

The following payment policy applies to outpatient rehabilitation and acute care hospitals where outpatient rehabilitation services are rendered.

This policy applies to Commercial¹ and Tufts Health Plan Medicare Preferred² products.

Reference the [Occupational Therapy Payment Policy](#), [Physical Therapy Payment Policy](#) or the [Speech Therapy Payment Policy](#) for information on professional services.

Policy

Tufts Health Plan reimburses 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 Information³

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 Web site for our self-service channel options. Benefit specifics should be verified prior to initiating services by logging on to our [Web site](#) or by contacting [Provider Services](#).

Tufts Health Plan Medicare Preferred

Member eligibility can be verified [electronically](#) and detailed benefit coverage may be verified by logging on to our [Web site](#) or by contacting [Tufts Health Plan Medicare Preferred Customer Relations](#).

Tufts Medicare Preferred products follow Medicare coverage guidelines. Tufts Health Plan cannot cover items and services not covered under Tufts Health Plan's Medicare approved benefit plan. However, Tufts Medicare Preferred currently covers a limited number of non-Medicare covered items as supplemental benefits under this Medicare-approved plan.

Note: Supplemental benefits are subject to change each year.

Member Responsibility

Copayments, deductible and/or coinsurance may be applied depending upon the Member's benefit plan specifics.

Tufts Health Plan recommends not billing the Member for the deductible and/or coinsurance 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.

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

² Tufts Health Plan Medicare Preferred products include [HMO & PPO](#)

³ Eligibility is subject to retroactive reporting of disenrollment by the Member's employer group or Medicare.

This payment 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 and utilization management guidelines when applicable, adherence to plan policies and procedures and claims editing logic. This policy does not apply to Uniformed Services Family Health Plan or PHCS network also known as Multiplan Members. Providers in the New Hampshire service area are subject to CIGNA HealthCare's provider arrangement for the purpose of CareLinkSM Members.

Authorization/Notification Requirements

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

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

Occupational Therapy⁴

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 Therapy⁵

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 Therapy⁶

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.

Tufts Health Plan Medicare Preferred

Tufts Medicare Preferred HMO Members must obtain a written or electronic PCP referral for all authorized OT, PT or ST services. Tufts Health Plan Medicare Preferred will deny payment of any service that has not been authorized by a Member's PCP. In accordance with CMS policy, if a valid referral is not on file, the Member may be held responsible for payment only if the Member has signed the [Tufts Health Plan Medicare Preferred Notice of Financial Liability form](#).

Reference the [Tufts Medicare Preferred HMO Prior Authorization List](#) and the [Tufts Medicare Preferred PPO Prior Authorization List](#) for information on OT, PT and ST services requiring prior authorization for Tufts Medicare Preferred Members.

For a complete description of Tufts Health Plan's Commercial authorization and notification requirements, reference the Authorization section within the [Tufts Health Plan Commercial Provider Manual](#). Reference the Authorization chapter within the [Tufts Health Plan Medicare Preferred Provider Manual](#) for additional information on Tufts Medicare Preferred authorization requirements.

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Billing Information

- Reference the most updated industry standard codes.
- 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.

Tufts Health Plan Medicare Preferred Billing Information

- Submit itemization for each distinct date of service for all OT, PT, and ST claims.
- Submit Revenue code (s) with corresponding CPT/HCPCS procedure code (s), where applicable.

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 not be rejected when submitted electronically without a corresponding CPT and/or HCPCS procedure code if one can not be found (*EDI acceptance does not guarantee reimbursement*):

250 - Pharmacy	276 - Intraocular Lens	527- Visit Nurse to Home HH short area
251 - Generic	278 - Other Implants	528- RHC/FQHC visit to other (not 4,5)
252 - Non-Generic	279 - M&S Supplies - Other	621 - Incident to Radiology
258 - IV Solutions	370 - Anesthesia	622 - Incident to other Diagnostics
259 - Pharmacy - Other	371 - Incident to Radiology	656 - Hospice-Inpatient General Care
270 - M&S Supplies	372 - Incident to Other Diagnostic	659 - Hospice - Other
271 - Non-sterile Supplies	379 - Anesthesia – Other	663- Daily Respite Care
272 - Sterile Supplies	392- Processing and Storage	710 - Recovery Room
274 - Prosthetic/Orthopedic Devices	524- RHC/FQHC visit to SNF (Part A)	719 - Recovery Room - Other
275 - Pacemaker Supplies	525- 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.

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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 reimbursement information, reference page 6.

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 reimbursed via the network hospital outpatient surgical fee schedule.

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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
97533 ⁷	Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, 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

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Other Procedures

Procedure Codes	Description
97799	Unlisted physical medicine/rehabilitation service or procedure
G0281	Electrical stimulation, (unattended), to one or more areas for chronic stage III and stage IV pressure ulcers, arterial ulcers, diabetic ulcers, and venous stasis ulcers not demonstrating measurable signs of healing after 30 days of conventional care, as part of a therapy plan of care
G0283	Electrical stimulation (unattended), to one or more areas for indication(s) other than wound care, as part of a therapy plan.

Note: HCPCS Procedure codes G0281 and G0283 are reimbursable for services rendered to Tufts Health Plan Medicare Preferred Members only.

Reimbursement

Rehabilitation services rendered in the outpatient department of the hospital are reimbursed according to the Tufts Health Plan Network Hospital Outpatient Fee Schedule and/or other arrangements as applicable. Reference your current contract for details regarding reimbursement provisions. Ancillary providers are reimbursed according to their Provider Agreement. Claims are subject to payment edits that are updated at regular intervals and generally based on CMS, Specialty Society Guidelines, and National Correct Coding Initiative (CCI).

Occupational Therapy Services

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

Physical Therapy Services

Reimbursement for physical therapy treatments and modalities are reimbursed 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

Reimbursement for speech therapy services is included in the reimbursement 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 reimbursed separately, as they are included in the reimbursement 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.

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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.

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.

Document History

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

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