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 These policies may be superseded by mandates in provider or state contracts, or state, federal or CMS contracts and/or requirements.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.
POLICY

Johns Hopkins HealthCare’s claims processing systems contain edits to ensure claims for the evaluative procedures furnished by rehabilitative therapy clinicians – including physical therapists, occupational therapists and speech-language pathologists – are coded correctly. These edits ensure that when the codes for evaluative services are submitted, the therapy modifier (GP, GO or GN) that reports the type of therapy plan of care is consistent with the discipline described by the evaluation or re-evaluation code.

Therapy Modifiers: The new Physical Therapy (PT) and Occupational Therapy (OT) codes are added to the current list of evaluative procedures that require a specific therapy modifier to identify the plan of care under which the services are delivered to be on the claim for therapy services. Therapy modifiers GP, GO or GN are required to report the type of therapy plan of care – PT, OT, or ST (speech therapy), respectively. This payment policy requires that therapy modifiers accompany PT, ST and OT services.

DEFINITIONS

GN – Indicates services delivered under an outpatient speech-language therapy plan of care
GO – indicates services delivered under an outpatient occupational therapy plan of care
GP – indicates services delivered under an outpatient physical therapy plan of care

EXCLUSIONS

EXEMPTIONS

CROSS REFERENCE (with other relevant policies, procedures, and/or workflows)

This policy has been developed through consideration of the following:

- State Medicaid:
- Tricare:
APPROVALS

Steering Committee Approval Date:

Last Review Dates: