Neighborhood Health Plan of Rhode Island

THERAPEUTIC SERVICES (PHYSICAL & OCCUPATIONAL)

Payment policies apply to all in-network and out-of-network providers who render services to Neighborhood Health Plan of Rhode Island subscribers who are covered under the following products: Access (MED, CSN, SUB), Unity (RHO), Trust (RHE, RHP) and Health Benefit Exchange (HBE).
Members covered under the Extended Family Planning (EFP) product are not eligible for rehabilitation therapy services. EFP is not a comprehensive benefit package.
Benefit coverage limits may apply. It is the provider's responsibility to verify eligibility, coverage and authorization criteria prior to rendering services.

Please refer to Neighborhood's provider website at http://www.nhpri.org for specific provisions by product line.
This guideline is not a guarantee of reimbursement. Plan coverage, eligibility and claim payment edit rules may apply.

KEY CODING, BILLING AND REIMBURSEMENT GUIDELINES

- Services should be submitted on a valid CMS 1500 paper form or via Electronic Data Interchange (EDI) 837P format. Hospital based agencies should submit on a valid CMS 1450 (UB-04) form or EDI 837I format. Handwritten claims will not be accepted.
- Services must be performed by a contracted Physical or Occupational Therapist or contracted Therapy group in order to be reimbursed.
- *One initial evaluation and eight visits per 365 day period do not require authorization.
- Therapy codes are typically timed codes and are billed in 15 minute increments
- A single 15-minute unit of therapy is equal or greater than 8 minutes but less than 23 minutes.
- Therapists should not bill for any services performed for less than 8 minutes. Please follow the following guidelines for billing multiple units of therapy services:

Units reported on claim	**Number of minutes**
1 unit	>8 minutes through 22 minutes
2 units	>23 minutes through 37 minutes
3 units	>38 minutes through 52 minutes
4 units	>53 minutes through 67 minutes
5 units	>68 minutes through 82 minutes
6 units	>83 minutes through 97 minutes
7 units	>98minutes through 112 minutes
8 units	>113 minutes through 127 minutes

**Refer to Neighborhood's "Outpatient Rehab Therapies- Adults" clinical medical policy for clinical criteria and required supportive documents (Link on page 6)*

- Multiple therapy services performed on the same date are billed based on the "total treatment minute" guidelines for the same type of service: Modalities vs. Therapeutic procedures.

- The time documented for "timed therapy codes" excludes any other pre or post treatment services. Waiting times, independent (unattended) exercise time, rest periods, bathroom breaks, and clothing changes are excluded from the calculation of time.

- Medical record documentation by the therapist should indicate the beginning and ending times of each modality and the outcomes of each treatment. As in all therapy service, the patient's conditions along with the need for services that can only be provided by a licensed Therapist are key determinants of medical necessity.

- Code 97010 (application of modality to one or more areas; hot or cold packs) is a bundled procedure and not separately reimbursable per CPT and CCI edit rules.

Modifiers

Submit the appropriate modifiers when applicable.

GP	Services delivered under an outpatient PT plan of care
GO	Services delivered under an outpatient OT plan of care
59*	Distinct Procedural Service (documentation may be required)

*Note: Modifier 59 - Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used.

Written Treatment Plan/Plan of Care

1. Outpatient rehabilitation therapy services must relate directly and specifically to a written treatment plan (also known as the plan of care or plan of treatment).

2. The treatment plan must be established prior to treatment and established by a physician, an NPP, a physical therapist, an occupational therapist, or a speech-language pathologist.

3. The signature and professional identity of the person who established the treatment plan and the date it was established must be recorded with the treatment plan.

4. The established treatment plan requires the physician's/NPP's certification (with or without an order) to satisfy all of the certification requirements for the duration of the treatment plan, or 90 calendar days from the date of the initial treatment, whichever is less. The initial treatment includes the evaluation that resulted in the plan.

5. Timely certification of the initial treatment plan is met when the physician/NPP certification of the plan is documented, by signature or verbal order, and dated within 30 days following the first day of treatment (including evaluation). Verbal orders must be followed within 14 days by a signature and date.

6. If significant changes need to be made to the treatment plan, the physician/NPP certification is required.

7. The plan of care, at a minimum, should contain:

- Diagnoses;
- Long-term treatment goals;
- Type of rehabilitation therapy services (physical therapy, occupational therapy, or speech language pathology)
- Identifies each specific intervention, procedure or modality, in order to support billing and verify correct coding;
- Amount of therapy – number of treatment sessions in a day;
- Duration of therapy – number of weeks or number of treatment sessions; and
- Frequency of therapy – number of treatment sessions in a week.

8. Recertification documenting the need for continued or modified therapy should be signed whenever a significant modification of the treatment plan is needed, or at least every 90 days after initiation of treatment under the treatment plan. Recertification should be sooner when the duration of the treatment plan is less than 90 days.

PTA & OTA

- The supervising therapist performs the evaluation and establishes the plan of care
- The services the PTA/OTA provides are medically necessary
- The supervising therapist provides direct onsite supervision (i.e., he or she can be in the same building but not necessarily in the same room) or at least general supervision of the physical therapist.
- The supervising therapist must be immediately available to intervene. (i.e., he or she cannot be doing something that is uninterruptable.)
- The supervising therapist must have active ongoing involvement in the management and control of the patient's condition.
- If the patient presents with a new condition, the supervising therapist must see the patient.
- The PTA/OTA providing the service under the direct/general onsite supervision of the therapist must be an employee or an independent contractor of the practice.
- Include language that affirms the supervising therapist reviewed the plan of care with the PTA/OTA providing the service under their direction.

- Document regular meetings with the PTA/OTA where the supervising therapist reviewed the patient's progress.
- Indicate when the treatment has advanced to the next more complex or sophisticated task.

***Utilization of PTA**

In general supervision, the physical therapist is not required to be on-site for direction and supervision, but must be available at least by telecommunications. (i.e., PTA providing services in a home care setting.)

When supervising the physical therapist assistant in any off-site setting, the following requirements must be observed:

1. A physical therapist must be accessible by telecommunications to the physical therapist assistant at all times while the physical therapist assistant is treating patients/clients.

2. There must be regularly scheduled and documented conferences with the physical therapist assistant regarding patients/clients, the frequency of which is determined by the needs of the patient/client and the needs of the physical therapist assistant.

3. In those situations in which a physical therapist assistant is involved in the care of a patient/client, a supervisory visit by the physical therapist will be made:

    a. Upon the physical therapist assistant's request for a reexamination, when a change in the plan of care is needed, prior to any planned discharge, and in response to a change in the patient's/client's medical status.

    b. At least once a month, or at a higher frequency when established by the physical therapist, in accordance with the needs of the patient/client.

    c. A supervisory visit should include:

        i. An on-site reexamination of the patient/client.

        ii. On-site review of the plan of care with appropriate revision or termination.

        iii. Evaluation of need and recommendation for utilization of outside resources.

**Refer to RI Dept of Health Rules and Regulations for licensing Physical Therapists and Physical Therapists Assistants. Link on Page 6*

GENERAL DOCUMENTATION GUIDELINES

Medical Record Requirements for all provider types to insure the confidentiality of our members and limit the access to the records to authorized personnel only.

- An individual record must be established for each patient
- An organized record-keeping system must be in place to ensure that medical records are easily retrievable for review and available for use when needed. (At no time should the medical records be left in the home.)
- Medical records must be stored and maintained in a centralized and secured location accessible only to authorized personnel. For electronic medical records equivalent security must be provided.
- All medical records must be organized in the same specific order.
- All documents must be securely fastened in the record.
- Periodic training in confidentiality and security for patient information must be provided to employees with documentation of the time and dates of the training noted in their employee records.

Minimum Record Standards for all provider types to establish a complete and current medical record for each member who has been serviced or is currently under service by the contracted Physical, Occupational, and/or Speech Therapy provider:

- Member identifiers appear on all documentation. (This included both side of the document and contains the member's full names and one other unique identifier.)
- Entries are legible to others and are recorded in black or blue ink if on paper
- All documentation entries must be dated and include a complete dates of service, which includes the month, date, year and are authenticated by the author
- The documentation of services provided is to be completed at the time service is provided or as soon as reasonably possible. The specific amount of time spent providing the service to the patient must be documented.
- Documentation must support all codes submitted
- Only standard medical abbreviations should be used in documentation
- All patient encounters, including telephone, fax, and electronic message exchanges are to be documented
- Do not use corrective material (liquid/paper white out, labels) or delete entries from the original record. Drawing a line through an incorrect entry is appropriate with the initials of the person amending the record and the reason for the change.
- Documentation of any advance directives should be located in a prominent part of a member's medical record and includes whether or not a member has executed an advance directive, as well as documentation of any information about advance directives that was made available to the member
- Addendums to the original clinical/medical record must be signed and dated by the person who rendered the service with an attestation to the reason for the change. Changes must be made in a reasonable timeframe and as close to the time of service according to widely accepted medical recordkeeping practices

ADDITIONAL RESOURCES

Neighborhood Provider Manual
http://www.nhpri.org/Portals/0/Uploads/Documents/2014_Provider_Manual.pdf

Neighborhood Health Plan of RI Clinical Medical Policies Outpatient Rehab Therapies-Adult

http://www.nhpri.org/Portals/0/Uploads/Documents/CMP/CMP-049%20Outpatient%20Rehab%20Therapies%20-%20Adults%20DISC%209-16-2014.pdf

Neighborhood Health Plan of RI Benefit Coverage Summaries
http://www.nhpri.org/Providers/ResourcesFAQs.aspx

www.oig.hhs.gov , Federal Register (08-07-1998

Centers for Medicare and Medicaid Services
http://www.cms.gov/

Outpatient Rehabilitation Therapy Services: Complying with Documentation Requirements
www.cms.gov

(CMS Manual System (Pub 100-04 Medicare Claims Processing Transmittal 1019) :11 Part B Billing Scenarios for PTs and OTs

AMA CPT Coding publications

American Physical Therapy Association
http://integrity.apta.org/ReducingRisk/UnderstandingRisk/RiskAreas/Documentation/

RI Department of Health Rules and Regulations for licensing Physical Therapists and Physical Therapist Assistants [R5-40-PT/PTA]
http://sos.ri.gov/documents/archives/regdocs/released/pdf/DOH/7026.pdf

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Policy Changes:
3/17/2015 New version updated, Format change, PTA/OTA criteria added

DISCLAIMER:
Claims payment is subject to Neighborhood Health Plan of RI benefit coverage, member eligibility, claim payment edit rules, coding and documentation guidelines, authorization policies, provider contract agreements and state or federal regulations. All services billed to Neighborhood for reimbursement is subject to audit. Effective dates noted reflects the date the long standing policy was documented or updated to assist with provider education, unless otherwise noted.