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]

The following payment policy applies to Tufts Health Plan contracting providers listed below rendering services in an office or outpatient setting:

- Ancillary independent physical therapy practices or groups
- Independent occupational therapy practices or groups
- Speech therapists in an independent practice or groups

For information on Commercial products, click here. For information on Tufts Health Public Plans, click here.

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 physical therapy (PT), occupational therapy (OT) and speech therapy (ST) services, in accordance with the member's benefits.

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.

Note: There is no member responsibility for covered services for Tufts Health Plan SCO members.

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.

PCP referral is required for initial evaluations and all PT, OT, and/or ST visits. Prior authorization is not required for PT, OT, or ST services.

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.

- 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.

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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.

- Submit only one initial evaluation per diagnosis/condition
- Submit CPT code 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.

Physical Therapy Evaluations

Procedure Code	Description
97161	Physical therapy evaluation, low complexity
97162	Physical therapy evaluation, moderate complexity
97163	Physical therapy evaluation, high complexity
97164	Re-evaluation of physical therapy established plan of care

Occupational Therapy Evaluations

Procedure Code	Description
97165	Occupational therapy evaluation, low complexity
97166	Occupational therapy evaluation, moderate complexity
97167	Occupational therapy evaluation, high complexity
97168	Re-evaluation of occupational therapy established plan of care

Speech Therapy Evaluations

Procedure Code	Description
92521	Evaluation of speech fluency (e.g., stuttering, cluttering)
92522	Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria)
92523	Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria); with evaluation of language comprehension and expression (e.g., receptive and expressive language)
92524	Behavioral and qualitative analysis of voice and resonance
92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual
92508	Treatment of speech, language, voice, communication and/or auditory processing disorder; group, two or more individuals
92610	Evaluation of oral pharyngeal swallowing function
92526	Treatment of swallowing dysfunction and/or oral function for feeding

Modalities

Supervised

Procedure Code	Description
97012	Traction, mechanical
97016	Vasopneumatic devices
97018	Paraffin bath
97022	Whirlpool
97024	Diathermy (e.g., microwave)
97026	Infrared
97028	Ultraviolet

Constant Attendance

(Application of a modality that requires direct one-on-one patient contact by the provider)

Procedure Code	Description
97032	Electrical stimulation, each 15 minutes
97033	Iontophoresis, each 15 minutes
97034	Contrast baths, each 15 minutes
97035	Ultrasound, each 15 minutes
97036	Hubbard tank, each 15 minutes
97039	Unlisted modality (specify type and time if constant attendance)

Therapeutic Procedures

Procedure Code	Description
97110	Therapeutic procedure, one or more areas, each 15 minutes to develop strength and endurance, range of motion and flexibility
97112	Neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities
97113	Aquatic therapy with therapeutic exercises
97116	Gait training (includes stair climbing)
97124	Massage, including effleurage, pertissage and/or tapotement
97139	Unlisted therapeutic procedure
97140	Manual therapy techniques, one or more regions, each 15 minutes
97150	Therapeutic procedure(s), group (two or more individuals)
97530	Therapeutic activities, direct (one-on-one) patient contact by the provider, each 15 minutes
97532	Development of cognitive skills to improve attention, memory, problem solving, direct (one-on-one) patient contact by the provider, each 15 minutes
97533	Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one-on-one) patient contact by the provider, each 15 minutes
97535	Self-care/ home management training, direct one on one contact by provider, each 15 minutes
97537	Community/ work integration training, one-on-one contact by the provider, each 15 minutes
97542	Wheelchair management/ propulsion training, each 15 minutes
97760	Orthotic(s) fitting & training, upper extremity (ties), lower extremity (ties), and/or trunk, each 15 minutes
97761	Prosthetic training, upper and/or lower extremities, each 15 minutes
G0281	Electrical stimulation (unattended), to one or more areas, for chronic Stage III and Stage IV pressure ulcers, arterial ulcers, diabetic ulcers, and venous stasis ulcers not demonstrating measurable signs of healing after 30 days of conventional care, as part of a therapy plan
G0283	Electrical stimulation (unattended) to one or more areas for indication(s) other than wound care, as part of a therapy plan

Test and Measurements

Procedure Code	Description
97750	Physical performance test of measurement, with written report, each 15 minutes
97755	Assistive technology assessment, direct one-on-one contact by provider, with written report, each 15 minutes
97762	Checkout for orthotic/prosthetic use, established patient, each 15 minutes

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.

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 2023: Annual policy review; administrative updates
- February 2021: Policy reviewed by committee; template updates
- November 2018: Policy reviewed by committee; added existing PCP referral requirement; clarified billing instructions and linked to Unlisted/NOC payment policy for more information on submitting claims with unlisted procedure codes
- August 2018: Added claim edit for physical therapy services provided in an inpatient or outpatient hospital, effective for dates of service on or after October 1, 2018
- 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
- January 2017: Policy reviewed; template updates; combined separate PT, OT and ST policies into single policy; removed CPT codes 97001-97004, added 97161-97168.
- September 2015: Template conversion, template updates

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. This policy does not apply to the Private Health Care Systems (PHCS) network (also known as Multiplan). Tufts Health Plan reserves the right to amend a payment policy at its discretion.