Physical, Occupational, and Speech Therapy

Policy

Harvard Pilgrim reimburses physical therapy, occupational therapy, and speech therapy provided by contracted therapy providers in compliance with state mandates.

Policy Definition

Physical Therapy is the treatment of injuries or disorders using physical methods, such as exercise and massage. The goal of physical therapy is to relieve pain and to help the patient attain his or her maximum functional motor potential.

Occupational Therapy involves treatment that helps develop adaptive or physical skills that will help people return to the ordinary tasks of daily living. It focuses on the use of hands and fingers, coordination of movement, fine motor skills and self-help skills such as preparing meals and dressing.

Speech Therapy is the treatment of defects and disorders of speech and swallowing disorders.

Prerequisite(s)

Applicable Harvard Pilgrim referral, notification and authorization policies and procedures apply. Refer to *Referral, Notification and Authorization* for more information.

Harvard Pilgrim's policies and procedures related to referral, notification, prior authorization and prior approval must be followed for Harvard Pilgrim to reimburse services as a secondary carrier. Refer to the *Coordination of Benefits (COB) Claims* policy.

HMO/POS/PPO

- A physician order is required for initial evaluation.
- Notification is required for treatment beyond the initial evaluation. Refer to *Outpatient Rehabilitative Therapy Services Authorization* for specific requirements.
- Authorization is required for speech therapy services beyond the initial evaluation. Refer to the *Authorization Policy* for specific requirements.

Open Access HMO and POS

For *Open Access HMO and Open Access POS* products, no referral is required to see a contracted specialist.

- Authorization required for some dental procedures, including odontectomy, oral surgery in a surgical day care setting, and TMJ surgery. (Refer to *Dental Benefit Clinical Review* for specific requirements.)

Harvard Pilgrim Reimburses[1]

HMO/POS/PPO

Treatment Limitations

Treatment is limited to a maximum benefit as covered by the member's benefits plan.

Physical and Occupational Therapy

- Physical and occupational therapy services including initial evaluations, treatments and modalities subject to Harvard Pilgrim's claims auditing software, up to the daily global payment cap as applicable.
- Manual Lymphatic Drainage services for the treatment of lymphedema will be reimbursed up to a maximum of four units per day, per member, to the same provider, at the fee schedule rate when submitted on a CMS-1500 claim form. These services are not subject to the daily global payment cap. Please see the Provider Billing Guidelines section for additional billing requirements related to this reimbursement.

- One initial evaluation per condition or episode of illness. Note: If two or more evaluations are performed within a 60-day period, only the initial evaluation will pay. Any other evaluations will be reviewed upon appeal provided there is substantiating documentation supporting a new condition or episode of illness.
- In order to be reimbursed for therapy services, a contracted therapist or contracted therapy group practice must perform the treatments.

Speech Therapy

- Outpatient facility speech therapy services including initial evaluations, treatments and modalities subject to Harvard Pilgrim's claims auditing software, up to the daily global payment cap.
- Outpatient speech therapy services are covered to the extent described in the members benefit plan coverage.
- Professional speech therapy services are reimbursed based on industry standard coding and subject to Harvard Pilgrim's claims auditing software.
- Coverage is consistent with applicable state mandates.

Harvard Pilgrim Does *Not* Reimburse

HMO/POS/PPO

- Athletic training
- Avocational training/sport training
- Cognitive therapy for progressive disorders
- Cellular therapy
- Driving evaluations
- Educational services or testing
- Group physical and occupational therapeutic procedures
- Hot or cold packs
- Massage therapy, including neuromuscular therapy (when performed by anyone other than licensed PT/PTA's and OT/COTA's)
- Relaxation or stress management therapy and training
- Myotherapy
- Sensory integrative praxis testing (SIPT, Praxis test)
- Neuromuscular therapy (typically performed by a massage therapist)
- Obesity exercise conditioning clinics/ programs
- Vocational rehabilitation or evaluation

Provider Billing Guidelines and Documentation

Modifiers

Harvard Pilgrim requires the use of a HCPCS modifier as described below for all claim lines submitted with CPTs 97010-97546 or 97755-97799, physical or occupational therapy services. Failure to include a modifier when billing these CPTs will result in the denial of the claim line.

- Report GP modifier for Physical Therapy services: Services delivered under an outpatient physical therapy plan of care.
- Report GO modifier for Occupational Therapy services: Services delivered under an outpatient occupational therapy plan of care.

To avoid unnecessary appeals, if a provider receives a claim denial due to a missing "GO" or "GP" modifier and it's less than 90 days from the date of service, resubmit a clean claim that includes the appropriate modifier.

- Harvard Pilgrim prefers that a provider bill on a single line with a count (# of units).

Counting minutes for timed codes

- For services billed in 15-minute units, providers should not report services performed for less than 8 minutes; 7 minutes or less of a single service is not reportable.

Units reported on claim	Number of minutes
1 unit	8 minutes through 22 minutes
2 units	23 minutes through 37 minutes
3 units	38 minutes through 52 minutes
4 units	53 minutes through 67 minutes

If any 15 minute timed service that is performed for 7 minutes or less on the same day as another 15 minute timed service that was also performed for 7 minutes or less and the total time of the two is 8 minutes or greater, then bill one unit for the service performed for the most minutes.

Coding[2]

Code	Description	Comment
97012–97546; 97755–97799	Physical and Occupational Therapy services	Modifier GO or GP is required. Please refer to detailed coding below for non-covered PT/OT therapy services. Please bill for multiple units on one line with a count.
97170–97172	Athletic training evaluation	Not reimbursed
97010	Hot or cold packs	Not reimbursed
97140	Manual therapy techniques (e.g., mobilization/ manipulation, manual lymphatic drainage, manual traction), one or more regions, each 15 minutes	When billed for manual lymphatic drainage for treatment of lymphedema, up to four units will be reimbursed at the fee schedule rate and will not be subject to the daily global payment cap. Must be submitted with the following primary diagnosis. **ICD-10 Covered Indications**
97150	Therapeutic procedure(s), group (two or more individuals)	Not reimbursed
97545–97546	Work hardening/conditioning	Not reimbursed
97750	Physical performance test or measurement (e.g., musculoskeletal, functional capacity), with written report, each 15 minutes	Not reimbursed

Related Policies

Payment Policies

- CPT and HCPCS Level ll Modifiers
- Early Intervention
- Home Health Care
- Pulmonary Rehabilitation

Clinical/Authorization Policies

- Outpatient Rehabilitative Therapies

Referral, Notification & Authorization

- Notification Policy
- Prior Authorization Policy

PUBLICATION HISTORY

09/01/00	original documentation facility policy
04/01/01	treatment limit change to 60 consecutive days
06/01/01	authorization requirement changed to notification, with MA speech therapy exception
01/01/03	specified no treatment limitation for First Seniority members
10/01/03	original documentation professional policy, annual review; coding updates
04/30/04	treatment request authorization changed to review; billing date of service clarified, added work hardening/conditioning and functional capacity to services that are not reimbursed
01/31/06	annual review and coding update; added to HPHC does not reimburse: athletic training, avocational training/sport training, educational services or testing, group therapy, neuromuscular therapy, obesity exercise conditioning clinics/programs, relaxation or stress management therapy, vocational rehabilitation or evaluation
01/31/07	annual review; no changes
07/31/07	criteria for reimbursement of professional MLD services added
01/31/08	annual review and coding updated rev codes
01/31/09	annual review; clarified prerequisites, treatment limitations and speech therapy coverage
05/15/09	added denial for hot/cold packs
11/15/09	annual review; added additional related policies
11/15/10	annual review; added compliance with state mandates and edits for clarity
05/15/11	added modifier GO and GP billing requirement
12/15/11	annual review; minor edits for clarity
01/01/12	removed First Seniority Freedom information from header
11/15/12	annual review; minor edits
12/15/13	annual review; added clarification for billing timed codes
01/15/14	annual coding update; removed 92506, deleted code effective 1/1/2014
06/15/14	added clarification to “initial evaluation per condition or episode of illness” for PT and OT; added *Connecticut Open Access HMO* referral information to prerequisites
12/15/14	annual review; no changes
07/15/15	ICD-10 coding update
12/15/15	annual review; added instructions to bill for multiple units on one line with a count
12/15/16	annual review; removed “greater than” symbol from grid with instructions for billing timed codes
01/15/17	annual coding update
12/15/17	annual review; added speech therapy codes
01/01/18	updated Open Access Product referral information under Prerequisites
12/03/18	annual review; removed ICD-9 indications; updated related policies; administrative edits
01/02/20	annual review; no changes
01/04/21	annual review; updated Provider Billing and Documentation Guidelines
12/01/21	annual review; no changes

[1]This policy applies to the products of Harvard Pilgrim Health Care and its affiliates—Harvard Pilgrim Health Care of Connecticut, Harvard Pilgrim Health Care of New England, and HPHC Insurance Company—for services performed by contracted providers. Payment is based on member benefits and eligibility, medical necessity review, where applicable, and provider contractual agreement. Payment for covered services rendered by contracted providers will be reimbursed at the lesser of charges or the contracted rate. (Does not apply to inpatient per diem, DRG, or case rates.) HPHC reserves the right to amend a payment policy at its discretion. CPT and HCPCS codes are updated annually. Always use the most recent CPT and HCPCS coding guidelines.

[2]The table may not include all provider claim codes related to physical therapy, occupational therapy, and speech therapy.