Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
www.mass.gov/masshealth

MassHealth
Transmittal Letter THP-25
January 2012

TO: Therapists Participating in MassHealth

FROM: Julian J. Harris, M.D., Medicaid Director

RE: Revisions to Subchapter 6 (Service Codes and Descriptions)

Section 6507 of the federal Patient Protection and Affordable Care Act (Public Laws 111-148 and 111-152), as implemented by the Centers for Medicare & Medicaid Services (CMS), requires state Medicaid agencies to incorporate compatible methodologies of the National Correct Coding Initiative (NCCI). NCCI was implemented by CMS to promote national correct coding methodologies and to control improper coding leading to inappropriate payment. This requirement is effective for claims for dates of service on or after October 1, 2010, that are processed by MassHealth on or after April 1, 2011.

Medically Unlikely Edits (MUEs)

MUEs are units-of-service edits that define for certain HCPCS/CPT codes the number of units of service beyond which the reported number of units of service is unlikely to be correct. Providers are advised to review *All Provider Bulletin 209*, issued in April 2011, which describes in greater detail NCCI MUE requirements and provides the link to the CMS Web site that providers may access to obtain a full list codes to which MUEs apply.

To conform to NCCI coding edits, MassHealth has updated Subchapter 6 of the *Therapist Manual* to reflect revisions made to the maximum units allowed for service codes **92507, 92508, 92526, and 97150** from four units per visit to one unit per visit. These service codes were previously payable for MassHealth based on a 15-minute unit (maximum four units per visit), and are now payable based on a single unit (maximum one unit per visit) instead of on minutes.

Consequently, the Division of Health Care Finance and Policy (DHCFP) has revised the rates for these four codes. The new rates for these codes took effect for dates of service beginning June 1, 2011. MassHealth had previously informed providers of these changes through message text issued in June of 2011.

Fee Schedule

If you wish to obtain a fee schedule, you may download the Division of Health Care Finance and Policy regulations at no cost at www.mass.gov/dhcfp. You may also purchase a paper copy of Division of Health Care Finance and Policy regulations from either the Massachusetts State Bookstore or from the Division of Health Care Finance and Policy (see addresses and telephone numbers below). You must contact them first to find out the price of the paper copy of the publication. The regulation title is 114.3 CMR 39.00: Rehabilitation Clinic Services, Audiological Services, Restorative Services.

Massachusetts State Bookstore
State House, Room 116
Boston, MA 02133
Telephone: 617-727-2834
www.mass.goc/sec/spr

Division of Health Care Finance and Policy
Two Boylston Street
Boston, MA 02116
Telephone: 617-988-3100
www.mass.gov/dhcfp

Procedure-to-Procedure Code Pair Editing

In addition to implementing MUEs as described above, MassHealth has also implemented NCCI procedure-to-procedure code pair editing, which are automated prepayment edits that prevent improper payment when certain service codes are billed by the same provider for the same member on the same date of service. Therapy providers are again advised to review *All Provider Bulletin 209*, which describes in greater detail NCCI procedure-to-procedure edit requirements and provides the link to the CMS Web site that providers may access to obtain a full list of codes to which procedure-to-procedure edits apply. **Note:** Procedure-to-procedure edits are applied to certain combinations of codes in accordance with the NCCI as implemented by MassHealth.

Claims Processing

All therapy claims submitted to MassHealth for dates of service on or after October 1, 2010, that are processed on or after April 1, 2011, will be edited for NCCI procedure-to-procedure edits. With the exception of claims for service codes 92507, 92508, 92526 and 97150, therapy claims submitted to MassHealth for dates of service on or after October 1, 2010, that are processed on or after April 1, 2011, will be edited for NCCI MUEs. Claims with Service Codes 92507, 92508, 92526, and 97150 with dates of service on or after October 1, 2010, that are processed on or after June 1, 2011 will be edited for MUEs. Any such claims using HCPCS/CPT codes that include code pairs on the NCCI edit list, or using codes billed with units of service greater than the MUE limit, will result in payment denials.

Due to the timing of system updates, MassHealth may need to later reprocess and adjust claims to ensure proper NCCI editing.

Please note that MUE limits and procedure-to-procedure code edits supersede any approved prior authorizations (PAs) in the system. Claims over the MUE limit or that include code pairs on the NCCI edit lists will be denied even if they have an approved PA that would otherwise allow coverage and payment of the service. If a claim with such an approved PA is denied solely due to NCCI editing, providers should request agency review of the denial. Consult *All Provider Bulletin 209* for further information about NCCI editing, including Agency review and appeals of claims denials.

MassHealth Web Site

This transmittal letter and attached pages are available on the MassHealth Web site at www.mass.gov/masshealth.

Questions

If you have any questions about the information in this transmittal letter, please contact MassHealth Customer Service at 1-800-841-2900, e-mail your inquiry to providersupport@mahealth.net, or fax your inquiry to 617-988-8974.

NEW MATERIAL
(The pages listed here contain new or revised language.)

Therapist Manual

Pages vi, vii, and 6-1 through 6-4

OBSOLETE MATERIAL
(The pages listed here are no longer in effect.)

Therapist Manual

Pages vi, vii, and 6-1 through 6-4 — transmitted by Transmittal Letter THP-23

The regulations and instructions governing provider participation in MassHealth are published in the Provider Manual Series. MassHealth publishes a separate manual for each provider type.

Each manual in the series contains administrative regulations, billing regulations, program regulations, service codes and descriptions, billing instructions, and general information. MassHealth's regulations are incorporated into the Code of Massachusetts Regulations (CMR), a collection of regulations promulgated by state agencies within the Commonwealth and by the Secretary of State. Regulations promulgated by MassHealth are assigned Title 130 of the Code. Pages that contain regulatory material have a CMR chapter number in the banner beneath the subchapter number and title.

Administrative regulations and billing regulations apply to all providers and are contained in 130 CMR Chapter 450.000. These regulations are reproduced as Subchapters 1, 2, and 3 in this and all other provider manuals.

Program regulations cover matters that apply specifically to the type of provider for which the manual was prepared. For therapists, those matters are covered in 130 CMR Chapter 432.000, reproduced as Subchapter 4 in the *Therapist Manual*.

Revisions and additions to the manual are made as needed by means of transmittal letters, which provide instructions for substituting, adding, or removing pages. Some transmittal letters will be directed to all providers; others will be addressed to providers in specific provider types. In this way, a provider will receive all those transmittal letters that affect its manual, but no others.

The Provider Manual Series is intended for the convenience of providers. Neither this nor any other manual can or should contain every federal and state law and regulation that might affect a provider's participation in MassHealth. The provider manuals represent instead MassHealth's effort to give each provider a single convenient source for the essential information providers need in their routine interaction with MassHealth and with MassHealth members.

601 Introduction

(A) MassHealth pays for the services represented by the codes listed in Subchapter 6 in effect at the time of service, subject to all conditions and limitations in MassHealth regulations at 130 CMR 432.000 and 450.000. A therapist may request prior authorization for any medically necessary service reimbursable under the federal Medicaid Act in accordance with 130 CMR 450.144, 42 U.S.C. 1396d(a), and 42 U.S.C. 1396d(r)(5) for a MassHealth Standard or CommonHealth member younger than 21 years of age, even it if is not designated as covered or payable in Subchapter 6 of the *Therapist Manual*.

(B) A unit is defined as a specified period of time to be used when billing on the MassHealth-designated claim form or when requesting services on the MassHealth-designated prior-authorization form. A unit may equal 15 minutes or one hour, or may not have a defined time frame, depending upon the particular service code. For additional definitions, please refer to 130 CMR 432.000.

602 Service Codes and Descriptions: Physical Therapy

When providing therapy services in an out-of-office location, use the appropriate place of service when billing for physical therapy services. Unless otherwise indicated, the maximum allowable number of units for therapeutic treatment is four per therapy visit (e.g., maximum of one hour per member per visit per day). A therapy visit may include a combination of therapeutic procedures and modalities. Note: Procedure-to-procedure edits will be applied to certain combinations of codes in accordance with the National Correct Coding Initiative (NCCI) as implemented by MassHealth.

Service Code	Modifier	Service Description
97001		Physical therapy evaluation (per hour with a maximum of two hours)
97001	HA	Physical therapy evaluation, child/adolescent program (for children aged 21 or under, per hour with a maximum of three hours)
97001	TF	Physical therapy evaluation, intermediate level of care (for mentally retarded and developmentally disabled adults aged 22 or older, per hour with a maximum of three hours)
97010		Application of a modality to one or more areas; hot or cold packs
97012		traction, mechanical
97014		electrical stimulation (unattended)
97016		vasopneumatic devices
97018		paraffin bath
97024		diathermy (e.g., microwave)
97026		infrared
97028		ultraviolet
97032		Application of a modality to one or more areas; electrical stimulation (manual), each 15 minutes
97033		iontophoresis, each 15 minutes
97034		contrast baths, each 15 minutes
97035		ultrasound, each 15 minutes

603 Service Codes and Descriptions: Physical Therapy (cont.)

Service Code	Modifier	Service Description
97039		Unlisted modality (specify type and time if constant attendance)
97110		Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility
97112		neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities (each 15 minutes)
97116		gait training (includes stair climbing) (each 15 minutes)
97124		massage, including effleurage, petrissage, and/or tapotement (stroking, compression, percussion) (each 15 minutes)
97139		Unlisted therapeutic procedure (specify) (each 15 minutes)
97140		Manual therapy techniques (e.g., mobilization/manipulation, manual lymphatic drainage, manual traction), one or more regions, each 15 minutes
97150	GP	Therapeutic procedure(s), group (two or more individuals) (Use modifier GP to denote group physical therapy.) (services delivered under an outpatient physical therapy plan of care) (maximum one unit per visit)
97530		Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes

604 Service Codes and Descriptions: Occupational Therapy

When providing therapy services in an out-of-office location, use the appropriate place of service when billing for occupational therapy services. Unless otherwise indicated, the maximum allowable number of units for individual therapeutic treatment is four per therapy visit (e.g., a maximum of one hour per member per visit per day), Note: Procedure-to-procedure edits will be applied to certain combinations of codes in accordance with the National Correct Coding Initiative (NCCI) as implemented by MassHealth.

Service Code	Modifier	Service Description
97003		Occupational therapy evaluation
97003	HA	Occupational therapy evaluation, child/adolescent program (for children aged 21 or under, per hour, with maximum of three hours)
97003	TF	Occupational therapy evaluation, intermediate level of care (for mentally retarded and developmentally disabled adults aged 22 or older, per hour, with maximum of three hours)
97150	GO	Therapeutic procedure(s), group (two or more individuals) (services delivered under an outpatient occupational therapy plan of care) (Use modifier GO to denote group occupational therapy.) (maximum one unit per visit)
97530		Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes
97535		Self-care/home management training (e.g., 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 by provider, each 15 minutes

604 Service Codes and Descriptions: Occupational Therapy (cont.)

Service Code	Modifier	Service Description
97761		Prosthetic training, upper and/or lower extremities, each 15 minutes

605 Service Codes and Descriptions: Speech/Language Therapy

When providing therapy services in an out-of-office location, use the appropriate place of service when billing for speech therapy services. Note: Procedure-to-procedure edits will be applied to certain combinations of codes in accordance with the National Correct Coding Initiative (NCCI) as implemented by MassHealth.

Service Code	Modifier	Service Description
92506		Evaluation of speech, language, voice, communication, and/or auditory processing (per hour, with maximum of three hours)
92506	HA	Evaluation of speech, language, voice, communication, auditory processing, child/adolescent program (for children aged 21 or younger) (per hour, with maximum of four hours)
92507		Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual (maximum one unit per visit)
92508		group, two or more individuals (maximum one unit per visit)
92526		Treatment of swallowing dysfunction and/or oral function for feeding (maximum one unit per visit)
92610		Evaluation of oral and pharyngeal swallowing function (per hour, maximum of one hour)

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