

Authorization Page
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PERMANENT ADMINISTRATIVE RULES

Oregon Health Authority, Division of Medical Assistance Programs	410
Agency and Division	Administrative Rules Chapter Number
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Upon filing.	
Adopted on	
11/04/2014	
Effective date	

RULE CAPTION

Amend Rule for Clarity and to Ensure Language Is Consistent with Division Prior Authorization Requirements

Not more than 15 words

RULEMAKING ACTION

ADOPT:

AMEND: 410-131-0080

REPEAL:

RENUMBER:

AMEND & RENUMBER:

Stat. Auth.: ORS 413.042, 414.065

Other Auth.:

Stats. Implemented: ORS 414.065

RULE SUMMARY

The Division needs to amend the rule listed above to ensure clarity and consistency in rule text.

Rhonda Bussek

Rhonda Bussek

6-25-19

Authorized Signer

Printed Name

Date

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410-131-0080

Therapy Plan of Care and Record Requirements

- (1) A therapy plan of care is required for prior authorization (PA) for payment.
- (2) The therapy plan of care must include:
 - (a) Client's name, diagnosis, and type, amount, frequency and duration of the proposed 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 Oregon Administrative Rule (OAR) 410 division 127.
- (3) The therapy treatment plan and regimen will be taught to the client, family, foster parents, or caregiver during the therapy treatments. No extra treatments will be authorized for teaching.
- (4) A therapy plan of care shall comply with the relevant state licensing authority's standards.
- (5) If a state licensing authority has not adopted therapy plan of care standards, the therapy plan of care must include:
 - (a) The need for continuing therapy clearly stated;
 - (b) Changes to the therapy plan of care, including changes to duration and frequency of intervention, and
 - (c) Any changes or modifications to the plan of care shall be documented, signed, and dated by the prescribing practitioner or therapist who developed the plan.
- (6) Therapy records must include:
 - (a) A written referral, including:
 - (A) The client's name;
 - (B) The ICD-9-CM diagnosis code; and

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

(b) A copy of the signed therapy plan of care must be on file in the provider's therapy record prior to billing for services;

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

(d) Modalities used on each date of service;

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

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

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 688.135, 414.065