Therapy Care
Frequently Asked Questions

PacificSource Community Solutions

1. What are the types of therapy?

Types of therapy are grouped by rehabilitative therapy and habilitative therapy—both of which include physical therapy (PT), occupational therapy (OT), and speech therapy (ST).

- Rehabilitative therapy involves care that helps a person re-establish, restore, or improve skills for daily living that have been lost or impaired because of illness, injury, or disability.
- Habilitative therapy includes care to help people learn or improve skills and help them function with daily living; habilitative therapy is designed to establish skills that have not yet been acquired at an age-appropriate level. Examples include therapy for a child who isn't walking or talking at the expected age.

Other types of therapy include alternative therapies, such as chiropractic, acupuncture, massage, and yoga.

There's also pulmonary and cardiac rehabilitation. Pulmonary rehabilitation helps patients who suffer from a respiratory disease. Cardiac rehabilitation is for those who have been diagnosed with a heart condition. After a health incident or surgery, for example, these therapies help patients resume normal activities as quickly as possible.

2. Where can I locate the Oregon Health Plan Guideline Notes for "therapy criteria"?

The OHP Prioritized List of Health Services can be found on these two web pages:

- **OHA Prioritized List of Health Services**
- **PacificSource LineFinder**

3. What therapy services are included in the Guideline Notes?

The Oregon Health Authority (OHA) Guideline Notes identify procedures and therapies that are covered by insurance. This is a summary of therapy services that appear in the Guideline Notes:

- **Guideline Note 6, Rehabilitative and Habilitative Therapies**

  The quantitative limits in this guideline note do not apply to mental health or substance abuse conditions.

  A total of 30 visits per year of rehabilitative therapy and a total of 30 visits per year of habilitative therapy (physical, occupational, and speech therapy) are included on these lines 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. Massage therapy (CPT 97124) is included in these service limits. When billing CPT 97124, there must be a minimum of 8 minutes of massage provided. Massage is limited to no more than one session per week.

Physical, occupational, and speech therapy are only included on these lines when the following criteria are met:

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

No limits apply while in a skilled nursing facility for the primary purpose of rehabilitation, an inpatient hospital, or an inpatient rehabilitation unit.

Spinal cord injuries, traumatic brain injuries, or cerebral vascular accidents are not subject to the visit limitations during the first year after an acute injury.

- **Guideline Note 56, Non-Interventional Treatments for Conditions of the Back and Spine**

  Patients seeking care for back pain should be assessed for potentially serious conditions ("red flag" symptoms requiring immediate diagnostic testing), as defined in Diagnostic Guideline D4. Patients lacking red flag symptoms should be assessed using a validated assessment tool (for example, STarT Back Assessment Tool) in order to determine their risk level for poor functional prognosis based on psychosocial indicators.

  For patients determined to be low risk on the assessment tool, the following services are included on these lines:

  a. Office evaluation and education
  b. Up to four total visits, consisting of the following treatments: OMT/CMT, acupuncture, and PT/OT. Massage, if available, may be provided as part of these four total visits.
  c. First line medications: NSAIDs, acetaminophen, and/or muscle relaxers. Opioids may be considered as a second line treatment, subject to the limitations on coverage of opioids in **Guideline Note 60 Opioids for Conditions of the Back and Spine.**

  For patients determined to be medium or high risk on the validated assessment tool, as well as patients undergoing opioid tapers as in **Guideline Note 60 Opioids for Conditions of the Back and Spine,** the following treatments are included on these lines:

  » Office evaluation, consultation, and education
  » Cognitive behavioral therapy. The necessity for cognitive behavioral therapy should be re-evaluated every 90 days and coverage will only be continued if there is documented evidence of decreasing depression or anxiety symptomatology, improved ability to work/function, increased self-efficacy, or other clinically significant, objective improvement.
  » Prescription and over-the-counter medications; opioid medications subject to the limitations on coverage of opioids in **Guideline Note 60 Opioids for Conditions of the Back and Spine.** See evidence table.
  » The following evidence-based therapies, when available, may be provided: yoga, massage (when not billed under 97124 and limited to one session per week), Pilates, supervised exercise therapy, intensive interdisciplinary rehabilitation. HCPCS S9451 is only included on Line 399 for the provision of yoga or supervised exercise therapy.

» A total of 30 visits per year of any combination of the following evidence-based therapies when available and medically appropriate. These therapies are only included on these lines if provided by a provider licensed to provide the therapy and when there is documentation of measurable clinically significant progress toward the therapy plan of care goals and objectives using evidence-based objective tools (for example, Oswestry, Neck Disability Index, SF-MPQ, and MSPQ). Therapy types include:

a. Rehabilitative therapy (physical and/or occupational therapy), if provided according to **Guideline Note 6 Rehabilitative and Habilitative Therapies.** Rehabilitation services provided under this guideline also count towards visit totals in Guideline Note 6. Massage billed under CPT 97124 is included in this category and is subject to the restrictions on massage in Guideline Note 6.

b. Chiropractic or osteopathic manipulation

c. Acupuncture

Mechanical traction (CPT 97012) is not included on these lines, due to the lack of effectiveness for treatment of back and neck conditions.

The development of this guideline note was a result of the Health Evidence Review Commission (HERC) coverage guidelines on Low Back Pain Non-Pharmacologic, Non-Invasive Intervention, Low Back Pain, Pharmacological and Herbal Therapies. See **OHA Evidence-based Reports.**

- **Guideline Note 92, Acupuncture**

  Inclusion of acupuncture (CPT 97810-97814) on the Prioritized List has the following limitations:

  » **Line 1 Pregnancy**
  Acupuncture pairs on Line 1 for the following conditions and codes:

  ▪ **Hyperemesis gravidarum**
  ICD-10-CM: O21.0, O21.1
  Acupuncture pairs with hyperemesis gravidarum when a diagnosis is made by the maternity care provider and referred for acupuncture treatment for up to 12 sessions of acupressure/acupuncture per pregnancy.

  ▪ **Breech presentation**
  ICD-10-CM: O32.1
  Acupuncture (and moxibustion) is paired with breech presentation when a referral with a diagnosis of breech presentation is made by the maternity care provider, the patient is between 33 and 38 weeks gestation, for up to 6 sessions per pregnancy.

  ▪ **Back and pelvic pain of pregnancy**
  ICD-10-CM: O99.89
  Acupuncture is paired with back and pelvic pain of pregnancy when referred by maternity care provider/primary care provider for up to 12 sessions per pregnancy.

  » **Line 4 Substance Use Disorder, Line 62 Substance-Induced Mood, Anxiety, Delusional and Obsessive-Compulsive Disorders, Line 65 Substance-Induced Delirium; substance Intoxication and Withdrawal Tobacco Dependence**
  Acupuncture is included on these lines only when used as part of a documented broader treatment plan that offers patients a variety of evidenced-based interventions, including behavioral interventions, social support, and Medication Assisted Treatment (MAT), as appropriate.

» **Line 5 Tobacco Dependence**
Acupuncture is included on this line for a maximum of 12 sessions per quit attempt up to two quit attempts per year; additional sessions may be authorized if medically appropriate. Lines 92, 111, 112, 114, 125, 129, 133, 135, 157, 158, 190, 198, 199, 207, 209, 213, 214, 228, 233, 236, 237, 256, 257, 259, 260, 269, 274, 284, 285, 292, 311, 312, 313, 326, 339, 369, 393, 394 416, 432 and 552
Acupuncture is paired with only with the ICD-10 code G89.3 Neoplasm related pain (acute) (chronic) when there is active cancer and limited to 12 total sessions per year; patients may have additional visits authorized beyond these limits if medically appropriate.

» **Line 200 Chronic Organic Mental Disorders Including Dementias**
Acupuncture is paired with the treatment of post-stroke depression only (ICD-10-CM F06.31 or F06.32). Treatments may be billed to a maximum of 30 minutes face-to-face time and limited to 12 total sessions per year, with documentation of meaningful improvement; patients may have additional visits authorized beyond these limits if medically appropriate.

» **Line 358 Scoliosis**
Acupuncture is included on this line with visit limitations as in **Guideline Note 56 Non-interventional Treatments for Conditions of the Back and Spine.**

» **Line 399 Conditions of the Back and Spine**
Acupuncture is included on this line with visit limitations as in **Guideline Note 56 Non-interventional Treatments for Conditions of the Back and Spine.**

» **Line 407 Migraine Headaches**
Acupuncture pairs on Line 407 for migraine (ICD-10-CM G43.0, G43.1, G43.5, G43.7, G43.8, G43.9), for up to 12 sessions per year.

» **Line 461 Osteoarthritis and Allied Disorders**
Acupuncture pairs on Line 461 for osteoarthritis of the knee only (ICD-10-CM M17), for up to 12 sessions per year.

» **Line 534 Tension Headaches**
Line 534 is below the current funding line. Acupuncture is included on Line 540 534 for treatment of tension headaches (ICD-10-CM G44.2), for up to 12 sessions per year.

The development of this guideline note was informed by a HERC coverage guidance. **OHA Evidence-based Reports.**

- **Guideline Note 187, Pulmonary Rehabilitation**
  - » No prior authorization is required for pulmonary rehabilitation
  - » To review criteria, you can find the guideline note in the OHP Prioritized List at **OHA Prioritized List of Health Services.**

4. What information is required when submitting a preapproval request?

- Member name, date of birth, and member ID number
- Referring provider information and contact information
- Treating provider or facility name and contact information

- Diagnosis code(s)
- Number of visits
- Type of service
- Start date of request and timeframe (start and end dates must be clearly defined)
- Chart notes are always required
- Current evaluation, re-evaluation and/or progress notes
- Prescription (Rx) or order from prescribing provider

5. What do I need to know about the number of covered visits?

Therapy services are based on medical necessity for the member's condition; limits on the number of visits are based on guidelines described by the Milliman Care Guidelines (MCG) as well as medical necessity. To better understand the number of covered visits, here's more:

- If 30 visits for one therapy modality are requested in one prior authorization, this does not allow for any more visits to be used for any other therapy modality. The member's benefit would be used for that entire year. Example: 30 visits are requested for physical therapy in one prior authorization. This does not allow for any more visits in that entire year for occupational therapy or other alternative therapies (such as chiropractic, acupuncture, massage, and yoga).
- 30 visits are a **combined total** per year for **both** rehabilitative and alternative therapy visits. See Guideline Note 6.
- Habilitative therapy allows for 30 visits per year.
- Pulmonary and Cardiac Rehab are not included in the 30-visit limit.

6. What are CPT codes and what is their role?

CPT codes are Common Procedural Technology codes. They're numbers assigned to every task and service a medical practitioner may provide to a patient including medical, surgical, and diagnostic services. Other considerations:

- CPT codes are no longer required when submitting a prior authorization for PT/OT/ST therapy.
- CPT codes are now in a service group
- Prior Authorization Submission:
  - » Type of therapy (such as PT/OT/ST) are entered as service groups. The prior authorization will be reviewed for an above-the-line or below-the-line (ATL/BTL) diagnosis and the number of visits being requested (units equal visits). The visit limitation is 30 visits per calendar year; a combination with PT/OT/ST and alternative therapy.
- Billing: Providers will bill for what services they provided on a day. (Services are based on a universal CPT (current procedural terminology) coding system maintained by the American Medical Association.) Service groups have covered and noncovered codes. Codes that appear on the claims will be reviewed if covered or not covered and get paid accordingly.

- Example of a portal submission is below. This example indicates a request for 30 visits:

7. What is the benefit year for therapies?

The benefit year is based on a calendar year from January 1 to December 31.

8. Can providers bill for an office visit?

In-network office visits are considered referrals, and don't require any prior authorization.

- If you are going to bill for an office visit, a referral will need to be requested separately from a prior authorization. Office visits will need to be requested on a referral.
- For rehabilitative therapy, no referral or prior authorization is necessary for the evaluation.
- For alternative therapy, a referral is necessary for the initial evaluation.

9. Is a prescription (Rx) or order necessary for treatment?

Yes. A member cannot have a covered treatment at a rehab facility or alternative provider without a written order (OAR 410-131-0080 (7)). Other considerations:

- A prior authorization with a prescription or order from the referring provider is required.
- No prior authorization is required for pulmonary and cardiac rehab.

10. What particular information about alternative therapy should I be aware of?

- U.S. Department of Health and Human Services has deemed that chiropractic services are not appropriate for infants. Some exceptions may apply through a medical diagnosis.
- Children under the age of 14 should not be receiving chiropractic adjustments (also according to the U.S. Department of Health and Human Services). Some exceptions may apply through a medical diagnosis.
- A STarT Back Tool (SBT) is required beginning at the age of 14.
- If a member has received their 30 visits for physical therapy and is now submitting prior authorization for alternative therapy, it will be denied. The member has used their 30-visit total for the year.

- Chiropractors may submit a prior authorization to another therapy, such as acupuncture or massage, only if they have sub referral authority granted from the member's primary care provider or the request is primary care provider-approved.
- Massage should not be asked for as a stand-alone service. Stand-alone massage is only covered for a back condition.