JOHNS HOPKINS HEALTH PLANS	Johns Hopkins Health Plans **Provider Relations and Network Innovation Reimbursement Policy**	*Policy Number*	RPC.010
		Effective Date	10/10/2024
		Approval Date	06/20/2022
	Subject **Therapy Modifiers- Rehabilitative and Habilitative Care (PT, OT, ST/SLP)**	*Supersedes Date*	06/20/2022
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Keywords: Habilitative, Occupational Therapy, Physical Therapy, Rehabilitative, Speech Therapy

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I. ABOUT OUR REIMBURSEMENT POLICIES

The most current version of the reimbursement policies can be found on www.hopkinsmedicine.org.

Johns Hopkins Health Plan LLC (JHHP) reimbursement policies serve as a guide to assist in accurate claim submissions and outline the basis for reimbursement of services covered by a member's JHHP benefit plan. The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a guarantee that you will be reimbursed. Services must meet prior authorization and medical necessity guidelines appropriate to the procedure and diagnosis, as well as to the member's state of residence. Providers are expected to and must follow proper billing and submission guidelines. Providers are required to use industry standard, compliant codes on all claim submissions. Services must be billed with valid ICD-10 diagnosis codes, Healthcare Common Procedure Coding System/Current Procedural Terminology (HCPCS/CPT) codes, place of service (POS) codes, and/or revenue codes as defined by the Centers for Medicare & Medicaid Services (CMS) and in the American Medical Association's (AMA's) "CPT Manual".

The codes billed should denote the services and/or procedures performed. The billed code(s) are required to be fully supported in the patient's medical record and/or office notes and JHHP reserves the right to request the records. If a corrected claim is filed, it must comply with timely filing to be reprocessed through the claims system. Corrected claims are for administrative errors on the claim (i.e., misspelled name, CPT/HCPCS code transposed, wrong DOB, missing modifier, etc.). Intentionally changing the CPT/HCPCS or diagnosis code in order to get the claim paid, after the billed service was denied, is not a correction. The medical records must match the services billed. Unless otherwise noted within the policy, our policies apply to both participating and nonparticipating providers and facilities.

JHHP policies apply to all practitioners, hospitals, providers, or suppliers eligible to bill the relevant HCPCS/CPT codes pursuant to applicable portions of the Social Security Act (SSA) of 1965, the Code of Federal Regulations (CFR), and Medicare rules. JHHP reimbursement policies are developed based on nationally accepted industry standards, coding principles, and follows the CMS guidelines, and the CMS developed National Correct Coding Initiative (NCCI) program to prevent inappropriate payment of services that should not be reported together. These policies may be superseded by regulatory mandates in provider or state contracts, or state, federal or CMS contracts and/or requirements. If appropriate, when coding/ billing guidelines or current reimbursement policies are not followed, JHHP may:

- Reject or deny the claim

- Recover and/or recoup claim payment

JHHP reserves the right to modify policies at any time and publish new versions when necessary. System logic or setup may prevent the loading of policies into the claims platforms in the same manner as described; however, JHHP strives to minimize these modifications. When there is an update, policies will be published on our website.

II. PURPOSE

This policy provides basic reimbursement guidance on the appropriate reporting of both rehabilitative and habilitative therapy services, rendered by a qualified therapist, for physical therapy (PT), occupational therapy (OT) and/or speech-language pathology (SLP) therapy services, which is an integral part of a therapy plan of care. It is the policy of Johns Hopkins Health Plans (JHHP) to follow CMS billing and reimbursement guidelines for therapy services. This policy applies to therapy services reported on a CMS-1500 or CMS-1450 (UB-04) or their electronic equivalents, when billed in accordance with the members covered plan benefits, and when all billing requirements are met.

III. POLICY STATEMENT

JHHP will process and reimburse appropriately billed claims, submitted for covered services, by a network or non-network therapist, physician and/or non-physician practitioner, billing for physical therapy, speech-language pathology or occupational therapy services. In addition, JHHP will align with regulatory, state and federal guidance to identify physician and non-physician services that are eligible as reimbursable or non-reimbursable, as applicable to the member's plan. Each line of business possesses its own unique contract and guidelines for benefit and payment purposes. As such, there could be various factors that may impact reimbursement, including but not limited to legislative mandates, provider contracts, and/or the member's benefit coverage, prior authorization, including provisions addressing services rendered by non-participating providers, which may supplement, modify, or supersede this policy.

*Providers are responsible to review the **"EXCEPTIONS & EXCLUSIONS" Sections** below for specific plan guidance, as some guidelines in this policy may not be applicable to all health plans/products.*

IV. PROVIDER BILLING GUIDELINES AND DOCUMENTATION

1. In alignment with CMS guidelines, therapy services may only be rendered and billed by a qualified therapist.
2. When submitting claims for therapy services, including services rendered by Physical Therapy Assistants (PTA), Occupational Therapy Assistants (OTA) services, or Speech-Language Pathology Assistants (SLPA), the required modifier(s) must be reported in the correct order, or the service will be denied.
   - Claims that do not follow the CMS modifier position guidelines will be denied.
3. Medically necessary services which are integral to a therapy plan of care and deemed therapy services, must be rendered by a qualified therapist or a physician, or non-physician practitioner, and payment will include their incident to services.
4. Appropriate documentation must support all codes billed. Claims for some therapy services may be pended for further review.
   - JHHP reserves the right to request medical records in order to confirm proper billing, prior to payment, when necessary. Any improper billing may result in payment reduction or denial for specific charges.
   - JHHP may conduct medical record documentation reviews on a randomly selected sample of practitioners or on providers who render services outside their regular scope of practice or assigned specialty.
   - Refer to the JHHP resources and guidelines for all of our health plans for additional information about Medical Record Standards Documentation.
5. In certain situations, therapy services may require prior authorization, which must be approved and obtained prior to services being rendered, or the claim may be denied. Prior authorization is not a guarantee of payment.

V. EXCEPTIONS AND EXCLUSIONS

1. When applicable, the billing guidance in this policy may not apply to outpatient rehabilitation services provided by:
   - Critical Access Hospitals (CAH), 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.
2. **Maryland Waiver Hospitals** - In accordance with §1814 (b)(3) of the Act, services provided by hospitals in Maryland are subject to the billing and reimbursement guidance of the Health Services Cost Review Commission (HSCRC). Claims from hospitals that are under the jurisdiction of the HSCRC will be processed and reimbursed under the terms of the HSCRC waiver.
3. **EHP**- Claims submitted for Habilitative services, must include modifier 96.
4. **PPMCO**-Therapy services addressed in this policy are reimbursed in accordance to the Maryland Medicaid Administration Professional Services Provider Manual.
   - JHHP requires all providers (i.e., ordering, referring, rendering, servicing, billing) delivering services to Maryland Medicaid members to have an active enrollment status in the electronic Provider Revalidation and Enrollment Portal (ePREP) on the date of service.
   - Claims submitted by individual providers, provider groups and facilities who are inactive or unregistered in ePREP will not be reimbursed.
   - Providers are solely responsible for ensuring their information in the ePREP portal is valid and active.
5. **USFHP**- JHHP will process and reimburse therapy claims in accordance with TRICARE guidance. Please consult the authoritative guidance found in the TRICARE Manuals to obtain additional specific information on policy, benefits, and coverage not addressed in this reimbursement policy.

VI. CODES, TERMS and DEFINITIONS

Term	Definition
Group Therapy Services	Group therapy is outpatient physical therapy services (which includes outpatient speech-language pathology services) and outpatient occupational therapy services provided simultaneously to two or more individuals by a practitioner as group therapy services. The individuals can be, but need not be performing the same activity. The physician or therapist involved in group therapy services must be in constant attendance, but one-on-one patient contact is not required.
Incident to a Therapist	There is no coverage for services provided incident to the services of a therapist.
Habilitative/Habilitation services	Health care services that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who isn't 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.

Medically Necessary	Health care services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms, inlcuding habilitation, and that meet accepted standards of medicine.
Occupational Therapy Services	Occupational therapy is medically prescribed treatment concerned with improving or restoring functions which have been impaired by illness or injury or, where function has been permanently lost or reduced by illness or injury, to improve the individual's ability to perform those tasks required for independent functioning.
Physical Therapy (PT) Services	Physical therapy services are those services provided within the scope of practice of physical therapists and necessary for the diagnosis and treatment of impairments, functional limitations, disabilities or changes in physical function and health status. Physical therapy services include testing, measurement, assessment and treatment of the function, or dysfunction, of the neuromuscular, musculoskeletal, cardiovascular and respiratory system, and establishment of a maintenance therapy program for an individual whose restoration potential has been reached.

Qualified Therapist	A qualified therapist includes a physical therapist, occupational therapist or speech-language pathologist who meets regulatory qualifications as applicable, including state licensure or certification. The person who furnishes the service to the patient must, at least, be a graduate of a program of training for one of the therapy services as described above. That means that the services of athletic trainers, massage therapists, recreation therapists, kinesiotherapists, low vision specialists or any other profession may not be billed as therapy services. For the purposes of this policy, a qualified therapist may be one of the following practitioner types, identified by CMS, performing services within the scope of their practice: • 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.
Qualified Speech-Language Pathologist	A qualified speech-language pathologist for coverage purposes must meet one of the following requirements: • The education and experience requirements for a Certificate of Clinical Competence in (speech-language pathology) granted by the American Speech Language Hearing Association; or • Meets the educational requirements for certification and is in the process of accumulating the supervised experience required for certification.
Rehabilitative/Rehabilitation services	Health care services that help a person keep, get back, or improve skills and functioning for daily living that have been lost or impaired because they were 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.

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 (refer to CMS) 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 Modifiers

Modifier	Definition
CO	Outpatient occupational therapy services furnished in whole or in part by an occupational therapy assistant.
GO	Services delivered under an outpatient occupational therapy plan of care.
CQ	Outpatient physical therapy services furnished in whole or in part by a physical therapist assistant.
GP	Services delivered under an outpatient physical therapy plan of care.
GN	Services delivered under an outpatient speech-language pathology plan of care.
KX	Services are medically necessary, as specified in the medical policy, and are justified with the appropriate documentation in the patient's medical record.
96	Habilitative Services
97	Rehabilitative Services

VII. REFERENCES

This policy has been developed through consideration of the following:

- CMS Annual Therapy Update
- COMAR- Maryland Department of Health- Maryland Medicaid Administration
- CPT Copyright American Medical Association. All rights reserved. CPT® is a registered trademark of the American Medical Association
- JHHP Reimbursement Policies
- Maryland Medicaid Professional Services Provider Manual
- Medicare Benefit Policy Manual-Chapter 15- Covered Medical and Other Health Services
- Medicare Claims Processing Manual Chapter 5-Outpatient Rehabilitation and CORF/OPT Services

- NCCI for Medicaid | CMS
- NCCI for Medicare | CMS
- TRICARE Reimbursement Manual

VIII. APPROVALS

Date	Review/Revision	Reason for Modification	Approved By
10/10/2024	Revision	Updated: policy language, formatting and references	Reimbursement Policy Committee (RPC)
6/08/2020	Review	Updated: policy language, formatting and references	Reimbursement Policy Committee (RPC)
9/01/2017	Revision	Updated: policy language, formatting and references	Reimbursement Policy Committee (RPC)