

The following payment policy applies to Tufts Health Plan[®] commercial contracted ancillary independent physical therapy practices or groups.

This policy applies to commercial¹ products. For information on Tufts Medicare Preferred HMO's policies and procedures, [click here](#).

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

Policy

Tufts Health Plan covers medically necessary physical therapy (PT) services, as described below.

General Benefit Information²

Services and subsequent payment are based on the member's benefit plan document. Providers and their office staff are required to use self-service channels to verify effective dates and copayments for commercial members prior to initiating services.

Reference the [Electronic Services](#) section of our website for our self-service channel options. Benefit specifics should be verified prior to initiating services by logging on to our [website](#) or by contacting [Provider Services](#).

Member Responsibility

Copayments, deductible and/or coinsurance may be applied pursuant to the member's benefit plan document.

Tufts Health Plan recommends not billing the member for the coinsurance and/or deductible amount until the claim has processed so that the appropriate member responsibility can be determined. Both the provider's Statement of Account (SOA) and the Electronic Remittance Advice (ERA) will reflect the member's responsibility amount.

Authorization Requirements

Reference the [Authorization Policy](#) for specific referral and authorization requirements.

Services Requiring Prior Authorization

Depending upon the service, while you may not be the provider responsible for obtaining prior authorization, as a condition of payment you will need to make sure that prior authorization has been obtained.

Note: Members are not eligible for more than two therapy evaluations in a year, unless otherwise indicated in the member's Handbook. If a second evaluation is needed, a new PCP referral will be required.

Reference the [Physical Therapy Authorization Program Medical Necessity Guidelines](#) for information on how to obtain authorization for continuation of treatment beyond the 8th visit. Providers must complete the [Tufts Health Plan Physical Therapy Authorization Form](#) and submit it to the Tufts Health Plan Precertification Department to obtain prior authorization for continuation of treatment.

¹ Commercial products include [HMO, POS, PPO & CareLinkSM](#) when Tufts Health Plan is primary administrator.

² Eligibility is subject to retroactive reporting of disenrollment.

All PT referrals and authorizations are valid for visits that occur within the calendar or plan³ year that the referral is issued. If a member is in need of PT services in the following calendar or plan year, the member's PCP, if applicable, must issue a new referral for an initial evaluation and up to 8 visits. Additional services will require authorization by the Tufts Health Plan Precertification Department.

Providers are reminded to ask patients whether they have received therapy services from any other provider. When applicable, PCPs may only issue a referral for the initial evaluation and up to a maximum of 8 medically necessary therapy visits. If a member has received any number of therapy services from another physical therapy provider, the therapy visits that have already occurred will be applied to the 8 visit maximum. Once the initial evaluation and 8 therapy visits have occurred, any continuation of PT services must be authorized by the Tufts Health Plan Precertification Department. Benefit visit limits do not apply to the treatment of autism spectrum disorders; however, medical necessity guidelines still apply.

Note: If a member has already received 8 therapy visits from one PT provider and then chooses to see another PT provider after the 8 visits have been completed, the new PT provider is responsible for obtaining prior authorization as the initial 8 visits have been exhausted.

Reference the Medical Necessity Guidelines in the [Clinical Resources](#) section of our website for information regarding Autism services.

Note: Reference the Rhode Island Medical Necessity Guidelines for Rhode Island-based members.

Some procedures require prior authorization with the Tufts Health Plan Precertification Department. Reference the [Clinical Resources](#) section of our website for a list of procedures, services and items that require prior authorization. Reference the [CareLinkSM Prior Authorization List](#) for a list of procedures, services and items requiring prior authorization for CareLink members.

For a complete description of Tufts Health Plan's commercial authorization requirements, reference the Authorization section within the [Tufts Health Plan Commercial Provider Manual](#).

Billing Information

- Submit the most updated industry-standard codes.
- Submit standard CPT and HCPCS modifiers in accordance with the appropriate CPT or HCPCS procedure code(s).
- For more information regarding modifiers refer to the [Modifier Payment Policy](#).
- Submit appropriate ICD-9 diagnosis codes carried out to the highest level of specificity.
- Submit standard CPT or HCPCS procedure codes listed within this document.

Note: Annually and quarterly, HIPAA medical code sets⁴ undergo revision by CMS, AMA and CCI. Revisions typically include adding, deleting or redefining the description or nomenclature of new HCPCS, CPT procedure and ICD-9 diagnosis codes. As these revisions are made public, Tufts Health Plan will update its system to reflect these changes.

EDI Claim Submitter Information

- Submit claims in HIPAA compliant 837P format for professional services. Claims billed with non-standard codes will reject if billed electronically.

Paper Claim Submitter Information

- Submit claims on a CMS-1500 form for professional services. Claim line(s) billed with non-standard codes will deny.

³ The 12-month period designated by the employer group. This 12-month period is when benefit limits are calculated.

⁴ HIPAA medical code sets include HCPCS, CPT Procedure and ICD-9 diagnosis codes.

The following codes are applicable to physical therapy services:

Procedure Code	Description
97001	Physical Therapy Evaluation (Only one initial evaluation per day per condition may be billed)
97002	Physical Therapy Re-Evaluation

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

Modalities-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 (2 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
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

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

Other Procedures

Procedure Code	Description
97799	Unlisted physical medicine/rehabilitation service or procedure

Compensation/Reimbursement Information

Providers are compensated according to their Tufts Health Plan Provider Agreement. Claims are subject to payment edits that are updated at regular intervals and generally based on Centers for Medicare & Medicaid Services (CMS), specialty society guidelines, drug manufacturers' package label inserts and the National Correct Coding Initiative (CCI).

Note: Tufts Health Plan only compensates physical therapists practicing in contracted sites that are credentialed by Tufts Health Plan's Allied Health Department. Tufts Health Plan does not compensate medical doctors for physical therapy services.

Daily Payment Maximum

Physical therapy treatments and modalities are priced according to fee schedule arrangements and are subject to a daily payment maximum. Contracted procedure codes for physical therapy services will be applied to the daily payment maximum. Reference your Provider Agreement for information regarding the daily maximum rate.

Note: Compensation for the initial evaluation code 97001 is not subject to the daily payment maximum.

Statement of Account (SOA)

The SOA is sent to all providers to provide information on the status of the claim(s) submitted to Tufts Health Plan. The SOA indicates status of claims payments, denials and pending claims.

If the procedure code(s) submitted is not used in processing, the SOA will reflect the actual procedure code(s) utilized by Tufts Health Plan to process the claim.

Effective January 1, 2012, paper Statements of Account and the Summary of Account on Tufts Health Plan's secure Provider website will no longer display embedded procedure code modifiers or any Tufts Health Plan unique characters.

Electronic Remittance Advice (ERA)

The HIPAA compliant 835 ERA is an EDI transaction that providers may request to electronically post paid and denied claims information to their accounts receivable system.

When an industry-standard code(s) is submitted and accepted by Tufts Health Plan, the electronic remittance advice will reflect the code(s) submitted and the actual procedure code(s) utilized by Tufts Health Plan for claims processing.

Additional Resources

[Outpatient Rehabilitation Payment Policy](#)

[Inpatient Rehabilitation Payment Policy](#)

[Home Health Care Payment Policy](#)

Document History

February 2008: Revised general benefit information with self-service channels information.

January 2009: Clarified that the policy applies to ancillary providers.

April 2011: Added a note that Tufts Health Plan does not compensate medical doctors for performing PT services in an M.D. office setting.

May 2011: Added that visit limits do not apply to the treatment of autism spectrum disorders.

October 2011: Added reference to Autism Medical Necessity Guidelines, 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 your office/facility did not comply with this payment policy, Tufts Health Plan will expect your office/facility to refund all payments related to non-compliance.

This policy provides information on Tufts Health Plan claims adjudication processing guidelines. As every claim is unique, the use of this policy is not a guarantee of payment nor a final prediction 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 guidelines when applicable, and adherence to plan policies and procedures and claims editing logic.

This policy does not apply to Tufts Medicare Preferred HMO or Private Health Care Systems (PHCS) network, also known as Multiplan. This policy applies to CareLink when CIGNA HealthCare is Primary Administrator for providers in Massachusetts and Rhode Island service areas for pricing purposes only. Providers in the New Hampshire service area are subject to CIGNA HealthCare's provider arrangement for the purpose of servicing CareLink members.