Questions and answers about prepayment review of outpatient occupational, physical and speech therapy claims

This fact sheet answers questions the Oregon Health Authority has received about the prepayment review process for fee-for-service outpatient therapy claims, which began July 1, 2019.

General requirements

What codes are subject to prepayment review?

Oregon Administrative Rules 410-131-0160(6)(a-v) and 410-129-0200(2)(a-b) list the specific codes subject to review.

- OHA's claim system automatically suspends all codes listed in these rules for manual review.
- Approximately 800 PPR therapy claims are received each day.

OAR 410-131-0200 notes that evaluation and re-evaluation codes are exempt from review.

- Do not submit a plan of care for claims that only contain these codes.
- Claims with these codes are processed as normal and do not suspend for manual review.

What are the basics of coverage?

Program-specific requirements:

1. Members have an annual limit of 30 rehabilitative and 30 habilitative visits.
2. Visits exceed the 30-visit limit require prior authorization.
3. Each claim must be supported by a valid plan of care, approved by OHA.

For all fee-for-service claims billed to OHA:

1. Services must be part of the member's OHP benefit package.
2. The member must be covered under FFS OHP for the dates billed. This means the member is not enrolled in a CCO or OHA covers the service for both CCO and FFS members.
3. The rendering and billing provider must be actively enrolled with OHA.
4. The primary diagnosis must pair with the billed service(s) on a line that is above the current funding line of the Prioritized List of Health Services.

OHA's claim review process

Does OHA have to review every claim?

If the claim meets all documentation requirements OHA only has to review the first claim in a therapy series. If the first claim is approved, all subsequent claims in the series will automatically process.

If the first claim is denied, all subsequent claims in the series will deny. Do not submit further claims until OHA approves the initial claim.

What are OHA's processing times?

OHA reviews claims by order received. Claims are allowed a minimum "resting period" of 2 business days to give providers time to submit supporting documentation to OHA.

How does OHA process these claims?

OHA searches their claim system for a valid plan of care. The plan of care needs to match the claim's client ID and date of service information.

- If a valid plan of care exists, OHA will approve the claim and release it for processing.
- If there is no valid plan of care, OHA will deny the claim.

How does OHA notify providers about the status of a claim?

OHA notifies the provider whether the initial claim was approved or denied. Denials will include the reasons for denial.

Documentation requirements

What is required?

There must be a rehabilitative or habilitative therapy plan of care to receive payment. OHA will reimburse for the level of care or type of service that meets the client's medical need consistent with the HERC Prioritized List and Guideline Notes.

What does the plan of care need to include?

The plan of care must contain the following elements (according to the Standards of Therapy issued by your licensing board):

1. Patient's name
2. ICD-10 primary diagnosis code, as listed on the order for the therapy services
3. Type of therapy
4. Amount of therapy (i.e., total number of visits)
5. Frequency of therapy (i.e., number of visits per week, month)
6. Duration of therapy (i.e., a dated time span with "From" and "To" service dates)
7. Individualized, measurable goals
8. Plan to address home exercise program
9. Dated signature of the therapist

What happens when there is missing, incomplete or illegible documentation?

The claim will deny, and a letter will be sent to the provider showing the reason for denial.

How do I extend the approved dates for an existing plan of care?

The plan of care is valid for the length of therapy or a maximum of one year, whichever is shorter.

If a patient has a reevaluation, recertification or extension to their therapy, this documentation can be attached to the next therapy claim billed after the initial certification period has expired.

Billing

How do I submit the plan of care with the initial claim?

You have two ways to do this:

Paper claim

Mail the claim to OHA with the plan of care attached.

Electronic claim

Bill electronically. Fax the plan of care to OHA at 503-378-3086 using the EDMS Coversheet.

- Under "Document Type," choose "Claims Documentation"
- Under "Document Identification Number," enter the claim's Internal Claim Number (ICN) in the ICN field.

How do I rebill for a partially paid initial claim?

Adjust the claim in the Provider Web Portal at https://www.or-medicaid.gov. Fax the plan of care to OHA at 503-378-3086 using the EDMS Coversheet.

- Under "Document Type," choose "Claims Documentation"
- Under "Document Identification Number," enter the claim's Internal Claim Number (ICN) in the ICN field.

How do I rebill for a denied claim?

Submit a new claim on paper or electronically as described above.

How do I bill OHA as secondary?

For private health insurance:

If the primary pays each line and the TPL payment is entered on the claim OHA/OHP will process the claim for secondary benefits as per the patient benefit plan.

If insurance doesn't pay, bill OHA. Enter the two-digit third-party resource (TPR) code that explains why. and a valid POC will need to be attached to the first claim of this nature.

For Medicare-Medicaid claims:

If Medicare pays for the services as primary:

- Bill Medicare first.
- Report private health insurance as secondary and OHA (Medicaid) last.

If the Medicare claim does **not** cross over to OHA:

- Bill OHA using the OHP 505.

If there are multiple line items on the claim, report the Medicare payment on each applicable line. Otherwise, the claim will deny because the system cannot calculate the coinsurance correctly.

If Medicare doesn't pay:

- Bill OHA.
- Enter the two-digit third-party resource (TPR) code that explains why.
- Attach a valid plan of care to the initial claim.

What is the error code we will see on the remittance advice?

The error code will be 4813.

Prior authorizations

What if the codes do not pair and we want to request an exception?

To request an exception, you will need to submit a prior authorization request. To learn more, read OHA's fact sheet about asking OHA to approve treatment for unfunded or comorbid conditions.

What if Medicaid is secondary insurance?

Medicaid is always payor of last resort. Refer to the primary payer for their approval and billing procedures.