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TEMPORARY ADMINISTRATIVE ORDER

INCLUDING STATEMENT OF NEED & JUSTIFICATION

DMAP 18-2019

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

FILED
06/18/2019 11:38 AM
ARCHIVES DIVISION
SECRETARY OF STATE
& LEGISLATIVE COUNSEL

FILING CAPTION: Adding Prepayment Review Criteria to Address Prior Authorization Backlog

EFFECTIVE DATE: 07/01/2019 THROUGH 12/27/2019

AGENCY APPROVED DATE: 06/17/2019

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NEED FOR THE RULE(S):

The Division needs to amend these rules to trial prepayment review in lieu of prior authorization to address prior authorization backlog and meet our agency needs more efficiently.

JUSTIFICATION OF TEMPORARY FILING:

The Authority finds that failure to act promptly will result in serious prejudice to the public interest, the Authority, and recipients of Medicaid benefits. These rules need to be adopted promptly so that the Authority may begin to trial a method that has been successful for Medicare. Medicaid is experiencing a significant prior authorization backlog that needs to be addressed.

DOCUMENTS RELIED UPON, AND WHERE THEY ARE AVAILABLE:

CMS-10421 at https://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing-Items/CMS-10421.html?DLPage=1&DLFilter=10421&DLSort=1&DLSortDir=descending

RULES:

410-129-0020, 410-129-0060, 410-129-0070, 410-129-0080, 410-129-0200, 410-129-0220, 410-131-0080, 410-131-0120, 410-131-0160

AMEND: 410-129-0020

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

RULE SUMMARY: There is a need to address the prior authorization backlog that is causing delay in recipient services. The prepayment review will allow recipients to receive services without delay. Revisions to the therapy rules will allow for services to be provided for specific procedures paired to above the line diagnoses without the need to wait for prior authorization approval.

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 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 claims subject to prepayment review (PPR) or requiring 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 for equine related modalities.
(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 ICD diagnosis code;
(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, ORS 414.065

AMEND: 410-129-0060

RULE TITLE: Prescription Required

RULE SUMMARY: There is a need to address the prior authorization backlog that is causing delay in recipient services. The prepayment review will allow recipients to receive services without delay. Revisions to the therapy rules will allow for services to be provided for specific procedures paired to above the line diagnoses without the need to wait for prior authorization approval.

RULE TEXT:

(1) The prescription is the written order by the prescribing practitioner pursuant to state law governing SLP, audiology, and hearing aid services. Prescription shall specify the ICD diagnosis code for all SLP, audiology, and hearing aid services that require payment/prior authorization.

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

(3) A written order:

(a) Is required for the initial evaluation;

(b) For therapy, shall specify the ICD diagnosis code, service, amount, and duration required.

(4) Written orders shall be submitted with claims that are subject to PPR or that require PA request, and a copy shall be on file in the provider's therapy record. The written order and the treatment plan shall 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 practice, i.e., primary care physician (not appropriate for an orthopedic specialist, chiropractor, gynecologist, etc.).

STATUTORY/OTHER AUTHORITY: ORS 413.042

STATUTES/OTHER IMPLEMENTED: ORS 414.025, ORS 414.065

AMEND: 410-129-0070

RULE TITLE: Limitations

RULE SUMMARY: There is a need to address the prior authorization backlog that is causing delay in recipient services. The prepayment review will allow recipients to receive services without delay. Revisions to the therapy rules will allow for services to be provided for specific procedures paired to above the line diagnoses without the need to wait for prior authorization approval.

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 habilitative and 30 rehabilitative visits per calendar year.

(c) The following SLP services are not subject to PPR and 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 (SGD) 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 SGD requires PA. Rental of a SGD 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) 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 frequencies: 1000, 2000, 3000, and 4000 Hertz (Hz);

(c) 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

AMEND: 410-129-0080

RULE TITLE: Prepayment Review (PPR) and Prior Authorization (PA) for payment

RULE SUMMARY: There is a need to address the prior authorization backlog that is causing delay in recipient services. The prepayment review will allow recipients to receive services without delay. Revisions to the therapy rules will allow for services to be provided for specific procedures paired to above the line diagnoses without the need to wait for prior authorization approval.

RULE TEXT:

(1) Speech-language pathology, audiology, and hearing aid providers are subject to PPR or shall obtain PA for services exceeding 30 habilitative and 30 rehabilitative visits in a calendar year.

(2) Providers shall request PA as follows (see the SLP, 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 an MCE, from the MCE;

(d) For clients requiring visits in excess of 30 habilitative visits and 30 rehabilitative visits per calendar year.

(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.

(4) For services subject to PPR and to ensure reimbursement of SLP services, beyond the initial evaluation, the SLP provider must submit all required supporting documentation:

(a) Upon submission of the first claim in a series of claims in each therapy plan of care as established by prescribing practitioner per OAR 410-129-0020 for claims subject to PPR;

(b) Request a PA within five working days following 30 rehabilitative or 30 habilitative visits within a calendar year if additional visits are necessary:

(A) PA requests dated within five working days 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 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 claims subject to PPR or that requires PA must include a therapy plan of care; and

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

(5) If the service or item is subject to PPR or requiring PA, the provider shall follow and comply with PPR or 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 services that require PA, or the Division shall deny the claim.

STATUTORY/OTHER AUTHORITY: ORS 413.042

STATUTES/OTHER IMPLEMENTED: ORS 414.025, ORS 414.065

AMEND: 410-129-0200

RULE TITLE: Speech-Language Pathology Procedure Codes

RULE SUMMARY: There is a need to address the prior authorization backlog that is causing delay in recipient services. The prepayment review will allow recipients to receive services without delay. Revisions to the therapy rules will allow for services to be provided for specific procedures paired to above the line diagnoses without the need to wait for prior authorization approval.

RULE TEXT:

(1) Inclusion of a current procedural terminology (CPT) or healthcare common procedure coding system (HCPCS) code in sections (2), (3) and (4) 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) The following Speech therapy services are subject to PPR, unless marked otherwise, when paired above the funding line on the HERC prioritized list (see OAR 410-141-0520), when visits have not exceeded the allowed 30 habilitative and 30 rehabilitative visits allowed in a calendar year:

(a) 92507 Treatment of speech, language, voice, communication and auditory processing disorder, individual; and

(b) 92508 Group, two or more individuals.

(3) PA is required for SLP services:

(a) When there is documented need for extended service, considering 60 minutes as the maximum length of a treatment session;

(b) When there is documented need for continuing rehabilitative or habilitative therapy, considering 30 habilitative and 30 rehabilitative visits in a calendar year;

(c) When requesting services for treatments that are below the funded line or not otherwise excluded from coverage per OAR 410-141-0480;

(d) For the following services:

(A) E2500 Speech generating device, digitized speech, using prerecorded messages, less than or equal to eight minutes recording time;

(B) E2502 Speech generating device, digitized speech, using prerecorded messages, greater than eight minutes but less than 20 minutes;

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

(D) E2506 Speech generating device, digitized speech, using prerecorded messages, greater than 40 minutes recording time;

(E) E2508 Speech generating device, synthesized speech, requiring message formulation by spelling and access by physical contact with the device;

(F) E2510 Speech generating device, synthesized speech, permitting multiple methods of message formulation and multiple methods of device access;

(G) E2511 Speech generating software program for personal computer or personal digital assistance;

(H) E2512 Accessory for speech generating device, mounting system;

(I) E2599 Accessory for speech generating device, not otherwise classified;

(J) L7520 Repair prosthetic device, labor component, for 15 minutes;

(K) L8510 Voice amplifier; and

(L) V5336 Repair, modification of augmentative communication system or device excluding adaptive hearing aid.

(4) Services not subject to PPR or PA:

(a) 92521 Evaluation of speech fluency (e.g., stuttering, cluttering);

(b) 92522 Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria);

(c) 92523 Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria) with evaluation of language comprehension and expression (e.g., receptive and expressive language);

(d) 92524 Behavioral and qualitative analysis of voice and resonance;

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

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

(g) 92610 Evaluation of oral and pharyngeal swallowing function, limited to two per 12-month period;

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

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

(j) S9152 Speech therapy, re-evaluation, limited to four per 12-month period;

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

(L) 92526 Treatment of swallowing dysfunction and oral function for feeding;

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

(n) L7510 Repair of prosthetic device, repair or replace minor parts;

(o) L8500 Artificial larynx, any type;

(p) L8501 Tracheostomy speaking valve;

(q) L8507 Tracheoesophageal voice prosthesis, patient inserted, any type, each;

(r) L8509 Tracheoesophageal voice prosthesis, inserted by a licensed health provider, any type;

(s) L8515 Gelatin capsule, application device for use with tracheoesophageal voice prosthesis, each; and

(t) L9900 Orthotic and prosthetic supply necessary or service component of another HCPCS L code (PA required).

STATUTORY/OTHER AUTHORITY: ORS 413.042

STATUTES/OTHER IMPLEMENTED: ORS 414.025, ORS 414.065

AMEND: 410-129-0220

RULE TITLE: Augmentative Communications System or Device

RULE SUMMARY: There is a need to address the prior authorization backlog that is causing delay in recipient services. The prepayment review will allow recipients to receive services without delay. Revisions to the therapy rules will allow for services to be provided for specific procedures paired to above the line diagnoses without the need to wait for prior authorization approval.

RULE TEXT:

(1) Augmentative Communications System or Device and the necessary attachment equipment to bed or wheelchair are a covered benefit of the Division.

(2) The requested system or device shall be approved, registered, or listed as a medical device with the Food and Drug Administration.

(3) Criteria for coverage: Providers shall meet each of the following components and submit documentation to the Division with claims subject to PPR and with PA request for review:

(a) A physician's statement of diagnosis and medical prognosis (not a prescription for an augmentative device) documenting the inability to use speech for effective communication as a result of the diagnosis;

(b) Reliable cognitive ability and a consistent motor response to communicate that can be measured by standardized or observational tools:

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

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

(c) The client shall be assessed by a SLP and when appropriate an occupational therapist or physical therapist. The evaluation report shall include:

(A) A completed OHA 3047 form: Augmentative Communication Device Selection Report Summary (page 1) and required elements of the Formal Augmentative/Alternative Communication Evaluation (page 2). Attach additional pages required to complete information requested;

(B) An explanation of why this device is best suited for this client and why the device is the lowest level that will meet basic functional communication needs;

(C) Evidence of a documented trial of the selected device and a report on the client's success in using this device; and

(D) A therapy treatment plan with the identification of the individual responsible to program the device and monitor and reevaluate on a periodic basis.

(d) Providers send requests for augmentative communications systems or devices to the Division; and

(e) The manufacturer's MSRP and the vendor's acquisition cost quotations for the device shall accompany each request including where the device is to be shipped.

(4) The Division shall reimburse for the lowest level of service that meets the medical need.

STATUTORY/OTHER AUTHORITY: ORS 413.042

STATUTES/OTHER IMPLEMENTED: ORS 413.042, ORS 414.065

AMEND: 410-131-0080

RULE TITLE: Therapy Plan of Care and Record Requirements

RULE SUMMARY: There is a need to address the prior authorization backlog that is causing delay in recipient services. The prepayment review will allow recipients to receive services without delay. Revisions to the therapy rules will allow for services to be provided for specific procedures paired to above the line diagnoses without the need to wait for prior authorization approval.

RULE TEXT:

(1) There must be a rehabilitative or habilitative therapy plan of care to receive payment.
(2) The Division shall authorize 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 guideline notes.
(3) The rehabilitative or habilitative therapy plan must adhere to the licensing board requirements of care and shall include:
(a) Client's name, ICD diagnosis code, and type, amount, frequency, and duration of the proposed rehabilitative or habilitative therapy;
(b) Individualized, measurably objective 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) For home health clients, any additional requirements included in OAR chapter 410 division 127.
(4) The therapy treatment plan and regimen shall be taught to the client, family, foster parents, or caregiver during the therapy treatments. The client must be present for demonstrating therapy during teaching to assure therapy regimen is performed safely and correctly. The division may not authorize extra treatments for teaching.
(5) A therapy plan must comply with the relevant state licensing authority's standards.
(6) If a state licensing authority has not adopted therapy plan of care standards, the therapy plan of care shall include:
(a) The need for continuing rehabilitative or habilitative therapy clearly stated;
(b) Changes to the rehabilitative or habilitative therapy plan of care, including changes to duration and frequency of intervention; and
(c) Any changes or modifications to the therapy plan of care shall be documented, signed, and dated by the prescribing practitioner or therapist who developed the plan.
(7) Therapy records shall include:
(a) A written referral, including:
(A) The client's name;
(B) The ICD-10-CM diagnosis code; and
(C) Specification of 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;
(c) Documents, evaluations, re-evaluations, and progress notes to support the rehabilitative or habilitative 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, documented and signed by the therapist; and
(f) Documentation of splint fabrication and time spent fabricating the splint.

STATUTORY/OTHER AUTHORITY: ORS 413.042

STATUTES/OTHER IMPLEMENTED: ORS 688.135, 414.065

AMEND: 410-131-0120

RULE TITLE: Limitations of Coverage and Payment

RULE SUMMARY: There is a need to address the prior authorization backlog that is causing delay in recipient services. The prepayment review will allow recipients to receive services without delay. Revisions to the therapy rules will allow for services to be provided for specific procedures paired to above the line diagnoses without the need to wait for prior authorization approval.

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 440.110.

(2) PT/OT initial evaluations and re-evaluations do not require PA and are not subject to prepayment review (PPR), 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 are subject to PPR and require PA following 30 visits in a calendar year. See OAR 410-131-0160.

(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) Are subject to PPR and require PA following 30 habilitative and 30 rehabilitative visits in a calendar year;

(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.

(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 HERC's Prioritized List pursuant to OARs 410-141-0480 and 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 the following splint supplies:

(A) Application of splints:

(i) 29105 Application of long arm splint (shoulder to hand);

(ii) 29125 Application of non-moveable, short arm splint (forearm to hand);

(iii) 29126 Application of moveable, hinged short arm splint (forearm to hand);
(iv) 29130 Application of non-moveable, hinged finger splint;
(v) 29131 Application of moveable, hinged finger splint.
(B) Supplies to create splints:
(i) Q4017 Cast supplies, long arm splint, adult (11 years +), plaster;
(ii) Q4018 Cast supplies, long arm splint, adult (11 years +), fiberglass;
(iii) Q4019 Cast supplies, long arm splint, pediatric (0-10 years), plaster;
(iv) Q4020 Cast supplies, long arm splint, pediatric (0-10 years), fiberglass;
(v)Q4021 Cast supplies, short arm splint, adult (11 years +), plaster;
(vi) Q4022 Cast supplies, short arm splint, adult (11 years +), fiberglass;
(vii) Q4023 Cast supplies, short arm splint, pediatric (0-10 years), plaster;
(viii) Q4024 Cast supplies, short arm splint, pediatric (0-10 years), fiberglass;
(ix) Q4049 Finger splint, static;
(x) Q4051 Splint supplies, miscellaneous (includes thermoplastics, strapping, fasteners, padding and other supplies).
(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.

STATUTORY/OTHER AUTHORITY: ORS 413.042

STATUTES/OTHER IMPLEMENTED: ORS 414.065

AMEND: 410-131-0160

RULE TITLE: Prepayment Review (PPR) and Prior Authorization (PA) for Payment

RULE SUMMARY: There is a need to address the prior authorization backlog that is causing delay in recipient services. The prepayment review will allow recipients to receive services without delay. Revisions to the therapy rules will allow for services to be provided for specific procedures paired to above the line diagnoses without the need to wait for prior authorization approval.

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) For certain covered services on an FFS basis, billing is subject to Prepayment Review (PPR) before payment may be made and requires a PA for certain covered services or items before the service may be provided for 30 habilitative visits or 30 rehabilitative visits in a calendar year. A PT/OT provider assumes full financial risk in providing services to an FFS client in providing services that are not in compliance with Oregon Administrative Rules. See also OAR 410-120-1320 Authorization of Payment:

(a) PT/OT initial evaluations and re-evaluations are not subject to PPR and do not require a PA;

(b) To ensure reimbursement of PT/OT services and procedures beyond the initial evaluation, the PT/OT provider must submit all required supporting documentation:

(A) Upon submission of the first claim in a series of claims in each therapy plan of care as established by prescribing practitioner per OAR 410-131-0080 for claims subject to PPR;

(B) Request a PA within five working days following 30 rehabilitative or 30 habilitative visits within a calendar year if additional visits are necessary:

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

(ii) PA requests dated beyond five working days 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 claims subject to PPR or that require PA must 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 PPR or requiring PA, the PT/OT provider shall follow and comply with PPR and 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) The following services are subject to PPR when paired above the funding line on the HERC prioritized list (see OAR 410-141-0520) if visits have not exceeded the allowed 30 habilitative and 30 rehabilitative visits allowed in a calendar

year:
(a) 95831 Manual muscle testing of arm, leg or trunk;
(b) 95832 Manual muscle testing of hand;
(c) 95833 Manual muscle testing of whole body;
(d) 95834 Manual muscle testing of whole body including hands;
(e) 95851 Range of motion testing of arm, leg or each spine section;
(f) 95852 Range of motion testing of hand;
(g) 97012 Application of mechanical traction to 1 or more areas;
(h) 97022 Application of whirlpool therapy to 1 or more areas;
(i) 97036 Physical therapy treatment to 1 or more areas, Hubbard tank, each 15 minutes;
(j) 97110 Therapeutic exercise to develop strength, endurance, range of motion, and flexibility, each 15 minutes;
(k) 97112 Therapeutic procedure to re-educate brain-to-nerve-to-muscle function, each 15 minutes;
(L) 97113 Water pool therapy with therapeutic exercises to 1 or more areas, each 15 minutes;
(m) 97116 Walking training to 1 or more areas, each 15 minutes;
(n) 97124 Therapeutic massage to 1 or more areas, each 15 minutes;
(o) 97140 Manual (physical) therapy techniques to 1 or more regions, each 15 minutes;
(p) 97150 Therapeutic procedures in a group setting (1 visit = 1 unit);
(q) 97530 Therapeutic activities to improve function, with one-on-one contact between patient and provider, each 15 minutes;
(r) 97532 Development of cognitive skills to improve attention, memory, or problem solving, each 15 minutes;
(s) 97535 Self-care or home management training, each 15 minutes;
(t) 97542 Wheelchair management, each 15 minutes;
(u) 97755 Assistive technology assessment to enhance functional performance, each 15 minutes; and
(v) 97761 Training in use of prosthesis for arms and/or legs, per 15 minutes.
(7) PA is required when:
(a) There is documented need for extended service, considering 60 minutes as the maximum length of a treatment session;
(b) There is documented need for continuing rehabilitative or habilitative therapy, considering 30 habilitative and 30 rehabilitative visits in a calendar year.
(c) Requesting services for treatments that are below the funded line or not otherwise excluded from coverage per OAR 410-141-0480.

STATUTORY/OTHER AUTHORITY: ORS 413.042

STATUTES/OTHER IMPLEMENTED: ORS 414.025, ORS 414.065