

Physical and Occupational Therapy Services Provider Guide

Use this guide as a supplement to the Physical and Occupational Therapy Services (PT/OT) Oregon Administrative Rules ([OAR 410 Division 131](#)). See current PT/OT rules for official policies regarding billing.

Contents (last updated August 31, 2015)

Client eligibility and enrollment	1
Prior authorization.....	1
Information needed to request PA	1
Billing.....	2
Claim status and adjustments.....	2

Client eligibility and enrollment

Refer to [General Rules](#) and [OHP Rules](#) for information about the service coverage according to OHP benefit plans and the Prioritized List of Health Services.

The [OHP eligibility verification page](#) explains how to verify eligibility using the Provider Web Portal, Automated Voice Response, or electronic data interchange (EDI) 270/271 transaction.

Prior authorization

Submit prior authorization (PA) requests to DMAP using the [Provider Web Portal \(instructions\)](#) or the [MSC 3971 \(instructions\)](#).

For complete instructions on how to submit PA requests to DMAP, see the [Prior Authorization Handbook](#). For OHP coordinated care organization (CCO) or managed care plan members, contact the CCO/plan for PA instructions.

Information needed to request PA

DMAP may automatically deny requests that do not include one or more of the following pieces of information.

- Information in **bold** is required for correct processing.
- If using the [MSC 3971](#) to submit the request, fax the completed form to 503-378-5814 for routine requests or 503-378-3435 for immediate/urgent requests.

Information needed	New PA	Existing PA
Section I - Provider number - Enter the NPI.	X	
Section II - Type of PA request - Mark “Occupational” or “Physical Therapy”	X	

Information needed	New PA	Existing PA
Section III -Client ID -The 8-digit Medicaid ID. and client's name	X	X
Section IV <ul style="list-style-type: none"> ■ Estimated length of treatment ■ Frequency - Frequency of treatment ■ Length of time per session <p>Diagnosis Code – obtained from the prescribing practitioner – The diagnosis code must be the reason chiefly responsible for the service being provided as shown in the medical records</p> <ul style="list-style-type: none"> ■ Use ICD-9 codes for dates of service on or before 9/30/2015. ■ Use ICD-10 codes for dates of service on or after 10/1/2015. 	X	
Section V - Procedure codes and units of service	X	
Section VIII - The therapist's name and NPI.	X	
Section IX - Date of request and expected service begin/ end dates	X	
Notes <ul style="list-style-type: none"> ■ For new PA: Goals and objectives ■ For changes to existing PA: The change and reason for it. 	X	X
Attachments Describe and attach the following: <ul style="list-style-type: none"> ■ A proper written order from the prescribing practitioner that includes the diagnosis code. ■ If there are changes to the original order, describe and attach the new order. ■ Copy of recent evaluation/assessment. 	X	X

Billing for PT/OT services

Use the Provider Web Portal professional claim, 837P or CMS-1500.

- For procedures, enter the most appropriate code as described in [OAR 410-131-0280](#).
- **Billing instructions** are available on the [OHP provider billing tips page](#).
- **For information about electronic billing**, go to the [Electronic Business Practices Web page](#).

Claim status and adjustments

For information about the paper remittance advice and other ways to get claim status information via the Provider Web Portal, AVR or EDI 835 (Electronic Remittance Advice), go to the [OHP remittance advice page](#).

For information about how to adjust a claim, refer to the [Claim Adjustment Handbook](#).