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

FILING CAPTION: Amending Home Health rules to comply with federal regulations 42 CFR 440.70, 484.80.

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RULES:
410-127-0020, 410-127-0040, 410-127-0060, 410-127-0200

AMEND: 410-127-0020

RULE TITLE: Definitions

NOTICE FILED DATE: 01/07/2020

RULE SUMMARY: CMS published a final rule implementing section 6407 of the ACA and section 504 of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) which amended the Medicaid regulations at 42 CFR 440.70. These regulations became effective 7/1/16 although states were not required to implement these changes until 2017. These changes were implemented by OHA in 2017, however legal advocates and APD requested clarification in rule regarding the role of the home health aide and that coverage of home health services is not contingent on the client needing nursing facility or therapy services. In addition, changes were made to requirements for home health aides in the Medicare and Medicaid Conditions of Participation for Home Health Agencies at 42 CFR 484.80, therefore this was also added to the home health rules.

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” as it relates to home health services, means a place of temporary or permanent residence used as an individual’s home including assisted living facilities, residential care facilities and foster homes. This does not include a hospital, nursing facility, intermediate care facility for individuals with intellectual disabilities, any setting that exists primarily for the purpose of providing medical/nursing care, or any setting in which payment is or could be made under Medicaid for inpatient services that include room and board.
(7) “Home Health Agency” means a public or private agency or organization that meets requirements for participation in Medicare, including the capitalization requirements under 42 CFR 489.28, and is licensed by the Authority as a home health agency in Oregon. 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 all requirements for home health aide as defined in the Medicare Conditions of Participation at 42 CFR 484.80 and who is certified as a nursing assistant by the Oregon State Board of Nursing in accordance with OAR chapter 851, division 062.
(9) “Home Health Aide Services” means services provided by a home health aide on a part-time or intermittent basis, 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 services or other services under the home health services plan of care needed to maintain the client’s health or to facilitate treatment of the client’s illness or injury. These services must not duplicate other Medicaid-paid personal care services.
(10) “Home Health Services” means the following items and services furnished to a client who is under the care of a physician, by a home health agency, under a plan established and periodically reviewed by a physician, on a visiting basis:
(a) Part-time or intermittent nursing care provided by or under the supervision of a registered nurse;
(b) Physical, occupational, or speech-language pathology services;
(c) Part-time or intermittent home health aide services provided by a home health aide who has successfully completed the required training and certification; and,
(d) Medical supplies and durable medical equipment.
(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 health services that meet 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, psychosocial, and cognitive status;

(c) Types of services;

(d) Specific therapy services;

(e) Frequency and duration of visits to be made;

(f) Supplies and equipment needed;

(g) Prognosis;

(h) Rehabilitation potential;

(i) Functional limitations;

(j) Activities permitted;

(k) Nutritional requirements;

(L) All medications and treatments;

(m) Safety measures to protect against injury;

(n) Discharge plans including patient and caregiver education and training to facilitate timely discharge;

(o) Patient-specific measurable outcomes/goals;

(p) If home health services are initiated following a hospital discharge, an assessment of client’s level of risk for hospital emergency department visits or hospital readmission;

(q) Additional interventions/orders the home health agency or physician chooses to include.

(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 127, 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

RULE TITLE: Coverage

NOTICE FILED DATE: 01/07/2020

RULE SUMMARY: CMS published a final rule implementing section 6407 of the ACA and section 504 of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) which amended the Medicaid regulations at 42 CFR 440.70. These regulations became effective 7/1/16 although states were not required to implement these changes until 2017. These changes were implemented by OHA in 2017, however legal advocates and APD requested clarification in rule regarding the role of the home health aide and that coverage of home health services is not contingent on the client needing nursing facility or therapy services. In addition, changes were made to requirements for home health aides in the Medicare and Medicaid Conditions of Participation for Home Health Agencies at 42 CFR 484.80, therefore this was also added to the home health rules.

RULE TEXT:

(1) Medically appropriate home health services may be covered on a visiting basis to eligible clients as ordered by a physician and part of a written plan of care. Coverage of home health services is not contingent on the client needing nursing, nursing facility or therapy services.

(2) Home health services may be provided in the client's home or any setting in which normal life activities take place other than a hospital, nursing facility, intermediate care facility for individuals with intellectual disabilities, any setting that exists primarily for the purpose of providing medical/nursing care, or any setting in which payment is or could be made under Medicaid for inpatient services that include room and board.

(3) 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.

(4) 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.

(5) The plan of care must be reviewed and signed by the physician who established the plan of care at least every 60 days to continue services.

(6) 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

AMEND: 410-127-0060

RULE TITLE: Reimbursement and Limitations

NOTICE FILED DATE: 01/07/2020

RULE SUMMARY: CMS published a final rule implementing section 6407 of the ACA and section 504 of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) which amended the Medicaid regulations at 42 CFR 440.70. These regulations became effective 7/1/16 although states were not required to implement these changes until 2017. These changes were implemented by OHA in 2017, however legal advocates and APD requested clarification in rule regarding the role of the home health aide and that coverage of home health services is not contingent on the client needing nursing facility or therapy services. In addition, changes were made to requirements for home health aides in the Medicare and Medicaid Conditions of Participation for Home Health Agencies at 42 CFR 484.80, therefore this was also added to the home health rules.

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/HSD/OHP/Pages/Policy-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 services that are 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) Home health aide services are limited to those ordered by a physician, included in the plan of care, permitted to be performed under state law, consistent with home health aide training, and under the direction of a registered nurse or licensed therapist familiar with the client and the client's plan of care. These services must not duplicate other Medicaid-paid personal care services.

(D) 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;

(E) 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;

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

(b) Services not covered:

(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: 410-127-0200

RULE TITLE: Home Health Revenue Center Codes

NOTICE FILED DATE: 01/07/2020

RULE SUMMARY: CMS published a final rule implementing section 6407 of the ACA and section 504 of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) which amended the Medicaid regulations at 42 CFR 440.70. These regulations became effective 7/1/16 although states were not required to implement these changes until 2017. These changes were implemented by OHA in 2017, however legal advocates and APD requested clarification in rule regarding the role of the home health aide and that coverage of home health services is not contingent on the client needing nursing facility or therapy services. In addition, changes were made to requirements for home health aides in the Medicare and Medicaid Conditions of Participation for Home Health Agencies at 42 CFR 484.80, therefore this was also added to the home health rules.

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