Physical and Occupational Therapy (PT/OT) Payment Policy

Policy

The Plan reimburses medically necessary covered physical and occupational therapy services furnished by plan providers, including physicians, qualified non-physician practitioners (i.e., nurse practitioners, physician assistants, and clinical nurse specialists), and physical and occupational therapists.

For Medicare members (Fallon Medicare Plus, NaviCare and PACE), therapy services may also be provided by appropriately supervised licensed physical or occupational therapist assistants. Under Massachusetts General Law, a physical therapist assistant (PTA) may only provide services under the supervision and direction of a physical therapist (PT), and an occupational therapist assistant (OTA) may only provide services under the supervision and direction of an occupational therapist (OT). Services provided by therapy students or therapy aides with or without qualified supervision are not reimbursable in any setting.

MassHealth changed its policy regarding services rendered by therapy assistants, effective for dates of service on or after November 26, 2021, subject to the supervision requirements set forth in 130 CMR 432.000, MassHealth will reimburse for services of physical therapy assistants (PTAs) and occupational therapy assistants (OTAs). This applies to both individually enrolled therapy providers and to therapy group practices under 130 CMR 432.404(E) (**MassHealth Transmittal Letter THP-27, November 2021**). This change in policy regarding services rendered by therapy assistants also applies to the Plan's MassHealth members.

Fallon Health does not cover therapy services provided by PTAs or OTAs for commercial plan members.

Updates related to coronavirus disease 2019 (COVID-19) for MassHealth ACO, NaviCare and Summit ElderCare plan members:

Effective March 10th, 2020, Governor Baker declared a State of Emergency in Massachusetts due to 2019 novel coronavirus (COVID-19). In light of the State of Emergency, MassHealth authorized certain COVID-19-related administrative flexibilities to long-term services and supports (LTSS) providers. These flexibilities were communicated in a guidance document titled **MassHealth LTSS Provider Information: Updates Related to the Coronavirus Disease 2019 (COVID-19)**. Information provided in this guidance is effective for the duration of the State of Emergency declared via the **Governor's Executive Order No 591**. The State of Emergency in Massachusetts ended on June 15, 2021.[1]

The following administrative flexibilities will be allowed during the State of Emergency in accordance with LTSS guidance:

- **Prior authorization extensions -** Therapy Providers may request the continuation of an existing prior authorization. The provider must submit an extension request prior to the end date of the existing prior authorization. Extension requests may be approved for periods up to 30 days depending on the therapy provider's ability to assess the member's continuing need for therapy services. Prior authorization extensions will not be approved for requests to increase the frequency of services.
- **Medical referral requirements -** If a therapy provider is unable to acquire a written medical referral from a licensed physician prior to initiation of therapy services, or for any subsequent 60-day period, as described in 130 CMR 432.415, the therapy provider may obtain a verbal

[1] Order Announcing the Termination of the March 10, 2020 State of Emergency and Rescinding COVID-19 Executive Orders Issued Pursuant to the Massachusetts Civil Defense Act, available at: https://www.mass.gov/info-details/covid-19-state-of-emergency.

medical referral from a licensed physician approving the provision of therapy services. The verbal medical referral for therapy services must include the date and time acquired, as well as the signature of the licensed therapist obtaining the verbal medical referral and must be maintained in the member's record. The therapist provider must acquire the written medical referral for therapy services prior to billing the Plan.

- **Telehealth -** A Therapy Provider may conduct required in-person activities via telehealth (including telephone and live video) in accordance with the standards set forth in the All Provider Bulletin 289, as determined necessary by the Therapy Provider. The performance and delivery of therapy services via telehealth must be clearly documented in the member's medical record. Please refer to Fallon Health's Telemedicine Payment Policy for additional information related to the delivery of therapy services via telehealth and billing/coding guidelines.

Through All Provider Bulletin 314, MassHealth announced that it would maintain the agency's telehealth policy through the date that is 90 days after the termination of the State of Emergency in the Commonwealth due to the Coronavirus disease 2019 (COVID-19) outbreak. Managed Care Entity Bulletin 60 required managed care plans to maintain telehealth policy consistent with All Provider Bulletin 314. Through All Provider Bulletin 324, which supersedes All Provider Bulletin 314, MassHealth maintained and extended the telehealth policy set forth in All Provider Bulletin 314 and extended that policy through October 15, 2021. Managed Care Entity Bulletin 68 required managed care plans to maintain telehealth policy consistent with All Provider Bulletin 324. Through All Provider Bulletin 327, which supersedes All Provider Bulletin 324, MassHealth set forth MassHealth's updated telehealth policy effective for dates of service on or after October 16, 2021. MassHealth anticipates this policy to remain in place through at least December 31, 2022. Managed Care Entity Bulletin 74 requires managed care plans to maintain telehealth policy consistent with All Provider Bulletin 327.

Effective for dates of service on or after October 16, 2021, and through at least December 31, 2022, physical and occupational therapy providers may deliver clinically appropriate, medically necessary MassHealth-covered therapy services to MassHealth members via telehealth, in accordance with MassHealth Managed Care Entity Bulletin 74 and notwithstanding any regulation to the contrary.

Consistent with MassHealth Therapist Bulletin 17, telehealth may be used for therapist services that
a) require the member's consent, documented as described below; and
b) are follow-up visits that do not require any hands-on care.

Follow-up visits do not include evaluations or re-evaluations and may be conducted telephonically if appropriate, but live video is preferred.

Interactive audio and video telehealth may be used, with the member's consent, to conduct a comprehensive evaluation and/or reevaluation under 130 CMR 432.411, 432.415, and 432.416 for members receiving therapy if they have concerns due to COVID-19. Telephone (audio-only) telehealth is not permitted when conducting a comprehensive evaluation and/or reevaluation under 130 CMR 432.411, 432.415, and 432.416 for members receiving therapy who have concerns due to COVID-19.

Providers must obtain verbal consent from a member, and the member's caregiver/legal guardian if applicable, prior to the initiation of telehealth and must document the consent in the member's record.

All documentation requirements of 130 CMR 450.000 and 130 CMR 432.000 apply when services are delivered via telehealth and the documentation must also include:
a) indication in the visit note that the service was provided via telehealth,
b) description in the visit note of the rationale for service via telehealth, and

c) for dates of service on or after September 13, 2021, the following new visit note: On [DATE], member has requested and verbally consented to their comprehensive evaluation, reevaluation, and/or visit being completed via telehealth due to COVID-19. On [DATE], therapist staff discussed the safety protocols that are used during any in-person visit, including but not limited to PPE use and COVID precautions but member still requested telehealth instead of an in-person visit.

Definitions

Physical therapy (PT) is the treatment of disease, injury, or deformity by physical methods.

Occupational therapy (OT) is a form of therapy for those recuperating from physical or mental illness that encourages rehabilitation through the performance of activities required in daily life.

Massachusetts General Law (Chapter 112, Section 23A) defines “physical therapist assistant", as a person duly licensed in accordance with Chapter 112, Section 23B and who assists in the practice of physical therapy under the direction of a duly licensed physical therapist. Similarly, an “occupational therapist assistant’ is defined as a person duly licensed in accordance with Chapter 112, Section 23B and who assists in the practice of occupational therapy who works under the supervision of a duly licensed occupational therapist.

- Physical Therapist Assistant (PTA) - A PTA must be currently licensed by and in good standing with the Massachusetts Division of Professional Licensure, Board of Allied Health Professionals as a PTA. PTAs must work under the supervision of a licensed physical therapist. Supervision of PTAs must be performed following state regulatory guidance. For physical therapy, see 259 CMR 5.00: Physical Therapist.
- Occupational Therapy Assistant (OTA) - An OTA must be currently licensed by and in good standing with the Massachusetts Division of Professional Licensure, Board of Allied Health Professionals as an OTA. OTAs must work under the supervision of a licensed occupational therapist Supervision of OTAs must be performed following state regulatory guidance. For occupational therapy, see 259 CMR 3.00: Occupational Therapists.

Reimbursement

Physical therapy and occupational therapy services are reimbursed according to fee schedule arrangements.

Claims are subject to payment edits that are updated at regular intervals and are generally based on Centers for Medicare & Medicaid Services (CMS) and National Correct Coding Initiative (NCCI) guidelines.

Each date of service should be billed on an individual claim line. Claims billed with date ranges are subject to denial.

The following codes will deny vendor liable for all lines of business:

97545	Work hardening/conditioning; initial 2 hours
97546	Work hardening/conditioning; each additional hour (List separately in addition to code for primary procedure)

Outpatient therapy services provided by skilled nursing facilities and home health agencies to Medicare members with Part B coverage

When allowed by their provider contract with the Plan, SNFs and home health agencies may provide outpatient therapy services under a therapy plan of care to Medicare members with Medicare Part B coverage in accordance with Medicare Benefit Policy Manual Chapter 15, Sections 220 and 230 and Medicare Claims Processing Manual, Chapter 5. Outpatient therapy services provided under a therapy plan of care must be billed with therapy procedure codes (CPT/HCPCS), therapy revenue codes (042X, 043X, 044X), therapy modifiers (GN, GO and GP) and therapy assistant modifiers (CQ and CO), as applicable.

- SNFs may bill for outpatient therapy services provided to residents who are not in a covered SNF stay and to nonresidents who are receiving outpatient rehabilitation services from the SNF.
- Home health agencies may bill for outpatient therapy services provided to patients who are not homebound or otherwise receiving services under a home health plan of care.

Payment reduction for services provided in whole or in part by physical therapy assistants (PTAs) or occupational therapy assistants (OTAs) to Fallon Medicare Plus, NaviCare and PACE (including Summit Eldercare and Fallon Health Weinberg) plan members

Effective for claims processed on or after March 1, 2022, the Plan will apply a 15% payment reduction for outpatient physical therapy and occupational therapy services provided in whole or in part by a PTA or OTA to a Fallon Medicare Plus, NaviCare or PACE plan member. A service is furnished in whole or in part by a PTA or OTA when more than 10% of the service is furnished by the PTA or OTA. Documentation in the medical record must be sufficient to know whether a specific service was furnished independently by a therapist or a therapist assistant, or was furnished in part by a therapist assistant, in sufficient detail to permit the determination of whether the 10% standard was exceeded.

For additional information, refer to MLN Matters Article MM12397 dated November 22, 2021 and Change Request 12397 also dated November 22, 2021.

Referral/notification/prior authorization requirements

Referral and prior authorization requirements vary according to product; contact Customer Service for eligibility and benefit information.

Unlisted codes require prior authorization.

For services requiring a referring/ordering physician, the name and NPI of the referring/ordering provider must be reported on the claim.

Billing/coding guidelines

Reimbursement will be made according to individual contract terms.

It is the responsibility of the provider to code to the highest level specified in the ICD-10-CM.

The Plan allows one evaluation every 60 days.

Services provided by PTAs and OTAs must be billed using the NPI of the supervising therapist.

Therapy modifiers

To align with the Centers for Medicare & Medicaid Services (CMS), effective for dates of service on or after March 1, 2021, the Plan will require therapy modifiers on all claims for outpatient therapy services. This requirement applies to providers submitting professional claims, including physicians, qualified non-physician practitioners, physical therapists in private practice and occupational therapists in private practice, and to providers submitting institutional claims (UB-04), including acute outpatient hospitals, comprehensive outpatient rehabilitation facilities (CORFs), skilled nursing facilities (SNFs) and home health agencies.

Claims for outpatient physical and occupational therapy services must include one of the following modifiers to identify the plan of care under which the service was delivered:

- GP modifier – Services delivered under an outpatient physical therapy plan of care; or
- GO modifier – Services delivered under an outpatient occupational therapy plan of care.

Because the GP and GO therapy modifiers are specific to the PT or OT plan of care, only one of these modifiers is allowed per claim line.

Effective March 1, 2021, institutional claims for outpatient physical or occupational therapy services delivered under a therapy plan of care must report revenue code 042X with a GP modifier or 043X with a GO modifier, as appropriate, along with the procedure code for the

service. Institutional claims for outpatient therapy services that do not meet this requirement will be returned to the provider.

Services provided by therapy assistants for Medicare members

For Fallon Medicare Plus, NaviCare and PACE (including Summit Eldercare and Fallon Health Weinberg) plan members, the services of supervised PTAs and OTAs are covered therapy services. PTAs and OTAs may not provide evaluative or assessment services, make clinical judgments or decisions; develop, manage, or furnish skilled maintenance program services; or take responsibility for the service. They act at the direction and under the supervision of the treating physical or occupational therapist (as applicable) and in accordance with state laws.

Services provided by an PTA or OTA must be billed using the NPI of the supervising physical or occupational therapist.

CMS has established two modifiers, CQ and CO, to indicate services furnished in whole or in part by a PTA or OTA, respectively. The modifiers are defined as follows:

- CQ modifier: Outpatient physical therapy services furnished in whole or in part by a physical therapist assistant
- CO modifier: Outpatient occupational therapy services furnished in whole or in part by an occupational therapy assistant

The CQ modifier must be reported with the GP therapy modifier and the CO modifier must be reported with the GO therapy modifier. Claims with modifiers not so paired will be denied.

Effective for dates of service on or after March 1, 2021, the CQ and CO modifiers must be reported when applicable by therapists in private practice, outpatient hospitals, rehabilitation agencies, skilled nursing facilities, home health agencies and comprehensive outpatient rehabilitation facilities (CORFs) for PTA and OTA services provided to Fallon Medicare Plus, NaviCare and PACE (including Summit Eldercare and Fallon Health Weinberg) plan members.

When a therapy service is defined in 15-minute increments, services billed on the same day, to the same plan member will not be considered duplicates when one claim line is submitted with modifier CQ or CO and another is not, for example:

Code	Units of Service	Therapy Modifier	Therapy Assistant Modifier
97110	1	GP	
97110	1	GP	CQ

CMS provides billing examples using the CQ and CO modifiers for services furnished in whole or in part by PTAs and OTAs at: https://www.cms.gov/medicare/therapy-services/billing-examples-using-cqco-modifiers-services-furnished-whole-or-part-ptas-and-otas.

The services of PTAs and OTAs may not be billed incident to the services of physicians or NPPs, because PTAs/OTAs do not meet the qualifications of a therapist. Only the services of a licensed/registered physical therapist or occupational therapist can be billed “incident to” a physician service. However, if a PT and PTA (or an OT and OTA) are both employed in a physician’s office, the services of the PTA, when directly supervised by the PT, or the services of the OTA, when directly supervised by the OT, may be billed by the physician group as physical therapy or occupational therapy services using the NPI of the PT or OT. If the PT or OT does not have an NPI, the services of the PTA or OTA cannot be billed incident to the physician services because they do not meet the qualifications in 42 CFR 484.4 (Medicare Benefit Policy Manual, Chapter 15, Section 230.5).

CPT 97033 – Iontophoresis (to one or more areas)

Iontophoresis is the introduction into the tissues, by means of an electric current, of the ions of a chosen medication. Iontophoresis is covered for treatment of intractable, disabling primary focal hyperhidrosis (ICD-10-CM codes L74.510, L74.511, L74.512, L74.513 or L74.519) that has not

been responsive to recognized standard therapy. Good hygiene measures, extra-strength antiperspirants (for axillary hyperhidrosis), and topical aluminum chloride should initially be tried.

CPT 97033 requires direct (one-on-one) contact with the patient by the provider (constant attendance). Coverage for direct (one-on-one) contact codes indicates the provider is performing the modality and cannot be performing another procedure at the same time. Only the actual time of the provider's direct contact with the patient, providing services requiring the skills of a therapist, is covered for direct (one-on-one) contact codes.

CPT 95992 – Canalith repositioning (e.g., Epley or Semont maneuver), per day

Effective March 1, 2022, coverage for canalith repositioning is limited to the treatment of benign paroxysmal positional vertigo. Claims for CPT 97033 must be submitted with one of the following ICD-10-CM diagnosis codes: H81.11, H81.12, H81.13 (may be primary or secondary, up to the fourth diagnosis code position).

Canalith repositioning is reported once per date of service regardless of the amount of time spent. When provided during the same encounter as an E&M service, a significant and separately identifiable reason supporting the E&M service should be present. It would not be appropriate to report CPT 95992 in conjunction with nystagmus testing codes 92531 and 92532 on the same day.

Outpatient cognitive rehabilitation services (CPT 97129 and 97130) for commercial plan members

Cognitive rehabilitation, as a distinct and definable component of the rehabilitation process, may be considered medically necessary in the rehabilitation of plan members with cognitive impairment due to COVID-19.

As required by Section 70 of Chapter 260 of the Acts of 2020, effective for dates of service on or after 01/01/2021, Fallon Health will waive cost-sharing for commercial plan members for cognitive rehabilitation (CPT 97129 and 97130) related to the treatment of COVID-19 when provided by both in-network and out-of-network providers.

Massachusetts Division of Insurance (DOI) Bulletin 2021-08 further requires these services to be provided without the use of prior authorization processes.

Per ICD-10-CM instructions, for sequela of COVID-19, assign a code(s) for the specific symptom(s) or condition(s) first, followed by U09.9, Post COVID-19 condition, unspecified, in a secondary position.

- For dates of service 01/01/2021 through 09/30/2021, ICD-10-CM diagnosis code B94.8, Sequelae of other specified infectious and parasitic diseases, will waive cost-sharing.
- For dates of service 10/01/2021 and onward, ICD-10-CM diagnosis code U09.9, Post COVID-19 condition, unspecified, will waive cost-sharing.

Physical and occupational therapy procedure codes

The following codes are included below for informational purposes only; inclusion of a code does not constitute or imply coverage.

Code	Description
97010	Application of a modality to 1 or more areas; hot or cold packs (Covered for MassHealth ACO, NaviCare and PACE only; for commercial and Medicare Advantage plan members, CPT code 97010 is not separately reimbursed.)

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) (Covered for MassHealth ACO plan members only)
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)
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)
97129	Therapeutic interventions that focus on cognitive function (eg, attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (eg, managing time or schedules, initiating, organizing, and sequencing tasks), direct (one-on-one) patient contact; initial 15 minutes
97130	Therapeutic interventions that focus on cognitive function (eg, attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (eg, managing time or schedules, initiating, organizing, and sequencing tasks), direct (one-on-one) patient contact; each additional 15 minutes (list separately in addition to code for primary procedure)
97139	Unlisted therapeutic procedure (specify)
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)

97161	Physical therapy evaluation: low complexity, requiring these components: A history with no personal factors and/or comorbidities that impact the plan of care; An examination of body system(s) using standardized tests and measures addressing 1-2 elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions; A clinical presentation with stable and/or uncomplicated characteristics; and Clinical decision making of low complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 20 minutes are spent face-to-face with the patient and/or family.
97162	Physical therapy evaluation: moderate complexity, requiring these components: A history of present problem with 1-2 personal factors and/or comorbidities that impact the plan of care; An examination of body systems using standardized tests and measures in addressing a total of 3 or more elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions; An evolving clinical presentation with changing characteristics; and Clinical decision making of moderate complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 30 minutes are spent face-to-face with the patient and/or family.
97163	Physical therapy evaluation: high complexity, requiring these components: A history of present problem with 3 or more personal factors and/or comorbidities that impact the plan of care; An examination of body systems using standardized tests and measures addressing a total of 4 or more elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions; A clinical presentation with unstable and unpredictable characteristics; and Clinical decision making of high complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 45 minutes are spent face-to-face with the patient and/or family.
97164	Re-evaluation of physical therapy established plan of care, requiring these components: An examination including a review of history and use of standardized tests and measures is required; and Revised plan of care using a standardized patient assessment instrument and/or measurable assessment of functional outcome Typically, 20 minutes are spent face-to-face with the patient and/or family.
97165	Occupational therapy evaluation, low complexity, requiring these components: An occupational profile and medical and therapy history, which includes a brief history including review of medical and/or therapy records relating to the presenting problem; An assessment(s) that identifies 1-3 performance deficits (ie, relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and Clinical decision making of low complexity, which includes an analysis of the occupational profile, analysis of data from problem-focused assessment(s), and consideration of a limited number of treatment options. Patient presents with no comorbidities that affect occupational performance. Modification of tasks or assistance (eg, physical or verbal) with assessment(s) is not necessary to enable completion of evaluation component. Typically, 30 minutes are spent face-to-face with the patient and/or family.
97166	Occupational therapy evaluation, moderate complexity, requiring these components: An occupational profile and medical and therapy history, which includes an expanded review of medical and/or therapy records and additional review of physical, cognitive, or psychosocial history related to current functional performance; An assessment(s) that identifies 3-5 performance deficits (ie,

	relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and Clinical decision making of moderate analytic complexity, which includes an analysis of the occupational profile, analysis of data from detailed assessment(s), and consideration of several treatment options. Patient may present with comorbidities that affect occupational performance. Minimal to moderate modification of tasks or assistance (eg, physical or verbal) with assessment(s) is necessary to enable patient to complete evaluation component. Typically, 45 minutes are spent face-to-face with the patient and/or family.
97167	Occupational therapy evaluation, high complexity, requiring these components: An occupational profile and medical and therapy history, which includes review of medical and/or therapy records and extensive additional review of physical, cognitive, or psychosocial history related to current functional performance; An assessment(s) that identifies 5 or more performance deficits (ie, relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and Clinical decision making of high analytic complexity, which includes an analysis of the patient profile, analysis of data from comprehensive assessment(s), and consideration of multiple treatment options. Patient presents with comorbidities that affect occupational performance. Significant modification of tasks or assistance (eg, physical or verbal) with assessment(s) is necessary to enable patient to complete evaluation component. Typically, 60 minutes are spent face-to-face with the patient and/or family.
97168	Re-evaluation of occupational therapy established plan of care, requiring these components: An assessment of changes in patient functional or medical status with revised plan of care; An update to the initial occupational profile to reflect changes in condition or environment that affect future interventions and/or goals; and a Revised plan of care. A formal re-evaluation is performed when there is a documented change in functional status or a significant change to the plan of care is required. Typically, 30 minutes are spent face-to-face with the patient and/or family.
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 (eg, activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact, each 15 minutes
97537	Community/work reintegration training (eg, shopping, transportation, money management, avocational activities and/or work environment/modification analysis, work task analysis, use of assistive technology device/adaptive equipment), direct one-on-one contact, each 15 minutes (Covered Medicare plan members (Fallon Medicare Plus, NaviCare and PACE))
97542	Wheelchair management (eg, assessment, fitting, training), each 15 minutes
G0283	Electrical stimulation (unattended), to one or more areas for indications(s) other than wound care, as part of a therapy plan of care (Covered commercial and Medicare members only (Fallon Medicare Plus, NaviCare and PACE))

Therapy modifiers

Effective for dates of service on or after March 1, 2021, the Plan will require therapy modifiers on all claims for outpatient therapy services.

Modifier	Description
GP	Services delivered under an outpatient physical therapy plan of care
GO	Services delivered under an outpatient occupational therapy plan of care

Therapy assistant modifiers

To be used by therapists in private practice, outpatient hospitals, rehabilitation agencies, skilled nursing facilities, home health agencies and comprehensive outpatient rehabilitation facilities (CORFs) on claims for services furnished in whole or in part by a PTA or OTA to Fallon Medicare Plus, NaviCare and PACE (including Summit Eldercare and Fallon Health Weinberg) plan members.

CQ	Outpatient physical therapy services furnished in whole or in part by a physical therapist assistant
CO	Outpatient occupational therapy services furnished in whole or in part by an occupational therapy assistant

Policy history

Origination date: February 1, 2017
Previous revision date(s): N/A
Connection date & details:
March 2017 – Introduced policy.
April 2018 – Annual Review, no updates.
October 2018 – Clarified claims should be billed per date of service and not date ranges.
October 2019 – Updated coverage of codes 97545/97546.
June 2020 – Updates for COVID-19 for MassHealth ACO and NaviCare in accordance with MassHealth LTSS guidance.
June 26, 2020 – Updates for COVID-19 for Summit ElderCare in accordance with MassHealth LTSS guidance.
January 2021 – Added requirement for therapy modifiers on claims for physical and occupational therapy services.
July 2021 – Clarified modifier requirements under Billing/coding guidelines.
January 2022 – Updated to include information on billing for iontophoresis (CPT 97033) and canalith repositioning (CPT 95992); coverage for services of physical therapy assistants (PTAs), occupational therapy assistants (OTAs) for MassHealth members for dates of service on or after November 26, 2021; and notification of payment reduction for services provided in whole or in part by PTAs or OTAs to Fallon Medicare Plus, NaviCare and PACE plan members effective for dates of service on or after March 1, 2022.
April 2022 - Billing/coding guidelines updated to include cognitive rehabilitation services.
July 2022 – Updated Policy section with information about coverage for therapy services delivered via telehealth for MassHealth members following the end of the state of emergency due to COVID-19.

The criteria listed above apply to Fallon Health Plan and its subsidiaries. This payment policy has been developed to provide information regarding general billing, coding, and documentation guidelines for the Plan. Even though this payment policy may indicate that a particular service or supply is considered covered, specific provider contract terms and/or member individual benefit plans may apply and this policy is not a guarantee of payment. The Plan reserves the right to apply this payment policy to all of the Plan companies and subsidiaries. The Plan routinely verifies that charges billed are in accordance with the guidelines stated in this payment policy and are appropriately documented in the medical records. Payments are subject to post-payment audits and retraction of overpayments.