Harvard Pilgrim Health Care | TUFTS Health Plan

Point32Health companies

Payment Policy:
Outpatient Rehabilitation Facility

Applies to:

Commercial Products

☐ Harvard Pilgrim Health Care Commercial products
☒ Tufts Health Plan Commercial products

Public Plans Products

☒ Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product)
☒ Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans
☒ Tufts Health RITogether – A Rhode Island Medicaid Plan
☒ Tufts Health One Care – A dual-eligible product

Senior Products

☒ Tufts Health Plan Senior Care Options (SCO) (a dual-eligible product)
☒ Tufts Medicare Preferred HMO/PPO (Medicare Advantage products)

Policy

Tufts Health Plan covers medically necessary outpatient physical therapy (PT), occupational therapy (OT) and speech therapy (ST) rehabilitation services rendered in contracted outpatient rehabilitation facilities and acute care hospitals, in accordance with the member's benefits.

General Benefit Information

Services and subsequent payment are pursuant to the member's benefit plan document. Member eligibility and benefit specifics should be verified prior to initiating services by logging on to the secure Provider portal or by contacting Provider Services.

Referral/Prior Authorization/Notification Requirements

Certain procedures, items and/or services may require referral and/or prior authorization. While you may not be the provider responsible for obtaining prior authorization, as a condition of payment you must confirm that prior authorization has been obtained. For more information, refer to the Referral, Authorization and Notification Policy.

A referral is required for initial therapy evaluations and the number of visits specified in the medical necessity guidelines for habilitative and rehabilitative physical, occupational, and speech therapy. Prior authorization is required if continuation of services beyond the limits specified in the medical necessity guidelines is needed.

All referrals and/or prior authorizations are valid for visits that occur in the calendar or plan year in which they were issued. The member's PCP, if applicable, must issue a new referral for habilitative or rehabilitative PT and/or OT services for the following calendar or plan benefit year. ST referrals do not expire at the end of the benefit year.

Providers are reminded to ask members if they have received habilitative or rehabilitative services from any other provider. Any visits that a member has previously received from another provider are applied to the treating visit maximum per calendar or plan year.

Note: If a member chooses to see a new provider after already receiving the allowed number of treating visits from another provider, the new provider must obtain a separate prior authorization, as the initial visits have been exhausted.

Senior Products
PCP referral is required for initial evaluations and all PT, OT, and/or ST visits for Tufts Medicare Preferred HMO members. Prior authorization is not required.

Billing Instructions

Unless otherwise stated, Tufts Health Plan follows AMA coding guidelines. Refer to current industry standard coding guidelines for a complete list of ICD, CPT/HCPCS, revenue codes, modifiers and their usage. Providers may only bill the procedure code(s) in accordance with the applicable financial exhibits of their provider agreements or applicable fee schedules.

- 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 only one initial evaluation per diagnosis/condition.
- Submit the appropriate revenue code for PT, OT and ST services

Treatment and modality procedure codes include, but are not limited to, the codes contained in providers' contracts and the applicable medical necessity guidelines as referenced and linked to above. Tufts Health Plan recognizes modality procedure codes for PT and OT.

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	Units Reported on Claim	Number of Minutes
1 unit	8-22 minutes	3 units	38-52 minutes
2 units	23-37 minutes	4 units	53-67 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, bill one unit for the service performed for the most minutes.

Compensation/Reimbursement Information

Providers are compensated according to the applicable network contracted rates and fee schedules. Outpatient therapy providers are compensated for the modalities contained in providers' contracts when billed with the appropriate revenue code(s).

Commercial and Senior Products

Daily Payment Maximum

PT, OT and ST treatments and modalities are priced according to fee schedule arrangements and are subject to daily payment maximums. Contracted procedures codes for PT, OT and ST services will be applied to the daily payment maximum. Refer to the current provider contract for information regarding the daily maximum rate.

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

Tufts Health Public Plans

- PT evaluation codes 97161-97172 are not compensated if billed within one month of codes 97161-97172.
- PT services provided by a physical or occupational therapist or a speech-language pathologist are not compensated if the same code was billed by any outpatient hospital for the same date of service.
- Non-therapy services billed with therapy services modifiers GN, GO or GP are not compensated

Additional Resources

- Physical, Occupational, and Speech Therapy Professional Payment Policy

Document History

- January 2024: Template updates; added existing counting minutes for timed services information
- May 2020: Policy reviewed by committee; added applicable Tufts Health Public Plans content; clarified authorization and referral requirements; template updates
- June 2018: Template updates
- February 2018: Added claim edits for therapeutic services and physical medicine modalities, effective for dates of service on or after April 1, 2018

Background and Disclaimer Information

This policy applies to the products of Harvard Pilgrim Health Care and Tufts Health Plan and their affiliates, as identified in the check boxes on the first page for services performed by contracted providers.

Payment is based on member benefits and eligibility on the date of service, medical necessity review, where applicable, and the provider's network participation agreement with the Plan. As every claim is unique, this policy is neither a guarantee of payment, nor a final indication 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 requirements (when applicable), adherence to Plan policies and procedures, and claims editing logic. An authorization is not a guarantee of payment.

Point32Health reserves the right to amend a payment policy at its discretion. CPT and HCPCS codes are updated as applicable; please adhere to the most recent CPT and HCPCS coding guidelines.

We reserve the right to conduct audits on any provider and/or facility to ensure accuracy and compliance with the guidelines stated in this payment policy. If such an audit determines that a provider/facility did not comply with this payment policy, Harvard Pilgrim Health Care and Tufts Health Plan will expect the provider/facility to refund all payments related to noncompliance.