, for home health services and certain medical equipment, a face-to-face encounter with the OHP fee-for-service client must be conducted within established timeframes. This aligns timeframes with similar regulatory requirements for Medicare home health services. Repealing OAR 410-127-0050 as copayments are no longer required.

RULE TEXT:

(1) Medically appropriate home health services may be covered on a visiting basis to eligible clients in their homes as part of a written plan of care.

(2) Home health services require a face-to-face encounter as described in OAR 410-127-0045 consistent with federal Medicaid regulations at 42 CFR 440.70.

(3) Home health services must be prescribed by a physician, and the signed order must be on file at the home health agency. The prescription must include the ICD-10-CM diagnosis code indicating the reason the home health services are requested. The orders on the plan of care must specify the type of services to be provided to the client with respect to the professional who will provide them, the nature of the individual services, specific frequency, and specific duration. The orders must clearly indicate how many times per day, each week or each month the services are to be provided. The plan of care must include the client's condition, the rationale for the care plan including justification for the required skill level of care, and the summary of care for additional certification periods.

(4) The plan of care must be reviewed and signed by the physician every two months to continue services.

(5) The following services or items are covered, if diagnoses are on the portion of the prioritized list above the line funded by the legislature:

(a) Skilled nursing services;

(b) Skilled nursing evaluation (includes Outcome and Assessment Information Set (OASIS) assessment);

(c) Home health aide services;

(d) Occupational therapy services;

(e) Occupational therapy evaluation, which may include OASIS assessment;

(f) Physical therapy services;

(g) Physical therapy evaluation, which may include OASIS assessment;

(h) Speech-language pathology services, which may include OASIS assessment;

(i) Speech-language pathology evaluation, which may include OASIS assessment;

(j) Medical and surgical supplies.

STATUTORY/OTHER AUTHORITY: ORS 413.042

STATUTES/OTHER IMPLEMENTED: ORS 414.065

ADOPT: 410-127-0045

REPEAL: Temporary 410-127-0045 from DMAP 29-2017(TEMP)

RULE TITLE: Face-to-Face Encounter Requirements for Home Health Services

NOTICE FILED DATE: 11/17/2017

RULE SUMMARY: Medicaid regulations at 42 CFR 440.70 were revised consistent with section 6407 of the Affordable Care Act of 2010 and section 504 of the Medicare Access and CHIP Reauthorization Act of 2015 to add requirements that, for home health services and certain medical equipment, a face-to-face encounter with the OHP fee-for-service client must be conducted within established timeframes. This aligns timeframes with similar regulatory requirements for Medicare home health services. Repealing OAR 410-127-0050 as copayments are no longer required.

RULE TEXT:

(1) The Division requires that for the initial ordering of home health services, an in-person face-to-face encounter that is related to the primary reason the client requires the home health services must occur within not more than 90 days before or 30 days after the start of services.

(2) The face-to-face encounter shall be conducted by:

(a) The certifying physician (MD or DO); or

(b) An authorized non-physician practitioner (NPP); or

(c) An attending or post-acute physician for clients admitted to home health immediately after an acute or post-acute stay.

(3) Authorized NPP's for home health services are nurse practitioners, a clinical nurse specialist working in collaboration with the physician, or a physician assistant under the supervision of a physician.

(4) If an authorized NPP performs the face-to-face encounter, they shall communicate the clinical findings to the certifying physician. Those clinical findings must be incorporated into a written or electronic document included in the client's medical record.

(5) The certifying physician shall document that the client was evaluated or treated for a condition that supports the need for the home health services ordered within no more than 90 days before or 30 days after the start of services. The certifying physician shall also document the name of the practitioner who conducted the encounter and the date of the encounter.

(6) The documentation of the face-to-face encounter must be a separate and distinct section of or an addendum to the certification and must be clearly titled, dated, and signed by the certifying physician.

(7) A face-to-face encounter must occur for certification any time a new start of care assessment is completed to initiate care for the home health services.

(8) If a dually eligible client begins home health under Medicare and transitions to Medicaid, the Medicare face-to-face encounter documentation shall meet the Medicaid face-to-face requirement.

(9) The home health agency shall maintain documentation of the qualifying face-to-face encounter and provide this documentation to the Division with the prior authorization request for services.

STATUTORY/OTHER AUTHORITY: 411.404, 414.065

STATUTES/OTHER IMPLEMENTED: 414.065

REPEAL: 410-127-0050

REPEAL: Temporary 410-127-0050 from DMAP 29-2017(TEMP)

RULE TITLE: Client Copayments

NOTICE FILED DATE: 11/17/2017

RULE SUMMARY: Medicaid regulations at 42 CFR 440.70 were revised consistent with section 6407 of the Affordable Care Act of 2010 and section 504 of the Medicare Access and CHIP Reauthorization Act of 2015 to add requirements that, for home health services and certain medical equipment, a face-to-face encounter with the OHP fee-for-service client must be conducted within established timeframes. This aligns timeframes with similar regulatory requirements for Medicare home health services. Repealing OAR 410-127-0050 as copayments are no longer required.

RULE TEXT:
Copayments may be required for certain services. See OAR 410-120-1230 for specific details.

STATUTORY/OTHER AUTHORITY: ORS 413.042

STATUTES/OTHER IMPLEMENTED: ORS 414.065

AMEND: 410-127-0060

REPEAL: Temporary 410-127-0060 from DMAP 29-2017(TEMP)

RULE TITLE: Reimbursement and Limitations

NOTICE FILED DATE: 11/17/2017

RULE SUMMARY: Medicaid regulations at 42 CFR 440.70 were revised consistent with section 6407 of the Affordable Care Act of 2010 and section 504 of the Medicare Access and CHIP Reauthorization Act of 2015 to add requirements that, for home health services and certain medical equipment, a face-to-face encounter with the OHP fee-for-service client must be conducted within established timeframes. This aligns timeframes with similar regulatory requirements for Medicare home health services. Repealing OAR 410-127-0050 as copayments are no longer required.

RULE TEXT:

(1) The Division reimburses home health services on a fee schedule by type of visit (see home health rates on the Authority's website at: http://www.oregon.gov/OHA/healthplan/pages/home-health.aspx).

(2) The Division recalculates its home health services rates every other year. The Division shall reimburse home health services at a level of 74 percent of Medicare costs reported on the audited, most recently accepted or submitted Medicare Cost Reports prior to the rebase date and pending approval from the Centers for Medicare and Medicaid Services (CMS), and, if indicated, legislative funding authority.

(3) The Division shall request the Medicare Cost Reports from home health agencies with a due date and shall recalculate potential rates based on the Medicare Cost Reports received by the requested due date. The home health agency shall submit requested cost reports by the date requested.

(4) The Division reimburses only for service that is medically appropriate.

(5) Limitations:

(a) Limits of covered services:

(A) Skilled nursing visits are limited to two visits per day with payment authorization;

(B) All therapy services are limited to one visit or evaluation per day for physical therapy, occupational therapy, or speech-language pathology services. Therapy visits require payment authorization;

(C) The Division shall authorize home health visits for clients with uterine monitoring only for medical problems that could adversely affect the pregnancy and are not related to the uterine monitoring;

(D) Medical supplies must be billed at acquisition cost, and the total of all medical supply revenue codes may not exceed $50 per day. Only supplies that are used during the visit or the specified additional supplies used for current client/caregiver teaching or training purposes as medically appropriate are billable. Client visit notes must include documentation of supplies used during the visit or supplies provided according to the current plan of care;

(E) Durable medical equipment must be obtained by the client by prescription through a durable medical equipment provider.

(b) Not covered service:

(A) Service not medically appropriate;

(B) A service for a diagnosis that does not appear on a line of the Prioritized List of Health Services that has been funded by the Oregon Legislature (OAR 410-141-0520);

(C) Medical social worker service;

(D) Registered dietician counseling or instruction;

(E) Drug and biological;

(F) Fetal non-stress testing;

(G) Respiratory therapist service;

(H) Flu shot;

(I) Psychiatric nursing service.

STATUTORY/OTHER AUTHORITY: ORS 413.042

STATUTES/OTHER IMPLEMENTED: ORS 414.065

AMEND: 410-127-0065

REPEAL: Temporary 410-127-0065 from DMAP 29-2017(TEMP)

RULE TITLE: Signature Requirements

NOTICE FILED DATE: 11/17/2017

RULE SUMMARY: Medicaid regulations at 42 CFR 440.70 were revised consistent with section 6407 of the Affordable Care Act of 2010 and section 504 of the Medicare Access and CHIP Reauthorization Act of 2015 to add requirements that, for home health services and certain medical equipment, a face-to-face encounter with the OHP fee-for-service client must be conducted within established timeframes. This aligns timeframes with similar regulatory requirements for Medicare home health services. Repealing OAR 410-127-0050 as copayments are no longer required.

RULE TEXT:

(1) Physicians shall sign for services they order. This signature shall be handwritten or electronic, and it must be in the client's medical record.

(2) The ordering physician shall ensure the authenticity of the signature.

STATUTORY/OTHER AUTHORITY: ORS 413.042

STATUTES/OTHER IMPLEMENTED: ORS 414.065

AMEND: 410-127-0080

REPEAL: Temporary 410-127-0080 from DMAP 29-2017(TEMP)

RULE TITLE: Prior Authorization

NOTICE FILED DATE: 11/17/2017

RULE SUMMARY: Medicaid regulations at 42 CFR 440.70 were revised consistent with section 6407 of the Affordable Care Act of 2010 and section 504 of the Medicare Access and CHIP Reauthorization Act of 2015 to add requirements that, for home health services and certain medical equipment, a face-to-face encounter with the OHP fee-for-service client must be conducted within established timeframes. This aligns timeframes with similar regulatory requirements for Medicare home health services. Repealing OAR 410-127-0050 as copayments are no longer required.

RULE TEXT:

(1) Home health providers must obtain prior authorization (PA) for services as specified in rule.

(2) Providers must request PA as follows (see the Home Health Supplemental Information booklet for contact information) and include the documentation requirements from the supplemental (e.g., face-to-face encounter, plan of care, primary diagnosis, initial assessment, evaluation, etc.):

(a) For clients enrolled in a Coordinated Care Organization (CCO) or a Prepaid Health Plan (PHP), from the CCO or the PHP;

(b) For all other clients, from the Division.

(3) For services requiring authorization, providers must contact the responsible unit for authorization within five working days following initiation or continuation of services. The FAX or postmark date on the request shall be honored as the request date. The provider shall obtain payment authorization. Authorization shall be given based on medical appropriateness and appropriate level of care, cost, and effectiveness as supported by submitted documentation. The plan of care submitted must include the client's condition, the rationale for the care plan including justification for the required skill level of care, and the summary of care for additional certification periods.

(4) Payment authorization does not guarantee reimbursement (e.g., eligibility changes, incorrect identification number, provider contract ends).

(5) For rules related to authorization of payment including retroactive eligibility, see General Rules OAR 410-120-1320.

STATUTORY/OTHER AUTHORITY: ORS 413.042

STATUTES/OTHER IMPLEMENTED: ORS 414.065

AMEND: 410-127-0200

REPEAL: Temporary 410-127-0200 from DMAP 29-2017(TEMP)

RULE TITLE: Home Health Revenue Center Codes

NOTICE FILED DATE: 11/17/2017

RULE SUMMARY: Medicaid regulations at 42 CFR 440.70 were revised consistent with section 6407 of the Affordable Care Act of 2010 and section 504 of the Medicare Access and CHIP Reauthorization Act of 2015 to add requirements that, for home health services and certain medical equipment, a face-to-face encounter with the OHP fee-for-service client must be conducted within established timeframes. This aligns timeframes with similar regulatory requirements for Medicare home health services. Repealing OAR 410-127-0050 as copayments are no longer required.

RULE TEXT:

Payment authorization is required for those services indicated by the Code PA. Following are the procedure codes to be used for billing:

(1) Medical/surgical supplies and devices:

(a) 270 -- General classification;

(b) 271 -- Non sterile supply;

(c) 272 -- Sterile supply.

(2) Physical Therapy:

(a) 421 -- Visit charge -- PA;

(b) 424 -- Evaluation (includes OASIS assessment) or re-evaluation.

(3) Occupational Therapy:

(a) 431 -- Visit charge -- PA;

(b) 434 -- Evaluation or re-evaluation.

(4) Speech-language pathology:

(a) 441 -- Visit charge -- PA;

(b) 444 -- Evaluation (includes OASIS assessment) or re-evaluation.

(5) Skilled nursing:

(a) 551 -- Visit charge -- PA;

(b) 559 -- Other skilled nursing -- evaluation (includes OASIS assessment).

(6) Home health aide -- 571 -- Visit charge -- PA.

(7) Total charge -- 001 -- Total Charge.

STATUTORY/OTHER AUTHORITY: ORS 413.042

STATUTES/OTHER IMPLEMENTED: ORS 414.065