DEPARTMENT OF HUMAN SERVICES, DEPARTMENTAL ADMINISTRATION AND MEDICAL ASSISTANCE PROGRAMS

DIVISION 129

SPEECH-LANGUAGE PATHOLOGY, AUDIOLOGY AND HEARING AID SERVICES

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410-129-0000 Foreword

(1) The Speech-Language Pathology, Audiology and Hearing Aid Services Guide is a user's manual designed to assist providers in preparing health claims to the Office of Medical Assistance Programs (OMAP) for clients with medical assistance coverage. This guide contains information on policy, services regarding payment authorization/prior authorization, service limitations, service criteria, billing instructions and rules governing OMAP providers of speech-language pathology, audiology and hearing aid services. All of the OMAP guides are intended to be used in conjunction with the General Rules for Oregon Medical Assistance Programs and the Oregon Health Plan Administrative Rules provider guide. Rules and definitions within those guides are applicable to provision of services.

(2) Instructions on completing claim forms, Administrative Rules and examples of some completed forms are included in the Speech-Language Pathology, Audiology and Hearing Aid Services guide. A section listing procedure codes and their definitions, restrictions and limitations is also included. An addendum includes documentation standards, requirements and recommended formats for the individual treatment record.

(3) The Office of Medical Assistance Programs (OMAP) endeavors to furnish medical providers with up-to-date billing, procedural information, and guidelines to keep pace with program changes and governmental requirements.

(4) Providers are responsible for maintaining current publications provided by OMAP.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: HR 5-1991, f. 1-18-91, cert. ef. 2-1-91; OMAP 36-1999, f. & cert. ef. 10-1-99

410-129-0010 Purpose

In conjunction with the General Rules for Oregon Medical Assistance Programs and the Oregon Health Plan Administrative rules, these rules are hereby established by the Office of Medical Assistance Programs (OMAP) for the purpose of supervising and controlling payments for speech-language pathology, audiology and hearing aid services provided to those Office of Medical Assistance Programs clients eligible to receive such services under the provisions of Oregon State Statutes. OMAP will reimburse for the lowest level of service that meets the medical need.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: AFS 14-1982, f. 2-16-82, ef. 3-1-82; AFS 49-1982, f. 4-30-82 & AFS 52-1982, f. 5-28-82, ef. 5-1-82 for providers located in the geographical areas covered by the AFS branch offices located in North Salem, South Salem, Dallas, Woodburn, McMinnville, Lebanon, Albany and Corvallis, ef. 6-30-82 for remaining AFS branch offices; AFS 67-1985, f. 11-19-85, ef. 12-1-85; HR 5-1991, f. 1-18-91, cert. ef. 2-1-91; Renumbered from 461-021-0300; OMAP 36-1999, f. & cert. ef. 10-1-99

410-129-0020 Therapy Goals/Outcome

(1) Therapy will be based on a prescribing practitioner's written order and a therapy treatment plan with goals and objectives developed from an evaluation or re-evaluation.

(2) The therapy regimen, will be taught to the patient, family, foster parents, and/or caregiver to assist in the achievement of the goals and objectives.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.060
Hist.: HR 5-1991, f. 1-18-91, cert. ef. 2-1-91; HR 27-1993, f. & cert. ef. 10-1-93; HR 36-1994, f. 12-30-94, cert. ef. 1-1-95; OMAP 36-1999, f. & cert. ef. 10-1-99

410-129-0040 Maintenance

(1) Therapy becomes maintenance when any one of the following occur:

(a) The therapy treatment plan goals and objectives are reached; or

(b) There is no progress toward the therapy treatment plan goals and objectives; or

(c) The therapy treatment plan does not require the skills of a therapist; or

(d) The patient, family, foster parents, and/or caregiver have been taught and can carry out the therapy regimen and are responsible for the maintenance therapy.

(2) Therapy that becomes maintenance is not a covered service.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: HR 5-1991, f. 1-18-91, cert. ef. 2-1-91; HR 27-1993, f. & cert. ef. 10-1-93; OMAP 36-1999, f. & cert. ef. 10-1-99

410-129-0060 Prescription Required

(1) The prescription is the written order by the prescribing practitioner pursuant to state law governing speech-pathology, audiology and hearing aid services.

(2) The provision of speech therapy services must be supported by a written order and a therapy treatment plan signed by the prescribing practitioner. A practitioner means a person licensed pursuant to State law to engage in the provision of health care services within the scope of the practitioner's license and/or certification.

(3) A written order:

(a) is required for the initial evaluation;

(b) for therapy, must specify the ICD-9-CM diagnosis code, service, amount and duration required.

(4) Written orders must be submitted with the payment (prior) authorization request and a copy must be on file in the provider's therapy record. The written order and the treatment plan must be reviewed and signed by the prescribing practitioner every six months.

(5) Authorization of payment to an audiologist or hearing aid dealer for a hearing aid will be considered only after examination for ear pathology and written prescription for a hearing aid by an ear, nose, and throat specialist (ENT) or general practitioner who has training to examine the ear and performs within the scope of his/her practice, i.e. primary care physician (not appropriate is an orthopedic specialist, chiropractor, gynecologist, etc.).

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.096
Hist.: AFS 67-1985, f. 11-19-85, ef. 12-1-85; HR 5-1991, f. 1-18-91, cert. ef. 2-1-91; Renumbered from 461-021-0301; HR 27-1993, f. & cert. ef. 10-1-93; HR 36-1994, f. 12-30-94, cert. ef. 1-1-95; OMAP 36-1999, f. & cert. ef. 10-1-99

410-129-0065 Licensing Requirements

(1) Speech Pathologists:

(a) ORS 681, 681.420 and 681.460, Board of Examiners in Speech Pathology and Audiology Chapter 335, will govern the practice of licensed speech pathologists. Licensed speech pathologists may enroll as providers and be reimbursed for services;

(b) Services of graduate students in speech-language pathology, under supervision of a licensed Speech Pathologist during training or during the Clinical Fellowship Year are reimbursable to the licensed supervising speech pathologist. Graduate speech-language pathologists who are performing a clinical fellowship year need to hold a provisional license issued by the Oregon Board of Examiners in Speech Pathology and Audiology. ORS 681.325 "Issuance of Conditional License Scope of Practice and Renewal";

(c) Services of a licensed speech pathologist while teaching or supervising students in speech pathology will not be reimbursed.

(2) Audiologists. ORS 681, 681.420 and 681.460, Board of Examiners in Speech Pathology and Audiology Chapter 335, will govern the practice of licensed audiologists. Licensed audiologists may enroll as providers and be reimbursed for services.

(3) Hearing Aid Dealers. ORS 694.015 through 694.199, Board of Hearing Aid Dealers licensing program Chapter 333 will govern the services by licensed hearing aid dealers. Licensed hearing aid dealers may enroll as providers and be reimbursed for services.

Stat. Auth.: ORS 409
Stats.Implemented: ORS 414.065
Hist.: HR 27-1993, f. & cert. ef. 10-1-93; OMAP 36-1999, f. & cert. ef. 10-1-99

410-129-0070 Limitations

(1) The rules contained in OAR 410-129-0010 – 410-129-0080 and 410-129-0220 also apply to services delivered by home health agencies and by hospital-based therapists in the outpatient setting. They do not apply to services provided to hospital inpatients. Billing and reimbursement for therapy services delivered by home health agencies and hospital outpatient departments is to be in accordance with the rules in their respective provider guides.

(2) Speech Pathology:

(a) All speech pathology services will be performed by a licensed speech pathologist or a graduate student in training or a graduate speech pathologist in the Clinical Fellowship Year being supervised by a licensed speech pathologist. Only therapy and evaluation services rendered on-site are billable under the codes listed in the Speech-Language Pathology, Audiology and Hearing Aid Services provider guide;

(b) Speech pathology therapy treatments may not exceed one hour per day, either group or individual. Treatment must be either group or individual, and cannot be combined in the authorization period;

(c) Therapy records must include:

(A) Documentation of each session;

(B) Therapy provided and amount of time spent; and

(C) Signature of the therapist.

(d) Documentation (progress notes, etc.) must be retained in the provider's records. All report and clinical notes by graduate students in training or graduate speech pathologists in the clinical fellowship year must be countersigned by the supervising licensed speech pathologist;

(e) Services of a graduate student in training or a graduate speech pathologist during the clinical fellowship year, under direct supervision of a licensed speech pathologist are reimbursable to the licensed supervisor under the following conditions:

(A) Supervision must occur on the same premises and the supervisor must be readily accessible to the resident performing the actual service;

(B) Strict supervision requirements adhering to the American Speech-Language-Hearing Association requirements must be followed, which includes a minimum amount of time the supervisor must be physically present during therapy and evaluation time. Therapy is 15 minutes per hour and evaluation time is 30 minutes per hour;

(C) Documentation of the supervisor must clearly indicate her/his level of involvement in the delivery of each service in order to assure quality of care to the client;

(D) Documentation by the graduate student in training or the Clinical Fellow must demonstrate to the satisfaction of the agency that services are medically appropriate in continuing the plan and treatment plan for the client in clear, legible notation.

(f) Services Which Do Not Require Payment Authorization:

(A) One speech/language and swallowing screening will be reimbursed per calendar year;

(B) Two Assessments for Speech/Language will be reimbursed per calendar year;

(C) Two Assessments for Dysphagia will be reimbursed per calendar year;

(D) One Assessment for augmentative communication system or device will be reimbursed per recipient per calendar year;

(E) One Assessment for voice prosthesis or artificial larynx will be reimbursed per calendar year;

(F) Purchase, repair or modification of electrolarynx;

(G) Supplies for speech therapy will be reimbursed up to two times per calendar year, not to exceed $5.00 each.

(g) Services Which Require Payment Authorization:

(A) All speech pathology therapy treatments;

(B) Augmentative communication system or device, purchase or rental. An augmentative communication system or device is limited to one month. All rental fees must be applied to the purchase price;

(C) Repair/modification of augmentative communication system or device.

(h) Services Not Covered:

(A) Services of a licensed speech pathologist while teaching or supervising students of speech pathology will not be reimbursed;

(B) Maintenance therapy is not reimbursable as described in 410-129-0040.

(3) Audiology and Hearing Aid Dealer Services:

(a) All hearing services will be performed by licensed audiologists or hearing aid dealers;

(b) One (monaural) hearing aid may be reimbursed every five years for adults who meet the following criteria (or more frequently if hearing thresholds have decreased significantly, as determined during at the authorization process): Loss of 45 decibel (dB) hearing level or greater in two or more of the following three frequencies: 1000, 2000, and 3000 Hertz (Hz) in the better ear;

(c) Adults who meet the criteria above and, in addition, have vision correctable to no better than 20/200 in the better eye, may be authorized for two hearing aids for safety purposes. Submit a vision evaluation with the payment authorization request;

(d) Two (binaural) hearing aids will be reimbursed no more frequently than every three years for children who meet the following criteria:

(A) Pure tone average of 25dB for the frequencies of 500Hz, 1000Hz and 2000Hz; or

(B) High frequency average of 35dB for the frequencies of 3000Hz, 4000Hzand 6000Hz.

(e) An assistive listening device may be authorized for individuals aged 21 or over who are unable to wear, or who cannot benefit from, a hearing aid. An assistive listening device is defined as a simple amplification device designed to help the individual hear in a particular listening situation. It is restricted to a hand-held amplifier and headphones;

(f) Services Which Do Not Require Payment Authorization:

(A) One basic audiologic assessment in a calendar year;

(B) One Basic comprehensive audiometry (audiologic evaluation) -- per calendar year;

(C) One Hearing aid evaluation/tests/selection -- per calendar year;

(D) One Electroacoustic evaluation for hearing aid; monaural -- per calendar year;

(E) One Electroacoustic evaluation for hearing aid; binaural - per calendar year;

(F) Hearing aid batteries -- maximum of 60 individual batteries per calendar year. Must meet the criteria for a hearing aid.

(g) Services which require payment authorization:

(A) Hearing aids;

(B) Repair of hearing aids, including ear mold replacement;

(C) Hearing aid dispensing and fitting fees;

(D) Assistive listening devices.

(h) Services Not Covered:

(A) FM systems -- vibro-tactile aids;

(B) Earplugs;

(C) Adjustment of hearing aids is included in the fitting and dispensing fee, and is not reimbursable separately;

(D) Aural rehabilitation therapy is included in the fitting and dispensing fee, and is not reimbursable separately;

(E) Tinnitis masker(s).

[ED. NOTE: Forms referenced in this rule are available from the agency.]

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: HR 27-1993, f. & cert. ef. 10-1-93; HR 36-1994, f. 12-30-94, cert. ef. 1-1-95; OMAP 36-1999, f. & cert. ef. 10-1-99; OMAP 38-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 39-2001, f. 9-24-01, cert.e f. 10-1-01

410-129-0080 Prior Authorization of Payment

(1) Payment authorization is approval by Office of Medical Assistance Programs (OMAP) or the local Senior and Disabled Services Division (SDSD) branch office for services which are medically appropriate.

(2) Payment authorization is required for speech-language pathology, audiology and hearing aid services as indicated in the Procedure Codes section of the OMAP Speech-Language, Pathology, Audiology and Hearing Aid Services provider guide. For therapy services requiring authorization, providers must contact OMAP or SDSD for authorization within five working days following initiation of services. Authorization will be given based on medical appropriateness and appropriateness of the therapy given. Hearing aids and other devices must be authorized prior to delivery of any services. It is the provider's responsibility to obtain a payment authorization.

(3) Where to request Payment Authorization:

(a) Managed Care plan members: Services for clients identified on the OMAP Medical Care Identification as having an "OMAP Contracted Plan" will be authorized by the plan. Contact the plan to determine their procedures;

(b) Adult and Family Services (AFS) and State Office for Services to Children and Families (SCF) clients: Services for clients identified on the OMAP Medical Care Identification as AFS and SCF (SCF is shown on the Medical ID as CSD) will be authorized by OMAP. Send all required documentation to OMAP;

(c) Senior and Disabled Services Division (SDSD) clients: Services for clients identified on the OMAP Medical Care Identification as SDSD clients (except requests for augmentative communications systems or devices) will be authorized by the local branch shown on the Medical Care Identification. Augmentative communications systems or devices will be authorized by OMAP;

(d) Medically Fragile Children's Unit (MFCU) clients: Services to clients identified on the Medical Care Identification as MFCU clients will be authorized by the Medically Fragile Children's Unit.

(4) Information needed to request payment authorization:

(a) A copy of the written prescription and the appropriate OMAP 3071 (3071H for audiology and hearing aid services; 3071S for speech pathology services) and a copy of the therapy treatment plan must be submitted with each request. The request must document medical appropriateness including diagnosis and specify services requested;

(b) When requesting prior authorization, include all pertinent medical history, including therapy received from public or private programs, in the documentation. This may include, but is not limited to:

(A) Individual Family Service Plan (IFSP);

(B) Individual Education Plan (IEP);

(C) Individual Program Plan (IPP);

(D) Individual Service Plan (ISSP); or

(E) Plan of Care (POC).

(5) Include the following information on the OMAP 3071:

(a) Client's name;

(b) Medical Assistance Program ID number;

(c) Procedure codes;

(d) Provider number;

(e) Therapist's name and specific performing provider number;

(f) Medical justification;

(g) ICD-9 codes;

(h) Date(s) of service;

(i) Frequency, duration, length of service;

(j) Usual and customary charge.

(6) Submit the following information with the payment authorization request for a hearing aid:

(a) History of hearing aid use;

(b) Audiogram;

(c) Physician's prescription indicating medical appropriateness for hearing aid use (see OAR 410-129-0060);

(d) Pertinent medical history;

(e) Specific brand and model of hearing aid being requested;

(f) Submit documentation identifying single unit cost for hearing aid.

(7) A payment authorization number must be present on all speech-language pathology, audiology and hearing aid claims for procedure codes which require payment authorization, or the claim will be denied.

(8) A valid prescription of a licensed practitioner is required for all speech-language pathology services performed by a provider other than a physician.

(9) A valid prescription of a physician is required for all hearing aids provided by an audiologist or hearing aid dealer.

(10) Payment authorization does not guarantee eligibility. It is the provider's responsibility to check for eligibility on the date of service. Payment authorization does not relieve the provider of the responsibility to follow all applicable rules regarding the provision of service.

(11) Requests to change an existing payment authorization should be mailed or faxed to the appropriate agency. Include the following:

(a) client name;

(b) Medicaid recipient number;

(c) payment authorization number; and

(d) Documentation to support the requested change.

(12) How to obtain Payment Authorization:

(a) Determine client eligibility. Check the client's Medical Care Identification. An explanation of eligibility/coverage messages shown on the Medical Care Identification is included in the General Rules; or

(b) Call the Automated Information System (AIS). See the AIS Guide for instructions.

(13) Always place the Payment Authorization number in Field 23 of the HCFA-1500 billing form or Field 23B of the OMAP 505.

[ED. NOTE: Forms referenced in this rule are available from the agency.]

[Publications: Publications referenced are available from the agency.]

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: AFS 14-1982, f. 2-16-82, ef. 3-1-82; AFS 49-1982, f. 4-30-82 & AFS 52-1982, f. 5-28-82, ef. 5-1-82 for providers located in the geographical areas covered by the AFS branch offices located in North Salem, South Salem, Dallas, Woodburn, McMinnville, Lebanon, Albany and Corvallis, ef. 6-30-82 for remaining AFS branch offices; AFS 14-1984(Temp), f. & ef. 4-2-84; AFS 22-1984(Temp), f. & ef. 5-1-84; AFS 40-1984, f. 9-18-84, ef. 10-1-84; AFS 67-1985, f. 11-19-85, ef. 12-1-85; AFS 7-1988, f. & cert. ef. 2-1-88; HR 5-1991, f. 1-18-91, cert. ef. 2-1-91; Renumbered from 461-021-0310; HR 11-1992, f. & cert. ef. 4-1-92; HR 27-1993, f. & cert. ef. 10-1-93; OMAP 36-1999, f. & cert. ef. 10-1-99; OMAP 38-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 39-2001, f. 9-24-01, cert.e f. 10-1-01

410-129-0100 Medicare/Medicaid Claims

(1) When an individual, not in managed care, has both Medicare and Medicaid coverage, audiologists must bill audiometry and all diagnostic testings to Medicare first. Medicare will automatically forward these claims to Medicaid. Payment will be made at OMAP rates. Payment will be based on either Medicare's maximum allowable rate or OMAP's maximum allowable rate, whichever is the lesser.

(2) Audiologists must bill all hearing aids and related services directly to OMAP on an OMAP 505. Payment authorization is required on most of these services. (See Procedure Code Section of the Speech-Language, Pathology, Audiology and Hearing Aid provider guide.)

(3) If Medicare transmits incorrect information to OMAP, or if an out-of-state Medicare carrier or intermediary was billed, providers must bill OMAP using an OMAP 505 form. If any payment is made by OMAP, an Adjustment Request must be submitted to correct payment, if necessary.

(4) Send all completed OMAP 505 forms to: Office of Medical Assistance Programs.

(5) Hearing Aid Dealers bill all services directly to OMAP on a HCFA-1500. Payment authorization must be requested when required. (See Procedure Code section of the Speech-Language, Pathology, Audiology and Hearing Aid provider guide.)

(6) Speech Pathologists bill all services directly to OMAP on a HCFA-1500. Prior authorization must be requested when required. (See Procedure Code section of the Speech-Language, Pathology, Audiology and Hearing Aid provider guide.)

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: HR 5-1991, f. 1-18-91, cert. ef. 2-1-91; HR 11-1992, f. & cert. ef. 4-1-92; OMAP 36-1999, f. & cert. ef. 10-1-99

410-129-0120 How to Complete a HCFA-1500

(1) The HCFA-1500 is a required billing form. Each HCFA-1500 is a complete billing document. If there is not enough space on the HCFA-1500 to bill all procedures, complete a new billing form for the rest of the procedures. Do not "carry over" totals from one HCFA-1500 to another. Completed HCFA-1500 forms must be sent to: Office of Medical Assistance Programs (OMAP). Unit further notice from OMAP, providers may bill using either the HCFA-1500 claim form dated 1/84 or the newly revised HCFA-1500, dated 12/90. If providers choose to use the 12/90 form, they must follow these instructions. If the unrevised HCFA-1500 billing form is used, providers must continue to use the instructions as they are currently shown in the Provider Guide.

(2) The following fields are always required to be completed:

(a) Insured's I.D. Number: The eight-digit number found on the OMAP Medical Card;

(b) Patient's Name: The name as it appears on the OMAP Medical Card;

(c) Name of Referring Physician or Other Source: Enter the name of the referring provider, HMO/PCO (if the client is in a prepaid health plan), or the primary care physician if the patient is restricted;

(d) ID Number of Referring Physician: Enter the OMAP provider number of the referring provider, HMO/PCO (if the client is in a prepaid health plan), or the primary care physician if the patient is restricted;

(e) Date of Service: Must be numeric (05/03/92). If "From-To" dates are used, a service must have been provided on each consecutive day but not more than once per day;

(f) Place of Service: Where service is provided:

(A) 2 -- Outpatient hospital/OP department;

(B) 3 -- Practitioner's office;

(C) 4 -- Patient's home;

(D) 7 -- Intermediate care facility;

(E) 8 -- Skilled nursing facility;

(F) C -- Residential treatment center.

(g) Type of Service Codes (TOS): Use Type of Service "J" in this field;

(h) Procedures, Services or Supplies: Use only the CPT Codes, HCPCS Codes or OMAP Unique Codes listed in the Speech-Pathology Guide;

(i) Charges: Enter a charge for each line item;

(j) Days or Units: This number must match the number of days in the Date of Service Field or the number of units of services provided;

(k) Total Charge: Enter the total amount for all charges listed on this HCFA-1500;

(l) Balance Due: Enter the balance (the information in the Total Charge Field minus the information in the Amount Paid Field);

(m) Provider Number: Enter the OMAP billing or provider number here.

NOTE: Only one number may be entered in this field.

(3) The following fields are required, when applicable:

(a) Other Insured's Name: This information is listed on the Medical Card. Use the Third Party Resource (TPR) codes found in the Billing Section to indicate response received from other resources;

(b) Is Patient's Condition Related To: Complete as appropriate when an injury is involved;

(c) Reserved for Local Use (Field 10d): Put a "Y" in this field if the service was an emergency;

(d) Prior Authorization Number: If required, enter the Prior Authorization number here;

(e) Reserved for Local Use -- (Field 24K): Enter the OMAP performing provider number here, unless it is used in the Provider Number Field;

(f) Amount Paid: Enter the total amount paid from other resources. Do not include OMAP copayments in this field. Do not show any payment from OMAP on this line. If the patient has other insurance and this amount is zero, there must be a two-digit "reason" code in Field 9.

(4) Third Party Resource (TPR) Code:

(a) Select one code from either the single or the multiple insurance coverage lists. Enter this code in Field 9 on the HCFA-1500 or OMAP 505;

(b) Single Insurance Coverage. Select the most appropriate code when the patient has only one insurance policy in addition to Medicaid:

(A) UD -- Service Under Deductible;

(B) NC -- Service Not Covered by Insurance Policy;

(C) PN -- Patient Not Covered by Insurance Policy;

(D) IC -- Insurance Coverage Canceled/ Terminated;

(E) IL -- Insurance Lapsed or not in Effect on Date of Service;

(F) IP -- Insurance Payment Went to Policyholder;

(G) PP -- Insurance Payment Went to Patient;

(H) NA -- Service not Authorized or Prior Authorized by Insurance;

(I) NE -- Service not Considered Emergency by Insurance;

(J) NP -- Service not Provided by Primary Care Provider/ Facility;

(K) MB -- Maximum Benefits Used for Diagnosis/ Condition;

(L) RI -- Requested Information not Received by Insurance from Patient;

(M) RP -- Requested Information not Received by Insurance from Policyholder;

(N) MV -- Motor Vehicle Accident Fund Maximum Benefits Exhausted;

(O) AP -- Insurance mandated under administrative/court order through an absent parent -- Not paid within 30 days (effective November 1, 1991);

(P) OT -- Other (if above codes do not apply, include detailed information of why no TPR payment was made).

(c) Multiple Insurance Coverage. Select most appropriate code when the patient has more than one insurance policy in addition to Medicaid:

(A) MP -- Primary Insurance Paid -- Secondary Paid;

(B) SU -- Primary Insurance Paid -- Secondary Under Deductible;

(C) MU -- Primary and Secondary Under Deductible;

(D) PU -- Primary Insurance Under Deductible -- Secondary Paid;

(E) SS -- Primary Insurance Paid -- Secondary Service Not Covered;

(F) SC -- Primary Insurance Paid -- Secondary Patient Not Covered;

(G) ST -- Primary Insurance Paid -- Secondary Insurance Canceled/Terminated;

(H) SL -- Primary Paid -- Secondary Lapsed or Not in Effect;

(I) SP -- Primary Paid -- Secondary Payment Went to Patient;

(J) SH -- Primary Paid -- Secondary Payment Went to Policyholder;

(K) SA -- Primary Paid -- Secondary Denied -- Service Not Authorized or Prior Authorized; (L) SE -- Primary Paid -- Secondary Denied -- Service Not Considered Emergency;

(M) SF -- Primary Paid -- Secondary Denied -- Service Not Provided by Primary Care Provider/Facility;

(N) SM -- Primary Paid -- Secondary Denied -- Maximum Benefits Used for Diagnosis/ Condition;

(O) SI -- Primary Paid -- Secondary Denied -- Requested Information Not Received from Policyholder;

(P) SR -- Primary Paid -- Secondary Denied -- Requested Information not Received from Patient;

(Q) MC -- Service Not Covered by Primary or Secondary Insurance;

(R) MO -- Other (if above codes do not apply, include detailed information of why no TPR payment was made).

Stat. Auth.: ORS 184.750 & ORS 184.770
Stats. Implemented:
Hist.: HR 5-1991, f. 1-18-91, cert. ef. 2-1-91; HR 11-1992, f. & cert. ef. 4-1-92; OMAP 80-2002, f. 12-24-02, cert. ef. 1-1-03

410-129-0140 Instructions on How to Complete the OMAP 505

(1) *Patient's Name: Enter the name as it appears on the Medical Card.

(2) *Insured's Medicaid Number: Enter the eight digit number from the Medical Card.

(3) *Insured's Group Number: The Medicare number as it appears on the client's Medicare Identification Card. (Example: 123456789A or 234567890C1).

(4) *Other Health Insurance Coverage: If no payment was received from Medicare, this space must be used to explain why no payment was made. Select a two-digit "Reason" code from the Third Party Resource (TPR) codes that are found in the billing section of this Guide. Be sure that this "reason" code is the first entry in Field 9, followed by the name of the Third party Resource (Medicare). Example: Medicare paid nothing ("Reason" code NC, Not Covered). Enter: NC-Medicare. Do not mail the Medicare EOB in with your claims.

(5) ** Was Condition Related To: Complete if service is related to an injury/accident.

(6) **If an Emergency Check Here: Check here if the service was performed as an emergency.

(7) *Name of Referring Physician or Other Source: Enter the OMAP provider number of the referring provider, HMO/PCO referrals, restricted patient referrals. If this service is the result of an HMO or PCO referral, the OMAP provider number of the HMO or PCO Plan must be entered here.

(8) **Prior Authorization: If required, enter the prior authorization number here.

(9) *Date of Service: Use a six digit numeric date. If a "From-To" date range is used, all services must be on consecutive days.

(10) *Place of Service: Where service is provided:

(a) 1 = Inpatient hospital;

(b) 2 = Outpatient hospital/OP department/ER;

(c) 3 = Practitioner's office;

(d) 4 = Patient's home;

(e) 7 = Intermediate care facility;

(f) 8 = Skilled nursing facility;

(g) C = Residential treatment center.

(11) *Procedure Code: Enter the CPT Codes, HCPCS Codes or OMAP Unique Procedure Codes listed in this Guide.

(12) *Days or Units: Enter the number of services or units billed.

(13) *Type of Service Codes (TOS): Use Type of Service "J".

(14) *Charges Billed Medicare: Enter the total dollar amount you billed to Medicare for each service.

(15) *Medicare's Allowed Charges: Enter the dollar amount allowed by Medicare for each service.

(16) **Provider Number: Enter the OMAP provider number here unless it is used in Field 34.

(17) *Total Charge: Add the charges in Field 24G and enter the total dollar amount billed Medicare.

(18) *Medicare Total Payment: Enter the total dollar amount paid by Medicare for the services.

(19) **Insurance Other than Medicaid/ Medicare: Enter any amount paid by another resource, other than Medicare, such as other health insurance, or "Spend-Down" (client responsibility). Do not include OMAP copayments in this field. If the amount is zero, put in a "0".

(20) *Balance Due: Subtract the amounts in Fields 28 and 30 from Field 27 and enter the balance in this field. An amount must be put in this field.

(21) Your Patient's Account Number: If the patient account number is entered here, OMAP will print that number on the Remittance Advice.

(22) *Physician's or Supplier's name, Address, Zip Code and Phone Number: Only the OMAP provider number is required.

* = Required Field** = Required When Applicable

Stat. Auth.: ORS 184.750 & ORS 184.770
Stats. Implemented: ORS 414.065
Hist.: HR 5-1991, f. 1-18-91, cert. ef. 2-1-91; OMAP 81-2002, f. 12-24-02, cert. ef. 1-1-03

410-129-0180 Procedure Codes

(1) Procedure codes listed in the Speech-Language Pathology, Audiology and Hearing Aid Services Provider Guide are intended for use by licensed speech-language pathologists, licensed audiologists and certified hearing aid dealers.

(2) Physicians and nurse practitioners are subject to the administrative rules contained in OMAP's Medical-Surgical Services Provider Guide and must bill OMAP using the processes and procedure codes identified in that Guide.

[Publications: The publication(s) referred to or incorporated by reference in this rule are available from the agency.]

Stat. Auth.: ORS 184.750, ORS 184.770, ORS 409.010 & ORS 409.110
Stats. Implemented:
Hist.: HR 5-1991, f. 1-18-91, cert. ef. 2-1-91; HR 27-1993, f. & cert. ef. 10-1-93

410-129-0190 Client Copayments

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

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist. OMAP 80-2002, f. 12-24-02, cert. ef. 1-1-03

410-129-0195 Copayment for Standard Benefit Package

(1) A client receiving the Standard Benefit Package may be subject to copayments for Speech-Language Pathology, Audiology and Hearing Aids services. Table 129-0195 lists applicable copayments. See General Rules 410-120-1235 for additional information.

(2) Speech services that are listed in Table 129-0195 are covered on the Standard Benefit Package.

(3) Speech services that are not listed in Table 129-0195 are not covered on the Standard Benefit Package.

(4) Hearing aids, hearing aid repairs, and examinations and audiological diagnostic services only performed to determine the need for or the appropriate type of hearing aid(s) are not covered under the Standard Benefit Package.

(5) Audiological services that are listed in Table 129-0195 are covered under the Standard Benefit Package except as described in (4) of this rule.

(6) Audiological services that are not listed in Table 129-0195 are not covered under the Standard Benefit Package. Table 129-0195.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 3-2003, f. 1-31-03, cert. ef. 2-1-03

Table 129-0195

The following services are covered under the OHP Standard Benefit Package

Code	Copay Amount
V5362	$5.00
V5363	$5.00
92506	$5.00
G0195	$5.00
G0196	$5.00
V5364	$5.00
92525	$5.00
92526	$5.00
92507	$5.00
92508	$5.00
92541	$5.00
92542	$5.00
92543	$5.00
92544	$5.00
92545	$5.00
92546	$5.00
92547	$5.00
92551	$5.00
92552	$5.00
92553	$5.00
92555	$5.00

Code	Copay Amount
92556	$5.00
92557	$5.00
92562	$5.00
92563	$5.00
92564	$5.00
92565	$5.00
92567	$5.00
92568	$5.00
92569	$5.00
92571	$5.00
92572	$5.00
92576	$5.00
92577	$5.00
92579	$5.00
92582	$5.00
92583	$5.00
92585	$5.00
92586	$5.00
92587	$5.00
92588	$5.00
92589	$5.00

410-129-0200 Speech-Language Pathology Procedure Codes

(1) Speech Therapy Services. Table 200-1.

(2) Other Speech Services. Table 200-2.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Stats. Implemented: ORS 414.065
Hist.: HR 5-1991, f. 1-18-91, cert. ef. 2-1-91; HR 11-1992, f. & cert. ef. 4-1-92; HR 27-1993, f. & cert. ef. 10-1-93; HR 36-1994, f. 12-30-94, cert. ef. 1-1-95; OMAP 36-1999, f. & cert. ef. 10-1-99; OMAP 6-2000, f. 3-31-00, cert. ef. 4-1-00; OMAP 20-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 10-2002, f. & cert. ef. 4-1-02; OMAP 22-2003, f. 3-26-03, cert. ef. 4-1-03

Table 0200-1 Speech Therapy Services

V5362	Speech screening—Limited to one per calendar year
V5363	Language screening—Limited to one per calendar year
92506	Evaluation of speech, language, voice, communication, auditory processing and/or aural rehabilitation status—Limited to two per calendar year
V5364	Dysphagia screening study—Limited to one per calendar year
92526	Treatment of swallowing dysfunction and/or oral function for feeding requires payment authorization prior to provision of services
92507	Treatment of speech/language, voice, communication and/or auditory processing disorder (includes aural rehabilitation) requires payment authorization prior to provision of services
92508	Group, two or more individuals requires payment authorization prior to provision of services
92610	Evaluation of oral and pharyngeal swallowing function - Limited to two per calendar year
92611	Motion fluoroscopic evaluation of swallowing function by cine or video recording—Limited to two per calendar year

Table 0200-2 Other Speech Services

92607	Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; first hour
92608	each additional 30 minutes (List separately in addition to code for primary procedure)
92609	Therapeutic services for the use of speech-generating device, including programming and modification
K0541	Speech Generating Device, Digitized Speech using pre-recorded messages, less than or equal to 8 minutes recording time—requires payment authorization prior to provision of services
K0542	Speech Generating Device, Digitized Speech using pre-recorded messages, greater than 8 minutes recording time—requires payment authorization prior to provision of services
K0543	Speech Generating Device, Synthesized Speech, requiring message formulation by spelling and access by physical contact with the device—requires payment authorization prior to provision of services
K0544	Speech Generating Device, Synthesized Speech, permitting multiple methods of message formulation and multiple methods of device access—requires payment authorization prior to provision of services
K0545	Speech Generating Software Program, for personal computer or personal digital assistant—requires payment authorization prior to provision of services

K0546	Accessory for Speech Generating Device, mounting system—requires payment authorization prior to provision of services
K0547	Accessory for Speech Generating Device, not otherwise classified—requires payment authorization prior to provision of services
V5336	Repair/Modification of Augmentative Communication System or Device (excludes adaptive hearing aid)—requires payment authorization prior to provision of services
A4649	Supplies for speech therapy—Limited to two per calendar year, not to exceed $4.75 each
L8501	Tracheostomy Speaking Valve
L8500	Artificial larynx, any type
L7510	Repair of prosthetic device, repair or replace minor parts—requires payment authorization prior to provision of services
L7520	Repair prosthetic device, labor component, per 15 minutes—requires payment authorization prior to provision of services
L9900	Orthotic and prosthetic supply necessary and/or service component of another HCPCS L code
L8507	Tracheo-esophageal voice prosthesis, patient inserted, any type, each
L8509	Tracheo-esophageal voice prosthesis, inserted by a licensed health provider, any type

92597	Evaluation for use and/or fitting of voice prosthetic device to supplement oral speech
L8510	Voice amplifier

410-129-0220 Augmentative Communications System or Device

(1) The Office of Medical Assistance Programs (OMAP) will cover dedicated communication systems or devices and necessary attachments, (i.e. to bed or wheelchair).

(2) All requests for these systems, devices and necessary attachments will be reviewed for medical appropriateness.

(3) All required supporting documentation must be submitted prior to review. A form has been developed that outlines the necessary information required for review. A written narrative should be attached to provide a sufficient level of detail.

(4) If, in the opinion of OMAP, the clinical documentation furnished does not support the services requested, the request will be denied.

(5) Criteria: The following criteria must be met before any request for an augmentative communication system or device will be considered:

(a) A physician's statement of diagnosis and medical prognosis including the necessity to communicate medical needs must be submitted;

(b) A reliable and consistent motor response which can be used to communicate must be identified;

(c) As measured by standardized or observational tools, the individual must have the cognitive ability of:

(A) Object permanence -- ability to remember objects and realize they exist when they are not seen;

(B) Means end -- ability to anticipate events independent of those currently in progress. The ability to associate certain behaviors with actions that will follow.

(d) The client must be assessed by a team consisting of a Speech Pathologist and when appropriate an Occupational Therapist and/or Physical Therapist. Formal evaluation reports should be included;

(e) Devices evaluated must be documented with an explanation of why this particular device is best suited for this individual and why the device is the lowest level which will meet basic functional communication needs;

(f) There must be a documented trial of the selected device and a report on the success in using this device;

(g) A therapy treatment plan must be developed stating who will program the device, monitor and reevaluate the user on a periodic basis. Indicate the individual who will be responsible for carrying out the plan;

(h) Requests for Augmentative Communications Systems or Devices are sent to Office of Medical Assistance Programs;

(i) A vendor's price quotation for the device must accompany each request including where the device is to be shipped;

(j) Submit with the request for authorization for an augmentative communication system or device:

(A) A formal augmentative communication assessment report -- required elements are listed on the reverse of the OMAP 3047 form;

(B) A physician's prescription of diagnosis and prognosis (not a prescription for an augmentative device).

(6) OMAP will reimburse for the lowest level of service that meets the medical need. Table 0220.

[ED. NOTE: The Table and Form(s) referenced in this rule are available from the agency.]

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: HR 40-1990(Temp), f. & cert. ef. 11-15-90; HR 5-1991, f. 1-18-91, cert. ef. 2-1-91; HR 11-1992, f. & cert. ef. 4-1-92; HR 36-1994, f. 12-30-94, cert. ef. 1-1-95; OMAP 36-1999, f. & cert. ef. 10-1-99; OMAP 38-2000, f. 9-29-00, cert. ef. 10-1-00

Table 0220

Submit with the request for authorization for an augmentative communication system or device:

1) A *formal augmentative communication assessment report* – required elements are listed on the reverse of the OMAP 3047 form in the Forms Section.

2) A physician's prescription of diagnosis and prognosis (*not* a prescription for an augmentative device).

410-129-0240 Audiologist and Hearing Aid Procedure Codes

(1) Audiologist and Hearing Aid Procedure Codes.

Table 0240-1

(2) Special Otorhinolaryngologic Services codes: These codes apply [only] to services for cochlear implants. These services include medical diagnosis evaluation by the otology physician.

Table 0240-2

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: HR 5-1991, f. 1-18-91, cert. ef. 2-1-91; HR 11-1992, f. & cert. ef. 4-1-92; HR 27-1993, f. & cert. ef. 10-1-93; OMAP 36-1999, f. & cert. ef. 10-1-99; OMAP 38-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 10-2002, f. & cert. ef. 4-1-02; OMAP 22-2003, f. 3-26-03, cert. ef. 4-1-03

Table 0240-1 Audiologist and Hearing Aid Procedure Codes

92553	Pure tone audiometry, air and bone - limited to one per calendar year
92557	Comprehensive audiometry threshold evaluation and speech recognition Includes pure tone, air and bone, and speech threshold and discrimination. Also includes testing necessary to determine feasibility of amplification
92590	Hearing aid examination and selection; monaural May include sound field speech reception tests, speech discrimination tests, determination of appropriate style of hearing aid, and to determine if the ear should receive amplification
92591	Hearing aid examination and selection; binaural May include sound field speech reception tests, speech discrimination tests, determination of appropriate style of hearing aid, and which ear should receive amplification
V5011	Fitting/orientation/checking of hearing aid. Includes adjusting aid to the wearer, instructions to wearer, and follow-up care - requires payment authorization prior to provision of services
V5160	Hearing aid dispensing fee, binaural - requires payment authorization prior to provision of services
V5200	Hearing aid dispensing fee, CROS - requires payment authorization prior to provision of services
V5240	Hearing aid dispensing fee, BICROS - requires payment authorization prior to provision of services

V5241	Hearing aid dispensing fee, monaural hearing aid, any type - requires payment authorization prior to provision of services
S9092	Canolith repositioning, per visit, limited to one per calendar year

Table 0240-2 Special Otorhinolaryngologic Services codes

92601	Diagnostic analysis of cochlear implant, patient under 7 years of age; with programming
92602	subsequent reprogramming
92603	Diagnostic analysis of cochlear implant, age 7 years or older; with programming
92604	subsequent reprogramming
92510	Aural rehabilitation following cochlear implant (includes evaluation of aural rehabilitation status and hearing, therapeutic services) with or without speech processor programming -- requires payment authorization prior to provision of services
97703	Checkout for orthotic/prosthetic use, established patient, each 15 minutes — requires payment authorization prior to provision of services
L8619	Cochlear implant external speech processor, replacement
L7510	Repair of prosthetic device, repair or replace minor parts — requires payment authorization prior to provision of services
L7520	Repair prosthetic device, labor component, per 15 minutes

410-129-0260 Hearing Aids and Hearing Aid Technical Service and Repair

(1) Hearing Aids must be billed to the Office of Medical Assistance Programs at the provider's Acquisition Cost, and will be reimbursed at such rate. For purposes of this rule, Acquisition Cost is defined as the actual dollar amount paid by the provider to purchase the item directly from the manufacturer (or supplier) plus any shipping and/or postage for the item.

(2) Submit history of hearing aid use and an audiogram when requesting payment authorization for the first four codes in this rule.

Table 129-0260.
Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.
Hist.: HR 5-1991, f. 1-18-91, cert. ef. 2-1-91; HR 11-1992, f. & cert. ef. 4-1-92; HR 27-1993, f. & cert. ef. 10-1-93; OMAP 36-1999, f. & cert. ef. 10-1-99; OMAP 38-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 20-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 39-2001, f. 9-24-01, cert.e f. 10-1-01; OMAP 10-2002, f. & cert. ef. 4-1-02; OMAP 1-2003, f. 1-31-03, cert. ef. 2-1-03; OMAP 22-2003, f. 3-26-03, cert. ef. 4-1-03

Table 129-0260

92594	Electroacoustic evaluation for hearing aid; monaural
92595	Electroacoustic evaluation for hearing aid; binaural
V5014	Repair/modification of hearing aid - requires payment authorization prior to provision of services
V5266	Hearing aid batteries - limited to 60 individual batteries per calendar year
V5264	Ear mold/insert, not disposable, any type - requires payment authorization prior to provision of services
V5274	Assistive listening device, not otherwise specified - requires payment authorization prior to provision of services
V5030	Hearing aid, monaural, body worn, air conduction - requires payment authorization prior to provision of services
V5040	Hearing aid, monaural, body worn, bone conduction –requires payment authorization prior to provision of services
V5050	Hearing aid, monaural, in the ear - requires payment authorization prior to provision of services
V5060	Hearing aid, monaural, behind the ear - requires payment authorization prior to provision of services
V5130	Hearing aid, binaural, in the ear - requires payment authorization prior to provision of services
V5140	Hearing aid, binaural, behind the ear - requires payment authorization prior to provision of services

V5170	Hearing aid, CROS, in the ear - requires requires payment authorization prior to provision of services
V5180	Hearing aid, CROS, behind the ear - requires requires payment authorization prior to provision of services
V5210	Hearing aid, BICROS, in the ear - requires payment authorization prior to provision of services
V5220	Hearing aid, BICROS, behind the ear - requires payment authorization prior to provision of services

410-129-0280 Hearing Testing for Diagnostic Purposes (On Physician's Referral Only)

A physician's referral is required for the tests shown in this rule. The tests may only be performed and billed by a licensed audiologist or a licensed physician. Table 0280.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: HR 5-1991, f. 1-18-91, cert. ef. 2-1-91; HR 11-1992, f. & cert. ef. 4-1-92; HR 27-1993, f. & cert. ef. 10-1-93; OMAP 36-1999, f. & cert. ef. 10-1-99; OMAP 20-2001, f. 3-30-01, cert. ef. 4-1-01

Table 0280 Hearing Testing

92541	Spontaneous nystagmus test, including gaze and fixation nystagmus, with recording
92542	Positional nystagmus test, minimum of four positions, with recording
92543	Caloric vestibular test, each irrigation (binaural, bithermal stimulation constitutes four tests) with recording
92544	Optokinetic nystagmus test, bidirectional, foveal or peripheral stimulation, with recording
92545	Oscillating tracking test, with recording
92546	Sinussoidal vertical axis rotational testing
92547	Use of vertical electrodes in any or all of above tests counts as one additional test
92551	Screening test, pure tone, air only
92552	Pure tone audiometry (threshold); air only
92555	Speech audiometry; threshold only
92556	with speech recognition
92562	Loudness balance test, alternate binaural or monaural
92563	Tone decay test
92564	Short increment sensitivity index (SISI)
92565	Stenger test, pure tone

92567	Tympanometry
92568	Acoustic reflex testing
92569	Acoustic reflex decay test
92571	Filtered speech tests
92572	Staggered spondaic word test
92576	Synthetic sentence identification test
92577	Stenger test, speech
92579	Visual reinforcement audiometry (VRA)
92582	Conditioning play audiometry
92583	Select picture audiometry
92585	Auditory evoked potentials for evoked response audiometry and/or testing of the central nervous system; comprehensive
92586	Auditory evoked potentials for evoked response audiometry and/or testing of the central nervous system; limited
92587	Evoked Otacoustic Emissions - limited (single stimulus level, either transient or distortion products)
92588	Evoked Otacoustic Emissions - comprehensive or diagnostic evaluation (comparison of transient and/or distortion product otoacoustic emissions at multiple levels and frequencies)
92589	Central auditory function test(s) (specify)