Department of Human Services

Long-Term Care Community Nursing

Rule Information and

Required Forms

DHS
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of Human Services

Aging and People with Disabilities and
Medical Assistance Programs

Oregon Health Authority

Topics

- Agency Information

- Oregon Health Plan Overview

- Long-Term Care Community Nursing (LTCCN) Oregon Administrative Rules (OARs)
  - Program overview
  - Provider required forms

- Billable services

- Resources

Agency Information

Aging and People with Disabilities (APD)

- A division of the Department of Human Services (DHS)

- Maintains policies and program information for the Oregon Medicaid Long-Term Care Community Nursing

Medical Assistance Programs (MAP)

- A division of the Oregon Health Authority (OHA)

- Oversees provider enrollment and payment for the Oregon Medicaid program

- Maintains MMIS

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Oregon Health Authority

Oregon Health Plan

- Oregon Health Plan (OHP) is Oregon's Medicaid program

- Administered by the Oregon Health Authority's Division of Medical Assistance Programs

- Serves more than a million of Oregon's population

- Works in conjunction with the Department of Human Services

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LONG-TERM CARE COMMUNITY NURSING

Program and Policy

http://www.dhs.state.or.us/policy/spd/rules/411_048.pdf

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Key Terms and Definitions

Aging and People with Disabilities (APD): a section of the Department of Human Services responsible for maintaining policies and programs for people with intellectual and developmental disabilities as well as the aging population

Brokerage (Support Services Brokerage): an entity or distinct operating unit within an existing entity that uses the principles of serf-determination to perform the functions associated with planning and implementation of support services for individuals with intellectual or developmental disabilities

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Key Terms and Definitions

Caregiver: 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)

Case Manager (CM): a person employed by the Department, Community Developmental Disability Program, Support Services Brokerage, or Area Agency on Aging (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

Key Terms and Definitions

Community Developmental Disability Program (CDDP): the program responsible for plan authorization, delivery and monitoring of services for individuals with intellectual or developmental disabilities

Delegation: for the purpose of these rules, the standards and processes described in OAR chapter 851, division 047

Direct Hands-on Nursing: 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

Key Terms and Definitions

Foster Home: any DHS-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

Home: a non-licensed setting where an individual is receiving Home and Community Based Care (HCBC) services

Key Terms and Definitions

Home and Community Based Services: services approved and funded by the Centers for Medicare and Medicaid Services for eligible individuals who are aged and physically disabled and for eligible individuals with intellectual disabilities and developmental disabilities in accordance with section 1915(c) under Title XIX of the Social Security Act

Local Office: DHS office, Area Agency on Aging, Support Services Brokerage office, 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

Key Terms and Definitions

Office of Developmental Disabilities Services (ODDS) Program: the state agency that provides funding and oversight for Medicaid-funded supports, services and programs for children and adults with intellectual and developmental disabilities

Medication Review: a review focused on the 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

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Key Terms and Definitions

Personal Agent: a person who is a case manager for the provision of case management services; works directly with individuals and the legal or designated representatives and families of individuals, if applicable, to provide or arrange for support services; is a trained employee of a brokerage or a person who has been engaged under contract to the brokerage to allow the brokerage to meet responsibilities in geographic areas where personal agent resources are severely limited; the person-centered plan coordinator of an individual as defined in the Community First Choice State Plan Amendment

RN: 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

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Key Terms and Definitions

Service Coordinator: a person employed by the Department or Community Developmental Disability Program who assesses the service needs of an applicant, verifies eligibility, and offers service choices to the eligible individual. The service coordinator authorizes and implements an individual's plan for services and monitors the services delivered

Support Services Brokerage: an entity or distinct operating unit within an existing entity that uses the principles of self-determination to perform the functions associated with planning and implementation of support services for individuals with intellectual or developmental disabilities

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Long-Term Care Community Nursing Program

- Supports the Medicaid Home and Community Based Care (HCBC) services

    To maintain health, safety and community living while honoring the individual's autonomy and choices

- Services provided by DHS-contracted, self-employed RNs or In-Home or Home Health agencies

- Distinct set of services focused on individual's chronic and ongoing health and activities of daily living needs

    Provides eligible clients access to nurse delegation and teaching services

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Long-Term Care Community Nursing Program, continued

- Evaluation and identification of supports to help clients:
  - Maintain maximum function;
  - Minimize health risks; and
  - Autonomy and self management of healthcare

- Teaching, informing and delegation of nursing tasks:
  - Client, caregiver or family member regarding client health and safety in a home-based or foster home setting; and
  - Case managers and other health professionals

- Contractors submit claims for specific services to the MMIS and are paid standard rates

LTC Nursing Services

- Initial assessment

- Delegation of nursing tasks

- Teaching non-family

- Teaching family/ client

- Monitoring visits and medication review

- Care coordination

- Reassessment

Services Not Provided

- Crisis or 24/7 availability

- Delegation to support unscheduled or emergency placements

- Management of medically unstable or unpredictable conditions requiring on-site RN assessment

LTCCN Services Not Allowed

- No direct hands-on nursing care
  Medication set-up is not allowed

- Management of medically unstable or unpredictable conditions requiring on-site RN assessment

- Duplication of other nursing services (i.e. home health, hospice, in-home agency services, hospital discharge or transition planning)

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INDIVIDUAL ELIGIBILITY

Eligibility and Limitations

Individual Eligibility for LTCCN

Individual must be:

- Eligible for Medicaid home and community-based services;

- Living in a home or foster home; and

- Receiving
  - In-home services
  - AFH services
  - Independent Choices Program
  - State Plan Personal Care
  - State Plan K option; or
  - I/DD In-home or foster home, including brokerages

- Referred by their case manager for LTC Community Nursing services
  Individuals and providers may request LTC Community Nursing Services by contacting the case manager

Ineligible Individuals

Individuals residing in the following settings:

– Nursing facility;

– Assisted living facility;

– Residential care facility;

– 24-hour developmental disability group home or intermediate care facility for people with developmental disabilities;

– In a program or residing in a setting where nursing services are provided under a service rate; or

– Enrolled in PACE

Limitations

- Case managers cannot prior authorize LTC Community Nursing services that duplicate nursing services provided by Medicare or other Medicaid programs

- In-Home agencies must provide nursing services for their consumers per their licensing rule and contract

LONG-TERM CARE COMMUNITY NURSING

Provider and Case Manager Roles

LTCCN Providers

- Contractors with the Department, *not* employees
  - Self-employed RNs

  - Eligible In-Home Care and Home Health agencies

  - LTTCN contractors are responsible for adhering to program rules, individual licensing rules, Medicaid provider rules, and contract statement of work

- Roles
  - Teaching and delegation for the individual, family, or the caregivers

  - Providing client assessment and service planning

Case Manager and RN

RNs and individual Case Managers (CMs) work closely together

– CMs need to understand the services to be provided

– Required service plan review meetings at least every six months, per OAR 411-048-0180(4)(c)

– Discuss questions or concerns identified in service summaries

 • Speak clearly in a manner that is understood by both parties

 • Avoid medical terminology

– RNs must notify the CM if the person's health status changes or if the person has had a recent significant event, such as ER visit, change in physician, referral to home health or hospice

Required forms

Ensure communication between an RN and an individual's case manager and caregiver:

- Referral: used by both the case manager and RN to document referral process (SDS 0753)
- Service Plan (SDS 0754): authorized by the signed referral form and represents the information gathered in the Initial Assessment.
- Prior Authorization form (SDS 4102): accompanies the SDS 0754 and documents the estimated services needed, as described in the Nursing Service Plan, for up to six months
- Service Summary (SDS 0752): documents all contacts and services provided with the person, the caregivers and members of the healthcare team

REFERRAL PROCESS

Authorized services with the Client Referral

Reasons for Client Referral

- Need for delegation of nursing tasks
- Need for teaching of nursing tasks
- Medication safety issues
- Unexpected increase in emergency room or physician visits
- Changes in behavior or cognition
- Nutrition or pain issues
- Potential for skin breakdown
- Individual does not follow medical advice
- Change in medical condition
- History of recent, frequent falls
- New In-Home individual

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Client Referral (SDS 0753)

APD Long Term Care Community Nursing Program Client Referral

Case manager name: [ ] Phone: [ ] - [ ] - [ ]

Fax or email response to: case manager.

Fax: [ ] - [ ] - [ ] Email: [ ]

Date of referral: [ ] / [ ] / [ ] Recipient ID number: [ ]

Client: [ ] Date of birth: [ ] / [ ] / [ ]

Time at current location: [ ]

☐ In-home ☐ In-home agency ☐ Relative foster home ☐ Foster home

Address: [ ]

City: [ ] State: [ ] ZIP code: [ ]

Area code and phone number: [ ] - [ ] - [ ] Email: [ ]

Primary contact name: [ ] Phone: [ ] - [ ] - [ ]

Relationship to client: [ ]

In-Home Service provider/home care worker(s):

Name	Hours	Phone
[ ]	[ ]	[ ] - [ ] - [ ]
[ ]	[ ]	[ ] - [ ] - [ ]

Primary health care provider name: [ ] Phone: [ ] - [ ] - [ ]

Agencies involved with client: [ ]

Health/ADL status *(attach ISP or CAPS 003)*: [ ]

Reason for referral: ☐ Hospital/ER use ☐ Behavior or cognition changes ☐ Fall risk
☐ Pain issues ☐ Medication safety ☐ Nutrition, hydration, weight issues
☐ Skin issues ☐ Care giver education ☐ Multiple or complex medical diagnoses
☐ Delegation ☐ Other *(specify)*: [ ]

Information RN provider should know: ☐ check if additional information attached

[ ]

☐ **Referral accepted** ☐ **Referral declined** Provider number: [ ]

RN *(name and signature)*: [ ] Date: [ ] / [ ] / [ ]

CM *(name and signature)*: [ ] Date: [ ] / [ ] / [ ]

Form is completed by case manager (CM) and emailed to nurse. Nurse must respond in two (2) business days with signature indicating either acceptance or denial. CM signs returned form to verify authorization for nurse to provide and bill for Initial Assessment (T2024) and Delegation (S5115). Signed form is placed in client file and a copy sent to nurse.

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Client Referral (SDS 0753)

- Required form

- Must be referred by CM of individual may request LTCCN through their CM

- LTCCN provider has two business days to accept or deny

- SDS 0753 signed by both CM and LTCCN provider authorizes provider to complete Initial Assessment and RN delegation

- Provider must maintain completed SDS 0753

Referral Review

- The LTCCN provider is responsible to:
  - Screen the referral; make sure LTCCN is qualified to provide services the individual needs

  - Notify the individual's case manager to accept or refuse* the referral within two business days

  - Sign the client referral form

- **Upon provider's acceptance of and case manager's and provider's signatures on the referral, RN may provide initial assessment and begin delegation before completion of the prior authorization form (SDS 4102)**

* The RN may refuse any referral

Initial Assessment

- Provider's own form

- The RN must:
  - Perform the initial assessment within 10 business days of accepting the referral
  - Submit the Initial Assessment with the Nursing Service Plan and prior authorization (PA) form

- Bundled rate includes all nursing services (assessment, teaching, care coordination, and monitoring) except delegation until the date the PA is authorized

Initial Assessment

- Conduct and document comprehensive assessment per OAR 851-045-0030 (medication review required)

- Face-to-face comprehensive nursing assessment to identify community health support needs and the person's health goals

- Must be legible with no medical jargon

- Provider must submit a copy to the CM and maintain a copy

Delegation

- A critical component of the program provided by an RN that is comfortable with this unique and valuable task

- RN must:
  - Follow standards and documentation requirements for nursing tasks delegation as required by OAR 851-047
  - Determine to delegate, not delegate or rescind a nursing task
  - Provide an estimate of the number of hours of delegation the individual needs to the case manager on the Nursing Service Plan (SDS 0754)
  - Submit a Nursing Services Summary form (SDS 0752) to case manager to inform of initial and ongoing delegation services prior to billing service
  - Keep the adult foster home provider informed of the delegation decisions and activities

Nursing Service Plan (SDS 0754)

APD Long Term Care Community Nursing Service Plan

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Completed form is sent to the case manager (CM) with the SDS 4102 (Prior Authorization) or whe[n] the form is to provide CM with description of the services that the nurse estimates he/she will prov[ide] assessment or reassessment.

Indicate delegation and estimated units here

Date received:

Client name:	Client ID number:	Service period dates: From:	To:
Nurse's name:	Nurse's phone number:	Nurse's email address (optional) or fax number:	
Signature:	Date:	Delegation: ☐ Yes ☐ No	☐ Estimated service units:

Attachments (include list):	Frequency of Monitoring visits/calls: ☐ Weekly ☐ 2x month ☐ 1x month ☐ Quarterly ☐ Other

Client's health goals (in his/her/family words):

Diagnosis:

Health needs which require nursing service	Client outcomes	RN services to be provided Assessment, medication review and/or teaching plans can be attached if referred to in plan.

Completion of this form may not meet all standards required for nursing practice as defined in Standards and Scope of Practice for RN, OAR 851, Division 045.
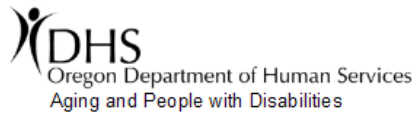
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https://apps.state.or.us/Forms/Served/se0754.pdf

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NURSING SERVICE PLAN

Nursing Service Plan (SDS 0754)

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APD Long Term Care Community Nursing Service Plan

Completed form is sent to the case manager (CM) with the SDS 4102 (Prior Authorization) or whenever the plan is updated. Purpose of the form is to provide CM with description of the services that the nurse estimates he/she will provide, based on the individuals initial assessment or reassessment.

Date received: _____

Client name:	Client ID number:	Service period dates: From: To:	
Nurse's name:	Nurse's phone number:	Nurse's email address *(optional)* or fax number:	
Signature:	Date:	Delegation: ☐ Yes ☐ No	☐ Estimated service units:

Attachments *(include list)*:	Frequency of Monitoring visits/calls: ☐ Weekly ☐ 2x month ☐ 1x month ☐ Quarterly ☐ Other
Client's health goals *(in his/her/family words)*:	
Diagnosis:	

Health needs which require nursing service	Client outcomes	RN services to be provided Assessment, medication review and/or teaching plans can be attached if referred to in plan.

Completion of this form may not meet all standards required for nursing practice as defined in Standards and Scope of Practice for RN, OAR 851, Division 045.

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https://apps.state.or.us/Forms/Served/se0754.pdf

Nursing Service Plan (SDS 0754)

- Required form

- To communicate the individual's health issues, desired outcomes, and the specific activities

- Timing and submission of service plan
  - With PA
  - When the Nursing Service Plan is updated

- Provider must submit a copy to the CM and maintain a copy of the SDS 0754

Nursing Service Plan (SDS 0754)

- Nursing Service Plan (SDS 0754) must:
  - Be based upon the most recent assessment
  - Identify specific RN services to assist the person in meeting identified needs
  - Describe the needs of the individual and the individual's caregiver
  - Identify the nursing interventions including the specific type, frequency and nursing services to be provided, including information to support estimated service hours on PA

- RN must attend at least two Nursing Service Plan review meetings per year with the case manager*

* May meet by phone if mutually agreed upon

PRIOR AUTHORIZATION (SDS 4102)

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Prior Authorization Form (SDS 4102)

Case manager: _____   Date received: _____

Service period: _____   PA number: _____

Client name: _____   ID number: _____

RN name: _____   Provider number: _____

Email: _____   RN phone/fax number: _____

Procedure Codes		Maximum Units Per Date of Service (DOS)
S5116	Teaching Non-Family	12
S5110	Teaching Family/Client	12
T1002	Monitoring Visit	12
T1016	Care Coordination	12
96151	Reassessment	12

RN: Enter the number of hours/units for each type of service the client is expected to need for a service period not to exceed six months. Calculate the cost. 15 minute unit rate set in current APD Rate Schedule.

Procedure Code/Service	Estimated Hours in Service Period	Estimated Units (15 minutes = 1 unit)	Estimated Cost for Services Period (number units x current unit rate)
S5116/ Teaching Non-Family:			
S5110/ Teaching Family/Client:			
T1002/ Monitoring Visit:			
T1016/ Care Coordination:			
96151/ Reassessment:			
Total:			

RN signature: _____   Date: _____

CM or Local Office
Supervisor* Authorization: _____   Date: _____

* Signature verifies that the client's current Nursing Service Plan SDS 0754 was reviewed and that services are authorized for the service period noted if provided according to OAR 411-048.

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https://apps.state.or.us/Forms/Served/se4102.pdf

Prior Authorization Form (SDS 4102)

- Required form

- LTCCN is responsible to request PA of services from CM
  - <u>Estimate</u> of service units for up to six months
  - Refer to 2013 LTCCN Procedure Codes & Payment Authorization Guidelines for detailed guidance on service descriptions and service units
  - NO requests to backdate or add service units or procedure codes after the PA has ended

- Provider must submit a copy to the CM and maintain a copy of the SDS 4102 or verification of authorization of PA from MMIS Provider Web Portal

Services Requiring Prior Authorization (SDS 4102) Approval

- Teaching

- Monitoring

- Care coordination

- Reassessment

All services must be provided by an RN in accordance with APD rules, section 411-048

Prior Authorization

- RN estimates hours needed for community nursing services within a six-month time period

- RN must ensure assessment and Nursing Service Plan (SDS 0754) is submitted with the PA form (SDS 4102) for CM to review requested hours

- Case manager reviews the PA form (SDS 4102) within five business days

- PA for initial assessment and delegation is only granted after the referral form is signed by the LTCCN provider and case manager

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Nursing Service Plan Review Meeting

- Review Prior Authorization request with CM

- At least two Nursing Service Plan review meetings required between LTCCN and CM*, per OAR 411-048-0180(4)(c)

- During meeting review Initial Assessment, Nursing Service Plan, and Prior Authorization (SDS 4102)

- Information sharing with CM
  - RN to CM Conditions CM may not be aware of
  - CM to RN Conditions RN may not be aware of
  - Preferred Communication methods for both RN and CM

* May meet by phone if mutually agreed upon

PRIOR AUTHORIZED (SDS 4102) NURSING SERVICES

Teaching

For individual, family, and/ or caregivers on how to safely provide community health supports

RN must:

- Use health promotion strategies and help the person identify and meet community health goals

- Follow standards and documentation requirements for teaching health promotion as required by OAR 851-045-0060

- Develop an overall teaching plan to describe and document why teaching is needed and specific goals for the individual

- Follow standards to teach nursing tasks needed to meet the individual's health care needs, including non-injectable medications or anticipated emergencies*

- Complete and submit the Nursing Services Summary (SDS 0752) to the case manager to inform of ongoing teaching prior to billing for the service

* Standards: community based care RN delegation, OAR 851-047 and nursing care by a designated caregiver, OAR 851-048

Monitoring

Gather or exchange information through calls or visits with the individual or caregivers necessary to implement Nursing Service Plan activities and conduct a medication review

- Implement or oversee interventions identified in the Nursing Service Plan

- Determine if the client and caregivers are understanding teaching/ delegation instructions and Nursing Service Plan activities

Monitoring

RN must:

– Document the projected frequency of monitoring visits, and adjust based upon individual needs, on the Nursing Service Plan

– Provide a medication review (scope based on RN judgment)

– Complete and submit Nursing Services Summary form (SDS 0752) to the case manager to inform of ongoing monitoring prior to billing for the service

Nursing Service Plan (SDS 0754)

APD Long Term Care Community Nursing Service Plan

Completed form is sent to the case manager (CM) with the SDS 4102 (Prior Authorization) or whenever th[...] the form is to provide CM with description of the services that the nurse estimates he/she will provide, bas[...] assessment or reassessment.

Indicate projected frequency of monitoring visits here

Date[...]

Client name:	Client ID number:	Service period dates: From: To:	
Nurse's name:	Nurse's phone number:	Nurse's email address *(optional)* or fax number:	
Signature:	Date:	Delegation: ☐ Yes ☐ No	☐ Estimated service units:
Attachments *(include list)*:	Frequency of Monitoring visits/calls: ☐ Weekly ☐ 2x month ☐ 1x month ☐ Quarterly ☐ Other		
Client's health goals *(in his/her/family words)*:			
Diagnosis:			

Health needs which require nursing service	**Client outcomes**	**RN services to be provided** Assessment, medication review and/or teaching plans can be attached if referred to in plan.

Completion of this form may not meet all standards required for nursing practice as defined in Standards and Scope of Practice for RN, OAR 851, Division 045.

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https://apps.state.or.us/Forms/Served/se0754.pdf

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Medication Review

- Provided during each monitoring visit and as part of an initial assessment or reassessment

- RN must determine the scope of the medication review based on the needs of the individual or the caregiver

- Information gathered may result in changes to an RN's Teaching Plan or care coordination activity

Care Coordination

The Nurse:

- Gathers or shares information needed in the assessment and reassessment process to complete medication reviews or to implement the Nursing Service Plan*

- Provides and exchanges updated information to case managers, pharmacists, healthcare providers, non-caregiving family members, DME vendors or legal representatives

- Completes and submits a Nursing Services Summary form (SDS 0752) to the CM to inform them of ongoing care coordination <u>prior</u> to billing for the service

*All planned care coordination activities must be included in the Nursing Service Plan

Reassessment

- Provider's own form

- Face-to-face reassessment

- Reassessment is required for any change in condition or change in environment <u>and</u> at least annually

- Must be legible with no medical jargon

- Allow for Reassessment service units in PA

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Reassessment

The RN must:

- Update the Nursing Service Plan <u>at least</u> annually; more frequently with changes in individual's condition or environment

- Determine if the reassessment is focused or comprehensive

- Complete the reassessment within 10 business days of the start of the reassessment

- Provider must submit a copy to the CM and maintain a copy of the reassessment, including the Nursing Service Plan

- Complete and submit a Nursing Services Summary form (SDS 0752) to the CM to inform them of reassessment <u>prior</u> to billing for the service

Nursing Services Summary Form (SDS 0752)

Purpose of form is to provide:

a.) Case manager (CM) with current information on services provided to individual. Summary can be limited to one service date or provide information on services delivered over a time period that includes multiple dates; and

b.) Description of the services that the nurse has submitted claims for. Completed form must be provided to CM by the nurse within 10 business days of providing the last service described below or before submission of claim(s) whichever is sooner. CM must keep copy in client file.

Registered nurse (RN) name:	Phone:	Email or fax:	
Client name:	Client ID no.:		Date received:

Summary of client health status/change

{RN can highlight issues for this time period (e.g., client now requires delegation for insulin or client was hospitalized for hip fx)}

Case manager ALERT

{(Optional) RN to identify any actions or issues that need CM action}

Documentation

Documentation attached: ☐ Yes ☐ No {If RN references detail in the narration such as a teaching plan, an assessment or tracking long documenting care coordination. These materials can be attached. }

Date(s) of service: {Should link up to the claims date}	Service codes/types: {Should link to codes billed for on the date}	Time spent: {(Optional) Sum of hour or clock time which support MMIS claims.}

Narrative/description of actions taken by RN

{Include where service was delivered, names/initials of recipients/participants, what nurse did, actions or outcomes.}

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http://www.oregon.gov/dhs/spwpd/apd-providers/ltc-community-nurses/Pages/tools-resources.aspx
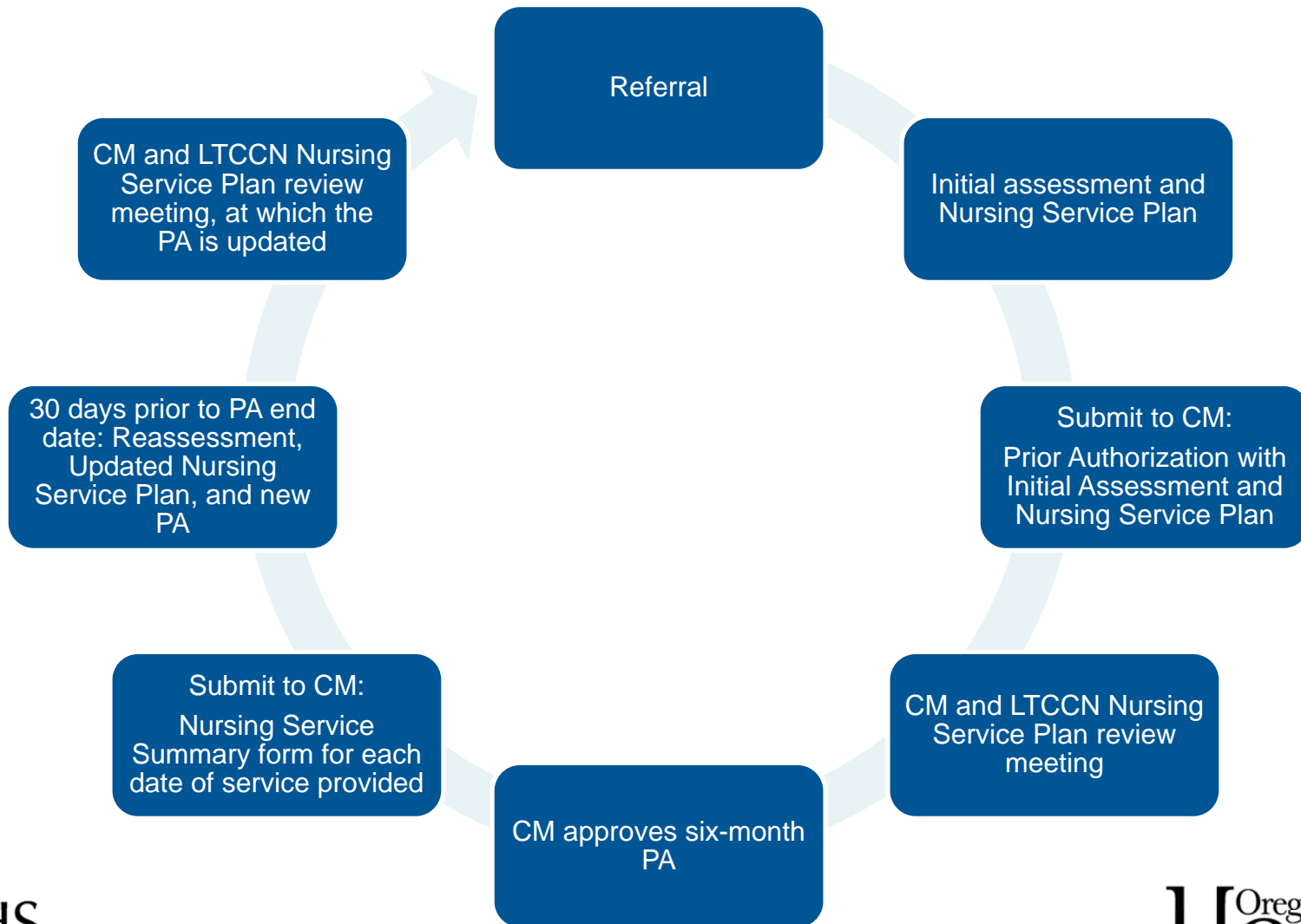
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Nursing Services Summary

- Required form

- Nursing Services Summary form (SDS 0752):
  - Must be used **regularly** as a communication tool for case managers and caregivers

  - Documentation and justification for billed service procedure code and service units

  - Documents monitoring, care coordination, teaching, delegation or other services as noted in rules

  - Complete and submit a Nursing Services Summary (SDS 0752) to the CM prior to billing, and maintain a copy

LTCCN Workflow

Referral

Initial assessment and Nursing Service Plan

Submit to CM:
Prior Authorization with Initial Assessment and Nursing Service Plan

CM and LTCCN Nursing Service Plan review meeting

CM approves six-month PA

Submit to CM:
Nursing Service Summary form for each date of service provided

30 days prior to PA end date: Reassessment, Updated Nursing Service Plan, and new PA

CM and LTCCN Nursing Service Plan review meeting, at which the PA is updated

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BILLABLE SERVICES

Services and Billing Codes

Non-Reimbursable Activities (APD-IM-12-080)*

- Effective 01/01/13, along with the new contractor rate

- LTCCN contractors may not request reimbursement for the following:
  - Time spent on documentation, research, scheduling, faxing or any other administrative/business activity (i.e. review of referral or prior authorization completion) that is not an allowed Medicaid service

  - Mileage or travel costs

  - Time spent in either local or central office policy meetings unless the meeting is designated by central office as "mandatory"

*Refer to billing guidelines for billable and non-billable services

Billable Codes

- T2024 – Initial Nursing Assessment and Service Plan

- S5115 – Delegation

- S5116 – Teaching, non-family

- S5110 – Teaching, individual or family

- T1016 – Care Coordination

- T1002 – Monitoring Visit

- 96151 – Reassessment

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Records Maintenance and Retention

- LTTCN provider must maintain a record of all nursing services provided to each assigned individual and the individual's caregiver

- Record must include:
  - Copies of all documentation provided to the local office; and
  - Additional documentation to meet OSBN or Medicaid rules

- Retention requirements
  - Retain the record at least until the RN no longer provides LTCCN services to the individual
  - Maintain original records for each individual following HIPAA practices for a period of seven years

RESOURCES AND Q & A

Resources

Long-Term Care Community Nursing

http://www.oregon.gov/dhs/spwpd/apd-providers/ltc-community-nurses/Pages/index.aspx

Billing Guidelines

http://www.oregon.gov/dhs/spwpd/apd-providers/ltc-community-nurses/Pages/tools-resources.aspx

Policies and forms, including APD-IM-12-080

http://www.oregon.gov/dhs/spwpd/apd-providers/ltc-community-nurses/Pages/tools-resources.aspx

DHS
Oregon Department
of Human Services

Oregon Health Authority

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Need Help?

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