

The following payment policy applies to Tufts Health Plan[®] commercial contracted outpatient rehabilitation and acute care hospitals where outpatient rehabilitation services are rendered.

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 occupational therapy (OT) outpatient physical therapy (PT), and speech therapy (ST) rehabilitation services, in accordance with the member's benefit plan document.

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 apply depending upon the member's benefit plan specifics.

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 preregistration, 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.

Some procedures require prior authorization with the Tufts Health Plan Precertification Department. Reference the [Clinical Resources](#) section of our Web site 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.

Note: Members are not eligible for more than two therapy evaluations in a year, unless otherwise indicated in the member's Handbook.

¹ Commercial products include [HMO, POS, PPO & CareLink when Tufts Health Plan is Primary Administrator](#)

² Eligibility is subject to retroactive reporting of disenrollment.

Occupational Therapy

Reference the [Occupational Therapy Authorization Program](#) for information on how to obtain prior authorization for continuation of treatment beyond 60 days from the date of the member's first therapy treatment visit. Providers must complete the Tufts Health Plan [Occupational Therapy Authorization Form](#) and submit it to Tufts Health Plan Precertification Department to obtain prior authorization.

Physical Therapy

Reference the [Physical Therapy Authorization Program](#) for information on how to obtain prior authorization after the eight treatment 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.

Speech Therapy

Reference the [Speech Therapy Medical Necessity Guidelines](#) for information on how to obtain prior authorization for speech therapy services. The therapist must complete the [Tufts Health Plan Speech Therapy Evaluation and Authorization Form](#), attach the results from the initial evaluation and fax them to the Tufts Health Plan Precertification Department.

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 one claim line per date of service to ensure appropriate claims processing and payment.
- Submit the ICD-9 diagnosis code(s) carried out to the highest level of specificity.
- Submit only one initial evaluation per diagnosis/condition.

Providers who bill PT services on a monthly basis are required to submit the appropriate itemization for each distinct date of service. Itemization for PT services must include the CPT or HCPCS procedure code, number of units billed and the dollar amount billed for each distinct date of service. If itemization submitted does not include this information, the claim(s) will be denied. A narrative description is not considered a complete claim.

Note: Annually and quarterly, HIPAA medical code sets³ 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 appropriate HIPAA compliant 837 format. Claims billed with non-standard codes will reject if billed electronically.
- Submit a corresponding CPT and/or HCPCS code for every Revenue Code submitted. Tufts Health Plan acknowledges that certain Revenue Codes may not have a corresponding CPT and/or HCPCS code; however, in all cases the provider is encouraged to find a procedure code for every Revenue Code.

Note: Tufts Health Plan has identified that the following Revenue Codes will be accepted when submitted electronically without a corresponding CPT and/or HCPCS procedure code if one can not be found (*EDI acceptance does not guarantee reimbursement*):

³ HIPAA medical code sets include HCPCS, CPT Procedure and ICD-9 diagnosis codes.

0250 - Pharmacy	0276 - Intraocular Lens	0527- Visit Nurse to Home HH short area
0251 - Generic	0278 - Other Implants	0528- RHC/FQHC visit to other (not 4,5)
0252 - Non-Generic	0279 - M&S Supplies - Other	0621 - Incident to Radiology
0258 - IV Solutions	0370 - Anesthesia	0622 - Incident to other Diagnostics
0259 - Pharmacy - Other	0371 - Incident to Radiology	0656 - Hospice-Inpatient General Care
0270 - M&S Supplies	0372 - Incident to Other Diagnostic	0659 - Hospice - Other
0271 - Non-sterile Supplies	0379 - Anesthesia – Other	0663- Daily Respite Care
0272 - Sterile Supplies	0392- Processing and Storage	0710 - Recovery Room
0274 - Prosthetic/Orthopedic Devices	0524- RHC/FQHC visit to SNF (Part A)	0719 - Recovery Room - Other
0275 - Pacemaker Supplies	0525- RHC/FQHC visit to Facility (not 4)	

Paper Claim Submitter Information

- Submit claims on an appropriate paper claim form. Claims billed with non-standard codes will deny.
- Submit a corresponding CPT and/or HCPCS procedure code for every date of service submitted when a date range is indicated in box 6 of the UB-04.
- Submit Revenue code (s) with corresponding CPT/HCPCS procedure code (s), where applicable.

Occupational Therapy Procedure Codes

The following codes are applicable to occupational therapy services only.

Procedure Codes	Description
97003	Occupational Therapy Evaluation (Submit this code for the initial evaluation visit only)
97004	Occupational Therapy Re-evaluation (Submit this code to represent subsequent treatment visits)

Note: Tufts Health Plan utilizes procedure code 97004 to represent occupational therapy re-evaluation and subsequent occupational therapy treatments. For compensation information, reference page 5.

Speech Therapy Procedure Codes

The following codes are applicable to speech therapy services only.

Procedure Codes	Description
92506	Speech Therapy Evaluation
92507	Speech Therapy Treatment
92610	Evaluation of oral and pharyngeal swallowing function
92526	Treatment of swallowing dysfunction and/or oral function for feeding

Physical Therapy Procedure Codes

The following codes are applicable to physical therapy services only.

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

Modalities-Constant Attendance

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

Procedure Codes	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)

Active Wound Care Management

Procedure Code	Description
97601	Removal of devitalized tissue from wound(s) selective debridement without anesthesia

Note: CPT Procedure code 97601 is compensated via the network hospital outpatient surgical fee schedule.

Test and Measurements

Procedure Codes	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

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

Other Procedures

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

Compensation/Reimbursement Information

Rehabilitation services rendered in the outpatient department of the hospital are compensated according to the Tufts Health Plan Network Hospital Outpatient Fee Schedule and/or other arrangements as applicable. Reference your current contract for details regarding compensation provisions. Ancillary providers are compensated according to their 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 National Correct Coding Initiative (CCI).

Occupational Therapy Services

Compensation for occupational therapy treatment is included in the compensation rate for procedure code 97004. Other services such as modalities billed for occupational therapy services will not be compensated separately, as they are included in the reimbursement rate for procedure code 97004.

Physical Therapy Services

Compensation for physical therapy treatments and modalities are compensated according to the fee schedule rates and are subject to a daily payment maximum.

Initial evaluation code 97001 is not subject to the daily payment maximum rate.

Speech Therapy Services

Compensation for speech therapy services is included in the compensation rate for procedure code 92506 and 92507. Other services such as length of time and modalities of treatment billed for speech therapy services will not be compensated separately, as they are included in the compensation rate for procedure code 92507.

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

[Occupational Therapy Payment Policy](#)

[Physical Therapy Payment Policy](#)

[Speech Therapy Payment Policy](#)

Document History

March 2008: Added procedure codes for OT, PT & ST services, clarified reimbursement information for OT, PT & St services.

November 2011: Template updates made.

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 neither 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 the 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 CareLink members.