Worker Guide: Direct Nursing MMIS Authorization

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Table of Contents

Overview

Description

Direct Nursing Services (DNS) authorization and payment instructions.

Purpose/rationale

To comply with federal and state requirements the department must assure an authorization and payment process for local Case Management Entities (CMEs). Under OAR 411-380, DNS providers create prior authorizations and are issued payments through the Medicaid Management Information System (MMIS).

Applicability

Services Coordinators and Personal Agents who support adults (21 years and older) who reside in adult foster care homes, 24-hour residential homes, or their own homes, and who qualify for Direct Nursing Services (hands on shift care nursing) as determined by ODDS clinical criteria, need to know to authorize and approve payment for the Direct Nursing Services.

Procedures that apply

MMIS authorization and payment

- All Direct Nursing Services providers must be qualified, enrolled DNS providers and meet all other rule eligibility.
- For individuals receiving DNS, Case Management Entities should assure current ISPs and a Direct Nursing Assessment Results Memorandum are attached in the eXPRS Plan of Care system.
- No hours of service will be paid before the start date of a Prior Authorization (PA). Direct Nursing hours identified on an ISP cannot exceed the number of hours identified on the Direct Nursing Memo. Direct Nursing hours that exceed the Prior Authorized amounts or exceeding the monthly hour allotment (as identified on Memo) will not be paid.
- For the DNS authorization and payment procedures, four different entities are responsible for clearly communicating and coordinating information to assure prior authorization and payment. These groups are:
    - Individuals, family, legal representatives, developmental disabilities service providers

- DNS Providers (Home Health or In-Home Agencies, Direct Nursing Services Agencies, and Self-employed RNs or LPNs)
- Case Management Entities (CDDPs or Brokerages)
- ODDS Central Office

Self-employed or agency providers

1. Comply with provider billing and payment requirements in OAR 411-380-0090 (1-5) as well as all other rule requirements.
2. After discussion with individual, family or developmental disabilities service provider, enter or load a request for Prior Authorization (PA) of hours into MMIS no later than the 25th of the month prior to anticipated service month to minimize the chance of unauthorized billing.
3. After the full month of services are delivered, invoices or timesheets are signed by the DNS provider, and individual, family or developmental disabilities service provider
4. Submit the invoice or signed timesheets to the case management entity (the specific contact varies depending on the CME); and
5. After ODDS approves the payment status of hours worked (verified by CME) make a claim for release of payment.

For the CME, following receipt of the email from the self-employed or Agency Provider

1. Verify the invoice or timesheets are within the authorized direct nursing hours in the ISP.
2. Verify all required documents per OAR have been received and are up to date. If not, the CME will hold the authorization until the required documents have been received by the CME. Required documents include the most up to date nursing care plan authored and signed by the Direct Nursing Services provider within the last 6 months and any other documents mutually agreed upon by the CME and DNS provider.

3. Email the DNS provider and odds.rnsupport@odhs.oregon.gov indicating that the hours authorized/worked are 'approved', with the PA number, individual's name and prime number

For ODDS, following receipt of the Prior Authorization into MMIS

1. Wait for the case management entity to email odds.rnsupport@odhs.oregon.gov with verification of approved invoice/timesheet at the end of the month
2. Convert the pending authorization in MMIS into approved status
3. Confirm approved status in email to the case manager and DNS provider.

Definition(s)

Case Management Entity: a CDDP or Support Service /Brokerage.

Direct Nursing Services: the services described in OAR 411-380-0050 determined medically necessary to support an individual with complex health management support needs in their home and community. Direct nursing services are provided on a shift staffing basis.

Home Health Agency: as defined in ORS 443.305.

In-Home Care Agency: as defined in ORS 443.305.

Direct Nursing Services agencies: as defined in OAR 411-323.

MMIS: Medicaid Management Information System. The automated claims processing and information retrieval system for handling all Medicaid transactions. The objectives of the system include verifying provider enrollment and individual eligibility, managing health care provider claims and benefit package maintenance, and addressing a variety of Medicaid business needs.

Prior Authorization Services: Payment authorization for direct nursing services given by the Department or contracted agencies of the Department prior to provision of the service. A physician referral is not a prior authorization for services.

Frequently asked questions

Q. As the Case Management Entity, are we responsible for authorization, review and approval of hours?

A. The Case Manager is responsible for the initial authorization of DNS services. The Case Management Entity is responsible:

- To assure the accurate monthly prior authorization of hours against the total allowable hours identified in the ISP
- Review of the provider signed timesheets or invoices to verify no overlapping nursing hours and that providers (individually and collectively) did not exceed total authorized hours
- That the CME has all required documents prior to approving hours
- The delivery (in a timely manner) of email confirming hours to the ODDS Central Office

Q. Do CMs have to wait for all provider timesheets to be sent in before reviewing, approving and sending each provider's confirmation email to ODDS?

A. No. Each Provider may submit for payment and be paid when all steps have been accurately completed. CMEs are responsible for reviewing the total tally of provider hours submitted. If the total hours authorized are exceeded, the CME should contact ODDS Central Office.

Q. Do the CMEs have to send Central Office copies of timesheets or invoices as part of the payment process?

A. Yes. All documentation (signed timesheets or invoices, confirmation emails to ODDS and any other authorization and payment communication) must be kept for auditing purposes. Providers must also maintain their own records per OARs 411-380-0080(6).

Q. Must providers use both a timesheet and invoice?

A. No. Providers may use either a timesheet or invoice as long as it contains all of the following information:

- Name of the individual
- Date: month/day/year
- Daily start and end time entries for hours worked for the month

- Clearly identifies the name of the DNS Provider (Agency or Self-Employed)
- Signature of DNS Provider (Agency or Self-Employed)
- Signature line for individuals, family, developmental disabilities service provider

Contact(s)

Send questions to odds.rnsupport@odhs.oregon.gov.

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