Division of Medical Assistance Programs
Policy and Planning Section

# Physical and Occupational Therapy Services Administrative Rulebook

## Chapter 410, Division 131

Effective April. 4, 2014

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**410-131-0040 Foreword for Physical and Occupation Therapy**

(1) The Division of Medical Assistance Programs (Division) Physical and Occupational Therapy (PT/OT) Services Program rules are designed to assist licensed physical and occupational therapists deliver health care services and prepare health claims for clients with medical assistance program coverage.

(2) Oregon Administrative Rules (OAR) 410-131-0040 through 410-131¬0160:

(a) Apply to services delivered by home health agencies and by hospital-based therapists in the outpatient setting. Billing and reimbursement for therapy services delivered by home health agencies and hospital outpatient departments are to be in accordance with the rules in their respective provider guides.; and

(b) Do not apply to services provided to hospital inpatients.

(3) The Division enrolls only the following types of providers as performing providers under the PT/OT program:

(a) A person licensed by the relevant State licensing authority to practice physical therapy; and

(b) A person licensed by the relevant State licensing authority to practice occupational therapy.

(4) The PT/OT program rules contain information on policy, prior authorization, and service coverage and limitations for some procedures. All Division rules are intended to be used in conjunction with the General Rules for Oregon Medical Assistance Programs (OAR 410 division 120) and the Oregon Health Plan (OHP) Administrative Rules (OAR 410 division 141).

(5) The Oregon Health Services Commission’s Prioritized List of Health Services is found in OAR 410-141-0520 and defines the services covered under the Division.

(6) The PT/OT provider must understand and follow all Division rules that are in effect on the date services are provided.

Stat. Auth.: ORS 413.042 and 414.065

Stats. Implemented: ORS 414.065

**410-131-0080 Therapy Plan of Care and Record Requirements**

(1) A therapy plan of care is required for prior authorization (PA) for payment.

(2) The therapy plan of care must include:

(a) Client's name, diagnosis, type, amount, frequency and duration of the proposed therapy;

(b) Individualized, measurably objective short-term and/or long-term functional goals;

(c) Documented need for extended service, considering 60 minutes as the maximum length of a treatment session;

(d) Plan to address implementation of a home management program as appropriate, from the initiation of therapy forward;

(e) Dated signature of the therapist or the prescribing practitioner establishing the therapy plan of care; and

(f) Evidence of certification of the therapy plan of care by the prescribing practitioner.

(3) The therapy treatment plan and regimen will be taught to the client, family, foster parents, or caregiver during the therapy treatments. No extra treatments will be authorized for teaching.

(4) A therapy plan of care requires reauthorization every 30 days:

(a) The need for continuing therapy must be clearly stated; and

(b) Changes to the therapy plan of care, including duration and frequency of intervention, must be documented, signed and dated by the prescribing practitioner.

(5) Therapy Records must include:

(a) A written referral, including:

(A) The client's name;

(B) The ICD-9-CM diagnosis code; and

(C) Must specify the type of services, amount, and duration required.

(b) A copy of the signed therapy plan of care must be on file in the provider's therapy record prior to billing for services. The therapy plan of care must be reviewed and signed by the prescribing practitioner every 30 days.

(c) Documents, evaluations, re-evaluations and progress notes to support the therapy treatment plan and prescribing provider's written orders for changes in the therapy treatment plan;

(d) Modalities used on each date of service;

(e) Procedures performed and amount of time spent performing the procedures is documented and signed by the therapist; and

(f) Documentation of splint fabrication and time spent fabricating the splint.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 688.135, 414.065

**410-131-0100 Maintenance**

(1) Determination of when maintenance therapy is reached is made through comparison of written documentation of evaluation of the last several functional evaluations related to initial baseline measurements.

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

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

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

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

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

(3) Maintenance therapy is not a reimbursable service.

(4) Re-evaluation to change the therapy plan of care and up to two treatments for brief retraining of the client, family, foster parents or caregiver are not considered maintenance therapy and are reimbursable.

(5) Providers must maintain adequate documentation as outlined in OAR 410-120-1360, Requirements for Financial, Clinical and Other Records.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 688.135, 414.065

**410-131-0120 Limitations of Coverage and Payment**

(1) Oregon Health Plan (OHP) Plus clients shall be responsible for paying a co-payment for some services. This co-payment shall be paid directly to the provider. See OAR 410-120-1230, Client Co-payment, and Table 120-1230-1 for specific details.

(2) The provision of PT/OT evaluations and therapy services require a prescribing practitioner referral, and services must be supported by a therapy plan of care signed and dated by the prescribing practitioner (see OAR 410-131-0080).

(3) PT/OT initial evaluations and re-evaluations do not require Prior Authorization (PA), but are limited to:

(a) Up to two initial evaluations in any 12-month period; and

(b) Up to four re-evaluation services in any 12-month period;

(4) Reimbursement is limited to the initial evaluation when both the initial evaluation and a re-evaluation are provided on the same day.

(5) All other occupational and physical therapy treatments require PA. See also OAR 410-131-0160 and Table 131-0160-1.

(6) A licensed occupational or physical therapist, or a licensed occupational or physical therapy assistant under the supervision of a therapist, must be in constant attendance while therapy treatments are performed:

(a) Duration—Therapy treatments may not exceed one hour per day each for occupational and physical therapy;

(b) Modalities:

(A) Require PA;

(B) Up to two modalities may be authorized per day of treatment;

(C) Need to be billed in conjunction with a therapeutic procedure code; and

(D) Each individual supervised modality code may be reported only once for each client encounter. See Table 131-0160-1.

(c) Massage therapy is limited to two units per day of treatment and shall only be authorized in conjunction with another therapeutic procedure or modality.

(7) Supplies and materials for the fabrication of splints must be billed at the acquisition cost, and reimbursement may not exceed the Division’s maximum allowable in

accordance with the physician fee schedule. Acquisition cost is purchase price plus shipping. Off-the-shelf splints, even when modified, are not included in this service.

(8) The following services are not covered:

(a) Services not medically appropriate;

(b) Services that are not paired with a funded diagnosis on the Health Evidence Review Commission's (HERC) Prioritized List of Health Services pursuant to OAR 410-141-0520;

(c) Work hardening;

(d) Back school/back education classes;

(e) Hippotherapy (e.g. horse or equine-assisted therapy);

(f) Services included in OAR 410-120-1200 Excluded Services Limitations;

(g) Durable medical equipment and medical supplies other than those splint supplies listed in Table 131-0120-1, OAR 410-131-0280; and

(h) Maintenance therapy (see OAR 410-131-0100).

(9) Physical capacity examinations are not a part of the PT/OT program but may be reimbursed as administrative examinations when ordered by the local branch office. See the Division's OARs 410, division 150 for information on administrative examinations and report billing.

(10) Table 131-0120-1.

Stat. Auth.: ORS 413-042

Stats. Implemented: ORS 688.135, 414.065

**Table 131-0120-1 Services That Do Not Require Payment Authorization**

This table is arranged to improve clarity and is not intended to provide complete guidance on service coverage. Refer to OARs 410-141-0480, 410-141-0500, and 410-141-0520 for information on covered services.

***Application of splints***

| |
|---|
| 29105 |
| 29125 |
| 29126 |
| 29130 |
| 29131 |

***Supplies to create splints***

| |
|---|
| Q4017 |
| Q4018 |
| Q4019 |
| Q4020 |
| Q4021 |
| Q4022 |
| Q4023 |
| Q4024 |
| Q4049 |
| Q4051 |

**410-131-0160 Prior Authorization for Payment**

(1) Most Oregon Health Plan (OHP) clients have prepaid health services, contracted for by the Oregon Health Authority (Authority) through enrollment in a Prepaid Health Plan (PHP). Client's who are not enrolled in a PHP receive services on an "open card" or "fee-for-service" (FFS) basis.

(2) The provider must verify whether a PHP or the Division of Medical Assistance Programs (Division) is responsible for reimbursement. Refer to OAR 410-120-1140 Verification of Eligibility.

(3) If a client is enrolled in a PHP there may be prior authorization (PA) requirements for some services that are provided through the PHP. Providers must comply with the PHP's PA requirements or other policies necessary for reimbursement from the PHP before providing services to any OHP client enrolled in a PHP. The physical or occupational therapy (PT/OT) provider needs to contact the client's PHP for specific instructions.

(4) If a client receives services on a FFS basis, the Division or their contractor may require a PA for certain covered services or items before the service can be provided or before payment will be made. A PT/OT provider assumes full financial risk in providing services to a FFS client prior to receiving authorization, or in providing services that are not in compliance with Oregon Administrative Rules (OARs). See OAR 410-120¬1320 Authorization of Payment, this rule and Table 131-0160-1 Services Require Payment Authorization:

(a) PT/OT initial evaluations and re-evaluations do not require a prior authorization (see OAR 410-131-0120);

(b) To ensure reimbursement for continuation of PT/OT services and procedures beyond the initial evaluation, the PT/OT provider must request a PA within five working days following initiation of services:

(A) PA requests dated within five working days of initiation of services may be approved retroactively to include services provided within five days prior to the date of the PA request;

(B) PA requests dated beyond five working days of initiating services will not be authorized retroactive, and if authorized will be effective the date of the PA request. The division recognizes the facsimile or postmark as the PA date of request;

(c) All PA requests require a therapy plan of care (see OAR 410-131-0080); and

(d) A PA is not required for Medicare-covered PT/OT services provided to dual-eligible clients, Medicare clients who are also Medicaid-eligible.

(5) If the service or item is subject to prior authorization, the PT/OT provider must follow and comply with PA requirements in these rules, and the General Rules, including but not limited to:

(a) The service is adequately documented (see OAR 410-120-1360 Requirements for Financial, Clinical and Other Records). Providers must maintain documentation in the provider's files to adequately determine the type, medical appropriateness, or quantity of services provided;

(b) The services provided are consistent with the information submitted when authorization was requested;

(c) The services billed are consistent with those services provided;

(d) The services are provided within the timeframe specified on the authorization of payment document; and

(e) Includes the PA number on all claims for occupational and physical therapy services that require PA, or the claim will be denied.

(6) Table 131-0160-1

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025 and 414.065

**Table 131-0160-1 Services Require Payment Authorization**

| | | |
|---|---|---|
| 95831 | 97110 | 97535 |
| 95832 | 97112 | 97542 |
| 95833 | 97113 | 97755 |
| 95834 | 97116 | 97760 |
| 95851 | 97124 | 97761 |
| 95852 | 97140 | 97762 |
| 97012 | 97150 (1 visit = 1 unit) | |
| 97022 | 97530 | |
| 97036 | 97532 | |