DHS Oregon Department of Human Services

Health Services
Office of Medical Assistance Programs

Physical and Occupational Therapy Services Rulebook

Includes:

1) Current Update Information (changes since last update)

2) Table of Contents

3) Complete set of PT/OT Services Administrative Rules

Physical and Occupational Therapy Services Rulebook

Update Information

for

April 1, 2005

Effective: April 1, 2005

OMAP updated the PT/OT Services Program Rulebook with the following:

OMAP amended 410-131-0120 and 410-131-0280 to clarify what services are funded under the Health Services Commission's Prioritized List of Health Services for the Oregon Health Plan.

OMAP also updated the Rulebook by adding a cover page and the Update Information to replace provider letters.

If you have questions, contact a Provider Services Representative toll-free at 1-800-336-6016 or direct at 503-378-3697.

DEPARTMENT OF HUMAN SERVICES

MEDICAL ASSISTANCE PROGRAMS

DIVISION 131

PHYSICAL AND OCCUPATIONAL THERAPY SERVICES

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410-131-0000 Foreword

(1) The Physical and Occupational Therapy Services guide is a user's manual designed to assist providers in program information and preparation of claims for Medical Assistance Program clients. The Physical and Occupational Therapy Services guide is used in conjunction with the General Rules for the Office of Medical Assistance Programs (OMAP) and the Oregon Health Plan Administrative Rules.

(2) Administrative rules, procedure codes, instructions on completing claim forms, and examples of forms are included in the Physical and Occupational Therapy Services guide.

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

[Publications: The publication(s) referenced in this rule are available from the agency.]

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065

10-1-00

410-131-0020 Purpose

In conjunction with the General Rules of Office of Medical Assistance Programs (OMAP) and the Oregon Health Plan Administrative Rules, these rules are hereby established by OMAP for the purpose of supervising and controlling payment for physical and occupational therapy services provided to those Medical Assistance Program clients eligible to receive such services under the provisions of Oregon State Statutes. OMAP will reimburse for the lowest level of service which meets the medical need.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
10-1-00

410-131-0040 Physical Therapy

Physical Therapy Licensing Board ORS 688.010 to 688.235 and Standards of Practice for Physical Therapy as well as the Standards of Ethical Conduct for the Physical Therapist Assistant established by the American Physical Therapy Association will govern the practice of physical therapy.

Stat. Auth.: ORS 184.750 & ORS 184.770
Stats. Implemented: ORS 688.010 - ORS 688.225
2-1-91

410-131-0060 Occupational Therapy

Occupational Therapy Licensing Board, ORS 675.210 to 675.340 and the Uniform Terminology for Occupational Therapy established by the American Occupational Therapy Association Inc., will govern the practice of occupational therapy.

Stat. Auth.: ORS 184.750 & ORS 184.770
Stats. Implemented: ORS 675.210 - ORS 675.340
2-1-91

410-131-0080 Therapy Plan of Care

(1) 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.

(2) Recertification of the therapy plan of care:

(a) Is required every 30 days from the initiation of treatment;

(b) The need for continuing therapy should be clearly stated;

(c) The therapy plan of care, duration and frequency of intervention, and any changes to previous therapy plan of care must be documented, signed and dated by the prescribing practitioner.

(3) Therapy Expected Outcome:

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

(b) When possible, the therapy regimen will be taught to the client, family, foster parents, and/or caregiver, who will carry out the therapy regimen to assist in the achievement of the goals and objectives.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
10-1-01

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.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
10-1-01

410-131-0120 Limitations

(1) OARs 410-131-0020 through 410-131-0160 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 are to be in accordance with the rules in their respective provider guides.

(2) Program Information -- 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 must not exceed one hour per day each for occupational and physical therapy;

(b) Maintenance Therapy -- Maintenance therapy means the goals and objectives have been reached, or there is no progress toward the goals and objectives, or the therapy does not require the skills of a therapist, and the client, family, foster parents, or caregiver have been taught and can carry out the therapy regimen. Maintenance therapy is not reimbursable;

(c) Modalities -- Up to two modalities may be authorized per day of treatment;

(d) Massage therapy, CPT 97124, is limited to two (2) units per day of treatment, and will only be authorized in conjunction with another therapeutic procedure or modality;

(e) Physical Capacity Examinations -- Physical capacity examinations are not a part of the Occupational and Physical Therapy program, but may be reimbursed as Administrative Examinations when ordered by the local branch office. See OAR 410 Division 150 for information on Administrative examinations and report billing;

(f) Re-Evaluations -- A re-evaluation to reassess or change the treatment plan and retrain the client, family, foster parents, or caregiver is reimbursable;

(g) Splint Fabrication -- Supplies and materials for the fabrication of splints must be billed at the acquisition cost, not to exceed $62.40. Acquisition cost is purchase price plus shipping. Off-the-shelf splints are not included in this service;

(h) Therapy Records -- Therapy records must include:

(A) A written order (including type, number and duration of services) and therapy treatment plan signed by the prescribing provider;

(B) 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;

(C) Modalities used on each date of service;

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

(E) Documentation of splint fabrication and time spent fabricating the

splint.

(i) Training -- 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.

(3) Payment Authorization:

(a) The following services do not require payment authorization for occupational or physical therapy:

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

(B) Up to four re-evaluation services in any 12-month period.

(b) All other occupational and physical therapy treatments require payment authorization.

(4) Services Not Covered -- The following services are not covered:

(a) Services that are not medically appropriate;

(b) Services that are not paired with a funded diagnosis on the Health Services Commission's Prioritized List of Health Services adopted under OAR 410-141-0520;

(c) Work hardening;

(d) Back school/back education classes;

(e) Hippotherapy;

(f) Durable medical equipment and medical supplies other than those listed in OAR 410-131-0280.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

4-1-05

410-131-0140 Prescription Required

(1) The prescription is the written referral by the prescribing practitioner.

(2) The provision of physical and occupational therapy services must be supported by a written referral and a therapy plan of care signed and dated by the prescribing practitioner. Evaluations and therapy services require a prescribing practitioner referral.

(3) A written referral must include:

(a) The client's name;

(b) The ICD-9-CM diagnosis code;

(c) The therapy referral must specify the services, amount, and duration required.

(4) 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.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.645

10-1-01

410-131-0160 Payment Authorization

(1) Payment authorization is approval by the Office of Medical Assistance Programs (OMAP), the Medically Fragile Children's Unit (MFCU), the OMAP Case Management Contractor, or the Managed Care Organizations (MCOs) for services.

(2) Payment authorization is required for physical and occupational therapy services as indicated in the "Occupational and Physical Therapy Codes" section of the Physical and Occupational Therapy rules. For services requiring authorization from OMAP or MFCU, and for continuation of those services, providers must contact OMAP or MFCU for authorization within five working days following initiation of services. For services requiring payment authorization from the OMAP Case Management Contractor, authorization must be obtained prior to the initiation of services. For fee-for-service case management clients, OMAP will not reimburse for a service that requires payment authorization if provided prior to receiving authorization from the OMAP Case Management Contractor. Services for clients enrolled in a Managed Care Organization (MCO) will be authorized by the MCO. Contact the MCO to determine their procedures.

(3) If service is provided prior to receiving authorization, the provider may be at risk for denial of authorization. It is the provider's responsibility to obtain payment authorization. The FAX or postmark date is recognized by OMAP as the date of request.

(4) A payment authorization number must be present on all claims for occupational and physical therapy services that require payment authorization or the claim will be denied.

(5) Payment authorization does not guarantee eligibility or payment. It is the provider's responsibility to check for eligibility on the date of service.

(6) Payment authorization does not relieve the provider of the responsibility to follow all applicable rules regarding the provision of services.

(7) Physical and occupational therapy services for OMAP fee-for-service clients with Medicare do not require payment authorization for Medicare covered services. For clients enrolled in a Managed Care Organization (MCO), contact the MCO for their procedures.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065

10-1-04

410-131-0180 Billing

(1) Billings for physical and occupational therapy services listed in the Physical and Occupational Therapy Services guide must be submitted on a CMS-1500 or an OMAP 505.

(2) Physical Therapy Assistants and Certified Occupational Therapy Assistants may provide services and bill using the provider number of their licensed supervisor.

(3) CMS-1500 forms are not provided by the Office of Medical Assistance Programs (OMAP). They may be obtained from local forms suppliers.

(4) Send completed CMS-1500 claim forms to OMAP.

(5) Electronic Billing -- Claims can be submitted electronically. For more information contact OMAP.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
10-1-02

410-131-0200 Medicare/Medical Assistance Program Claims

(1) If a client has both Medicare and Medical Assistance Program coverage and has not met the current Medicare maximum, bill Medicare first. Medicare will automatically forward your bill to the Office of Medical Assistance Programs (OMAP) for you. If Medicare transmits incorrect information to OMAP or if an out-of-state Medicare carrier or intermediary was billed, bill OMAP using an OMAP 505 form.

(2) If an incorrect payment is made by OMAP, submit an Adjustment Request (OMAP 1036) to correct payment.

(3) See OAR 410-120-1210 (General Rules) for information on OMAP reimbursement.

(4) Supplies of OMAP 505 forms can be obtained from the Department of Human Services (DHS) Office of Forms and Document Management.

(5) Send all completed OMAP 505 forms to OMAP.

Stat. Auth.: ORS 184.750 & ORS 184.770
Stats. Implemented: ORS 414.065

10-1-04

410-131-0270 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
1-1-03

410-131-0275 Copayment for Standard Benefit Package

Physical and Occupational Therapy services are not covered under the Standard Benefit Package. See General Rules, 410-120-1210 for additional information.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065

8-1-04

410-131-0280 Occupational and Physical Therapy Codes

(1) Occupational therapists and physical therapists should use any of the following codes which are applicable according to their Licensure and Professional Standards.

(2) Inclusion of a CPT/HCPCS code on the following tables does not imply that a code is covered. Refer to OARs 410-141-0480, 410-141-0500, and 410-141-0520 for information on covered services.

(3) Services which do not require payment authorization: Table 280-1.

(4) Services which require payment authorization:

(a) Modalities -- need to be billed in conjunction with a therapeutic procedure code;

(b) Supervised -- The application of a modality that does not require direct (one-on-one) client contact by the provider. Each individual code in this series may be reported only once for each client encounter: Table 280-2.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

4-1-05

Table 280-1

(1) Evaluations and Re-evaluations - Must be performed by licensed therapists only

Code	Procedure
97001	Physical therapy evaluation, per visit (not to be billed the same date as 97002)
97002	Physical therapy re-evaluation, per visit (not to be billed the same date as 97001)
97003	Occupational therapy evaluation, per visit (not to be billed the same date as 97004)
97004	Occupational therapy re-evaluation, per visit (not to be billed the same date as 97003)

(2) Application of splints

Code	Procedure
29105	Application of long arm splint (shoulder to hand) The only appropriate supply codes for use with this code are Q4017 through Q4020
29125	Application of short arm splint (forearm to hand); static The only appropriate supply codes for use with this code are Q4021 through Q4024
29126	Application of short arm splint (forearm to hand); dynamic The only appropriate supply codes for use with this code are Q4021 through Q4024
29130	Application of finger splint; static

The only appropriate supply code for use with this code is Q4049

29131 Application of finger splint; dynamic

The only appropriate supply code for use with this code is Q4051

(3) Supplies to create splints – Billed at acquisition cost, not to exceed $62.40.

Code	Procedure
Q4017	Cast supplies, long arm splint, adult (11 years +), plaster
Q4018	Cast supplies, long arm splint, adult (11 years +), fiberglass
Q4019	Cast supplies, long arm splint, pediatric (0-10 years), plaster
Q4020	Cast supplies, long arm splint, pediatric (0-10 years), fiberglass
Q4021	Cast supplies, short arm splint, adult (11 years +), plaster
Q4022	Cast supplies, short arm splint, adult (11 years +), fiberglass
Q4023	Cast supplies, short arm splint, pediatric (0-10 years), plaster
Q4024	Cast supplies, short arm splint, pediatric (0-10 years), fiberglass
Q4049	Finger splint, static
Q4051	Splint supplies, miscellaneous (includes thermoplastics, strapping, fasteners, padding and other supplies)

Table 280-2 Services Require Payment Authorization

Application of a modality to one or more areas.

97012 traction, mechanical

97014 electrical stimulation (unattended)

97022 whirlpool

Constant Attendance: The application of a modality that requires direct (one-on-one) client contact by the provider.

Application of a modality to one or more areas; each 15 minutes

97032 electrical stimulation (manual)

97036 Hubbard tank

(2) Therapeutic Procedures - Licensed therapist or licensed therapy assistant required to have direct (one-on-one) client contact.

Therapeutic procedure, one or more areas; each 15 minutes

97110 therapeutic exercises to develop strength and endurance, range of motion and flexibility

97112 neuromuscular re-education of movement, balance, coordination, kinesthetic sense, posture, and proprioception

97113 aquatic therapy with therapeutic exercises

97116 gait training (including stair climbing)

97124 massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion)

97140 manual therapy techniques (e.g., mobilization/manipulation, manual lymphatic drainage, manual traction)

Group Therapy

97150 Therapeutic procedure(s), group (2 or more individuals); 1 visit = 1 unit (not to be billed on same date of service as codes 97110 through 97140)

Orthotics fitting and training

97504 upper and/or lower extremities, each 15 minutes

Prosthetic training

97520 upper and/or lower extremities, each 15 minutes

Therapeutic activities

97530 direct (one-on-one) client contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes (not covered on same date as 97110)

97535 Self care/home management training (e.g., activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of adaptive equipment) direct one-on-one contact by provider, each 15 minutes

97542 Wheelchair management/propulsion training; each 15 minutes

(3) Tests and Measurements

95831 Muscle testing, manual (separate procedure); with report; extremity (excluding hand) or trunk

95832 hand (with or without comparison with normal side)

95833 total evaluation of body, excluding hands

95834 total evaluation of body, including hands

95851 Range of motion measurements and report (separate procedure); each extremity (excluding hand) or each trunk section (spine)

95852 hand, with or without comparison with normal side

97703 Checkout for orthotic/prosthetic use, established patient, each 15 minutes

97755 Assistive technology assessment (e.g., to restore,augment), or compensate for existing function, optimize functional tasks and/ or maximize environmental accessibility), direct one-on-one contact by provider, with written report, each 15 minutes

(4) Wound Care

97597 Removal of devitalized tissues from wound(s), selective debridement, without anesthesia (e.g., high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel, and forceps), with or without topical application(s) wound assessment, and instruction(s) for ongoing care, may include use of whirlpool, per session: total wound(s) surface less than or equal to 20 square centimeters

97598 Removal of devitalized tissues from wound(s), selective debridement, without anesthesia (e.g., high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel, and forceps), with or without topical application(s) wound assessment, and instruction(s) for ongoing care, may include use of whirlpool, per session: total wound(s) surface greater than 20 square centimeters

97602 Removal of devitalized tissue, non-selective debridement without anesthesia (e.g., wet-to-moist dressings, enzymatic, abrasion), including topical application(s), wound assessment, and instruction(s) for ongoing care per session