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# Physical and Occupational Therapy Services Payment Policy

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## Policy Statement

Physical therapy (PT) is the treatment of disease or injury by the use of therapeutic exercise and other interventions that focus on improving posture, locomotion, strength, endurance, balance, coordination, joint mobility, flexibility, a person's ability to go through the functional activities of daily living, and on alleviating pain.

Occupational therapy (OT) is a form of rehabilitation therapy involving the treatment of neuro-musculoskeletal and psychological dysfunction through the use of specific tasks or goal directed activities designed to improve the functional performance of an individual.

## Scope

This policy applies to:

- Medicaid** *excluding Extended Family Planning (EFP)*
- Commercial**
- Dual CONNECT (Coordination only D-SNP)**
- INTEGRITY for Duals (Fully Integrated D-SNP)**

## Prerequisites

Members must receive an order for outpatient therapy services from their primary care provider (PCP) or treating qualified provider that is separate from the provider rendering therapy services. The ordering/referring provider must be documented in the member's medical record, as well as, noted in Box 17 (referring provider) on the claim.

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). The treatment plan must be established prior to treatment and established by a physician, an NPP, a physical therapist, or an occupational therapist. The services provided must be:

- consistent with the nature and severity of illness,
- considered safe and effective for the patient's condition,
- used to restore function, or provided as part of a defined treatment plan for an acute illness, injury, or an acute exacerbation of a chronic illness with significant potential for functional recovery.

The services must be performed by a contracted Physical or Occupational Therapist or a contracted Therapy group in order to be reimbursed.



### **Physical Therapy Assistant (PTA) or Occupational Therapy Assistant (OTA)**

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:

- 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.
- 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.
- 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:
  - 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.
  - 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. A supervisory visit should include:
    - An on-site reexamination of the patient/client.
    - On-site review of the plan of care with appropriate revision or termination.
    - Evaluation of need and recommendation for utilization of outside resources.

It is the provider's responsibility to verify eligibility, coverage, and authorization criteria prior to rendering services.

For more information please refer to:

- Neighborhood's plan specific [Prior Authorization Reference page](#).
- Neighborhood's [Clinical Medical Policies](#).

Please contact Provider Services at 1-800-963-1001 for any questions regarding this policy.

### **Coverage**

A physical therapy session is typically defined as up to 1 hour of PT (treatment and/or evaluation) or up to 3 PT modalities provided on any given day.

An occupational therapy session is typically defined as up to 1 hour of occupational therapy (treatment and/or evaluation) on any given day.



## Coverage Limitations/Prior Authorization Requirements

### All Lines of Business

- Neighborhood has partnered with Evolent Health to manage physical medicine services. Authorization will be required for all physical and occupational therapy services.

### Coverage Exclusions

- Medicaid children – services as defined in the child’s Individual Education Plan (IEP) should be submitted to Medicaid Fee-for-Service<sup>1</sup>
- General Conditioning Programs
- Vocational rehabilitation, testing and screening focusing on job adaptability, job placement
- Rehabilitative services to restore function for a member's specific occupation
- Services provided solely for the convenience of the member or service provider

### Claims Submission

The codes in *Table 2* below are required to be billed with one of the following modifiers to distinguish the discipline under which the service was delivered. If one of the required modifiers is not appended these codes will deny.

- **GO-** Services delivered under an outpatient OT plan of care
- **GP-** Services delivered under an outpatient PT plan of care

The below modifiers are required when a service is provided by an occupational therapy assistant or a physical therapy assistant. Neighborhood will apply CMS reimbursement rules to all lines of business for these modifiers.

- **CO-** Occupational therapy services furnished in whole or in part by an occupational therapy assistant (OTA)
- **CQ-** Outpatient physical therapy services furnished in whole or in part by a physical therapy assistant (PTA)

Billable services are subject to contractual agreements, when applicable. Providers are required to submit complete claims for payment within contractually determined timely filing guidelines.

Coding must meet standards defined by the American Medical Association’s Current Procedural Terminology Editorial Panel’s (CPT®) codebook, the International Statistical Classification of Diseases and Related Health Problems, 10th revision, Clinical Modification (ICD-10-CM), and the Healthcare Common Procedure Coding System (HCPCS) Level II.

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<sup>1</sup> Contract between RI EOHHS and NHPRI: Special Education defined.

### Documentation Requirements

Neighborhood reserves the right to request medical records for any service billed. Documentation in the medical record must support the service(s) billed as well as the medical necessity of the service(s). Neighborhood follows CMS standards for proper documentation requirements.

To qualify for reimbursement, all records must be kept in accordance with Rhode Island state and federal regulations.

### Written Treatment Plan/Plan of Care

Neighborhood follows CMS requirements as outlined in the [Outpatient Rehabilitation Therapy Documentation Requirements](#).

#### The written treatment plan/plan of care, at a minimum, should contain:

- Diagnoses
- Short and Long-term treatment goals
- Type of rehabilitation therapy services (physical therapy and/or occupational therapy)
- 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
- Frequency of therapy – number of treatment sessions in a week.

### Member Responsibility

**Commercial** plans include cost-sharing provisions for coinsurance, copays, and deductibles. Members may have out of pocket expenses based on individual plan selection and utilization. Please review cost-sharing obligations or contact Member Services prior to finalizing member charges.

For Neighborhood CONNECT (Coordination only D-SNP plan), providers must submit claims to Neighborhood and any remaining copays/coinsurance amounts and Medicaid covered benefits to EOHHS for reimbursement.

### Coding

This policy may apply to the follow codes. Inclusion of a code in this policy does not guarantee coverage or that it will be reimbursed.

**Table 1: PT & OT Evaluation and Re-Evaluation Codes**

CPT Code	Description
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

CPT Code	Description
	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.

CPT Code	Description
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 reevaluation 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.

**Table 2: PT & OT Modalities**

CPT Code	Description
97010	Application of a modality to 1 or more areas; hot or cold packs
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)
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

CPT Code	Description
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)
97530	Therapeutic activities, direct (one-on-one) patient contact (use of dynamic activities to improve functional performance), 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
97542	Wheelchair management (eg, assessment, fitting, training), each 15 minutes
97750	Physical performance test or measurement (eg, musculoskeletal, functional capacity), with written report, each 15 minutes
97755	Assistive technology assessment (eg, to restore, augment or compensate for existing function, optimize functional tasks and/or maximize environmental accessibility), direct one-on-one contact, with written report, each 15 minutes
G0283	Electrical stimulation (unattended), to one or more areas for indication(s) other than wound care, as part of a therapy plan of care
S8948	Application of a modality (requiring constant provider attendance) to one or more areas; low-level laser; each 15 minutes
S9117	Back school, per visit

### Disclaimer

This payment policy is informational only and is not intended to address every situation related to reimbursement for healthcare services; therefore, it is not a guarantee of reimbursement.

Claim payments are subject to Neighborhood Health Plan of Rhode Island benefit coverage, member eligibility, claims payment edit rules, coding and documentation guidelines, authorization policies, provider contract agreements, and state and federal regulations. References to CPT or other sources are for definitional purposes only.



Neighborhood processes Dual CONNECT and INTEGRITY for Duals in accordance with CMS Medicare guidelines. Refer to [CMS Medicare guidance](#) for complete rules and claims processing policies.

This policy may not be implemented exactly the same way on the different electronic claims processing systems used by Neighborhood due to programming or other constraints; however, Neighborhood strives to minimize these variations.

The information in this policy is accurate and current as of the date of publication; however, medical practices, technology, and knowledge are constantly changing. Neighborhood reserves the right to update this payment policy at any time. All services billed to Neighborhood for reimbursement are subject to audit.

### Document History

Date	Action
01/01/2026	Annual Review Date. Updated policy template to include new lines of business. Updated Prior Authorizations, Member Responsibility and Disclaimer language. Updated Documentation Requirements to align with CMS.
03/19/2025	Annual Review Date. Updated policy name to remove Rehabilitation. Updated coverage exclusions. Added documentation requirements.
03/01/2025	Updated authorization language for INTEGRITY
06/01/2024	Annual Review Date. Updated authorization language for Medicaid and Commercial. Added CO/CQ modifier reimbursement language effective 7/15/24
10/01/2023	Updated visit limits and authorization requirement language for Integrity
03/29/2023	Annual Review Date. No content changes.
01/01/2023	Effective date for update to INTEGRITY to remove language around auth requirement after 24 visits
02/01/2022	Update to include requirement for referring provider
04/01/2021	Policy Update: Remove limit of 24 visits for Medicaid and Commercial LOB's effective 4/1/21.
01/01/2021	Policy Updates: Commercial and INTEGRITY benefit limits/auth requirements. Medicaid limit changed from rolling year to calendar year.
11/05/2020	Policy Review/Approval Date for 1/1/21 changes
10/01/2020	Policy effective.
07/16/2020	Policy Review/Approval Date