blue of california

Payment Policy

Physical Medicine	
Type: Payment Policy	**Policy Specific Section:** Payment
Original Policy Date: September 20, 2013	**Effective Date:** September 20, 2013

Description

Physical medicine is defined as the use of physical means in the diagnosis and treatment of disease or injury. It includes, but is not limited to the use of therapeutic procedures, active wound care management, tests and measures, orthotic and prosthetic management and the use of various physical agents applied to produce therapeutic changes to biologic tissue. These services are provided to meet the functional needs of a patient who suffers from physical impairment due to disease, trauma, congenital anomaly or prior therapeutic intervention. These services are designed to achieve specific diagnosis related goals in a patient who has a reasonable expectation of achieving measureable improvement in a reasonable and predictable period of time.

This payment policy only addresses the reimbursement for Physical medicine procedure codes and does not address the medical necessity. For services rendered by a Chiropractor see: Chiropractic Care Payment Policy.

Policy

The Physical Medicine Payment Policy applies to all licensed provider types billing physical medicine codes with exclusion to services rendered by a chiropractor which is covered in the Chiropractic Care Payment Policy.

Non Payable procedures

CPT code 97124 is not reimbursable when provided by massage therapists. This code may be provided by other licensed providers.

Reimbursement is not provided for Evaluation and Management (E/M) codes 99201-99499 when billed by a physical therapist or occupational therapist

Multiple Procedure Payment Reduction

The following will be processed using a tiered reimbursement methodology based on the highest to lowest RVU value and will be reimbursed at a percentage of the current fee schedule:
CPT codes 97001- 97799 (Physical Medicine and Rehabilitation; Therapeutic Procedures; Active Wound Care Management; Orthotic and Prosthetic Management).

The tiered reimbursement methodology will be applied to the reimbursement percentage to the following; when billing multiple services, individual services or multiple units of the same service.
Below are the reimbursement rate percentages for the different tiers:

Procedures	**Percentage of Reimbursement**
First code with highest Relative Value Units (RVUs)	100% of allowed amount
Second code with the next highest RVUs,	85% of allowed amount
Third code with the next highest RVUs	40% of allowed amount
Fourth code with the next highest RVU's	40% of allowed amount
Fifth and subsequent procedure codes	10% of allowed amount

All the applicable coding rules will be applied as noted in the Provider Manual such as; National Correct Coding Initiative (NCCI) guidelines, Medically Unlikely Edits (MUE) and Multiple Procedure Reduction for Surgery and Radiology

Rationale

Guideline

Blue Shield of California will reference national or regional industry standards for professional claims coding and payment and adhere to Centers for Medicare & Medicaid Services (CMS) and specifically NCCI guidelines, whenever available and applicable, to the extent that they are consistent with guiding principles. In claims payment scenarios where the NCCI guideline is lacking or insufficient, the Payment Policy Committee (PPC) may develop customized payment policies that are based on other accepted or analogous industry payment standards and which reflect the PPC's principle of reasonable reimbursement only for value-added services. When both CMS and American Medical Association are silent, Blue Shield of California may identify appropriate specialty input, which may include national or regional society guidelines, and expertise from specialty consultants/advisors.

Policy History

This section provides a chronological history of the activities, updates and changes that have occurred with this Payment Policy.

Effective Date	Action	Reason
09/20/2013	New Payment Policy	Payment Policy Committee

The materials provided to you are guidelines used by this plan to authorize, modify, or deny care for persons with similar illness or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under your contract. These Policies are subject to change as new information becomes available.