JOHNS HOPKINS MEDICINE JOHNS HOPKINS HEALTHCARE	Johns Hopkins HealthCare LLC **Provider Relations and Network Innovation Reimbursement Policy**	*Policy Number*	RPC.010
		Effective Date	09/01/2017
		Review Date	06/20/2022
	Subject **Therapy Modifiers - Rehabilitative and Habilitative Care (PT, OT, ST/SLP)**	*Revision Date*	05/29/2020
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This document applies to the following Participating Organizations:

EHP | Johns Hopkins Advantage MD | Priority Partners | US Family Health Plan

Keywords: Habilitative, Occupational Therapy, Physical Therapy, Rehabilitative, Reimbursement, Speech Therapy

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I. ACTION

__ New Policy

_X_ Revised Policy

__Repealed Policy Date:

__Superseded Policy Number:

The most current version of the reimbursement policies can be found on www.jhhc.com.

These policies serve as a guide to assist you in accurate claim submissions and to outline the basis for reimbursement if the service is covered by a member's Johns Hopkins HealthCare (JHHC) benefit plan. The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis as well as to the member's state of residence. You must follow proper billing and submission guidelines. You are required to use industry standard, compliant codes on all claim submissions. Services must be billed with ICD-10 codes, CPT codes, HCPCS codes and/or revenue codes. The codes denote the services and/or procedures performed. The billed code(s) are required to be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our policies apply to both participating and nonparticipating providers and facilities.

If appropriate coding/billing guidelines or current Reimbursement Policies are not followed, Johns Hopkins HealthCare (JHHC) may:

- Reject or deny the claim
- Recover and/or recoup claim payment

JHHC reimbursement policies are developed based on nationally accepted industry standards and coding principles. These policies may be superseded by mandates in provider, state or commercial client contracts, or state, federal or CMS contracts

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and/or requirements. System logic or setup may prevent the loading of policies into the claims platforms in the same manner as described; however, JHHC strives to minimize these variations.

JHHC reserves the right to review and revise our policies periodically when necessary. When there is an update, we will publish the most current policy on www.jhhc.com.

II. POLICY

It is the policy of Johns Hopkins HealthCare (JHHC) to follow CMS guidelines and allow reimbursement of outpatient therapy services (both rehabilitative and habilitative) when these services are provided by therapists, or as an integral part of a therapy plan of care, and the CPT/HCPCS code is accompanied with the appropriate therapy modifier(s).

III. SCOPE

This policy applies to all claims, submitted to a JHHC product, from network and non-network therapists, physicians and non-physician practitioners billing for physical therapy, speech-language pathology or occupational therapy services.

IV. DEFINITIONS

Habilitative services (and devices): Health care services and devices that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings."

Rehabilitative services (and devices): Health care services and devices that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Therapist: For the purposes of this policy, a Therapist may be one of the following practitioner types, identified by CMS, performing services within the scope of their practice (see *Scope of Practice* in References):

- Physical therapists in private practice (PTPPs),
- Occupational therapists in private practice (OTPPs),
- Speech-language pathologists in private practice (SLPPs),
- Physicians, including MDs, DOs, podiatrists and optometrists, and
- Certain non-physician practitioners (NPPs), acting within their State scope of practice, e.g., nurse practitioners, clinical nurse specialists, and physician assistants.

Therapy Services: Therapy services, as defined by CMS, include only physical therapy, occupational therapy and speech-language pathology services billed under codes identified on the therapy code list (see *CMS, Annual Therapy Update* in References) provided under a therapy plan of care, including their incident to services, and where the services are covered and appropriately delivered. These may be considered rehabilitative or habilitative services and devices.

Therapy Code Modifiers: Identify discipline of plan of care under which service is delivered:

- **Modifier GN** – Indicates services delivered under an outpatient speech-language therapy plan of care
- **Modifier GO** – indicates services delivered under an outpatient occupational therapy plan of care
- **Modifier GP** – indicates services delivered under an outpatient physical therapy plan of care
- **Modifier 96** – indicates services delivered under an habilitative therapy plan of care (EHP only)

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V. PROVIDER BILLING GUIDELINES AND DOCUMENTATION

Per CMS guidelines, therapy services may only be billed by a therapist (see Definitions). Claims submitted for therapy services must include the appropriate therapy modifier (GP, GO, GN), in the first position, or the claim will be denied.

EHP claims for habilitative services, must also include the modifier 96.

Examples of coding may include, but are not limited to the following, when the services are deemed therapy services, as rendered by a therapist or a physician, or non-physician practitioner, including their incident to services, and integral to a therapy plan of care:

a. “always therapy” codes (i.e., 97001- 97799, G0281,G0283,G0329) and
b. “sometimes therapy" codes (i.e., 97602, 97605, 97606, 97597, and 97598) and
c. CPT codes for the application of casts and strapping (i.e., 29000 through 29590),

For a more complete list, please see the Therapy Code List and Dispositions file on the CMS Annual Therapy Update link, in the References section.

Beginning January 1, 2020, CMS established two modifiers, CQ and CO, for services furnished in whole or in part by physical therapist assistants (PTAs) and occupational therapy assistants (OTAs). 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

When billing PTA and OTA services, the CQ and CO modifiers must be paired with the respective GP or GO therapy modifier. Claims billed without the appropriate GP or GO modifier, or those not following the modifier position guidelines above, will be denied.

VI. EXCLUSIONS

This requirement does not apply to outpatient rehabilitation services provided by:

• Critical access hospitals, which are paid on a cost basis;

• RHCs, and FQHCs for which therapy is included in the all-inclusive rate; or

• Providers that do not furnish therapy services

VII. EXEMPTIONS

N/A

VIII. REFERENCES

This policy has been developed through consideration of the following:

1. Scope of Practice policy, RPC.009
2. Social Security Act, Part E – Definition of Services, §§1861(g), 1861(p), 1861(ll), and 1861(s)(2)
3. 32 CFR 199.4 (a)(1) and (e)(24) - Tricare, Basic Benefits Program

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4. 42 CFR - Public Health; *Requirements for medical and other health services…* § 424.24(c), *Plan of treatment requirements for outpatient rehabilitation services* § 410.61, *Medical and other health services* § 410.10(b), *Services and supplies incident to…* § 410.26
5. 45 CFR §§156.110(a)(7) and 156.115(a)(5) - Public Welfare, *Essential Health Benefits Package*
6.
7. CMS, Medicare Benefit Policy Manual, Chapter 15- *Covered Medical and Other Health Services* , Section 220-*Coverage of Outpatient Rehabilitation Therapy Services*, and Section 230-*Practice of Physical Therapy, Occupational Therapy, and Speech Language Pathology*
8. CMS, Medicare Claims Processing Manual, Chapter 5-*Outpatient Rehabilitation and CORF/OPT Services*, Section 20-*HCPCs Coding Requirements*
9. CMS, Therapy Services, Annual Therapy Update
10. CMS Change Request 11362, Transmittal 4440
11. Tricare Policy Manual 6010.60-M, April 1, 2015; Chapter 7, Sections 18.1, 18.2, 18.3
12. Tricare Policy Manual 6010.60-M April 1, 2015; Chapter 11, Section 3.16 Physical Therapy Assistants – sub-section 5.0 Reimbursement
13. Tricare Policy Manual 6010.60-M April 1, 2015; Chapter 11, Section 3.17 Occupational Therapy Assistants – sub-section 5.0 Reimbursement
14. COMAR 10.09.17.04 – Medical Programs, Physical Therapy Services, Cover Services
15. COMAR 10.09.17.05 – Medical Programs, Physical Therapy Services, Limitations
16. COMAR 10.46.01.03 – Board of Occupational Therapy Practice, Standards of Practice

IX. APPROVALS

Reimbursement Policy Committee Date: June 8, 2020

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