# Requirements for fee-for-service outpatient physical, occupational and speech therapy claims

## Required documentation for all outpatient therapy claims

All outpatient therapy claims for services other than evaluation or re-evaluation require a current plan of care that complies with relevant state licensing authority standards of care and includes:

- Client's name, diagnosis, and type, amount, frequency, and duration of the proposed rehabilitative or habilitative therapy;
- Individualized, measurably objective functional goals;
- Documented need for extended service, considering 60 minutes as the maximum length of a treatment session;
- Plan to address implementation of a home management program as appropriate from the initiation of therapy forward;
- Dated signature of the therapist or the prescribing practitioner establishing the plan of care; and
- For home health clients, any additional requirements included in OAR 410-127.

If a state licensing authority has not adopted plan of care standards, the plan must also include:

- A clear statement about the need to continue habilitative or rehabilitative therapy;
- Changes to the plan of care, including changes to duration and frequency of intervention; and
- For each change on the plan of care, supporting documentation and the dated signature of the prescribing practitioner or therapist who developed the plan.

Documentation must show the therapy meets the requirements of Guideline Note 6:

- Therapy is provided by a licensed physical therapist, occupational therapist, speech language pathologist, physician, or other practitioner licensed to provide the therapy,
- There is objective, measurable documentation of clinically significant progress toward the therapy plan of care goals and objectives,
- The plan of care requires the skills of a medical provider, and
- The client and/or caregiver cannot be taught to carry out the regimen independently.

## Services that do not require prior authorization

Codes that do not require prior authorization are listed in these rules:

- For physical and occupational therapy: See OAR 410-131-0120 and 410-131-0160.
- For speech therapy: See OAR 410-129-0200.

The code(s) must pair with a condition on a funded line of the current Prioritized List of Health Services.

**How to submit documentation:**

Include documentation with the first claim billed for the plan of care. Bill the initial claim in one of these two ways.

- On the Provider Web Portal at https://www.or-medicaid.gov. Fax documentation under the EDMS Coversheet to 503-378-3086. Include the Provider ID, Recipient ID and Internal Control Number. **OR**
- Mail a paper claim with attached documentation to OHA at PO Box 14955, Salem OR 97309.

You should not bill OHA for subsequent visits until the initial claim is approved.

**If the claim meets all payment criteria:**

OHA will release the claim for payment and send separate notification about the number of habilitative and rehabilitative therapy visits the patient has remaining for the year.

You can bill OHA in the method you prefer for all subsequent claims under the current plan of care. Additional documentation is not required.

**If the claim does not meet all payment criteria:**

OHA will deny the claim and send a notice to the provider to explain why OHA denied the claim and the list the documentation needed for approval. The provider will then need to resubmit the claim with the required documentation. In addition:

- You cannot hold an OHP member responsible for payment if the denial was due to provider error (e.g., billing OHA when the member's CCO should cover the service, failure to submit required documentation, typos or clerical errors on the claim). See OAR 410-120-1280(1)(b).
- You may only bill the OHP member when you have confirmed that OHP will not cover the service, you have informed the member that the service is not covered, and the member agrees to pay for the service. See OAR 410-120-1280(3)(h).

## Services that require prior authorization

The following services still require prior authorization by OHA:

- Services to treat comorbid or unfunded conditions on the Prioritized List of Health Services,
- Any visits that exceed the annual limits of 30 habilitative visits or 30 rehabilitative visits established in Guideline Note 6,
- Visits longer than 60 minutes, and
- Any other special circumstances.

**How to submit documentation:**

Submit the documentation with a completed prior authorization request as described on OHA's Prior Authorization page.