Outpatient Physical, Occupational, and Speech Therapy

Policy

Mass General Brigham Health Plan reimburses participating providers for the provision of medically necessary outpatient physical therapy, occupational therapy, and/or speech therapy when all the following criteria are met:

- The program is designed to improve lost or impaired physical function or reduce pain from illness, injury, congenital defect or surgery *and;*
- The program is expected to result in significant therapeutic improvement and*;*
- The program is individualized and there is documentation outlining quantifiable, attainable treatment goals

This policy applies to outpatient physical, occupational or speech therapy delivered by Home Health Care providers as part of a Home Health Plan of Care. Please refer to the Home Health Care Agency Provider Payment Guideline for information regarding physical, occupational or speech therapy delivered by Home Health Care providers as part of a Home Health Plan of Care.

This policy does not apply to outpatient physical, occupational, or speech therapy delivered by Early Intervention providers to members who qualify for Early Intervention services.

Reimbursement

Providers are reimbursed according to the plan's network provider reimbursement or contracted rates. Claims are subject to payment edits that are updated at regular intervals.

Covered services are defined by the member's benefit plan. The manner in which covered services are reimbursed is determined by the Mass General Brigham Health Plan's Payment Policy and by the provider's agreement with Mass General Brigham Health Plan. Member liability amounts may include but are not limited to: copayments; deductible(s); and/or co-insurance; and will be applied dependent upon the member's benefit plan.

Various services and procedures require referral and/or prior authorization. Referral and prior authorization requirements can be located here.

Provider Payment Guidelines

Please reference procedure codes from the current CPT, HCPCS Level II, and ICD-10-CM manuals, as recommended by the American Medical Association (AMA), the Centers for Medicare & Medicaid Services (CMS), and the American Hospital Association. CMS and the AMA revise HIPAA medical codes on a pre-determined basis, including changes to CPT, HCPCS, and ICD-10 codes and definitions.

Please refer to the CMS or CPT guidelines for requisite modifier usage when reporting services. The absence or presence of a modifier may result in differential claim payment or denial.

Mass General Brigham Health Plan reviews claims to determine eligibility for payment. Services considered incidental, mutually exclusive, integral to the primary service rendered, or part of a global allowance, are not eligible for separate reimbursement. Please refer to General Coding and Billing for more information.

All claims are subject to audit; medical records may be requested from the provider.

Mass General Brigham Health Plan reimbursement is based on line of business. Unless otherwise specified within the medical policies, please follow the guidelines based on membership type:

Treatment is limited to a maximum benefit as defined in the member's plan. Please refer to the member's plan materials for more information.

If a member has received any number of physical/occupational therapy visits from another provider, the treatment visits that have already occurred are applied to the visit maximum, per benefit period.

The maximum allowable number of units of physical/occupational therapy is four (4) per day. A visit can include a combination of therapeutic procedures and modalities, not to exceed one hour per day. Initial physical therapy evaluation is not subject to the daily maximum count.

Prior authorization requirement applies to the following plans: MassHealth (Standard, Family Assistance, CarePlus).

Service	**Requirement**
Initial outpatient physical, occupational or speech therapy evaluation	No referral, notification or prior authorization required
Physical, occupational, and/or speech therapy outpatient treatment	Prior authorization is required. No referral required.

All other plans:

Service	Requirement
Initial outpatient physical, occupational or speech therapy evaluation	No referral, notification or prior authorization required.
Physical, occupational, and/or speech therapy outpatient treatment	No referral, notification or prior authorization required. PT and OT visits are reimbursed up to the maximum visits allowed as defined by the member's plan benefit.

Mass General Brigham Health Plan Reimburses

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

Mass General Brigham Health Plan Does *Not* Reimburse

- Athletic training
- Avocational training/sport training
- Back (spine) school
- Functional Capacity Evaluation (FCE) for worker's compensation
- Long-term rehabilitative services when significant therapeutic improvement is not expected
- Maintenance programs that aim to preserve the member's present level or function as well as aim to prevent regression of that function
- Massage therapy, including neuromuscular therapy, typically performed by a massage therapist
- Relaxation or stress management therapy or training
- Services provided by any person under the therapist's supervision
- Treatment intended to improve or maintain general physical condition
- 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
- Work hardening programs

Limitations

Where coverage exists, treatment is limited to a maximum benefit as defined in the member's plan. If a member has received any number of physical/occupational therapy visits from another provider, the treatment visits that have already occurred will be applied to the visit maximum, per benefit period.

The maximum allowable number of units of physical/occupational therapy is four per day. A visit can include a combination of therapeutic procedures and modalities, not to exceed one hour per day. Initial physical therapy evaluation is not subject to the daily maximum count.

Procedure Codes

Unless otherwise noted, all services below require Prior Authorization for MassHealth and CMA plans.
Note: Code descriptors modified from the AMA CPT for publishing purposes. This list of codes may not be all-inclusive and can and will change from time to time. Inclusion of a code in this document does not imply or guarantee coverage and/or reimbursement.

Physical Therapy and Occupational Therapy Services		
Code	**Descriptor**	**Comments**
97161	Physical therapy evaluation: low complexity	No prior authorization required
97162	Physical therapy evaluation: moderate complexity	No prior authorization required
97163	Physical therapy evaluation: high complexity	No prior authorization required
97164	Re-evaluation of physical therapy	No prior authorization required
97165	Occupational therapy evaluation	
97166	Occupational therapy evaluation, moderate complexity	
97167	Occupational therapy evaluation, high complexity	
97168	Re-evaluation of occupational therapy established plan of care	
97169	Athletic training evaluation, low complexity	
97170	Athletic training evaluation, moderate complexity	
97171	Athletic training evaluation, high complexity	

Physical Therapy and Occupational Therapy Services		
97172	Re-evaluation of athletic training established plan of care requiring these components	
97010	Application of a modality to 1 or more areas; hot or cold packs	Not Reimbursable
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)	Unlisted codes are not recognized. Refer to General Coding and Billing PPG

Physical Therapy and Occupational Therapy Services		
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)	
97127	Therapeutic interventions that focus on cognitive function	Report once per day
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)	Max 4 units allowed, append "GP" modifier for MassHealth claims
97530	Therapeutic activities, direct (one-on-one) patient contact (use of dynamic activities to improve functional performance), each 15 minutes	
97533	Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one-on-one) patient contact, each 15 minutes	
97535	Self-care/home management training	
97537	Community/work reintegration training	
97542	Wheelchair management (eg, assessment, fitting, training), each 15 minutes	

Physical Therapy and Occupational Therapy Services		
97545	Work hardening/conditioning; initial 2 hours	Not Reimbursable
97546	Work hardening/conditioning; each additional hour	Not Reimbursable
97750	Physical performance test or measurement	
97755	Assistive technology assessment	
97760	Orthotic(s) management and training (including assessment and fitting when not otherwise reported), upper extremity(ies), lower extremity(ies) and/or trunk, initial orthotic(s) encounter, each 15 minutes	Report only for initial encounter
97761	Prosthetic(s) training, upper and/or lower extremity(ies), initial prosthetic(s) encounter, each 15 minutes	Report only for initial encounter
97763	Orthotic(s)/prosthetic(s) management and/or training	
G0129	Occupational therapy services requiring the skills of a qualified occupational therapist	
S8950	Complex lymphedema therapy, each 15 minutes	

Speech Therapy Services		
Code	**Descriptor**	**Comments**
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	
92521	Nasal function studies (eg, rhinomanometry)	No prior authorization required
92522	Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria);	No prior authorization required
92523	Evaluation of speech sound production; w/Evaluation	No prior authorization required
92524	Behavioral and qualitative analysis of voice and resonance	No prior authorization required

Speech Therapy Services		
92526	Treatment of swallowing dysfunction and/or oral function for feeding	
92610	Evaluation of oral and pharyngeal swallowing function	No prior authorization required
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	
97532	Development of cognitive skills each 15 Minutes	
97533	Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one-on-one) patient contact, each 15 minutes	

Revenue Code	
Code (s)	**Service**
0420, 0421, 0422, 0423, 0429	Physical Therapy – prior authorization required for MassHealth and CMA
0424	Physical Therapy Evaluation – no prior authorization required
0430, 0431, 0432, 0433, 0439	Occupational Therapy
0434	Occupational Therapy Evaluation – no prior authorization required
0440, 0441, 0442, 0443, 0449	Speech Pathology
0444	Speech Pathology Evaluation – no prior authorization required

Provider Payment Guidelines and Documentation

- Bill each modality on a separate claim line with the appropriate count
- Bill one date of service per claim line

- Bill one initial PT/OT/ST evaluation code, once per member, per condition/episode of care, with a count of one
- Submit standard CPT/HCPCS codes as listed in this policy
- Submit the modifier that impacts reimbursement in the first modifier field, and any informational modifier(s) in the secondary modifier fields

Documentation

The information in the member'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.

Submit the following types of documentation in response to any requests for documentation.

- Diagnosis, date of onset or exacerbation of the disorder/diagnosis;
- PT/OT/ST 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 each treatment;
- Signature of the member's attending physician and therapist
- Concurrent documentation of the member's response to treatment as it relates to short- and long-term goals

The plan of care should be ongoing. Treatment should demonstrate reasonable expectation of improvement:

- PT/OT/ST is medically necessary only if there is reasonable expectation that the therapy will achieve measurable improvement in the member's condition in a reasonable and predictable time.
- The member should be regularly evaluated, and progress made toward the documented goals of therapy must be documented.

The need for extensive and 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 examination, and progress notes must also be available for review.

Related Documents

General Coding and Billing
Modifiers
MassHealth Not Payable Code List

References

- MassHealth, Therapist Manual for MassHealth Providers
- MassHealth Transmittal Letter THP-22, June 2005
- MassHealth Transmittal Letter DHP-25, April 2006
- Low Back Pain Fact Sheet | National Institute of Neurological Disorders and Stroke (nih.gov)
- Physical, Occupational and Speech Therapy Billing Guide; NHIC Corp. REF-EDO-0055, Version 6.0
- Centers for Medicare and Medicaid Services, Therapy Services

Publication History

Topic: **Physical, Occupational, and Speech Therapy**	**Owner:** **Network Management**

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*
March 19, 2013	*Authorization grid updated*
July 29, 2015	*Authorization grid, limitation, OT and ST added, procedure code grid, rev codes updated*
July 20, 2017	*Document review; template update; removal of reference to CMA*
May 1, 2018	*Document annual review; coding updates*
January 1, 2019	*Document restructure; codes, code descriptor and references updated. Removed 97532*

Provider Payment Guidelines

January 1, 2023	*Document rebrand; updated references*
January 1, 2024	*Annual review, no policy change*
January 1, 2025	*Annual review, no policy change*

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. Payment policies are intended to assist providers in obtaining Mass General Brigham Health Plan's payment information. Payment policy determines the rationale by which a submitted claim for service is processed and paid. Payment policy formulation takes into consideration a variety of factors including: the terms of the participating providers 'contract(s); scope of benefits included in a given member's benefit plan; clinical rationale, industry-standard procedure code edits, and industry-standard coding conventions.

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