



Health Systems Division
Integrated Health Programs

Physical and Occupational Therapy for Habilitative and Rehabilitative Services Administrative Rulebook

Chapter 410, Division 131

Effective August 1, 2016

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410-131-0040 Foreword for Physical and Occupational Therapy

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

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

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

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

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

(a) 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.

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

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

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

Stat. Auth.: ORS 413.042, 414.065

Stats. Implemented: ORS 414.065

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

- (1) A therapy plan of care is required for PA for payment.
- (2) The therapy plan of care shall 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 OAR chapter 410 division 127.
- (3) The therapy treatment plan and regimen shall be taught to the client, family, foster parents, or caregiver during the therapy treatments. No extra treatments shall 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 shall 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 shall include:
 - (a) A written referral, including:
 - (A) The client's name;

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(B) The ICD-10-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 shall 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

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

(c) The client, family, foster parents, or caregiver have been taught the therapy regimen and can carry out the maintenance therapy.

(3) Maintenance therapy is not a reimbursable service.

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

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

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065 & 688.135

410-131-0120 Limitations of Coverage and Payment

- (1) OHP Plus clients shall be responsible for paying a co-payment for some services. This co-payment shall be paid directly to the provider. See OAR 410-120-1230, Client Co-payment, and Table 120-1230-1 for specific details.
- (2) The provision of PT/OT evaluations and therapy services require a prescribing practitioner referral, and services shall be supported by a therapy plan of care signed and dated by the prescribing practitioner.
- (3) PT/OT initial evaluations and re-evaluations do not require PA, but are limited to:
 - (a) Up to two initial evaluations in any 12-month period; and
 - (b) Up to four re-evaluation services in any 12-month period;
- (4) Reimbursement is limited to the initial evaluation when both the initial evaluation and a re-evaluation are provided on the same day.
- (5) All other occupational and physical therapy treatments require PA. See also OAR 410-131-0160 and Table 131-0160-1.
- (6) A licensed occupational or physical therapist, or a licensed occupational or physical therapy assistant under the supervision of a therapist, shall be in constant attendance while therapy treatments are performed:
 - (a) Therapy treatments may not exceed one hour per day each for occupational and physical therapy;
 - (b) Modalities:
 - (A) Require PA;
 - (B) Up to two modalities may be authorized per day of treatment;
 - (C) Need to be billed in conjunction with a therapeutic procedure code; and
 - (D) Each individual supervised modality code may be reported only once for each client encounter. See Table 131-0160-1.
 - (c) Massage therapy is limited to two units per day of treatment and shall only be authorized in conjunction with another therapeutic procedure or modality.
- (7) Supplies and materials for the fabrication of splints 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) Hippotherapy (e.g. horse or equine-assisted therapy);

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

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

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

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

[ED. NOTE: Tables referenced are available from the agency.]

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 688.135, 414.065

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

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

Application of splints

29105
29125
29126
29130
29131

Supplies to create splints

Q4017
Q4018
Q4019
Q4020
Q4021
Q4022
Q4023
Q4024
Q4049
Q4051

410-131-0160 Prior Authorization for Payment

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

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

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

(4) If a client receives services on a FFS basis, the Division or their contractor may require a PA for certain covered services or items before the service 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 131-0160-1 (Services Require Payment Authorization):

(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 retroactive, 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, including but not limited to:

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(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 131-0160-1

[ED. NOTE: Tables referenced are available from the agency.]

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025 & 414.0655

Table 131-0160-1 Services Require Payment Authorization

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