

PHYSICAL THERAPY

Policy

NHP reimburses participating providers for the provision of medically necessary outpatient physical therapy when ALL of the following criteria are met: the program is designed to improve lost or impaired physical function or reduce pain resulting from illness, injury, congenital defect or surgery; the program is expected to result in significant therapeutic improvement over a clearly defined period of time; the program is individualized, and there is documentation outlining quantifiable, attainable treatment goals.

Prerequisites

Authorization, Notification and Referral

Service	Requirement
Initial outpatient physical therapy evaluation	No referral, notification or prior authorization
Physical therapy outpatient treatment	Prior authorization required for physical therapy treatment
For HVMA Members	A referral number for most specialists is required for NHP members with a Harvard Vanguard Medical Associates PCP seeking non-emergency care outside of the Harvard Vanguard Medical Associates Network. Please verify that the member has the appropriate referral number prior to rendering care.

Limitations

Where benefits coverage exists, treatment is limited to a maximum benefit as covered by the member's benefit plan. When the maximum benefit is exhausted, coverage is no longer provided even if medical necessity criteria are met.

Members are authorized for up to a maximum number of medically necessary physical therapy visits, per benefit plan. If a member has received any number of physical therapy visits from another physical therapy provider, the treatment visits that have already occurred will be applied to the annual visit maximum, per benefit plan.

The maximum allowable number of units of physical therapy treatment is four per day. A visit can include a combination of therapeutic procedures and modalities, not to exceed one hour per day. The initial physical therapy evaluation (CPT 97001) is not subject to the daily maximum count.

Member Cost-Sharing

The provider is responsible for verifying at each encounter, coverage, available benefits, and member out-of-pocket costs; copayments, coinsurance, and deductible required, if any.

Definitions

Acute or short-term back pain: Generally lasts from a few days to a few weeks. Most acute back pain is mechanical in nature - the result of trauma to the lower back or a disorder such as arthritis. Pain from trauma may be caused by sports injury, work around the house or in the garden, or a sudden jolt such as car accident or other stress on the spinal bones and tissues. Symptoms may range from muscle ache to shooting or stabbing pain, limited flexibility and/or range of motion, or an inability to stand straight. Occasionally, pain felt in one part of the body may “radiate” from a disorder or injury elsewhere in the body. Acute pain syndromes can become more serious if left untreated.

Avocation: Any activity taken up in addition to one's regular work or profession, usually for enjoyment; a hobby.

Chronic back pain: Measured by duration- pain that persists for more than 3 months. It is often progressive and the cause can be difficult to determine.

Duplicate therapy: If a patient receives both physical therapy and another treatment such as chiropractic manipulative treatments or occupational therapy, they should provide different treatments and not duplicate the same treatment. They must have separate treatment plans and goals.

Functional Capacity Evaluation (FCE): A systematic method of measuring an individual's ability to perform meaningful tasks on a safe and dependable basis, including work readiness; for all impairments, not just those that result in physical functional limitations.

Group physical therapy: Therapy provided to at least one member in a group of not more than six persons.

Hubbard tank: A tank designed for full immersion of the body, used for hydrotherapy. A narrow section at the middle of the tank allows the therapist to reach the patient, and wider sections at each end permit full abduction of the patient's legs and arms. The tank is fitted with an aerator that agitates the water and provides gentle massage and debridement of wounds. An overhead crane facilitates transfer of the patient to and from the tank. The Hubbard tank is especially useful in the treatment of patients with extensive burns and those with chronic multiple joint disorders.

Maintenance program: Repetitive services, required to maintain or prevent the worsening of function that do not require the judgment of a licensed therapist for safety and effectiveness. Maintenance begins when the therapeutic goals of a treatment plan have been achieved, or when no additional functional progress is apparent or expected to occur. Establishment of a maintenance program and the training of the member, member's family, or other persons to carry out the maintenance program is part of a regular treatment visit and not a separate service.

Manual therapy techniques: Skilled hand movements intended to improve tissue extensibility; increase range of motion; induce relaxation; mobilize or manipulate soft tissue and joints; modulate pain; reduce soft tissue swelling, inflammation, swelling or restriction. Procedures

and modalities may include manual lymphatic drainage, manual attraction, massage, mobilization/manipulation and passive function.

Out-of-office-visit: A therapy visit provided in a nursing facility, the member's home, or other out-of-office setting to which the therapist travels from his or her usual place of business. A visit can include a combination of therapeutic procedures and modalities, not to exceed four per therapy visit, (one hour per member, per visit, per day). The initial physical therapy evaluation (CPT 97001) is not subject to the daily maximum count.

Physical therapist: Health care professionals, licensed by the Massachusetts Division of Registration in Allied Health Professions, with extensive clinical experience who examine, diagnose, and then prevent or treat conditions that limit the body's ability to move and function in daily life.

Physical therapy: Services, including diagnostic evaluation and therapeutic intervention 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. Physical therapy emphasizes a form of rehabilitation focused on treatment of dysfunctions involving neuromuscular, musculoskeletal, cardiovascular/pulmonary, or integumentary systems through use of therapeutic interventions to optimize functioning levels.

Physical therapy office visit: A therapy visit provided in the therapist's office, group practice, or association of practitioners. A visit can include a combination of therapeutic procedures and modalities, not to exceed four per therapy visit, (one hour per member, per visit, per day). The initial physical therapy evaluation (CPT 97001) is not subject to the daily maximum count.

Re-evaluation: Additional objective information not included in other documentation. Re-evaluation is separately payable and is periodically indicated during an episode of care when the professional assessment of a clinician indicates a significant improvement, or decline, or change in the patient's condition or functional status that was not anticipated in the plan of care. Re-evaluations are not routinely covered for updating the plan of care. The decision to provide a re-evaluation shall be made by the clinician.

Therapeutic exercise: The systematic performance or execution of planned physical movements, postures, or activities intended to enable the patient/client to remediate or prevent impairments; enhance function; reduce risk; optimize overall health and; enhance fitness and well-being.

Time counts: Determining time counts towards 15 minute timed codes is the actual time spent in the delivery of the modality (the time the patient is treated) requiring constant attendance and therapy services. Pre- and post-delivery services are not to be counted in determining the treatment service time.

Unit: For physical therapy, units are reported based on the number of times the procedure, as described in the HCPCS code definition, is performed. When reporting services for HCPCS codes where the procedure is not defined by a specific timeframe, the provider enters "1" in the unit field. If the treatment/procedure is defined as 15 minutes and the therapist provided 30 minutes of the treatment/procedure, then the therapist enters "2" in the unit's field. The

beginning and ending time should be documented in the patient's record along with the note describing the treatment.

Neighborhood Health Plan Reimburses

- Physical therapy services including the initial evaluation, treatments and modalities as listed in the procedures table below, up to the daily global maximum per the member's benefit.
- Physical therapy services, when the participating therapist or group practice performs the treatments.

Neighborhood Health Plan Does *Not* Reimburse

- Treatment, separately on the same date as a comprehensive evaluation (CPT 97001) since the evaluation reimbursement includes reimbursement for both a written report and any treatment provided at the time of the evaluation.
- Services provided by any person under the therapist's supervision.
- Athletic training.
- Avocational training/sport training.
- Functional Capacity Evaluation (FCE) for workers compensation.
- Duplicative therapy/modalities for the same condition, when provided by such as a chiropractor or other health professional.
- Maintenance programs that preserve the patient's present level of function and prevent regression of that function.
- Treatment intended to improve or maintain general physical condition.
- Massage therapy, including neuromuscular therapy, typically performed by a massage therapist.
- Relaxation or stress management therapy or training.
- Treatments that do not require the skill of a qualified PT provider, such as passive range of motion (PROM) treatment not related to restoration of a specific loss of function.
- Vocational rehabilitation or evaluation and any program with the primary goal of returning an individual to work.
- Long-term rehabilitative services when significant therapeutic improvement is not expected.
- Work hardening programs.
- Back (spine) school.

Procedures Codes Applicable to Guideline

Note: This list of codes may not be all-inclusive.

Physical Therapy Services		
Code	Descriptor	Comments
97001	Physical therapy evaluation	One initial evaluation, per condition, per patient. No prior authorization required.
97002	Physical therapy re-evaluation	Prior authorization required
97005	Athletic training evaluation	Not a Covered Benefit
97006	Athletic training re-evaluation	Not a Covered Benefit
Therapeutic Procedures		

Physician or therapist required to have direct one-on-one patient contact		
97110	Therapeutic procedure, one or more areas, each 15 minutes; to develop strength and endurance, range of motion and flexibility	Covered under visit authorization, unless otherwise specified.
97112	Neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities; each 15 minutes	
97113	Therapeutic procedure, one or more areas, each 15 minutes; aquatic therapy with therapeutic exercises	
97116	Gait training therapy (includes stair climbing); each 15 minutes	
97124	Massage, including effleurage, petrissage and/or tapotment (stroking, compression, percussion); each 15 minutes	
97140	Manual therapy techniques, one or more regions; each 15 minutes	
97150	Group physical therapeutic procedure(s), 2 or more individuals; each 15 minutes	Prior authorization required For MassHealth members only, a maximum of 4 units per visit is allowed. Append modifier GP to CPT 97150.
97530	Therapeutic activities direct (one-on-one) patient contact by the provider; each 15 minutes	Covered under visit authorization, unless otherwise specified.
97542	Wheel chair management (eg, assessment, fitting, training) each 15 minutes	
97545-97546	Work hardening/conditioning	Not a Covered Benefit
Tests and Measurements		
97750	Physical performance test or measurement (eg, musculoskeletal, functional capacity), with written report, each 15 minutes	Covered under visit authorization, unless otherwise specified.
Orthotic Management & Prosthetic Management		
97761	Prosthetic training, upper and/or lower extremity(s), each 15 minutes	Covered under visit authorization, unless otherwise specified.
Supervised Modalities		
97010	Hot or cold packs therapy	Covered under visit authorization, unless otherwise specified.
97012	Mechanical traction therapy	
97014	Electric stimulation therapy (unattended)	
97016	Vasopneumatic device therapy	
97018	Paraffin bath therapy	
97022	Application of a modality to one or more areas; whirlpool	
97024	Diathermy e.g., microwave	
97026	Infrared therapy	
97028	Ultraviolet therapy	

Constant Attendance Modalities Provider required to have direct one-on-one patient contact		
97032	Electrical stimulation (manual), each 15 minutes	Covered under visit authorization, unless otherwise specified.
97033	Inontophoresis, each 15 minutes	
97034	Contrast baths, each 15 minutes	
97035	Ultrasound, each 15 minutes	
97036	Application of a modality to one or more areas; Hubbard tank, each 15 minutes	
Modifier: Required for MassHealth Members Only, When Applicable		
GP	Therapeutic services delivered under an outpatient physical therapy plan of care (for NHP, with a maximum of 4 units per visit)	For MassHealth members only, use with CPT 97150 (Group therapeutic procedure(s))

Provider Payment Guidelines

Submit standard CPT codes as listed in this policy.

Submit the modifier that impacts reimbursement in the first modifier field, and the informational modifier in the secondary modifier fields.

Bill one initial PT evaluation code (97001), once per member, per condition/episode of care, with a count of one.

Bill one date of service per claim line.

Bill each modality on a separate claim line with the appropriate count.

Physical medicine evaluation service procedures 97001-97002 should *not* be submitted with modifier -25. Instead, modifier -59 should be used to reflect a significant effort, separately identifiable from the physical medicine therapeutic procedures.

Append modifier GP, as appropriate to MassHealth member's claims.

Documentation

The information in the patient's record should support the medical necessity of the procedure as well as the nature and extent of the services rendered, the beginning and ending time of the treatment/procedure, along with the note describing the treatment. The mere statement or diagnosis of pain is not sufficient to support medical necessity for the treatments.

The following types of documentation of therapy services are expected to be submitted in response to any requests for documentation.

The diagnosis along with the date of onset or exacerbation of the disorder/diagnosis;

- PT Evaluation.
- Long term and short term goals that are specific, quantitative and objective.
- A reasonable estimate of when the goals will be reached;
- The specific treatment techniques and/or exercises to be used in treatment; and
- The frequency and duration of treatment.
- Signature of the patient's attending physician and physical therapist.
- Concurrent documentation of the patient's response to treatment as it relates to short and long term goals.

The plan of care should be ongoing and treatment should demonstrate reasonable expectation of improvement:

- PT is medically necessary only if there is reasonable expectation that the physical therapy will achieve measurable improvement in the patient’s condition in a reasonable and predictable time.
- The patient should be regularly evaluated and there should be documentation of progress made toward the goals of PT.

The need for extensive, prolonged course of treatment should be appropriate to the reported procedure code(s) and must be documented clearly in the medical record. Treatment should result in improvement or arrest of deterioration within a reasonable and generally predictable period of time. Any records supporting an appropriate history, physical exam, and progress notes must also be available for review.

References

Massachusetts Division of Medical Assistance Provider Manual Series: Therapist Manual, Transmittal Letters: THP-22, dated 07/01/2005; and THP 25 dated 6/01/2011

National Institute of Neurological Disorders and Stroke Low Back Pain Fact Sheet, last updated August 3, 2009. Prepared by Office of Communications and Publications, National Institute of Neurological Disorders and Stroke, National Institute of Health, Bethesda, MD 20892

Physical, Occupational and Speech Therapy Billing Guide; NHIC Corp. REF-EDO-0055, Version 6.0, February 2012, Medicare Part B Resources

Publication History

Topic: Physical Therapy	Owner: Provider Network Management
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September 1, 2009 *Original documentation*

February 26, 2010 *Procedure code grid updated*

April 6, 2012 *Authorization grid, limitations, member cost sharing, definitions, codes and references updated*

This document is designed for informational purposes only. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization/notification and utilization management guidelines when applicable, adherence to plan policies and procedures, claims editing logic, and provider contractual agreement. In the event of a conflict between this payment guideline and the provider’s agreement, the terms and conditions of the provider’s agreement shall prevail. Neighborhood Health Plan utilizes McKesson’s claims editing software, ClaimCheck, a clinically oriented, automated program that identifies the “appropriate set” of procedures eligible for provider reimbursement by analyzing the current and historical procedure codes billed on a single date of service and/or multiple dates of service, and also audits across dates of service to identify the unbundling of pre and post-operative care. Please refer to Neighborhood Health Plan’s Provider Manual Billing Guidelines section for additional information on NHP’s billing guidelines and administration policies. Questions may be directed to Provider Network Management at prweb@nhp.org.