Physical, Occupational, and Speech Therapy Professional Payment Policy

Applies to the following Tufts Health Plan products:

- ☒ Tufts Health Plan Commercial[1]
- ☐ Tufts Medicare Preferred HMO (a Medicare Advantage product)[2]
- ☐ Tufts Medicare Preferred PPO (a Medicare Advantage product)[2]
- ☐ Tufts Health Plan Senior Care Options (SCO) (a dual-eligible product)[2]

This payment policy applies to Tufts Health Plan contracting:

- Ancillary independent physical therapy practices or groups
- Independent occupational therapy practices or groups rendering services in an outpatient or office setting
- Speech therapists in an independent practice or groups rendering services in an outpatient or office setting

Refer to the applicable policies for information on Senior Products and Tufts Health Public Plans products.

In addition to the specific information contained in this policy, providers must adhere to the information outlined in the Professional Services and Facilities Payment Policy.

Note: Audit and disclaimer information is located at the end of this document.

POLICY

Tufts Health Plan covers medically necessary habilitative and rehabilitative physical therapy (PT), occupational therapy (OT), and speech therapy (ST) services, in accordance with the member's benefits.

Note: Members are covered for up to two evaluations per calendar or plan year.

Refer to the Autism Services: Physical, Occupational and Speech Therapy for Members with Autism Spectrum Disorders medical necessity guidelines for specific information regarding habilitative PT, OT and ST services for members with autism spectrum disorders.

GENERAL BENEFIT INFORMATION

Services and subsequent payment are pursuant to the member's benefit plan document. Member eligibility and benefit specifics should be verified prior to initiating services by logging on to the secure Provider portal or by contacting Provider Services.

REFERRAL/PRIOR AUTHORIZATION/NOTIFICATION REQUIREMENTS

Certain procedures, items and/or services may require referral and/or prior authorization. While you may not be the provider responsible for obtaining prior authorization, as a condition of payment you must confirm that prior authorization has been obtained. For more information, refer to the Referral, Prior Authorization, and Notification Policy.

A referral is required for initial therapy evaluations and the number of visits specified in the medical necessity guidelines for habilitative and rehabilitative physical, occupational, and speech therapy.

Prior authorization is required if continuation of services beyond the limits specified in the medical necessity guidelines is needed. To request continuation of services[3], providers should fax the appropriate authorization form for physical, occupational, or speech therapy to the Precertification Operations Department at 617-972-9409.

All referrals and/or prior authorizations are valid for visits that occur in the calendar or plan year in which they were issued. The member's PCP, if applicable, must issue a new referral for habilitative or

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[1] Commercial products include HMO, POS, PPO, and CareLink℠ when Tufts Health Plan is the primary administrator.
[2] Tufts Medicare Preferred and Tufts Health Plan SCO are collectively referred to in this payment policy as Senior Products.
[3] Requests for continuation of treatment may be backdated up to seven days.

rehabilitative PT and/or OT services for the following calendar or plan benefit year. ST referrals do not expire at the end of the benefit year.

Providers are reminded to ask members if they have received habilitative or rehabilitative services from any other provider. Any visits that a member has previously received from another provider are applied to the treating visit maximum per calendar or plan year.

Note: If a member chooses to see a new provider after already receiving the allowed number of treating visits from another provider, the new provider must obtain a separate prior authorization, as the initial visits have been exhausted.

BILLING INSTRUCTIONS

Unless otherwise stated, Tufts Health Plan follows industry standard coding guidelines. Refer to current industry standard coding guidelines for a complete list of ICD, CPT/HCPCS, revenue codes, modifiers, and their usage. Providers may only bill the procedure code(s) in accordance with the applicable financial exhibits of their provider agreements and applicable fee schedules. For more information, refer to the Professional Services and Facilities Payment Policy.

The absence or presence of a procedure code and/or modifier does not imply or guarantee coverage or compensation.

- Procedure codes eligible for compensation are outlined in the medical necessity guidelines for habilitative and rehabilitative physical, occupational, and speech therapy
- Submit only one initial evaluation per diagnosis/condition
- Submit the appropriate therapy modifier(s) for PT, OT, and ST services: GP (PT services), GO (OT services) and GN (ST services). Claims submitted without the corresponding therapy modifier(s) will be denied.

Treatment and modality procedure codes include, but are not limited to, the codes contained in the provider's health service agreements and the applicable medical necessity guidelines stated above. Providers may bill 97799 to indicate an unlisted physical medicine/rehabilitation service or procedure with supporting clinical documentation. Refer to the Unlisted/Not Otherwise Classified Codes Payment Policy for additional information on how to submit supporting documentation.

COMPENSATION/REIMBURSEMENT INFORMATION

Providers are compensated according to the applicable contracted rates and applicable fee schedules, regardless of the address where the service is rendered. For more information, refer to the Professional Services and Facilities Payment Policy.

Tufts Health Plan only compensates physical therapists, occupational therapists, and speech-language pathologists who are practicing in contracting sites that are contracted with Tufts Health Plan's Allied Health Department and have notified Tufts Health Plan using the ancillary practitioner data form prior to providing services. Tufts Health Plan does not compensate medical doctors for physical therapy services.

Daily Payment Maximum

PT and OT treatments and modalities are priced according to fee schedule arrangements and are subject to a daily payment maximum. Contracted procedure codes for PT and OT therapy services will be applied to the daily payment maximum. Refer to the current provider agreement for information regarding the daily maximum rate.

Note: Compensation for initial evaluation codes is not subject to the daily payment maximum.

Modalities

Compensation for PT and OT treatment and applicable modalities is included in the compensation rate for re-evaluation procedure codes.

ST Services

Compensation for ST services is included in the compensation rate for ST treatment (92507). Other services (e.g., length of time and modalities of treatment billed for ST services) will not be compensated separately, as they are included in the compensation rate for 92507.

Note: Tufts Health Plan does not routinely compensate 97033 (iontophoresis) if billed without a diagnosis of primary focal hyperhidrosis.

Services Provided in an Inpatient or Outpatient Hospital

Tufts Health Plan does not routinely compensate for services provided by a physical therapist, occupational therapist, or a speech-language pathologist if billed in place of service 19 (outpatient hospital – off campus), 21 (inpatient hospital) or 22 (outpatient hospital – on campus).

Therapeutic Services

Tufts Health Plan does not routinely compensate 95992 (canalith repositioning procedure) if billed without a diagnosis of benign paroxysmal vertigo.

ADDITIONAL RESOURCES

- Durable Medical Equipment and Medical Supplies Payment Policy
- Home Health Care Payment Policy
- Inpatient Rehabilitation and Long-Term Acute Care Payment Policy
- Orthotic and Prosthetic Payment Policy
- Outpatient Rehabilitation and Acute Care Facility Payment Policy
- Outpatient Cardiac and Pulmonary Rehabilitation Facility Payment policy

DOCUMENT HISTORY

- January 2022: Annual policy review; administrative updates
- March 2022: Clarified referral renewal requirements for PT and OT services
- February 2021: Policy reviewed by committee; clarified prior authorization requirements
- November 2018: Policy reviewed by committee; clarified authorization specifics for services and added links to medical necessity guidelines; added existing contracting requirements for compensation
- June 2018: Template updates
- February 2018: Added claim edits for therapeutic services and physical medicine modalities, effective for dates of service on or after April 1, 2018
- July 2017: Added edits for PT services provided in an inpatient or outpatient hospital, effective for dates of service on or after October 1, 2017
- January 2017: Policy reviewed; template updates; combined separate PT, OT, and ST policies into single policy; removed CPT codes 97001-97004, added 97161-97168.

AUDIT AND DISCLAIMER INFORMATION

Tufts Health Plan reserves the right to conduct audits on any provider and/or facility to ensure compliance with the guidelines stated in this payment policy. If such an audit determines that a provider/facility did not comply with this payment policy, Tufts Health Plan will expect the provider/facility to refund all payments related to noncompliance. For more information about Tufts Health Plan's audit policies, refer to the Provider website.

This policy provides information on Tufts Health Plan claims adjudication processes. As every claim is unique, this policy is neither a guarantee of payment, nor a final indication of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management requirements (when applicable), adherence to plan policies and procedures, and claims editing logic. An authorization is not a guarantee of payment. Claims for services subject to authorization may be reviewed for accuracy and compliance with payment policies.

This policy applies to the Tufts Health Plan products, as identified in the checkboxes on the first page, and to CareLink℠ for providers in Massachusetts and Rhode Island service areas. Providers in the New Hampshire service area are subject to Cigna's provider agreements with respect to CareLink members. Tufts Health Plan reserves the right to amend a payment policy at its discretion.