Physical and Occupational Therapy Services Payment Policy

Applicability

This Policy applies to the following Fallon Health products:
☒ Fallon Medicare Plus
☒ MassHealth ACO
☒ NaviCare HMO SNP
☒ Summit ElderCare (PACE)
☒ Fallon Health Weinberg PACE
☒ Community Care (Commercial/Exchange)*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.

Therapy Assistants
For Fallon Medicare Plus, NaviCare and PACE plan members 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.

For MassHealth ACO plan members, 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 therapy group practices under 130 CMR 432.404(E) (*MassHealth Transmittal Letter THP-27, November 2021*).

Fallon Health does not cover therapy services provided by PTAs or OTAs for Community Care members.

Flexibilities after the end of the COVID-19 Federal Public Health Emergency (FPHE) for MassHealth ACO plan members
MassHealth Therapist Bulletin 18 (April 2023) communicates provider requirements that were suspended during the COVID-19 FPHE and that will be enforced after the FPHE ends. This Bulletin also communicates changes in requirements implemented during the FPHE that will continue past the end of the FPHE and provides an update to telehealth policies for providers of therapy services. Therapist Bulletin 18 replaces all prior FPHE-related bulletins, specifically Therapist Bulletins 15, 16 and 17.

Verbal Medical Referral
For historical context, prior to May 12, 2023, if a therapy provider was unable to secure a written prescription for the initiation and recertification of therapy services, the therapy provider was able to obtain a verbal medical referral (oral prescription) from a physician or nurse practitioner. The written record of an oral prescription for therapy services included the date and time acquired, as well as the signature of the licensed therapist obtaining the oral prescription and was maintained in the member's record. The therapy provider acquired the written prescription for therapy

services before billing the Plan and complied with recordkeeping requirements of regulations 130 CMR 450.000 and 130 CMR 432.000 to be eligible for reimbursement.

On May 12, 2023, the flexibility, which allowed therapy providers to secure a verbal medical referral (oral prescription) for therapy services ended, and the Plan resumed applying the provisions of 130 CMR 432.415. This regulation provides that therapy providers must obtain a written prescription before a member can begin therapy services, and every sixty (60) days thereafter.

Therapy Telehealth Guidance

After the end of the FPHE, consistent with the federal Consolidated Appropriations Act of 2023, the Plan will continue to cover speech-language therapy services provided via telehealth until December 31, 2024, or when specified by MassHealth via regulation or Congress. See Consolidated Appropriations Act, 2023, H.R.2617, Sec. 4113, 117th Cong. (2022).[1] Please see below for additional telehealth guidance for speech-language therapy services.

Service Delivery Requirements

The Plan is not imposing specific requirements for technologies used to deliver services via telehealth and will reimburse speech-language therapy services delivered via telehealth for MassHealth ACO members, as long as such services

- are medically necessary;
- are clinically appropriate;
- meet requirements within 130 CMR 432.000 and 130 CMR 450.000; and
- meet all additional requirements of the therapy telehealth guidance in MassHealth Therapist Bulletin 18.

Providers are encouraged to use appropriate technologies to communicate with individuals and should, to the extent possible, ensure the same rights to confidentiality and security as provided in face-to-face services. Providers must inform members of any relevant privacy considerations.

Telehealth visits may be used for speech-language therapy services that

- require the member's consent, documented as described below; and
- are follow-up visits that do not require any hands-on care.

Live video telehealth may be used, with the member's consent, to conduct the comprehensive evaluation or reevaluation under 130 CMR 432.411, 432.415, and 432.416 for MassHealth ACO members receiving speech-language therapy services.

Telehealth may not be used for any speech-language therapy service specifically requiring hands-on care.

Member Consent

Providers must get verbal consent from a member, and the member's caregiver or legal guardian if applicable, before starting telehealth, and must document the consent in the member's record.

When requesting the member's consent, MassHealth speech and language therapy providers must provide the member with a statement explaining

- what a telehealth visit entails;
- what is expected from the member and the therapy provider;
- any relevant privacy considerations; and
- that the member may take back their consent for telehealth services at any time.

Information provided to members should be given in their preferred method of delivery and must be documented within the members' record.

[1] Congress has extended the Medicare fee-for-service telehealth flexibilities that were originally implemented during the COVID-19 public health emergency multiple times, with the latest extension expiring January 31, 2026.

Billing Instructions and Payment Rates for Therapist Services Delivered via Telehealth
Speech and language therapy providers must include Place of Service 02 or 10 and modifier "GT" when submitting claims for services delivered via telehealth. See **Billing/coding guidelines** below for procedure codes payable via telehealth (i.e., when submitted with modifier GT).

Rates of payment for speech-language therapy services delivered via telehealth will be the same as rates of payment for speech-language therapy services delivered via traditional (e.g., in-person) methods.

Failure to include modifier "GT" when submitting claims for Speech-Language Services delivered via telehealth may result in the imposition of sanctions pursuant to 130 CMR 450.238-450.240.

Important note: Although MassHealth allows reimbursement for delivering of certain services through telehealth, MassHealth does not require providers to deliver services via telehealth.

Documentation of Telehealth Services and Encounter Requirements
All documentation requirements of 130 CMR 450.000 and 130 CMR 432.000 apply when services are delivered via telehealth. The documentation must also include in the visit note:

- that the service was provided via telehealth; and
- a description of the rationale for service via telehealth.

Failure to maintain documentation requirements for services delivered via telehealth, may result in the sanctions pursuant to 130 CMR 450.238–240.

CMS flexibilities to fight COVID-19 for Fallon Medicare Plus, NaviCare, PACE and Community Care members
CMS waived the requirements of section 1834(m)(4)(E) of the Act and 42 CFR § 410.78 (b)(2), which specify the types of practitioners who may bill for their services when furnished as Medicare telehealth services from a distant site. The waiver of these requirements expands the types of health care professionals who can furnish distant site telehealth services to include all those who are eligible to bill Medicare for their professional services. As a result, a broader range of practitioners, such as physical therapists, occupational therapists, and speech language pathologists can use telehealth to provide many Medicare services. After the PHE ends, the Consolidated Appropriations Act, 2023 provides for an extension for this flexibility through December 31, 2024 (Physicians and Other Clinicians: CMS Flexibilities to Fight COVID-19, available at: https://www.cms.gov/files/document/physicians-and-other-clinicians-cms-flexibilities-fight-covid-19.pdf).[2]

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.

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. 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.

[2] Congress has extended the Medicare fee-for-service telehealth flexibilities that were originally implemented during the COVID-19 public health emergency multiple times, with the latest extension expiring January 31, 2026.

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. Similarly, an OTA 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.

Plan of Care - All physical and occupational therapy services must be provided under a written plan of care (also known as a treatment plan) established individually for the member. The plan of care must be established before treatment is begun. For Medicare plan members, the plan of care must meet requirements specified in Medicare Benefit Policy Manual, Chapter 15, Section 220.1.2. For MassHealth ACO members, the plan of care must meet requirements in 130 CMR 432.416(C).

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.

Work hardening/conditioning
These services are related solely to specific work skills and are not medically necessary for the diagnosis or treatment of an illness or injury. Claims submitted by contracted providers will deny vendor liable.

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

Physical and occupational therapy services provided incident to the services of physicians and non-physician practitioners for Fallon Medicare Plus, NaviCare, PACE and Community Care members
A physical or occupational therapist may be licensed under State law to perform physical or occupational therapy services, respectively, without physician supervision and have the service separately covered and reimbursed by the Plan as a physical or occupational therapy service. In order to have that same service covered as incident to the services of a physician or nonphysician practitioner (NPP) for Medicare or Community Care plan members, the service must be performed under the direct supervision of the physician/NPP, as an integral part of the physician/NPP's personal service. Therapy services provided and billed incident to the services of a physician/NPP also must meet all incident-to requirements in Medicare Benefit Policy Manual, Chapter 15, Section 230.5, and also in Chapter 15, Section 60.

- NPP means physician assistants, clinical nurse specialists, and nurse practitioners, who may, if state and local laws permit it, and when appropriate rules are followed, provide, certify or supervise therapy services (Medicare Benefit Policy Manual, Chapter 15, Section 220).
- The therapy services provided must relate directly to the physician/NPP service to which they are incident. This means that must have been a direct, personal, professional service furnished by the physician/NPP to initiate the course of treatment of which the therapy service being performed by the physical or occupational therapist is an incidental part, and there must be subsequent services by the physician/NPP of a frequency that reflects the physician/NPP's continuing active participation in and management of the course of treatment.

- This does not mean that to be considered incident to, each occasion of service by physical or occupational therapist needs also always be the occasion of an actual rendition of a personal professional service by the physician/NPP. Such a service could be considered to be incident to when furnished during a course of treatment where the physician performs an initial service and subsequent services of a frequency which reflect his/her active participation in and management of the course of treatment.
- The direct supervision requirement must be met with respect to every nonphysician service. Direct supervision means that the supervising physician/NPP must be present in the office suite and immediately available to furnish assistance and direction throughout the performance of the procedure. It does not mean that the physician/NPP must be present in the same room in the office where the service is performed.
- For outpatient physical and occupational therapy services that are provided incident to the services of physicians/NPPs, the requirement for physical/occupational therapy licensure as defined in Medicare Benefit Manual, Chapter 15, Section 230.3 (B) does not apply; all other personnel qualifications do apply.
- The supervising physician or NPP must be legally authorized to practice physical or occupational therapy, as applicable, by the state in which he or she performs direct supervision.
- Services must be furnished under a plan of care as described in section 220.1.2 of Chapter 15 of the Medicare Benefit Manual.
- Physical and occupational therapy services provided incident to the services of physicians and NPPs apply to therapy services performed in the physician/NPP's office.

Multiple procedure payment reductions for outpatient therapy services for Fallon Medicare Plus, NaviCare, PACE and Community Care members

Effective for dates of service on or after April 1, 2026, the Plan applies a multiple procedure payment reduction (MPPR) to professional claims for therapy codes with a Multiple Procedure (MULT PROC) Indicator of "5" on the Medicare Physician Fee Schedule (MPFS). Therapy codes with a Multiple Procedure (MULT PROC) Indicator of "5" on the Medicare Physician Fee Schedule (MPFS) are "always therapy" codes.

- The MPPR applies to claims submitted on the same date of service for the same member by the same provider. For therapy services furnished by a group practice or incident to a physician's service, the MPPR applies to all services furnished to a patient on the same day, regardless of whether the services are provided in one therapy discipline or multiple disciplines, e.g., physical therapy, occupational therapy, or speech-language pathology.
- Eligible therapy procedures will be grouped based on the same member and same date of service. Within a "group," claim lines will be sorted and ranked according to the highest non-facility Practice Expense RVU. For the procedure code that is ranked first and submitted with a quantity of one, no reduction will be applied. To determine which services will receive the MPPR, the Plan will rank services according to the applicable practice expense (PE) relative value units (RVU) and price the service with the highest PE RVU at 100% and apply the appropriate MPPR to the remaining services**.**

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 members
Effective 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 Medicare Advantage or PACE plan member. A service is considered to be 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.

Providers are required to report line item dates of service for outpatient rehabilitation services. Claim lines that span two or more dates and claim lines without dates of service are subject to denial.

Claims for outpatient therapy services must be submitted with a corresponding HCPCS code even if the provider contract pays based on a revenue code. This is required for compliance with Section 1834(k)(5) of the Social Security Act and to facilitate proper claims payment.

Services provided by PTAs and OTAs must be billed using the name and 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 (physician assistants, nurse practitioners, and certified nurse specialists), physical therapists in private practice, occupational therapists in private practice, and speech-language pathologists in private practice, as well as 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, occupational therapy and speech-language pathology 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

- GO modifier – Services delivered under an outpatient occupational therapy plan of care
- GN modifier - Services delivered under a speech-language therapy plan of care

Only one of these modifiers is allowed per claim line.

Effective for dates of service on or after April 1, 2026, the Plan has implemented edits that will deny professional claims for “always therapy” codes when they do not contain the appropriate therapy modifier for the applicable HCPCS code, regardless of the provider who furnishes them.

All outpatient therapy services furnished by physical therapists, occupational therapists or speech-language pathologists, regardless of whether they are designated as “always therapy” or “sometimes therapy” are considered therapy services and must be delivered under a therapy plan of care. Effective for dates of service on or after April 1, 2026, the Plan has implemented edits that will deny professional claims outpatient therapy services furnished by physical therapists, occupational therapists or speech-language pathologists when the claim line does not contain the appropriate therapy modifier for the applicable HCPCS code.

Institutional claims for outpatient physical, occupational or speech-language therapy services delivered under a therapy plan of care may only report revenue code 042X with claim lines containing the GP modifier, revenue code 043X with claim lines containing the GO modifier, and revenue code 044X with claim lines containing the GN modifier, along with the procedure code for the service.

Effective for dates of service on or after July 1, 2026, the Plan will deny 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 Advantage (including Fallon Medicare Plus and NaviCare) and PACE (including Summit Eldercare and Fallon Health Weinberg) plan members, the services of supervised PTAs and OTAs are covered therapy services.

A physical therapist must supervise PTAs. An occupational therapist must supervise OTAs. The level and frequency of supervision differs by setting (and by state or local law). General supervision is required for PTAs and OTAs in all settings unless state practice requirements are more stringent, in which case state or local requirements must be followed. See specific settings for details (Medicare Benefit Policy Manual, Chapter 15, Section 230.1.C and 230.2.C, Transmittal R12975CP).

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.

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

Medicare Advantage (including Fallon Medicare Plus and 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. 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).

Reporting of service units with HCPCS
When reporting service units for HCPCS codes where the procedure is not defined by a specific timeframe ("untimed" HCPCS), the provider enters "1" in the field labeled units. For timed codes, units are reported based on the number of times the procedure is performed, as described in the HCPCS code definition.

To eliminate improper payment for outpatient therapy services, the Plan has implemented edits, effective for dates of service on or after April 1, 2026, which will deny claims for "untimed" service codes billed with units exceeding the allowed units. Some untimed codes may be billed by one discipline (e.g., PT) and not by others (e.g., OT or SLP).

Several CPT codes used for therapy modalities, procedures, and tests and measurements specify that the direct (one on one) time spent in patient contact is 15 minutes. Providers report these "timed" procedure codes for services delivered on any single calendar day using CPT codes and the appropriate number of 15 minute units of service.

For any single timed CPT code in the same day measured in 15 minute units, providers bill a single 15-minute unit for treatment greater than or equal to 8 minutes through and including 22 minutes. If the duration of a single modality or procedure in a day is greater than or equal to 23 minutes, through and including 37 minutes, then 2 units should be billed. When more than one service represented by 15 minute timed codes is performed in a single day, the total number of minutes of service determines the number of timed units billed. Refer to Medicare Claims Processing Manual, Chapter 5, Section 20.2. D. for examples of how to count the appropriate number of units for the total therapy minutes provided.

Providers report the code for the time actually spent in the delivery of the modality requiring constant attendance and therapy services. Pre- and post-delivery services are not to be counted in determining the treatment service time. In other words, the time counted as "intra-service care" begins when the therapist or physician (or an assistant under the supervision of a physician or therapist) is directly working with the patient to deliver treatment services. The patient should already be in the treatment area (e.g., on the treatment table or mat or in the gym) and prepared to begin treatment. The time counted is the time the patient is treated.

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.

Physical and occupational therapy procedure codes

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

Modifier	Description
GN	Services delivered under an outpatient speech-language therapy plan of care
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) for services furnished in whole or in part by a PTA or OTA to Medicare Advantage (including Fallon Medicare Plus and NaviCare) and PACE (including Summit Eldercare and Fallon Health Weinberg) plan members.

Modifier	Description
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 Medicare Advantage, NaviCare and PACE plan members effective for dates of service on or after March 1, 2022. January 2026 – Under Policy, removed Updates related to coronavirus disease 2019 (COVID-19) for MassHealth ACO, NaviCare and Summit ElderCare plan members, as no longer applicable and added new sections for Flexibilities After the End of the COVID-19 FPHE for MassHealth ACO members, and (2) CMS flexibilities for Medicare Advantage, NaviCare, PACE and Community Care Members; under Reimbursement, added new section for Multiple Procedure Payment Reductions for Outpatient Therapy Services; under Billing/coding guidelines, updated Therapy Modifiers section to include notification that effective for dates of service on or after April 1, 2026, the Plan has implemented edits that will deny professional claims for services when they do not contain the appropriate therapy modifier (GP, GO, GN), regardless of the provider who furnishes them; under Billing/coding guidelines, added new section for Reporting of Service Units With HCPCS to include notification that effective for dates of service on or after April 1, 2026, the Plan has implemented edits, effective for dates of service on or after April 1, 2026, that will deny claims for “untimed” service codes billed with units exceeding the allowed units.

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.