Reimbursement Policy

Outpatient Physical Therapy (PT), Occupational Therapy (OT), Speech Therapy (ST)

Policy Number: SCO 4.609
Version Number: 7
Version Effective Date: 01/01/2022

Product Applicability

☐ **All Plan+ Products**

Well Sense Health Plan
☐ Well Sense Health Plan

Boston Medical Center HealthNet Plan
☐ MassHealth MCO
☐ MassHealth ACO
☐ Qualified Health Plans/ConnectorCare/Employer Choice Direct
☒ Senior Care Options

Note: Disclaimer and audit information is located at the end of this document.

Policy Summary

The Plan reimburses covered services based on the provider's contractual rates with the Plan and the terms of reimbursement identified within this policy.

Prior-Authorization

Please refer to the Plan's Prior Authorization Requirements Matrix at www.bmchp.org.

+ *Plan* refers to Boston Medical Center Health Plan, Inc. and its affiliates and subsidiaries offering health coverage plans to enrolled members. The Plan operates in Massachusetts under the trade name Boston Medical Center HealthNet Plan and in other states under the trade name Well Sense Health Plan.

Provider Reimbursement

Outpatient Rehabilitation Modalities and Therapeutic Procedures

The Plan reimburses outpatient rehabilitation and therapeutic procedures that are designed to improve, develop, correct, rehabilitate, or prevent the worsening of physical functions that have been lost, impaired or reduced as a result of acute or chronic medical conditions, congenital anomalies, or injuries.

Reimbursement for Outpatient PT/OT/ST services is based on the Medicare Physician Fee Schedule and is subject to compliance with the following billing rules as well as other industry standards, such as CMS correct coding guidelines. Please refer to the member's Evidence of Coverage and Schedule of Benefits for maximum limits on services.

Initial Evaluations

Initial evaluations are completed to determine the medical necessity of initiating rehabilitative therapy or skilled instruction in maintenance activities that the patient and/or caregiver can perform at home. The following apply:

- Evaluation codes are untimed, billable as one unit.
- If treatment is given on the same day as the initial evaluation, the treatment is billed using the appropriate CPT codes. The documentation must clearly describe the treatment that was provided in addition to the evaluation.
- Do not bill test and measurement, range of motion (ROM) or manual muscle testing (MMT) codes on the same day as the initial evaluation. The procedures performed are included in the initial evaluation codes and are not allowed by the Correct Coding Initiative (CCI) edits.

Re-evaluations

A reevaluation is focused on evaluating the progress toward current goals and making a professional judgment about continued care, modifying goals and/or treatment, or terminating services. The following apply:

- Re-evaluation codes are untimed, billable as one unit.
- The Plan will not reimburse for a re-evaluation on the same date of service as therapeutic procedures and/or modalities unless supported by documentation.

Group / Individual Therapy

Group therapy consists of therapy treatment provided simultaneously to two or more patients who may or may not be doing the same activities. The following apply:

- If the therapist is dividing attention among the patients, providing only brief, intermittent personal contact, or giving the same instructions to two or more patients at the same time, one unit of CPT code 97150 is billed per patient.

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- The Plan pays a therapist for no more than one individual treatment and one group therapy session per member, per day. However, the group therapy session must be clearly distinct or independent from other services and billed using a -59, or X{EPSU} modifier.

Orthotic and Prosthetic Training

The Plan will reimburse for the orthotic or prosthetic training when it has not yet been performed by any other provider, (e.g., DME supplier).

Multiple Procedure Payment Reduction (MPPR) for Therapy Services

The Plan will apply MPPR to the practice expense (PE) payment of select therapy services in accordance with CMS guidelines. See the Plan's reimbursement policy*, Bilateral and Multiple Procedure Reductions, SCO 4.607*, for more information.

Physical Therapy Assistant (PTA)/Occupational Therapy Assistant (OTA) Services

The Plan follows Medicare rules regarding the required reporting and reimbursement for therapy services provided by a Physical Therapy Assistant (PTA)/Occupational Therapy Assistant (OTA).

Services reported with CQ/CO modifier will be reimbursed at 85% of the Medicare Physician Fee Schedule allowable amount.

Therapies Performed In the Home Setting

The Plan has separate billing rules and criteria for physical and occupational therapies performed in a home setting. Please refer to the Plan's *Medicare Certified Home Health Agency Services, SCO 4.7* and *Non-Medicare Certified Home Health Agency Services, SCO 4.6* reimbursement policies when the services will be performed in the member's home.

Service Limitations

The Plan does not reimburse for the following services:

- Maintenance therapy that does not require the skilled care of a licensed physical, occupational, or speech therapist.
- Speech-Language Pathologist (SLP) services rendered by a SLP assistant or aide.
- Students, aides, athletic trainers, exercise physiologists, massage therapists, recreation therapists, kinesiotherapists, low vision specialists, lymphedema specialists, Pilates instructors, rehabilitation technicians and life skills trainers are not considered qualified therapy professionals and may not bill their services, even if performed under the supervision of a qualified therapist.
- Services related to recreational activities.
- Services related to activities for the general good and welfare of the member, e.g., general exercises to promote overall fitness and flexibility, and activities to provide diversion or general motivation.

Applicable Coding and Billing Guidelines

Applicable coding is listed below, subject to codes being active on the date of service. Because the American Medical Association (AMA), Centers for Medicare & Medicaid Services (CMS), and the U.S. Department of Health and Human Services may update codes more frequently or at different intervals than Plan policy updates, the list of applicable codes may not be all inclusive. These codes are not intended to be used for coverage determinations.

Split Claim Billing

All related services must be reported on one claim. Subsequent related claims received after the initial claim will be denied. The initial claim must be resubmitted as a replacement claim.

Revenue Codes

Code	Description
0420	Physical Therapy - General Classification
0421	Physical Therapy - Visit
0424	Physical Therapy - Evaluation or Re-evaluation
0429	Physical Therapy - Other Physical Therapy
0430	Occupational Therapy - General Classification
0431	Occupational Therapy - Visit
0434	Occupational Therapy - Evaluation or Reevaluation
0439	Occupational Therapy - Other Occupational Therapy
0440	Speech-Language Pathology - General Classification
0444	Speech-Language Pathology - Evaluation or Reevaluation
0449	Speech-Language Pathology - Other Speech Therapy

Therapy Modifiers

Therapy modifiers must be used as instructed by CMS.

Modifier	Description
GN	Services delivered under an outpatient Speech Language Pathology plan of care
GO	Services delivered under an outpatient Occupational Therapy plan of care
GP	Services delivered under an outpatient Physical Therapy plan of care

Other Therapy Modifiers

Modifier	Description
CO	Outpatient occupational therapy services furnished in whole or in part by an occupational therapy assistant
CQ	Outpatient physical therapy services furnished in whole or in part by a physical therapist assistant

CPT/HCPCS Coding
CMS identifies HCPCS codes that are required for reporting OP therapy services. For a complete list of codes providers should reference the Medicare Therapy Services webpage.

Policy History

Original Approval Date	Original Effective Date	Policy Owner	Approved by
10/7/2015	01/01/2016	Payment Policy	SCO Product Subgroup

Policy Revisions History			
Review Date	**Summary of Revisions**	**Revision Effective Date**	**Approved by**
12/12/2016	Updated coding, added applicable medical policies	01/01/2017	Payment Policy Committee
12/08/2017	Updated codes with revised descriptions and new/deleted codes	01/01/2018	Payment Policy Committee
12/6/2018	Added other therapy modifier table	01/01/2019	Payment Policy Committee
06/18/2019	Termed functional reporting requirements effective dates of Service on or after 1/1/2019	07/01/2019	Payment Policy Committee
12/09/2019	Updated coding table	01/01/2020	Payment policy Committee
12/14/2021	Annual Review, updates to Modifier CQ/CO per CY 2022 Physician Final Rule, removed coding table and referenced Medicare Therapy list webpage	01/01/2022	Payment Policy Committee

Other Applicable Policies

Reimbursement Policies
- General Billing and Coding Guidelines, SCO 4.31
- General Clinical Editing and Payment Accuracy Review Guidelines, SCO 4.108
- Bilateral and Multiple Procedure Reductions, SCO 4.607
- Non-Medicare Certified Home Health Agency Services, SCO 4.6

- Medicare Certified Home Health Agency Services, SCO 4.7
- Modifiers, SCO 4.23

Medical Policies

- Occupational Therapy in the Outpatient Setting, OCA 3.53
- Physical Therapy in the Outpatient Setting, OCA 3.54
- Speech Therapy, Language Therapy, Voice Therapy, or Auditory Rehabilitation for a Member 21 Years of Age or Older in the Outpatient Setting, OCA 3.551
- Speech Therapy, Language Therapy, Voice Therapy, or Auditory Rehabilitation for a Member Age 20 or Younger in the Outpatient Setting, OCA 3.55

References

- Medicare Benefit Policy Manual, Chapter 12
- Medicare Claims Processing Manual , Chapter 5
- CMS Therapy Services webpage
- CMS Local Coverage Determination (LCD): Outpatient Physical and Occupational Therapy Services (L26884)
- CMS Local Coverage Determination (LCD): Speech-Language Pathology (L27404)

Disclaimer Information

This Policy provides information about the Plan's reimbursement/claims adjudication processing guidelines. The use of this Policy is neither a guarantee of payment nor a final prediction of how specific claim(s) will be adjudicated. Reimbursement is based on many factors, including member eligibility and benefits on the date of service; medical necessity; utilization management guidelines (when applicable); coordination of benefits; adherence with applicable Plan policies and procedures; clinical coding criteria; claim editing logic; and the applicable Plan – Provider agreement. Member cost-sharing (deductibles, coinsurance and copayments) may apply – depending on the member's benefit plan. Unless otherwise specified in writing, reimbursement will be made at the lesser of billed charges or the contractual rate of payment. Plan policies may be amended from time to time, at Plan's discretion. Plan policies are developed in accordance with applicable state and federal laws and regulations, and accrediting organization guidelines (including NCQA). The Plan reserves the right to conduct Provider audits to ensure compliance with this Policy. If an audit determines that the Provider did not comply with this Policy, the Plan will expect the Provider to refund all payments related to non-compliance. For more information about the Plan's audit policies, refer to the Provider Manual.