

Secretary of State
NOTICE OF PROPOSED RULEMAKING
A Statement of Need and Fiscal Impact accompanies this form.

Oregon Health Authority (Authority), Division of Medical Assistance Programs (Division)	410	
Agency and Division	Administrative Rules Chapter Number	
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Rules Coordinator	Address	Telephone

RULE CAPTION

Clearly Define Maintenance to Comply with Federal Requirements and General Language Cleanup
Not more than 15 words that reasonably identifies the subject matter of the agency's intended action.

RULEMAKING ACTION

Secure approval of new rule numbers (Adopted or Renumbered rules) with the Administrative Rules Unit prior to filing

ADOPT:

AMEND: OARs 410-129-0020, 410-129-0040, 410-129-0060, 410-129-0065, 410-129-0070, 410-129-0080, 410-129-0100, 410-129-0180, 410-129-0220, 410-129-0260, 410-131-0040, 410-131-0080, 410-131-0100, 410-131-0120 and 410-131-0160

REPEAL:

RENUMBER:

AMEND & RENUMBER:

Stat. Auth.: ORS 413.042, 414.065

Other Auth.:

Stats. Implemented: ORS 414.025, 414.065, 688.135

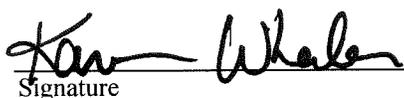
RULE SUMMARY

The Division needs to amend these rules to follow CMS direction.

The agency requests public comment on whether other options should be considered for achieving the rule's substantive goals while reducing the negative economic impact of the rule on business.

July 21, 2016, by 5 p.m. Send comments to: dmap.rules@state.or.us

Last Day for Public Comment (Last day to submit written comments to the Rules Coordinator)

	Karen Wheeler	5/20/16
Signature	Printed name	Date

Note: Notices must be submitted by the 15th day of the month to be published in the next month's *Oregon Bulletin*. A Rulemaking Hearing may be requested in writing by 10 or more people, or by an association with 10 or more members, within 21 days following notice publication or 28 days from the date notice was sent to people on the agency's interested party mailing list, whichever is later. In such cases a Hearing Notice must be published in the *Oregon Bulletin* at least 14 days before the hearing.

STATEMENT OF NEED AND FISCAL IMPACT

A Notice of Proposed Rulemaking Hearing or a Notice of Proposed Rulemaking accompanies this form.

Oregon Health Authority (Authority), Division of Medical Assistance Programs (Division)

410

Agency and Division

Administrative Rules Chapter Number

Clearly Define Maintenance to Comply with Federal Requirements and General Language Cleanup

Rule Caption (Not more than 15 words that reasonably identifies the subject matter of the agency's intended action.)

In the Matter of: The amendment of OARs 410-129-0020, 410-129-0040, 410-129-0060, 410-129-0065, 410-129-0070, 410-129-0080, 410-129-0100, 410-129-0180, 410-129-0220, 410-129-0260, 410-131-0040, 410-131-0080, 410-131-0100, 410-131-0120 and 410-131-0160

Statutory Authority: ORS 413.042, 414.065

Other Authority:

Stats. Implemented: ORS 414.025, 414.065, 688.135

Need for the Rule(s): The Division needs to amend these rules to follow CMS direction.

Documents Relied Upon, and where they are available: CIB 01-28-16, EHB, and 45 CFR section 156.115(a)(5)(i)

Fiscal and Economic Impact: The Division anticipates no significant fiscal or economic impact on the public, units of local government, small businesses, or the general public with these rule revisions.

Statement of Cost of Compliance:

1. Impact on state agencies, units of local government and the public (ORS 183.335(2)(b)(E)): Amending these rules will have no fiscal impact on the Authority, other state agencies, units of local government, the public, or businesses, including small businesses.

2. Cost of compliance effect on small business (ORS 183.336): There is no cost of compliance for small businesses as defined in ORS 183.336.

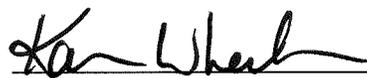
a. Estimate the number of small businesses and types of business and industries with small businesses subject to the rule: N/A

b. Projected reporting, recordkeeping and other administrative activities required for compliance, including costs of professional services: N/A

c. Equipment, supplies, labor and increased administration required for compliance: N/A

How were small businesses involved in the development of this rule? Small businesses are not impacted by this rule.

Administrative Rule Advisory Committee consulted?: No, this is a federal requirement that alternative benefit plan meets essential health benefit standards.


Signature


Printed Name

5/20/16
Date

DIVISION 129

SPEECH-LANGUAGE PATHOLOGY, AUDIOLOGY AND HEARING AID SERVICES

410-129-0020

Therapy Plan of Care, Goals/Outcomes and Record Requirements

(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.

(2) The therapy regimen shall be taught to individuals, including the patient, family members, foster parents, and caregivers who can assist in the achievement of the goals and objectives. The Division of Medical Assistance Programs (Division) shall not authorize extra treatments for teaching.

(3) All speech-language pathology (SLP) treatment services require a therapy plan of care that is required for prior authorization (PA) for payment.

(4) The SLP therapy plan of care shall include:

(a) Client's name and diagnosis;

(b) The type, amount, frequency, and duration of the proposed 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.

(5) SLP therapy records shall include:

(a) Documentation of each session;

(b) Therapy provided;

(c) Duration of therapy; and

(d) Signature of the sSpeech-Language -pathologist.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025, 414.065 & 681.205

410-129-0040

Maintenance

(1) Therapy becomes maintenance when any one of the following occur:

(a) The therapy treatment plan goals and objectives are reached and no further goals are needed; or

(b) There is no progress toward the rehabilitative or habilitative therapy-treatment plan goals and objectives; or

(c) The therapy treatment plan does not require the skills of a therapist; or

(d) The patient, family, foster parents, and/or caregiver have been taught ~~and can carry out the therapy regimen and~~ can carry out ~~are responsible for the maintenance therapy.~~

(2) Therapy that becomes maintenance is not a covered service.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065, 681.205 & 688.135

410-129-0060

Prescription Required

(1) The prescription is the written order by the prescribing practitioner pursuant to state law governing ~~speech-language[CSC1]-pathology, audiology and hearing aid services.~~ Prescription ~~must~~ shall specify the ICD-10-CM diagnosis code for all ~~speech-language[CSC2]-pathology, audiology and hearing aid services that require payment/prior authorization.~~

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

(3) A written order:

(a) Is required for the initial evaluation;

(b) For therapy, ~~must~~ shall specify the ICD-10-CM diagnosis code, service, amount, and duration required.

(4) Written orders ~~must~~ shall be submitted with the payment ~~(prior) authorization~~ PA request and a copy ~~must~~ shall be on file in the provider's therapy record. The written

order and the treatment plan ~~must~~ 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/her practice, i.e. primary care physician (not appropriate ~~is for~~ an orthopedic specialist, chiropractor, gynecologist, etc.).

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025 & 414.065

410-129-0065

Licensing Requirements

(1) The Division enrolls only the following types of providers as performing providers under the Speech-Language Pathology, Audiology and Hearing Aid Services program:

(a) ~~An person~~ individual licensed by the relevant state licensing authority to practice speech-language pathology (SLP);

(b) ~~An person~~ individual licensed by the relevant state licensing authority to practice audiology; and

(c) ~~An person~~ individual licensed by the relevant state licensing authority for "dealing in hearing aids" as defined in Oregon Revised Statute 694.015.

(2) The Oregon Board of Examiners for SLP and Audiology licenses (and the Division recognizes services provided by):

(a) Conditional Speech-Language Pathologists; and

(b) SLP Assistants.

(3) Services of graduate SLP students, furnished under a Conditional SLP License:

(a) Shall be provided in compliance with supervision requirements of the state licensing board and the American Speech-Language-Hearing Association;

(b) Shall be compliant with applicable record and documentation requirements (see also Oregon Administrative Rules in chapter 335, division 010); and

(c) Are reimbursed to the licensed supervising ~~s~~Speech-~~L~~Language ~~p~~Pathologist.

(4) The Division shall not reimburse for services of a licensed ~~s~~Speech-L~~L~~anguage ~~p~~Pathologist while the pathologist is teaching or supervising students in SLP.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025, 414.065

410-129-0070

Limitations

(1) ~~Speech-Language pathology (SLP) services:~~

(a) Shall be provided by a practitioner as described in OAR 410-129-0065(1);

(b) Therapy treatment:

(A) May not exceed one hour per day, either group or individual;

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

(C) Requires ~~prior authorization~~ PA.

(c) The following SLP services do not require payment authorization 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 and 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 12month period, not to exceed \$5.00 each;

(d) The purchase, rental, repair or modification of a speech-generating/augmentative communication system or device requires ~~prior authorization~~ 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. ~~See OAR 410-129-0220.~~

(2) Audiology and hearing aid services:

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

(b) Reimbursement is limited to one (monaural) hearing aid every five years for adults (age 21 and older) who meet the following criteria: Loss of 45 decibel (dB) hearing level or greater in two or more of the following three frequencies: 1000, 2000, and 3000 Hertz (Hz) in the better ear;

(c) Adults who meet the criteria above and, in addition, have vision correctable to no better than 20/200 in the better eye, may be authorized for two hearing aids for safety purposes. A vision evaluation shall be submitted with the ~~prior authorization~~PA request;

(d) 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;

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

(f) Services that do not require payment authorization:

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

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

(g) Services that require payment authorization:

- (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.

(h) Services not covered:

- (A) FM systems — vibro-tactile aids;
- (B) Earplugs;
- (C) Adjustment of hearing aids is included in the fitting and dispensing fee and is not reimbursable separately;
- (D) Aural rehabilitation therapy is included in the fitting and dispensing fee and is not reimbursable separately;
- (E) Tinnitus masker(s).

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065 & 681.325

410-129-0080

Prior Authorization

(1) Speech-language pathology, audiology and hearing aid providers ~~must~~shall obtain prior authorization (PA) for services as specified in rule.

(2) Providers ~~must~~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 Oregon Health Authority (Authority) 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 prepaid health plan, from the prepaid health plan;

(d) For all other clients, from the Division of Medical Assistance Programs (Division).

(3) For services requiring authorization, providers ~~must~~ 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 will be honored as the request date. It is the provider's responsibility to obtain payment authorization.

[Publications: Publications referenced are available from the agency.]

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025 & 414.065

410-129-0100

Medicare/Medicaid Claims

(1) When an individual, not in managed care, has both Medicare and Medicaid coverage, audiologists ~~must~~ shall bill audiometry and all diagnostic testings to Medicare first. Medicare will automatically forward these claims to Medicaid. Refer to OAR 410-120-1210 (General Rules) for information on Division reimbursement. For managed care clients with Medicare, contact the clients Managed Care Organization (MCO).

(2) Audiologists ~~must~~ shall bill all hearing aids and related services directly to the Division on a DMAP 505. Payment authorization is required on most of these services. (See ~~OARs 410-129-0240 and 410-129-0260~~)

(3) If Medicare transmits incorrect information to the Division, or if an out-of-state Medicare carrier or intermediary was billed, providers ~~must~~ shall bill the Division using a DMAP 505 form. If any payment is made by the Division, an adjustment request ~~must~~ shall be submitted to correct payment, if necessary.

(4) Send all completed DMAP 505 forms to the Division of Medical Assistance Programs.

(5) Hearing aid dealers ~~must~~ shall bill all services directly to the Division on a CMS-1500. Payment authorization is required on most services (~~See OARs 410-129-0240 and 410-129-0260~~).

(6) When a client, not in managed care, has both Medicare and Medicaid coverage, speech-language pathologists ~~must~~ shall bill services to Medicare first. Medicare will automatically forward these claims to Medicaid. Refer to OAR 410-120-1210 (General Rules) for information on Division reimbursement. For managed care clients with Medicare, contact the client's Managed Care Organization (MCO).

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025, 414.034, 414.065, 414.329, 414.706 & 414.710

410-129-0180

Procedure Codes

(1) Procedure codes listed in the Speech-Language Pathology, Audiology and Hearing Aid Services Program rules are intended for use by licensed speech-language pathologists, licensed audiologists, and certified hearing aid dealers.

(2) Physicians and nurse practitioners are subject to the administrative rules contained in the Division Medical-Surgical Services Program rules and ~~must~~ shall bill the Division using the processes and procedure codes identified in those rules.

~~[Publications: Publications referenced are available from the agency.]~~

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025 & 414.065

410-129-0220

Augmentative Communications System or Device

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

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

(3) Criteria for coverage: Providers ~~must~~ shall meet each of the following components and submit documentation to the Division with the ~~prior authorization~~ 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) ~~The client must have r~~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 ~~must~~ shall be assessed by a ~~s~~Speech-language ~~P~~pathologist and when appropriate an ~~o~~Occupational ~~t~~Therapist and/or ~~p~~Physical ~~t~~Therapist. The evaluation report(s) ~~must~~ shall include:

(A) A completed ~~D~~MAP-~~O~~H~~A~~ 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 particular 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 ~~must~~ 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.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 413.042 & 414.065

410-129-0260

Hearing Aids and Hearing Aid Technical Service and Repair

(1) Hearing aids ~~must~~ shall be billed to the Division of ~~Medical Assistance Programs~~ (Division) at the provider's acquisition cost, and ~~will~~ shall be reimbursed at such 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 and/or postage for the item.

(2) Submit history of hearing aid use and an audiogram when requesting payment authorization for hearing aids.

(3) Procedure codes: Table 129-0260.

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

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025, 414.065 & 681.205

DIVISION 131

PHYSICAL AND OCCUPATIONAL THERAPY FOR HABILITATIVE AND REHABILITATIVE SERVICES

410-131-0040

Foreword for Physical and Occupational Therapy

(1) ~~The Division of Medical Assistance Programs (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 person-individual~~ licensed by the relevant ~~S~~state licensing authority to practice physical therapy; and

(b) ~~An person-individual~~ licensed by the relevant ~~S~~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 ~~conjunction with~~ 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 ~~must~~ 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 prior authorization ~~(PA)~~ for payment.
- (2) The therapy plan of care ~~must~~ 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 Oregon Administrative Rule ~~(OAR)~~ chapter 410 division 127.
- (3) The therapy treatment plan and regimen shall will be taught to the client, family, foster parents, or caregiver during the therapy treatments. No extra treatments shall 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~~ 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 ~~must~~ shall include:

(a) A written referral, including:

(A) The client's name;

(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 ~~must~~ 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) There is no progress toward the therapy plan of care goals and objectives; or~~

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

~~(dc) The client, family, foster parents, and/or caregiver have been taught and can carry out the therapy regimen and are can carry out responsible for the maintenance therapy.~~

(3) Maintenance therapy is not a reimbursable service.

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

(5) Providers ~~must~~ 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) ~~Oregon Health Plan (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. [Table not included. See ED NOTE.]~~

(2) The provision of PT/OT evaluations and therapy services require a prescribing practitioner referral, and services ~~must~~ shall be supported by a therapy plan of care signed and dated by the prescribing practitioner (~~see OAR 410-131-0080~~).

(3) PT/OT initial evaluations and re-evaluations do not require ~~Prior Authorization (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. ~~[Table not included. See ED NOTE.]~~

(6) A licensed occupational or physical therapist, or a licensed occupational or physical therapy assistant under the supervision of a therapist, ~~must~~ shall be in constant attendance while therapy treatments are performed:

(a) ~~Duration~~—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. [~~Table not included. See ED. NOTE.~~]

(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 ~~must~~ 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 [~~Table not included. See ED. NOTE.~~]; 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 the Division's OARs chapter 410, division 150 for information on administrative examinations and report billing. [~~Table not included. See ED. NOTE.~~]

~~(10) Table 131-0120-1. [Table not included. See ED NOTE.]~~

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

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 688.135, 414.065

410-131-0160

Prior Authorization for Payment

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

(2) The provider ~~must~~ shall verify whether a PHP or the Division of Medical Assistance Programs (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 ~~prior authorization (PA)~~ requirements for some services that are provided through the PHP. Providers ~~must~~ 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~~ needs to 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~~ can be provided or before payment ~~may~~ will 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 (OARs). See also OAR 410-120-1320 (Authorization of Payment), this rule and Table 131-0160-1 (Services Require Payment Authorization):

(a) PT/OT initial evaluations and re-evaluations do not require a ~~PA~~ prior authorization (see OAR 410-131-0120);

(b) To ensure reimbursement for continuation of PT/OT services and procedures beyond the initial evaluation, the PT/OT provider ~~must~~ 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~~ will not be authorized retroactive, and if authorized ~~shall~~ will 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 requests require~~ a therapy plan of care (see OAR 410-131-0080); 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 PAprior-authorization, the PT/OT provider ~~must~~ shall follow and comply with PA requirements in these rules, and the General Rules, including but not limited to:

(a) The service is adequately documented (see OAR 410-120-1360 Requirements for Financial, Clinical and Other Records). Providers ~~must~~ 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-will be denied.

(6) Table 131-0160-1

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

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025 & 414.065