BlueCross BlueShield of Oklahoma

If a conflict arises between a Clinical Payment and Coding Policy ("CPCP") and any plan document under which a member is entitled to Covered Services, the plan document will govern. If a conflict arises between a CPCP and any provider contract pursuant to which a provider participates in and/or provides Covered Services to eligible member(s) and/or plans, the provider contract will govern. "Plan documents" include, but are not limited to, Certificates of Health Care Benefits, benefit booklets, Summary Plan Descriptions, and other coverage documents. BCBSOK may use reasonable discretion interpreting and applying this policy to services being delivered in a particular case. BCBSOK has full and final discretionary authority for their interpretation and application to the extent provided under any applicable plan documents.

Providers are responsible for submission of accurate documentation of services performed. Providers are expected to submit claims for services rendered using valid code combinations from Health Insurance Portability and Accountability Act ("HIPAA") approved code sets. Claims should be coded appropriately according to industry standard coding guidelines including, but not limited to: Uniform Billing ("UB") Editor, American Medical Association ("AMA"), Current Procedural Terminology ("CPT®"), CPT® Assistant, Healthcare Common Procedure Coding System ("HCPCS"), ICD-10 CM and PCS, National Drug Codes ("NDC"), Diagnosis Related Group ("DRG") guidelines, Centers for Medicare and Medicaid Services ("CMS") National Correct Coding Initiative ("NCCI") Policy Manual, CCI table edits and other CMS guidelines.

Claims are subject to the code edit protocols for services/procedures billed. Claim submissions are subject to claim review including but not limited to, any terms of benefit coverage, provider contract language, medical policies, clinical payment and coding policies as well as coding software logic. Upon request, the provider is urged to submit any additional documentation.

Physical Medicine and Rehabilitation Services

Policy Number: CPCP040

Version 1.0

Enterprise Clinical Payment and Coding Policy Committee Approval Date: January 12, 2024

Plan Effective Date: January 25, 2024

Description

This policy provides general information on billing and claims processing for physical medicine and rehabilitation services. Coverage decisions are subject to all terms and conditions of the applicable benefit plan, including specific exclusions and limitations, and to applicable state and federal law. Providers are urged to contact the Plan for specific coverage.

Definitions:

Durable Medical Equipment (DME)- Equipment that can withstand repeated use, is primarily and customarily used to serve a medical purpose, is generally not useful to a person in the absence of illness or injury and is appropriate for use in the home.

Home Setting- Includes the following- 1. The member's dwelling, such as a house, apartment, or other private living space. 2. A relative's home if the member lives there. 3. A place of residence used as a home or place of dwelling. 4. A home for the aged, retirement home or assisted living facility.

Modalities - Any physical agent applied to produce a therapeutic change to biological tissue; includes but is not limited to thermal, acoustic, light, mechanical, or electrical energy.

> **Supervised:** Provider needs to watch over the application, though not necessarily at the patient's side. These are procedure/service based and units are always one (1).
> **Constant Attendance:** Provider must be with the patient at all times. These are time-based, one unit = 15 minutes.

Prescription/Order- A written order/prescription is a written communication from a treating provider that documents the need for a member to be provided with an item of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) and/or services.

Qualified Healthcare Professional (QHP) - Is an individual who is qualified by education, training, licensure/regulation (when applicable) and facility privileging (when applicable) who performs a professional service within his/her scope of practice and independently reports that professional service.

Therapeutic Procedure - A manner of affecting change through the application of clinical skills and/or services that attempt to improve function.

Reimbursement Information:

Providers are to document and bill appropriately for all services submitted. The Plan reserves the right to request supporting documentation. Failure to adhere to coding and billing policies may impact claims processing and reimbursement. Claims may be reviewed on a case-by-case basis. If you have any questions, please contact your provider network representative.

Coding Standards

- Proper coding is essential for correct reimbursement. Providers are encouraged to utilize current copies of ICD-10 -CM, CPT, and HCPCS books published by the American Medical Association (AMA) and the Centers for Medicare & Medicaid Services (CMS).
- Use the diagnosis and procedure codes effective for the date of service.

Diagnosis Codes

- New ICD10-CM diagnosis codes are updated annually in October.
- Some diagnosis codes require a 7th digit to code to the highest specificity.
- Update diagnosis and coding for every new episode, including a re-exam or an examination for a 'new' problem. Document any diagnosis coding change even if it is minor.
- Link the diagnosis to the service provided to support necessity and specificity. For example, when performing manual therapy with manipulation, the diagnosis pointer code(s) should point to the specific diagnosed condition that supports specific procedure billed. (Box 24E of the CMS-1500 claim form).

Physical Medicine & Rehabilitation Codes

Providers must submit the most appropriate code(s) for physical medicine and rehabilitation services as described in the CPT Code Book. Refer to the "Physical Medicine and Rehabilitation" section of the most current publication. Additionally, for physical medicine and rehabilitation services to be considered for coverage, the following conditions must be documented to support the CPT codes:

- The therapy must be of a skilled nature and require the services of a qualified healthcare professional. When services are delegated, documentation must include details of what was delegated and who performed the service(s).
- The services/therapy must not be maintenance in nature. Ongoing physical medicine treatment after a condition has stabilized or reached a clinical plateau (maximum medical improvement) does not qualify as necessary and would be considered "maintenance care."
- Services performed must achieve a specific diagnosis-related goal.
- There must always be a documented expectation that the member will, in fact, achieve reasonable improvement over a predictable period of time for the services to be eligible for reimbursement.
- Physical therapy for performance of athletic conditioning is not reimbursable by the Plan.

The following are commonly used physical medicine & rehabilitation codes. This is not an all-inclusive list.

- **CPT 97110 (therapeutic exercises):** Documentation must include (1) the specific exercises performed, (2) the purpose of the exercises as related to function and (3) the start and stop times of the treatment or at a minimum, the direct one-on-one contact time spent on each individual activity. These exercises should require the skills of a qualified healthcare professional. Supervising patients who are exercising independently is not a skilled service. The expected functional performance improvement should be discernable in the records.

- **CPT 97112 (neuromuscular reeducation):** Documentation must include (1) the specific exercises/activities performed, (2) the purpose of the exercises/activities as related to function and (3) the start and stop times of the treatment or at a minimum, the direct one-on-one contact time spent on each individual activity. These activities should require the skills of a qualified healthcare professional. Supervising patients who are performing activities independently is not a skilled service. The expected functional performance improvement should be discernable in the records. Appropriate use of CPT 97112 is for neuromuscular (NM) diagnoses such as post-Cerebral Vascular Accident, Parkinson's Disease, cerebral palsy, Multiple Sclerosis, and other neuromuscular disorders. CPT 97112 is not appropriate for acute musculoskeletal problems and should not be used for spine or extremity stabilization. CPT code 97112 is not the appropriate code for providers using Soft Tissue Mobilization techniques. Direct patient contact: The above listed codes require direct one-on-one contact throughout the procedure. The provider is required to maintain visual, verbal, and/or manual contact with the patient. It may be appropriate to report CMT codes in addition to 97112 if it is performed in a spinal region outside of the manipulation.

- **CPT 97140 (manual therapy):** Documentation must include (1) the area being treated, (2) the therapy technique being used and (3) the start and stop times of the treatment or at a minimum, the direct one-on-one contact time spent on each individual activity. The manual therapy performed should require the skills of qualified healthcare professional. The expected functional performance improvement should be discernable

in the records. This code should not be used interchangeably with codes 98940-98942 or 97124; it may be appropriate to report CMT codes in addition to 97140 if it is performed in a body region outside of the manipulation.
Billing for multiple time-based codes such as several manual therapies (CPT 97140), when a CMT was the only service performed, is inappropriate. A CMT CPT code may not be replaced with another CPT code if the CMT was the actual service performed. It is a requirement to use the code that best describes the service rendered.

- **CPT 97530 (therapeutic activities):** Documentation must include (1) the area being treated, (2) the specific activity or technique being used and (3) the start and stop times of the treatment or at a minimum, the direct one-on-one contact time spent on each individual activity. These activities should require the skills of a qualified healthcare professional. Supervising patients who are exercising independently is not a skilled service. The expected functional performance improvement should be discernable in the records.

Evaluation and Management (E/M) Services (CPT Codes: 99202-99499)
To bill for an evaluation and management service, the complete CPT guidelines must be met for each service. The service must also be separately identifiable and distinct from any other service you perform on the patient that day. The Plan will not reimburse Physical and Occupational Therapists or Physical and Occupational Therapy Assistants for CPT evaluation and management codes 99202-99499.

Modifiers

For the purposes of this policy, a modifier should be appended to denote additional information about the service rendered.

CO	Outpatient occupational therapy services furnished in whole or in part by an occupational therapy assistant
CQ	Outpatient physical therapy services furnished in whole or in part by a physical therapist assistant
GO	Services delivered under an outpatient occupational therapy plan of care
GP	Services delivered under an outpatient physical therapy plan of care

Reporting Units for Timed Codes:

Some CPT codes for modalities are considered experimental, investigational and/or unproven (EIU) and are not covered by the plan, however there are some modalities that may be eligible for reimbursement and the following information will apply. When multiple units of therapies or modalities are provided, the 8-minute rule must be followed when billing for these services. A provider should not report a direct treatment service if only one attended modality or therapeutic procedure is provided in a day and the procedure is performed for less than 8 minutes.

- The time reported should be the time actually spent in the delivery of the modality and/or therapeutic procedure. This means that pre- and post-delivery services should not be counted in determining the treatment time.

- The time that the member spends not being treated, due to resting periods or waiting for a piece of equipment to become available, is not considered treatment time.
- All treatment time, including the beginning and ending time of the direct treatment, must be recorded in the member's medical record, along with the note describing the specific modality or procedure.
- Each minute of time may only be counted once. Any actual time the therapist uses to attend one-on-one to a member receiving a supervised modality cannot be counted for any other service provided by the therapist.

A unit of time is attained when the mid-point is passed. For example, for services billed in 15-minute units, providers should not report services performed for less than eight minutes. For any single timed CPT code in the same day measured in 15-minute units, providers must use a single 15-minute unit for treatment greater than or equal to 8 minutes through and including 22 minutes. Time intervals for 1 through 8 units are as follows:

- 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: ≥ 98 minutes through 112 minutes
- 8 units: ≥ 113 minutes through 127 minutes

If billing for more than one modality/therapy, time should not be combined to report units. Each unit for the modality/therapy is reported separately for each code.

Durable Medical Equipment (DME)

Prescription/Order for DME Supplies

A prescription/order must be readily available if requested for DME rentals or purchase. The prescription/order must be signed by the members treating qualified health care provider. When a qualified health care provider completes and signs the prescription/order, they are attesting that the information indicated on the form is correct and that the requested services are necessary and appropriate. Provider's prescription/order must be renewed annually.

The prescription/order for DME should include:

- Member's name, date of birth
- Diagnosis (Dx)
- Type of equipment/supplies ordered
- Provider's rationale for requesting the equipment
- Date of prescription/order
- Date and duration of expected use
- Quantity (if applicable)
- Provider name, address, and telephone number
- Legible provider signature and date

DME Components and Accessories

Repair, adjustment, or replacement of components and accessories of DME, as well as supplies and accessories necessary for effective functioning of covered DME items should be billed with the code which best describes the DME item. For Example, when ordering transcutaneous electrical nerve stimulations (TENS) replacement products, utilize CPT Code A4595 (electrical stimulator supplies) as opposed to billing the CPT Codes separately A4556 (electrodes), A4557 (leads), A4558 (conductive paste or gel), A4630 (replacement batteries).

Certain Customized DME

To qualify as "customized", a DME, prosthetic, or orthotic device must be specifically constructed to meet an individual member's specific needs. An invoice should be included with billing for any customized DME, prosthetic, or orthotic device for which a procedure code or HCPCS code does not exist.

The following are examples of items that **do not meet the requirement to be considered customized:**

- Adjustable brace with Velcro closures; AND
- Pull-on elastic brace; AND
- Lightweight, high-strength wheelchair with padding added.

The following additional criteria apply to custom-fitted and custom fabricated back braces.

- A custom-fitted back brace (a prefabricated back brace modified to a specific member) is considered necessary where there is a failure, contraindication, or intolerance to an unmodified, prefabricated (off the shelf) back brace.
- A custom-fitted back brace is considered necessary as the initial brace after a surgical stabilization of the spine following traumatic injury.
- A custom-fabricated back brace (individually constructed to fit a specific member from component materials) is considered necessary if there is a failure, contraindication, or intolerance to a custom-fitted back brace.
- Custom-fitted and custom-fabricated back braces are considered experimental and investigational when these criteria are not met.

Components of a Written Radiology Report

As a written record of the interpretive findings, the radiology report serves as an important part of the member's medical record and must contain the following items:

- Patient identification
- Location where studies were performed
- Study dates
- Types of studies
- Radiographic findings
- Diagnostic impressions; and
- Signature with professional qualifications included

Radiology reports may also include recommendations for follow-up studies and comments for further patient evaluation.

Additional Resources:

Medical Policies

DME101.000 DME Intro Policy

THE803.004 Heat and Cold Therapy Devices

THE803.008 Non-Covered Physical Therapy Services

THE803.010 Physical Therapy (PT) and Occupational Therapy (OT) Services

THE803.021 Non-Surgical Spinal Decompression Traction Devices

MED201.026 Surface Electric Stimulation

MED201.041 Interferential Current Stimulation

Clinical Payment and Coding Policies

CPCP016 Chiropractic Care Services

CPCP023 Modifier Reference Policy

CPCP029 Medical Record Documentation

CPCP033 Telemedicine and Telehealth Services

CPCP036 Paravertebral Facet Injection Procedure Coding & Billing Policy

References:

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Healthcare Common Procedure Coding System (HCPCS)

Policy Update History:

Approval Date	Description
03/15/2023	New Policy: Split from CPCP016 Chiropractic Care Services
1/12/2024	Annual Review