# Physical and Occupational Rehabilitation Services Payment Policy

## Policy Statement

Physical therapy (PT) is the treatment of disease or injury by the use of therapeutic exercise and other interventions that focus on improving posture, locomotion, strength, endurance, balance, coordination, joint mobility, flexibility, a person's ability to go through the functional activities of daily living, and on alleviating pain.
Occupational therapy (OT) is a form of rehabilitation therapy involving the treatment of neuro-musculoskeletal and psychological dysfunction through the use of specific tasks or goal directed activities designed to improve the functional performance of an individual.

## Scope

This policy applies to:

☒**Medicaid** *excluding Extended Family Planning (EFP)*
☒**INTEGRITY**
☒**Commercial**

## Prerequisites

Members must receive an order for outpatient therapy services from their primary care provider (PCP) or treating qualified provider that is separate from the provider rendering therapy services. The ordering/referring provider must be documented in the member's medical record, as well as, noted in Box 17 (referring provider) on the claim.

Outpatient rehabilitation therapy services must relate directly and specifically to a written treatment plan (also known as the plan of care or plan of treatment). The treatment plan must be established prior to treatment and established by a physician, an NPP, a physical therapist, or an occupational therapist. The services provided must be:

- consistent with the nature and severity of illness,
- considered safe and effective for the patient's condition,
- used to restore function, or provided as part of a defined treatment plan for an acute illness, injury, or an acute exacerbation of a chronic illness with significant potential for functional recovery.

The services must be performed by a contracted Physical or Occupational Therapist or a contracted Therapy group in order to be reimbursed.

**Physical Therapy Assistant (PTA) or Occupational Therapy Assistant (OTA)**

In general supervision, the physical therapist is not required to be on-site for direction and supervision, but must be available at least by telecommunications. (i.e., PTA providing services in a home care setting.) When supervising the physical therapist assistant in any off-site setting, the following requirements must be observed:

- A physical therapist must be accessible by telecommunications to the physical therapist assistant at all times while the physical therapist assistant is treating patients/clients.
- There must be regularly scheduled and documented conferences with the physical therapist assistant regarding patients/clients, the frequency of which is determined by the needs of the patient/client and the needs of the physical therapist assistant.
- In those situations in which a physical therapist assistant is involved in the care of a patient/client, a supervisory visit by the physical therapist will be made:
    - Upon the physical therapist assistant's request for a reexamination, when a change in the plan of care is needed, prior to any planned discharge, and in response to a change in the patient's/client's medical status.
    - At least once a month, or at a higher frequency when established by the physical therapist, in accordance with the needs of the patient/client. A supervisory visit should include:
        - An on-site reexamination of the patient/client.
        - On-site review of the plan of care with appropriate revision or termination.
        - Evaluation of need and recommendation for utilization of outside resources.

All services must be medically necessary to qualify for reimbursement. Neighborhood may use the following criteria to determine medical necessity:

- National Coverage Determination (NCD)
- Local Coverage Determination (LCD)
- Industry accepted criteria such as Interqual
- EOHHS recommendations
- Clinical Medical Policies (CMP)

It is the provider's responsibility to verify eligibility, coverage, and authorization criteria prior to rendering services.

For more information please refer to:

- Neighborhood's plan specific Prior Authorization Reference page.
- Neighborhood's Clinical Medical Policies.

Please contact Provider Services at 1-800-963-1001for any questions regarding this policy.

## Coverage

A physical therapy session is typically defined as up to 1 hour of PT (treatment and/or evaluation) or up to 3 PT modalities provided on any given day.

An occupational therapy session is typically defined as up to 1 hour of occupational therapy (treatment and/or evaluation) on any given day.

## Coverage Limitations/Prior Authorization Requirements

**INTEGRITY**

- **Outpatient Physical Therapy** – No authorization needed for the first 24 visits per calendar year.* Prior authorization is required for anything over 24 visits.
- **Outpatient Occupational Therapy** – No authorization needed for the first 24 visits per calendar year.* Prior authorization is required for anything over 24 visits.

* 24 visits per discipline

## Coverage Exclusions

- General Conditioning Programs
- Vocational rehabilitation, testing and screening focusing on job adaptability, job placement
- Rehabilitative services to restore function for a member's specific occupation
- Services provided solely for the convenience of the member or service provider

## Claims Submission

The codes in *Table 2* below are required to be billed with one of the following modifiers to distinguish the discipline under which the service was delivered. If one of the required modifiers is not appended these codes will deny.

- **GO**- Services delivered under an outpatient OT plan of care
- **GP**- Services delivered under an outpatient PT plan of care

The below modifiers are required when a service is provided by an occupational therapy assistant or a physical therapy assistant:

- **CO**- Occupational therapy services furnished in whole or in part by an occupational therapy assistant (OTA)
- **CQ**- Outpatient physical therapy services furnished in whole or in part by a physical therapy assistant (PTA)

Billable services are subject to contractual agreements, when applicable. Providers are required to submit complete claims for payment within contractually determined timely filing guidelines.

Coding must meet standards defined by the American Medical Association's Current Procedural Terminology Editorial Panel's (CPT®) codebook, the International Statistical Classification of Diseases and Related Health Problems, 10th revision, Clinical Modification (ICD-10-CM), and the Healthcare Common Procedure Coding System (HCPCS) Level II.

## Member Responsibility

**Commercial** plans include cost-sharing provisions for coinsurance, copays, and deductibles. Members may have out of pocket expenses based on individual plan selection and utilization. Please review cost-sharing obligations or contact Member Services prior to finalizing member charges.

## Coding

This policy may apply to the follow codes. Inclusion of a code in this policy does not guarantee coverage or that it will be reimbursed.

**Table 1: PT & OT Evaluation and Re-Evaluation Codes**

| CPT Code | Description |
|---|---|
| **97161** | Physical therapy evaluation: low complexity, requiring these components: A history with no personal factors and/or comorbidities that impact the plan of care; An examination of body system(s) using standardized tests and measures addressing 1-2 elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions; A clinical presentation with stable and/or uncomplicated characteristics; and Clinical decision making of low complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 20 minutes are spent face-to-face with the patient and/or family. |
| **97162** | Physical therapy evaluation: moderate complexity, requiring these components: A history of present problem with 1-2 personal factors and/or comorbidities that impact the plan of care; An examination of body systems using standardized tests and measures in addressing a total of 3 or more elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions; An evolving clinical presentation with changing characteristics; and Clinical decision making of moderate complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 30 minutes are spent face-to-face with the patient and/or family. |
| **97163** | Physical therapy evaluation: high complexity, requiring these components: A history of present problem with 3 or more personal factors and/or comorbidities that impact the plan of care; An examination of body systems using standardized tests and measures addressing a total of 4 or more elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions; A clinical presentation with unstable and unpredictable characteristics; and Clinical decision making of high complexity using standardized patient assessment instrument and/or measurable assessment of |

| CPT Code | Description |
|---|---|
| | functional outcome. Typically, 45 minutes are spent face-to-face with the patient and/or family. |
| **97164** | Re-evaluation of physical therapy established plan of care, requiring these components: An examination including a review of history and use of standardized tests and measures is required; and Revised plan of care using a standardized patient assessment instrument and/or measurable assessment of functional outcome Typically, 20 minutes are spent face-to-face with the patient and/or family. |
| **97165** | Occupational therapy evaluation, low complexity, requiring these components: An occupational profile and medical and therapy history, which includes a brief history including review of medical and/or therapy records relating to the presenting problem; An assessment(s) that identifies 1-3 performance deficits (ie, relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and Clinical decision making of low complexity, which includes an analysis of the occupational profile, analysis of data from problem-focused assessment(s), and consideration of a limited number of treatment options. Patient presents with no comorbidities that affect occupational performance.<br>Modification of tasks or assistance (eg, physical or verbal) with assessment(s) is not necessary to enable completion of evaluation component. Typically, 30 minutes are spent face-to-face with the patient and/or family. |
| **97166** | Occupational therapy evaluation, moderate complexity, requiring these components: An occupational profile and medical and therapy history, which includes an expanded review of medical and/or therapy records and additional review of physical, cognitive, or psychosocial history related to current functional performance; An assessment(s) that identifies 3-5 performance deficits (ie, relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and Clinical decision making of moderate analytic complexity, which includes an analysis of the occupational profile, analysis of data from detailed assessment(s), and consideration of several treatment options. Patient may present with comorbidities that affect occupational performance. Minimal to moderate modification of tasks or assistance (eg, physical or verbal) with assessment(s) is necessary to enable patient to complete evaluation component. Typically, 45 minutes are spent face-to-face with the patient and/or family. |
| **97167** | Occupational therapy evaluation, high complexity, requiring these components: An occupational profile and medical and therapy history, which includes review of medical and/or therapy records and extensive additional review of physical, cognitive, or psychosocial history related to current functional performance; An assessment(s) that identifies 5 or more performance deficits (ie, relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and Clinical decision making of high analytic complexity, which includes an analysis of the patient profile, analysis of data from |

| CPT Code | Description |
|---|---|
| | comprehensive assessment(s), and consideration of multiple treatment options. Patient presents with comorbidities that affect occupational performance. Significant modification of tasks or assistance (eg, physical or verbal) with assessment(s) is necessary to enable patient to complete evaluation component. Typically, 60 minutes are spent face-to-face with the patient and/or family. |
| **97168** | Re-evaluation of occupational therapy established plan of care, requiring these components: An assessment of changes in patient functional or medical status with revised plan of care; An update to the initial occupational profile to reflect changes in condition or environment that affect future interventions and/or goals; and A revised plan of care. A formal reevaluation is performed when there is a documented change in functional status or a significant change to the plan of care is required. Typically, 30 minutes are spent facetoface with the patient and/or family. |

**Table 2: PT & OT Modalities**

| CPT Code | Description |
|---|---|
| **97010** | Application of a modality to 1 or more areas; hot or cold packs |
| **97012** | Application of a modality to 1 or more areas; traction, mechanical |
| **97014** | Application of a modality to 1 or more areas; electrical stimulation (unattended) |
| **97016** | Application of a modality to 1 or more areas; vasopneumatic devices |
| **97018** | Application of a modality to 1 or more areas; paraffin bath |
| **97022** | Application of a modality to 1 or more areas; whirlpool |
| **97024** | Application of a modality to 1 or more areas; diathermy (eg, microwave) |
| **97026** | Application of a modality to 1 or more areas; infrared |
| **97028** | Application of a modality to 1 or more areas; ultraviolet |
| **97032** | Application of a modality to 1 or more areas; electrical stimulation (manual), each 15 minutes |
| **97033** | Application of a modality to 1 or more areas; iontophoresis, each 15 minutes |
| **97034** | Application of a modality to 1 or more areas; contrast baths, each 15 minutes |
| **97035** | Application of a modality to 1 or more areas; ultrasound, each 15 minutes |
| **97036** | Application of a modality to 1 or more areas; Hubbard tank, each 15 minutes |
| **97039** | Unlisted modality (specify type and time if constant attendance) |

| CPT Code | Description |
|---|---|
| **97110** | Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility |
| **97112** | Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities |
| **97113** | Therapeutic procedure, 1 or more areas, each 15 minutes; aquatic therapy with therapeutic exercises |
| **97116** | Therapeutic procedure, 1 or more areas, each 15 minutes; gait training (includes stair climbing) |
| **97124** | Therapeutic procedure, 1 or more areas, each 15 minutes; massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion) |
| **97129** | Therapeutic interventions that focus on cognitive function (eg, attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (eg, managing time or schedules, initiating, organizing, and sequencing tasks), direct (one-on-one) patient contact; initial 15 minutes |
| **97130** | Therapeutic interventions that focus on cognitive function (eg, attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (eg, managing time or schedules, initiating, organizing, and sequencing tasks), direct (one-on-one) patient contact; each additional 15 minutes (List separately in addition to code for primary procedure) |
| **97139** | Unlisted therapeutic procedure (specify) |
| **97140** | Manual therapy techniques (eg, mobilization/ manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes |
| **97150** | Therapeutic procedure(s), group (2 or more individuals) |
| **97530** | Therapeutic activities, direct (one-on-one) patient contact (use of dynamic activities to improve functional performance), each 15 minutes |
| **97535** | Self-care/home management training (eg, activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact, each 15 minutes |
| **97542** | Wheelchair management (eg, assessment, fitting, training), each 15 minutes |
| **97750** | Physical performance test or measurement (eg, musculoskeletal, functional capacity), with written report, each 15 minutes |

| CPT Code | Description |
|---|---|
| **97755** | Assistive technology assessment (eg, to restore, augment or compensate for existing function, optimize functional tasks and/or maximize environmental accessibility), direct one-on-one contact, with written report, each 15 minutes |
| **G0283** | Electrical stimulation (unattended), to one or more areas for indication(s) other than wound care, as part of a therapy plan of care |
| **S8948** | Application of a modality (requiring constant provider attendance) to one or more areas; low-level laser; each 15 minutes |
| **S9117** | Back school, per visit |

## Disclaimer

This payment policy is informational only and is not intended to address every situation related to reimbursement for healthcare services; therefore, it is not a guarantee of reimbursement.

Claim payments are subject to Neighborhood Health Plan of Rhode Island benefit coverage, member eligibility, claims payment edit rules, coding and documentation guidelines, authorization policies, provider contract agreements, and state and federal regulations. References to CPT or other sources are for definitional purposes only.

This policy may not be implemented exactly the same way on the different electronic claims processing systems used by Neighborhood due to programming or other constraints; however, Neighborhood strives to minimize these variations.

The information in this policy is accurate and current as of the date of publication; however, medical practices, technology, and knowledge are constantly changing. Neighborhood reserves the right to update this payment policy at any time. All services billed to Neighborhood for reimbursement are subject to audit.

## Document History

| Date | Action |
|---|---|
| **10/01/2023** | Updated visit limits and authorization requirement language for Integrity |
| **03/29/2023** | Annual Review Date. No content changes. |
| **01/01/2023** | Effective date for update to INTEGRITY to remove language around auth requirement after 24 visits |
| **02/01/2022** | Update to include requirement for referring provider |
| **04/01/2021** | Policy Update: Remove limit of 24 visits for Medicaid and Commercial LOB's effective 4/1/21. |
| **01/01/2021** | Policy Updates: Commercial and INTEGRITY benefit limits/auth requirements. Medicaid limit changed from rolling year to calendar year. |
| **11/05/2020** | Policy Review/Approval Date for 1/1/21 changes |

| Date | Action |
|---|---|
| **10/01/2020** | Policy effective. |
| **07/16/2020** | Policy Review/Approval Date |