BlueCross BlueShield of Minnesota

REIMBURSEMENT POLICY

Physical Therapy (PT) Modalities and Evaluation

Active

Policy Number:	Rehabilitative Services – 001
Policy Title:	Physical Therapy (PT) Modalities and Evaluation
Section:	Rehabilitative Services
Effective Date:	03/24/15

Description

This policy addresses coverage and coding for Physical Therapy (PT) services.

Definitions

PT is a branch of rehabilitative health to help patients regain or improve their physical abilities, such as mobility, strength, gait, endurance, coordination and balance. PT services are reported under CPT codes 97010-97799.

Policy Statement

The physical medicine codes 97010-97028, 97032-97036, 97039 require a physician or therapist to be in constant attendance.

The codes 97110- 97124 should be used for physical therapy procedures.

Coverage for manual therapy services (97140) provided is subject to the subscriber's contract benefits. Some benefit plans may not cover this service.

Additional physical therapy codes 97140-97542 and 97597-97606 should be used as defined in CPT.

A Physical therapist evaluations and re-evaluation services should be submitted using CPT codes 97161-97164. These codes may be reported separately if the patient's condition requires significant separately identifiable services, above and beyond the usual pre-service and post-service work associated with the procedure performed.

The modifier -25 (significant, separately identifiable evaluation and management service by the same physician on the same day as the procedure or other service) is not valid with the physical therapy (PT) evaluations and re-evaluation codes 97161-97164. The evaluation or re-evaluation codes will be allowed, as appropriate, when billed with other physical or occupational services on the same date. Because the modifier -25 is not valid with 97161-97164, if submitted, the service will be denied.

Use modifier 96 (following the CPT code) to identify habilitative services.
Use modifier 97 for rehabilitative services

Habilitative services help a person keep, learn, or improve skills and functioning for daily living. In contrast, rehabilitative services help a person keep, get back, or improve skills and

functioning for daily living that have been lost or impaired because a person was sick, hurt, or disabled.

Habilitative and rehabilitative services can involve the same services, provided in the same setting, to address the same functional deficits and achieve the same outcomes; the difference is whether they involve learning something new or relearning something that has been lost or impaired.

"Timed" Unit Reporting

When a procedure/service indicates time, more than half of the designated time must be spent performing the service in order for a unit to be billed. In the case of a fifteen (15) minute service, at least eight (8) minutes must be performed; for a thirty (30) minute service, at least sixteen (16) minutes must be performed; and for a sixty (60) minute service, at least thirty-one (31) minutes must be performed, and so on.

As defined in Appendix A of the AUC Minnesota Uniform Companion guide, section A.3.4.2. Units (basis for measurement), if more than one modality or therapy is performed, time cannot be combined to report units. Do not follow Medicare's rounding rules for speech (ST), occupational (OT) and physical therapy (PT) services. Each modality and unit(s) is reported separately by code definition. Do not combine codes to determine total time units. For example, if two fifteen (15) minute defined modalities are performed, but only seven (7) minutes or less are spent per modality, then neither service should be reported.

Exclusions:

Hot and Cold Pack

Blue Cross will not reimburse providers for the physical medicine hot and cold pack modality, CPT code 97010. Blue Cross reviewed the utilization of the hot and cold pack therapy code and determined that this modality is used in conjunction with and/or to enhance other services performed. Thus, 97010 will be denied as provider liability, whether billed alone or with another service.

Massage Therapy Exclusion

Blue Cross will not reimburse providers for massage therapy services (97124). Massage therapy will deny either as incidental (provider liability) or subscriber liability.

Massages that are provided as preparation for a physical medicine therapy are considered an integral part of the therapy. As such, we will deny it as provider liability. If a massage is billed alone, then it may be denied as a subscriber contract exclusion.

Provider liable:

Massage therapy may be denied incidental (provider liable) to physical medicine procedures billed on the same date of service. Refer to the 'General Coding - 003 - Code Editing Policy' for incidental and mutually exclusive denials. This denial will be upheld regardless of submission of the -59 modifier. Additionally, submission of the –GA modifier will not affect or change the denial. The patient is not responsible and must not be balance billed for any procedures for which payment has been denied or reduced by Blue Cross as the result of a coding edit. Edit denials are designed to ensure appropriate coding and to assist in processing claims accurately and consistently.

The code combinations and outcomes are listed below.

CODE	DENIAL	TO CODES
97124	Incidental	97110, 97112-97113, 97116, 97139-97140, 97150, 97530, 97533, 97535, 97537, 97542, 97545-97546, 98925-98929, 98940-98943

Subscriber Liable:
Coverage for massage therapy services provided without a physical medicine therapy is subject to the subscriber's contract benefits. Some benefit plans may not cover this service.

TMJ Orthotic Adjustments

Adjustments for TMJ orthotics are normally billed under CPT codes 97760-97763. These services are not separately covered with a TMJ diagnosis. These adjustments are considered an integral part of the splint therapy and as such will be denied regardless if billed alone or with another service.

Medicare Advantage Policy and Medicare Cost Plan

Rehabilitative Therapy Modifiers Required for Medicare Advantage Plans
Professional and facility providers are reminded to accurately bill rehabilitative therapies provided to subscribers enrolled in a Medicare Advantage plan. Medicare Advantage claims submitted to Blue Cross for rehabilitative therapies must include the appropriate modifier(s) as required by Medicare.

Rehabilitative therapies that are submitted for Medicare Advantage plan subscribers without the appropriate modifier will be denied with the Claim Adjustment Reason Code of 4, "The procedure code is inconsistent with the modifier used or a required modifier is missing."

Services submitted with a GP modifier are delivered under an outpatient physical therapy plan of care.

Modifier CQ is required when a patient is seen by a therapy assistant rather than a therapist. Modifier CQ – Outpatient physical therapy services furnished in whole or in part by a physical therapy assistant.

PT services are billable to Medicare as primary payer for Platinum Blue enrollees only.

Documentation Submission

Documentation must identify and describe the procedures performed and time spent for each service. The ordering physician and treatment plan must be documented. If a denial is appealed, this documentation must be submitted with the appeal.

Coverage

Eligible PT services will be subject to the Blue Cross fee schedule amount and any coding edits.

The following applies to all claim submissions.

All coding and reimbursement are subject to all terms of the Provider Service Agreement and subject to changes, updates, or other requirements of coding rules and guidelines. All codes are subject to federal HIPAA rules, and in the case of medical code sets (HCPCS, CPT, ICD), only

codes valid for the date of service may be submitted or accepted. Reimbursement for all Health Services is subject to current Blue Cross Medical Policy criteria. Reimbursement Policies and all other provisions of the Provider Service Agreement (Agreement).

In the event, any new codes are developed over the course of Provider's Agreement, such new codes will be reimbursed according to the standard or applicable Blue Cross fee schedule until such time as a new agreement is reached and supersedes the Provider's current Agreement.

All payment for codes based on Relative Value Units (RVU) will include a site of service differential and will be calculated, if appropriate, using the appropriate facility or non-facility components, based on the site of service identified, as submitted by Provider.

Coding

The following codes are included below for informational purposes only, and are subject to change without notice. Inclusion or exclusion of a code does not constitute or imply member coverage or provider reimbursement.

CPT / HCPCS Modifier:	25, CQ, GP, 96, 97
ICD Diagnosis:	N/A
ICD Procedure:	N/A
HCPCS:	97010-97799
Revenue Codes:	N/A
Deleted Codes:	

Policy History

Initial Committee Approval Date:	March 24, 2015
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