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CHAPTER 410
OREGON HEALTH AUTHORITY
HEALTH SYSTEMS DIVISION: MEDICAL ASSISTANCE PROGRAMS

FILING CAPTION: Face-to Face Encounter Compliance/Payment on SGD Accessories; Remove PA/Children; Hearing Aid Criteria

EFFECTIVE DATE: 11/06/2018

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RULES:
410-129-0020, 410-129-0070, 410-129-0075, 410-129-0080, 410-129-0085, 410-129-0200, 410-129-0240, 410-129-0260, 410-129-0280, 410-131-0040, 410-131-0120, 410-131-0160

AMEND: 410-129-0020

RULE TITLE: Therapy Plan of Care, Goals, Outcomes, and Record Requirements

NOTICE FILED DATE: 08/21/2018

RULE SUMMARY: The Division needs to adopt these rules to meet new Medicaid regulations of 42 CFR 440.70 and to specify payment methodology on items of significant varied costs. EPSDT requires Medicaid to remove PA requirements for children under 21. Agree to meet two hearing aid criteria with Representative Lewis.

RULE TEXT:
(1) Therapy shall be based on a prescribing practitioner's written order and therapy treatment plan with goals and objectives developed from an evaluation or re-evaluation. The limits, authorization, and plan of treatment criteria apply to both rehabilitative and habilitative therapy. The definition for both is the following:
(a) "Rehabilitative Services" means health care services that help an individual re-establish, restore, or improve skills and functioning for daily living that have been lost or impaired due to illness, injury, or disability;
(b) "Habilitative Services" means health care services that help an individual keep, learn, or improve skills and functioning for daily living, designed to establish skills that have not yet been acquired at an age-appropriate level. Examples include therapy for a child who is not walking or talking at the expected age;
(2) A total of 30 visits per year of rehabilitative therapy and a total of 30 visits per year of habilitative therapy (speech therapy) are included on these lines when medically appropriate. Additional visits, not to exceed 30 visits per year of rehabilitative therapy and 30 visits per year of habilitative therapy, may be authorized in cases of a new acute injury, surgery, or other significant change in functional status. Children under age 21 may have additional visits authorized beyond these limits if medically appropriate, pursuant to guideline note 6 of the Prioritized List of Health Services.
(3) The therapist shall teach the therapy regimen to individuals, including the client, family members, foster parents, and caregivers who can assist in the achievement of the goals and objectives. The client must be present when the therapy is

appropriately demonstrated at the time of teaching to assure that the therapy regimen is performed safely and correctly. The Division may not authorize extra treatments for teaching.
(4) All speech-language pathology (SLP) treatment services require a therapy plan of care that is required for prior authorization (PA) for payment.
(5) The Division shall provide authorization for the level of care or type of service that meets the client's medical need consistent with the Health Evidence Review Commission's (HERC) Prioritized List of Health Services (Prioritized List) and the American Hippotherapy Association's (AHA) position on coding and billing.
(6) These rules do not limit or affect any obligations of a school district or education entity eligible for reimbursement for covered, health-related services provided in support of a child with a disability education program required by state and federal law. School-sponsored services are supplemental to other health plan therapy services and are not considered duplicative. See OAR chapter 410, division 133 SBHS rules for services provided by public education providers and OAR 410-141-3420 (Managed Care Entity (MCE) Billing).
(7) The SLP therapy plan must adhere to the licensing board requirements of care and shall include:
(a) Client's name and diagnosis;
(b) The type, amount, frequency, and duration of the proposed rehabilitative or habilitative therapy;
(c) Individualized, measurably objective, short-term and long-term functional goals;
(d) Dated signature of the therapist or the prescribing practitioner establishing the therapy plan of care; and
(e) Evidence of certification of the therapy plan of care by the prescribing practitioner.
(8) SLP therapy records shall include:
(a) Documentation of each session. Records must include a record of history taken, procedures performed and tests administered, results obtained, and conclusions and recommendations made. Documentation may be in the form of a "SOAP" (Subjective Objective Assessment Plan) note or the equivalent;
(b) Therapy provided;
(c) Duration of therapy; and
(d) Signature of the speech-language pathologist.
(9) Documentation of clinical activities may be supplemented using flowsheets or checklists; however, these may not substitute for or replace detailed documentation of assessments and interventions.

STATUTORY/OTHER AUTHORITY: ORS 413.042

STATUTES/OTHER IMPLEMENTED: ORS 414.025, 414.065

AMEND: 410-129-0070

RULE TITLE: Limitations

NOTICE FILED DATE: 08/21/2018

RULE SUMMARY: The Division needs to adopt these rules to meet new Medicaid regulations of 42 CFR 440.70 and to specify payment methodology on items of significant varied costs. EPSDT requires Medicaid to remove PA requirements for children under 21. Agree to meet two hearing aid criteria with Representative Lewis.

RULE TEXT:

(1) SLP services:

(a) Shall be provided by a practitioner as described in OAR 410-129-0065;

(b) Requirements for rehabilitative and habilitative therapy treatment:

(A) May not exceed one hour per day each for a group or individual;

(B) Shall be either group or individual and may not be combined in the authorization period; and

(C) Require PA after 30 visits per calendar year.

(c) The following SLP services do not require PA but are limited to:

(A) Two SLP evaluations in a 12-month period;

(B) Two evaluations for dysphagia in a 12-month period;

(C) Up to four re-evaluations in a 12-month period;

(D) One evaluation for speech-generating/augmentative communication system or device shall be reimbursed per recipient in a 12-month period;

(E) One evaluation for voice prosthesis or artificial larynx shall be reimbursed in a 12-month period;

(F) Purchase, repair, or modification of electrolarynx;

(G) Supplies for speech therapy shall be reimbursed up to two times in a 12-month period, not to exceed $5 each.

(d) The purchase, rental, repair, or modification of a speech-generating/augmentative communication system or device must have PA. Rental of a speech-generating/ augmentative communication system or device is limited to one month. All rental fees shall be applied to the purchase price.

(2) Audiology and hearing aid services:

(a) All hearing services shall be performed by a licensed physician, audiologist, or hearing aid specialist;

(b) Two binaural hearing aids shall be reimbursed no more frequently than every five years for adults age 21 and older who meet the following criteria and medical necessity: Loss of 35 decibel (dB) hearing level or greater in two or more of the following three frequencies: 1000, 2000, 3000, and 4000 Hertz (Hz) in the better ear;

(c) Two binaural hearing aids shall be reimbursed no more frequently than every three years for children, birth through age 20, 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, 4000Hz, and 6000Hz.

(d) 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 listening situation. It is restricted to a hand-held amplifier and headphones;

(e) The following services do not require PA:

(A) One basic audiologic assessment in a 12-month period;

(B) One basic comprehensive audiometry (audiologic evaluation) in a 12-month period;

(C) One hearing aid examination and selection in a 12-month period;

(D) One pure tone audiometry (threshold) test; air and bone in a 12-month period;

(E) One electroacoustic evaluation for hearing aid; monaural in a 12-month period;

(F) One electroacoustic evaluation for hearing aid; binaural in a 12-month period;

(G) Hearing aid batteries — maximum of 60 individual batteries in a 12-month period. Clients shall meet the criteria for a hearing aid.

(f) The following services require PA:

(A) Hearing aids;

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

(C) Hearing aid dispensing and fitting fees;

(D) Assistive listening devices;

(E) Cochlear implant batteries.

(g) Services not covered:

(A) FM systems;

(B) Vibro-tactile aids;

(C) Earplugs;

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

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

(F) Tinnitus masker.

STATUTORY/OTHER AUTHORITY: ORS 413.042

STATUTES/OTHER IMPLEMENTED: ORS 414.065

ADOPT: 410-129-0075

REPEAL: Temporary 410-129-0075 from DMAP 30-2018

RULE TITLE: Face-to-Face Encounter Requirements for Fee-for-Service Clients

NOTICE FILED DATE: 08/21/2018

RULE SUMMARY: The Division needs to adopt these rules to meet new Medicaid regulations of 42 CFR 440.70 and to specify payment methodology on items of significant varied costs. EPSDT requires Medicaid to remove PA requirements for children under 21. Agree to meet two hearing aid criteria with Representative Lewis.

RULE TEXT:

(1) For initial ordering of speech generating devices (SGD), an in-person, face-to-face encounter that is related to the primary reason the client requires the medical equipment or supplies must occur no more than six months prior to the start of services:

(a) The face-to-face encounter shall be conducted and documented by the treating physician (MD or DO) or an authorized non-physician practitioner (NPP);

(b) Authorized NPPs for SGD are nurse practitioners, clinical nurse specialists working in collaboration with a physician, or physician assistants under the supervision of a physician;

(c) The physician or NPP conducting the face-to-face encounter shall document that the client is evaluated or treated for a condition that supports the need for the SGD ordered within six months prior to completing the written order for the equipment;

(d) If the NPP performing the face-to-face encounter does not have prescribing authority, the NPP shall communicate the clinical findings to the ordering physician;

(e) The ordering physician shall incorporate the clinical findings into a written or electronic document included in the client's medical record.

(2) If a dually eligible client is evaluated for medical equipment or supplies under Medicare and transitions to Medicaid, the Medicare face-to-face encounter documentation shall meet the Medicaid face-to-face requirement.

(3) The durable medical equipment (DME) supplier shall maintain documentation of the qualifying face-to-face encounter and provide the documentation when the item requires PA or at the Division's request.

(4) The table at https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/Downloads/DME_List_of_Specified_Covered_Items_updated_March_26_2015.pdf identifies the DME items subject to these face-to-face requirements.

STATUTORY/OTHER AUTHORITY: ORS 413.042, ORS 414.065

STATUTES/OTHER IMPLEMENTED: ORS 414.065

AMEND: 410-129-0080

RULE TITLE: Prior Authorization

NOTICE FILED DATE: 08/21/2018

RULE SUMMARY: The Division needs to adopt these rules to meet new Medicaid regulations of 42 CFR 440.70 and to specify payment methodology on items of significant varied costs. EPSDT requires Medicaid to remove PA requirements for children under 21. Agree to meet two hearing aid criteria with Representative Lewis.

RULE TEXT:

(1) Speech-language pathology, audiology, and hearing aid providers shall obtain PA for services, with the exception of up to 30 visits habilitative and 30 visits rehabilitative per year for children, 20 years and younger.

(2) Providers shall request PA as follows (see the Speech-Language Pathology, Audiology and Hearing Aid Services Program Supplemental Information booklet for contact information):

(a) For Medically Fragile Children's Unit (MFCU) clients, from the Authority's MFCU;

(b) For clients enrolled in the fee-for-service Medical Case Management program, from the Medical Case Management contractor;

(c) For clients enrolled in a MCE, from the MCE;

(d) For all adult clients,21 years and older, pursuant to chapter 410 division 129 rules;

(3) For services requiring PA, providers shall contact the responsible unit for authorization within five working days following initiation or continuation of services. The FAX or postmark date on the request shall be honored as the request date. It is the provider's responsibility to obtain PA.

[Publications referenced are available from the agency.]

STATUTORY/OTHER AUTHORITY: ORS 413.042

STATUTES/OTHER IMPLEMENTED: ORS 414.025, 414.065

ADOPT: 410-129-0085

REPEAL: Temporary 410-129-0085 from DMAP 30-2018

RULE TITLE: Payment Methodology

NOTICE FILED DATE: 08/21/2018

RULE SUMMARY: The Division needs to adopt these rules to meet new Medicaid regulations of 42 CFR 440.70 and to specify payment methodology on items of significant varied costs. EPSDT requires Medicaid to remove PA requirements for children under 21. Agree to meet two hearing aid criteria with Representative Lewis.

RULE TEXT:

(1) Speech-Language Pathology and Audiology outpatient services are priced based on RVU (Refer to OAR 410-120-1340(6)):

(a) Surgical procedures such as cochlear implants may be provided in a hospital or ambulatory surgical center (ASC) (Refer to OAR 410-120-1340 (6) and (8));

(b) The Division reimburses inpatient hospital service under the DRG methodology, unless specified otherwise in the Division's Hospital Services program administrative rules, chapter 410, division 125.

(2) The Division shall reimburse codes E2599 (Accessory for SGD, not otherwise classified) and E2512 (SGD accessory, mounting system) and any code that requires manual pricing, using 75 percent of the manufacturer's suggested retail price (MSRP). This is verifiable with quote, invoice, or bill from the manufacturer that clearly states the amount indicated is MSRP.

(3) Reimbursement on code E2599 (SGD accessory, not otherwise classified) shall be capped at $6,200.

(4) Reimbursement on accessory code E2512 shall be capped at $3,300.

(5) PA is required for SGD accessory code E2599 when the cost is greater than $520.

(6) PA is required for miscellaneous accessory code E2512 when the cost is greater than $480.

STATUTORY/OTHER AUTHORITY: ORS 413.042, ORS 414.065

STATUTES/OTHER IMPLEMENTED: ORS 414.065

AMEND: 410-129-0200

RULE TITLE: Speech-Language Pathology Procedure Codes

NOTICE FILED DATE: 08/21/2018

RULE SUMMARY: The Division needs to adopt these rules to meet new Medicaid regulations of 42 CFR 440.70 and to specify payment methodology on items of significant varied costs. EPSDT requires Medicaid to remove PA requirements for children under 21. Agree to meet two hearing aid criteria with Representative Lewis.

RULE TEXT:

(1) Inclusion of a current procedural terminology (CPT) or healthcare common procedure coding system (HCPCS) code in sections (2) and (3) does not mean a code is covered. Refer to OAR 410-141-0480, 410-141-0500, and 410-141-0520 for information on coverage.

(2) Speech therapy services codes and PA limitations pertaining to adults 21 years and older are the following:

(a) 92506 – Evaluation of speech, language, voice, communication, and auditory processing, limited to two per 12-month period.

(b) 92507 – Treatment of speech, language, voice, communication and auditory processing disorder, individual PA is required.

(c) 92508 – Group, two or more individuals, PA is required.

(d) 92526 – Treatment of swallowing dysfunction and oral function for feeding, PA is required.

(e) 92610 – Evaluation of oral and pharyngeal swallowing function, limited to two per 12-month period.

(f) 92611 – Motion fluoroscopic evaluation of swallowing function by cine or video recording, limited to two per 12-month period.

(g) S9152 – Speech therapy, re-evaluation, limited to four per 12-month period.

(3) Other speech services codes are the following:

(a) 92597 – Evaluation for use and fitting of voice prosthetic device to supplement oral speech;

(b) 92607 – Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient, first hour;

(c) 92608 – Each additional 30 minutes (List separately in addition to code for primary procedure);

(d) 92609 – Therapeutic services for the use of speech-generating device, including programming and modification;

(e) A4649 – Supplies for speech therapy, limited to two per calendar year not to exceed $4.75 each;

(f) E2500 – Speech generating device, digitized speech, using prerecorded messages, less than or equal to eight minutes recording time, PA is required;

(g) E2502 – Speech generating device, digitized speech, using prerecorded messages, greater than eight minutes but less than 20 minutes, PA is required;

(h) E2504 Speech generating device, digitized speech, using prerecorded messages, greater than 20 minutes but less than 40 minutes, PA is required;

(i) E2506 – Speech generating device, digitized speech, using prerecorded messages, greater than 40 minutes recording time, PA is required;

(j) E2508 – Speech generating device, synthesized speech, requiring message formulation by spelling and access by physical contact with the device, PA is required;

(k) E2510 – Speech generating device, synthesized speech, permitting multiple methods of message formulation and multiple methods of device access, PA is required;

(L) E2511 – Speech generating software program for personal computer or personal digital assistance, PA is required;

(m) E2512 – Accessory for speech generating device, mounting system, PA is required;

(n) E2599 – Accessory for speech generating device, not otherwise classified, PA is required;

(o) L7510 – Repair of prosthetic device, repair or replace minor parts, PA is required;

(p) L7520 – Repair prosthetic device, labor component, for 15 minutes, PA is required;

(q) L8500 – Artificial larynx, any type;

(r) L8501 – Tracheostomy speaking valve;
(s) L8507 – Tracheoesophageal voice prosthesis, patient inserted, any type, each;
(t) L8509 – Tracheoesophageal voice prosthesis, inserted by a licensed health provider, any type;
(u) L8510 – Voice amplifier, PA is required;
(v) L8515 – Gelatin capsule, application device for use with tracheoesophageal voice prosthesis, each;
(w) L9900 – Orthotic and prosthetic supply necessary or service component of another HCPCS L code;
(x) V5336 – Repair, modification of augmentative communication system or device excluding adaptive hearing aid, PA is required.

STATUTORY/OTHER AUTHORITY: ORS 413.042

STATUTES/OTHER IMPLEMENTED: ORS 414.025, 414.065

AMEND: 410-129-0240

RULE TITLE: Audiologist and Hearing Aid Procedure Codes

NOTICE FILED DATE: 08/21/2018

RULE SUMMARY: The Division needs to adopt these rules to meet new Medicaid regulations of 42 CFR 440.70 and to specify payment methodology on items of significant varied costs. EPSDT requires Medicaid to remove PA requirements for children under 21. Agree to meet two hearing aid criteria with Representative Lewis.

RULE TEXT:

(1) Inclusion of a CPT/HCPCS code on the following does not mean that a code is covered. Refer to OAR 410-141-0480, 410-141-0500, and 410-141-0520 for information on coverage.

(2) The following are Audiologist and hearing aid procedure codes:

(a) 92553 – Pure tone audiometry, air and bone, limited to one per calendar year;

(b) 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;

(c) 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;

(d) 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;

(e) V5261 – Hearing aid, digital, binaural and behind the ear requires PA;

(f) V5011 – Fitting, orientation, checking of hearing aid includes adjusting aid to the wearer, instructions to wearer, and follow-up care, and requires PA prior to provision of services;

(g) V5160 – Hearing aid dispensing fee, binaural, requires PA prior to providing services;

(h) V5200 – Hearing aid dispensing fee, CROS, requires PA prior to providing services;

(i) V5240 – Hearing aid dispensing fee, BICROS, requires PA prior to providing services;

(j) V5241 – Hearing aid dispensing fee, monaural hearing aid, any type, requires PA prior to providing services;

(k) S9092 – Canolith repositioning, per visit, limited to one per calendar year.

(3) Special otorhinolaryngologic services codes only apply to services for cochlear implants. These services include medical diagnosis evaluation by the otology physician:

(a) 92601 – Diagnostic analysis of cochlear implant, patient under seven years of age, with programming;

(b) 92602 – Subsequent reprogramming;

(c) 92603 – Diagnostic analysis of cochlear implant, age seven years or older, with programming;

(d) 92604 – Subsequent reprogramming;

(e) 92626 – Evaluation of auditory rehabilitation status, first hour;

(f) 92627 – Each additional 15 minutes;

(g) 92630 – Auditory rehabilitation; pre-lingual hearing loss;

(h) 92633 – Post-lingual hearing loss;

(i) L8614 – Cochlear device/system (only reimbursed to hospitals);

(j) L8615 – Headset/headpiece for use with cochlear implant device, replacement;

(k) L8616 – Microphone for use with cochlear implant device, replacement;

(L) L8617 – Transmitting coil for use with cochlear implant device, replacement;

(m) L8618 – Transmitter cable for use with cochlear implant device, replacement;

(n) L8619 – Cochlear implant external speech processor, replacement;

(o) L8621 – Zinc air battery for use with cochlear implant device, replacement, each (maximum of 420 batteries per 12 months);

(p) L8622 - Alkaline battery for use with cochlear implant device, replacement, each (maximum of 420 batteries per 12 months);

(q) L8623 – Lithium ion battery for use with cochlear implant device speech processor, other than ear level, replacement, each (maximum of two rechargeable per 12 months);
(r) L8624 –Lithium ion battery for use with cochlear implant device speech processor, ear level, replacement, each (maximum of two rechargeable per 12 months);
(s) L7510 – Repair of prosthetic device, repair or replace minor parts, requires PA prior to providing services;
(t) L7520 – Repair prosthetic device, labor component, for 15 minutes, requires PA prior to providing services.

STATUTORY/OTHER AUTHORITY: ORS 413.042

STATUTES/OTHER IMPLEMENTED: ORS 414.025, 414.065

AMEND: 410-129-0260

RULE TITLE: Hearing Aids and Hearing Aid Technical Service and Repair

NOTICE FILED DATE: 08/21/2018

RULE SUMMARY: The Division needs to adopt these rules to meet new Medicaid regulations of 42 CFR 440.70 and to specify payment methodology on items of significant varied costs. EPSDT requires Medicaid to remove PA requirements for children under 21. Agree to meet two hearing aid criteria with Representative Lewis.

RULE TEXT:

(1) The provider shall bill the Division for hearing aids at the provider's acquisition cost and shall be reimbursed at that 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 or postage.

(2) The provider shall submit history of hearing aid use and an audiogram when requesting PA for hearing aids.

(3) Procedure codes are the following:

(a) 92594 – Electroacoustic evaluation for hearing aid, monaural;

(b) 92595 – Electroacoustic evaluation for hearing aid, binaural;

(c) V5014 – Repair/modification of hearing aid, requires PA;

(d) V5266 – Hearing aid batteries, limited to 60 individual batteries per calendar year;

(e) V5264 – Ear mold/insert, not disposable, any type, requires PA;

(f) V5274 – Assistive listening device, not otherwise specified, requires PA;

(g) V5030 – Hearing aid, monaural, body worn, air conduction, requires PA;

(h) V5040 – Hearing aid, monaural, body worn, bone conduction, requires PA;

(i) V5050 – Hearing aid, monaural, in the ear, requires PA;

(j) V5060 – Hearing aid, monaural, behind the ear, requires PA;

(k) V5130 – Hearing aid, binaural, in the ear, requires PA;

(L) V5140 – Hearing aid, binaural, behind the ear, requires PA;

(m) V5170 – Hearing aid, CROS, in the ear, requires PA;

(n) V5180 – Hearing aid, CROS, behind the ear, requires PA;

(o) V5210 – Hearing aid, BICROS, in the ear- requires PA;

(p) V5220 – Hearing aid, BICROS, behind the ear- requires PA;

(q) V5246 – Hearing aid, digitally programmable analog, monaural, ITE (in the ear), requires PA;

(r) V5247 – Hearing aid, digitally programmable analog, monaural, behind the ear (BTE) requires PA;

(s) V5252 – Hearing aid, digital programmable, binaural, ITE, requires PA;

(t) V5253 – Hearing aid, digital programmable, binaural, BTE, requires PA;

(u) V5256 – Hearing aid, digital, monaural, ITE, requires PA;

(v) V5257 – Hearing aid, digital, monaural, BTE, requires PA.

STATUTORY/OTHER AUTHORITY: ORS 413.042

STATUTES/OTHER IMPLEMENTED: ORS 414.025, 414.065

AMEND: 410-129-0280

RULE TITLE: Hearing Testing for Diagnostic Purposes on Physician's Referral Only

NOTICE FILED DATE: 08/21/2018

RULE SUMMARY: The Division needs to adopt these rules to meet new Medicaid regulations of 42 CFR 440.70 and to specify payment methodology on items of significant varied costs. EPSDT requires Medicaid to remove PA requirements for children under 21. Agree to meet two hearing aid criteria with Representative Lewis.

RULE TEXT:

(1) 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.

(2) Procedure codes are the following:

(a) 92541 – Spontaneous nystagmus test, including gaze and fixation nystagmus, with recording;

(b) 92542 – Positional nystagmus test, minimum of four positions, with recording;

(c) 92543 – Caloric vestibular test, each irrigation (binaural, bithermal stimulation constitutes four tests) with recording;

(d) 92544 – Optokinetic nystagmus test, bidirectional, foveal or peripheral stimulation, with recording;

(e) 92545 – Oscillating tracking test, with recording;

(f) 92546 – Sinusoidal vertical axis rotational testing;

(g) 92547 – Use of vertical electrodes in any or all the above tests counts as one additional test;

(h) 92551 – Screening test, pure tone, air only;

(i) 92552 – Pure tone audiometry (threshold); air only;

(j) 92555 – Speech audiometry; threshold only;

(k) 92556 – With speech recognition;

(L) 92562 – Loudness balance test, alternate binaural or monaural;

(m) 92563 – Tone decay test;

(n) 92564 – Short increment sensitivity index (SISI);

(o) 92565 – Stenger test, pure tone;

(p) 92567 – Tympanometry;

(q) 92568 – Acoustic reflex testing; threshold;

(r) 92569 – Acoustic reflex testing; decay;

(s) 92571 – Filtered speech tests;

(t) 92572 – Staggered spondaic word test;

(u) 92576 – Synthetic sentence identification test;

(v) 92577 – Stenger test, speech;

(w) 92579 – Visual reinforcement audiometry (VRA);

(x) 92582 – Conditioning play audiometry;

(y) 92583 – Select picture audiometry;

(z) 92585 – Auditory evoked potentials for evoked response audiometry or testing of the central nervous system, comprehensive;

(aa) 92586 – Auditory evoked potentials for evoked response audiometry or testing of the central nervous system, limited;

(bb) 92587 – Evoked Otacoustic Emissions, - limited (single stimulus level, either transient or distortion products);

(cc) 92588 – Evoked Otacoustic Emissions, comprehensive or diagnostic evaluation (comparison of transient or distortion product otoacoustic emissions at multiple levels and frequencies);

(dd) 92589 Central auditory function tests (specify).

STATUTORY/OTHER AUTHORITY: ORS 413.042

STATUTES/OTHER IMPLEMENTED: ORS 414.025, 414.065

AMEND: 410-131-0040

RULE TITLE: Physical and Occupation Therapy

NOTICE FILED DATE: 08/21/2018

RULE SUMMARY: The Division needs to adopt these rules to meet new Medicaid regulations of 42 CFR 440.70 and to specify payment methodology on items of significant varied costs. EPSDT requires Medicaid to remove PA requirements for children under 21. Agree to meet two hearing aid criteria with Representative Lewis.

RULE TEXT:

(1) The Division's Physical and Occupational Therapy (PT/OT) Services 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. The limits, authorization, and plan of treatment criteria apply to both rehabilitative and habilitative therapy. The definition for both is the following:

(a) “Rehabilitative Services” means health care services that help an individual re-establish, restore, or improve skills and functioning for daily living that have been lost or impaired due to illness, injury, or disability;

(b) “Habilitative Services” means health care services that help an individual keep, learn, or improve skills and functioning for daily living, designed to establish skills that have not yet been acquired at an age-appropriate level. Examples include therapy for a child who is not walking or talking at the expected age;

(2) A total of 30 visits per year of rehabilitative therapy and a total of 30 visits per year of habilitative therapy (physical and occupational therapy) are included on these lines when medically appropriate. Additional visits, not to exceed 30 visits per year of rehabilitative therapy and 30 visits per year of habilitative therapy, may be authorized in cases of a new acute injury, surgery, or other significant change in functional status. Children under age 21 may have additional visits authorized beyond these limits if medically appropriate, as per guideline note 6 of the Prioritized List of Health Services.

(3) OAR 410-131-0040 through 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 must comply with the rules in their respective provider guides;

(b) Do not apply to services provided to hospital inpatients; and

(c) May not limit or effect any obligations of a school district or education entity eligible for reimbursement for covered, health-related services provided in support of a child with a disability education program required by state and federal law. School-sponsored services are supplemental to other health plan therapy services and are not considered duplicative. (See OAR chapter 410 division 133 SBHS rules for services provided by public education providers and OAR 410-141-3420 (Managed Care Entity (MCE) Billing and Payment).

(4) The Division shall enroll only the following types of providers as performing providers under the PT/OT program:

(a) An individual licensed by the relevant state licensing authority to practice physical therapy; and

(b) An individual licensed by the relevant state licensing authority to practice occupational therapy.

(5) All Division rules are intended to be used in addition to the General Rules for Health Systems Division programs (OAR 410 division 120) and the Oregon Health Plan (OHP) (OAR 410 division 141).

(6) The Oregon Health Evidence Review Commission’s (HERC) Prioritized List of Health Services is found in OAR 410-141-0520 and defines the covered services.

STATUTORY/OTHER AUTHORITY: ORS 413.042, 414.065

STATUTES/OTHER IMPLEMENTED: ORS 414.065

AMEND: 410-131-0120

RULE TITLE: Limitations of Coverage and Payment

NOTICE FILED DATE: 08/21/2018

RULE SUMMARY: The Division needs to adopt these rules to meet new Medicaid regulations of 42 CFR 440.70 and to specify payment methodology on items of significant varied costs. EPSDT requires Medicaid to remove PA requirements for children under 21. Agree to meet two hearing aid criteria with Representative Lewis.

RULE TEXT:

(1) The provision of PT/OT evaluations and therapy services require a prescribing practitioner referral, and services shall be supported by a therapy plan of care signed and dated by the prescribing practitioner as specified in 42 CFR 440.1110.

(2) PT/OT initial evaluations and re-evaluations do not require PA, but are limited to the following:

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

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

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

(4) School-sponsored therapy services are considered supplemental to other plan-covered therapy services that the student receives. School-based therapy services may not apply toward the client's maximum therapy allowances. (See OAR chapter 410, division 133 SBHS rules.)

(5) All other occupational and physical therapy treatments require PA following 30 visits in a calendar year. See 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 shall be in constant attendance while therapy treatments are performed:

(a) Rehabilitative and habilitative 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 on the day of treatment;

(C) Need to be billed in conjunction with a therapeutic procedure code, excluding procedure code S8940; 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 be authorized only in conjunction with another therapeutic procedure or modality.

(7) Supplies and materials for the fabrication of splints shall 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 and back education classes;

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

(f) Durable medical equipment and medical supplies other than those splint supplies listed in Table 410-131-0120-1.

(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 OAR chapter 410, division 150 for information on administrative examinations and report billing.

NOTE: Table 410-131-0120-1 is attached.

STATUTORY/OTHER AUTHORITY: ORS 413.042

STATUTES/OTHER IMPLEMENTED: ORS 414.065

Table 410-131-0120-1 Services That Do Not Require PA

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	Q4022
Q4018	Q4023
Q4019	Q4024
Q4020	Q4049
Q4021	Q4051

AMEND: 410-131-0160

RULE TITLE: Prior Authorization (PA) for Payment

NOTICE FILED DATE: 08/21/2018

RULE SUMMARY: The Division needs to adopt these rules to meet new Medicaid regulations of 42 CFR 440.70 and to specify payment methodology on items of significant varied costs. EPSDT requires Medicaid to remove PA requirements for children under 21. Agree to meet two hearing aid criteria with Representative Lewis.

RULE TEXT:
(1) Most OHP clients have prepaid health services contracted for by the Authority through enrollment in a Managed Care Entity (MCE).
(2) The provider shall verify whether an MCE or the Division is responsible for reimbursement. Refer to OAR 410-120-1140 Verification of Eligibility and Coverage.
(3) If a client is enrolled in an MCE, there may be PA requirements for some services that are provided through the MCE. Providers shall comply with the MCE's PA requirements or other policies necessary for reimbursement from the MCE before providing services to any OHP client enrolled in an MCE. The physical or occupational therapy (PT/OT) provider shall contact the client's MCE 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 may be provided or before payment may 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. See also OAR 410-120-1320 Authorization of Payment and Table 410-131-0160-1 Services Requiring PA:
(a) PT/OT initial evaluations and re-evaluations do not require a PA;
(b) To ensure reimbursement for continuation of PT/OT services and procedures beyond the initial evaluation, the PT/OT provider shall 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 may not be authorized retroactively and if authorized shall be effective the date of the PA request. The Division recognizes the facsimile or postmark as the PA date of request.
(c) All PA's shall include a therapy plan of care; 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 PA, the PT/OT provider shall follow and comply with PA requirements in these rules and the General Rules, (OAR chapter 410, division 120) including but not limited to:
(a) The service is adequately documented (see OAR 410-120-1360 Requirements for Financial, Clinical and Other Records). Providers shall 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 Division shall deny the claim.
(6) Table 410-131-0160-1.
NOTE: Table 410-131-0160-1 is attached.

STATUTORY/OTHER AUTHORITY: ORS 413.042

STATUTES/OTHER IMPLEMENTED: ORS 414.025, 414.065

Table 410-131-0160-1 Services Require Prior Authorization (Once visits exceed 30 visits a year for children (age 20 years or younger))

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