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Origination: October 17, 2024
Last Review: May 01, 2025
Next Review: October 17, 2026
Effective Date: October 01, 2025

Description

Provide guidelines for the payment of eligible services provided on outpatient facility claims rendered by Occupational (OT) & Physical (PT) therapy services definition of session.

Policy & Guidelines

Policy Statement

Effective with dates of service on or after October 01, 2025, Blue Cross and Blue Shield of Vermont (Blue Cross VT) payment for services associated with therapy services (Occupational & Physical) will be subject to maximum timed units limit per session as defined below.

Definition

Blue Cross VT provides reimbursement for the codes listed in the coding table (Table 1), in any combination and defines a therapy session:

Occupational & Physical Therapy Session is Defined:

- An OT/PT session is defined as up to (4) units of OT/PT services (including treatment and/or evaluation).
- Billing cannot exceed (4) units per session.
- If an evaluation or re-evaluation is performed it cannot exceed (1) unit, therefore there are no benefits for more than (3) additional timed units performed at the same session.

Provider Billing Guidelines and Documentation

Evaluation

An evaluation is essential to determine if services are medically necessary, gather baseline data, establish a treatment plan, and develop goals based on that data. An evaluation is needed before implementing any therapy treatment.

The plan of care should include:

- Prior functional level, if acquired condition;
- Objective, measurable, and functional descriptions of an individual's deficits using comparable and consistent methods;
- Specific statements of long- and short-term goals;
- Measurable objectives;
- A reasonable estimate of when the goals will be reached and rehabilitation prognosis;
- The specific treatment techniques and/or activities to be used in treatment;
- The frequency and duration of treatment;
- Discharge plan that is initiated at the start of treatment;
- All of the above required information will be documented with clear, legible notes that include the date of treatment and signature of the treating provider.

Progress Notes

Flow sheets are considered a component of the medical record but are not sufficient on their own unless they document or note the duration of treatment, modality parameters, and total treatment time, settings, and if the provider was in constant attendance. This information must be included in the medical record, either in flowsheets or in the progress note, to support both the procedure codes billed and the medical necessity of procedures performed.

It is also required that documentation demonstrates the progression and improvement of exercises performed, treatment parameters for each, treatment times performed and the total treatment time for the daily sessions and if the therapist was one-on-one with the patient. When patients are performing independently on exercise equipment (e.g. treadmills, bikes) and a provider is not in constant attendance for evaluation and instruction the provider should not bill for therapeutic procedures.

Documentation for Constant Attendance Procedures/Modalities

When documentation supports constant attendance therapeutic procedures or modalities being performed; time documentation in minutes is required in the medical record. The amounts of time versus the appropriate number of units. An 8-minute rule is applied for billing purposes:

Time of Therapy Delivered	Billable Units
Less Than 8 Minutes	1 Unit (Append -52 Modifier)
08-22 Minutes	1 Unit
23-37 Minutes	2 Units
38-52 Minutes	3 Units
53-67 Minutes	4 Units

Sessions

Occupational & Physical Therapy Session is Defined:

- An OT/PT session is defined as up to (4) units of OT/PT services (including treatment and/or evaluation).
- Billing cannot exceed (4) units per session.
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Self- Pay Agreement

A self-pay agreement must be entered into with the member prior to rendering any services described in this policy when a member chooses to pay, at their own expense, for services that exceed the limitations of coverage (i.e. visits beyond the 30 combined visit limit per plan year, or therapy sessions that exceed (4) units) and or any other excluded or non-covered services (i.e. wellness/preventative physical therapy/medicine services; care designed to prepare for specific occupational, leisure, or recreational activities or hobbies or sports; acupuncture or massage therapy (this list of examples is not all-inclusive). This self- pay agreement must be maintained as part of the member's medical record.

Services Not Eligible

A therapy session per day for outpatient services CANNOT exceed (4) units of Occupational or Physical therapy services (treatment and/or evaluation). If more than (4) units of therapy services are billed, the additional units will be denied as not medically necessary.

Benefit Determination Guidance

Payment for services is determined by the member's benefits. It is important to verify the member's benefits **prior** to providing the service to determine if benefits are available or if there is a specific exclusion in the member's benefit.

Eligible services are subject to applicable member cost sharing such as co-payments, co-insurance, and deductible.

Federal Employee Program (FEP): Members may have different benefits that apply. For further information, please contact FEP customer service or refer to the FEP Service Benefit Plan Brochure. It is important to verify the member's benefits **prior** to providing the service to determine if benefits are available or if there is a specific exclusion in the member's benefit.

Inter Plan Programs (IPP): In accordance with the Blue Cross and Blue Shield Association's Inter-Plan Programs Policies and Provisions, this payment policy governs billing procedures for goods or services rendered by a Vermont-based provider (Blue Cross VT is the local Plan), including services rendered to out-of-state Blue members. Provider billing practices,

payment policy and pricing are a local Plan responsibility that a member's Blue Plan must honor. A member's Blue Plan cannot dictate the type of claim form upon which services must be billed, codes and/or modifiers, place of service or provider type, unless it has its own direct contract with the provider (permitted only in limited situations). A member's Blue Plan cannot apply its local billing practices on claims rendered in another Plan's service area. A member's Blue Plan can only determine whether services rendered to their members are eligible for benefits. To understand if a service is eligible for payment, it is important to verify the member's benefits **prior** to providing services. In certain circumstances, the member may be financially responsible for services beyond the benefit provided for eligible services.

Claims are subject to payment edits that are updated at regular intervals and generally based on Current Procedural Terminology (CPT®), Health Care Procedural Coding System (HCPCS), Internal Classification of Diseases, CMS National Correct Coding Initiative Edits, Specialty Society guidelines, etc.

Eligible Providers

This policy applies to all providers/facilities contracted with the Plan's Network (participating/in- network) and any non-participating/out-of-network providers/facilities.

Audit Information

Blue Cross VT reserves the right to conduct audits on any provider and/or facility to ensure adherence with the guidelines stated in the payment policy. If an audit identifies instances of non-adherence with this payment policy, Blue Cross VT reserves the right to recover all non-adherence payments.

Legislative and Regulatory Guidelines

N/A

Related Policies

Occupational Therapy Corporate Medical Policy

Physical Therapy/Medicine Corporate Medical Policy

Document Precedence

The Blue Cross VT Payment Policy Manual was developed to provide guidance for providers regarding Blue Cross VT payment practices and facilitates the systematic application of Blue Cross VT member contracts and employer benefit documents, provider contracts, Blue Cross VT corporate medical policies, and Plan's claim editing logic. Document precedence is as follows:

1) To the extent that there may be any conflict between the Blue Cross VT Payment Policy Manual and the member contracts or employer benefit documents, the member contract or employer benefit document language takes precedence.
2) To the extent that there may be any conflict between the Blue Cross VT Payment Policy Manual and provider contract language, the provider contract language takes precedence.
3) To the extent that there may be any conflict between the Blue Cross VT Payment Policy Manual and corporate medical policy, the corporate medical policy takes precedence.
4) To the extent that there may be any conflict between the Blue Cross VT Payment Policy Manual and the Plan's claim editing solutions, the Plan's claim editing solution takes precedence.

Table 1: Therapy Procedure/Evaluation Codes

The following codes will be considered as medically necessary when applicable criteria have been met. For services that are measured in 15-minute time units per the code descriptor, time must be documented. Units are required in addition to the code for billing with one unit equaling 15 minutes.		
Code	**Description**	**Notes**
97032	Application of a modality to 1 or more areas; electrical stimulation (manual), each 15 minutes	
97034	Application of a modality to 1 or more areas; contrast baths, each 15 minutes	
97035	Application of a modality to 1 or more areas; ultrasound, each 15 minutes	
97036	Application of a modality to 1 or more areas; Hubbard tank, each 15 minutes	

The following codes will be considered as medically necessary when applicable criteria have been met. For services that are measured in 15-minute time units per the code descriptor, time must be documented. Units are required in addition to the code for billing with one unit equaling 15 minutes.		
Code	**Description**	**Notes**
97110	Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility	
97112	Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities	
97113	Therapeutic procedure, 1 or more areas, each 15 minutes; aquatic therapy with therapeutic exercises	
97116	Therapeutic procedure, 1 or more areas, each 15 minutes; gait training (includes stair climbing)	
97140	Manual therapy techniques (e.g., mobilization/ manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes	
97161	Physical therapy evaluation: low complexity, requiring these components: A history with no personal factors and/or comorbidities that impact the plan of care; An examination of body system(s) using standardized tests and measures addressing 1-2 elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions; A clinical presentation with stable and/or uncomplicated characteristics; and Clinical decision making of low complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 20 minutes are spent face-to-face with the patient and/or family.	Evaluation
97162	Physical therapy evaluation: moderate complexity, requiring these components: A history of present problem with 1-2 personal	Evaluation

The following codes will be considered as medically necessary when applicable criteria have been met. For services that are measured in 15-minute time units per the code descriptor, time must be documented. Units are required in addition to the code for billing with one unit equaling 15 minutes.		
Code	**Description**	**Notes**
	factors and/or comorbidities that impact the plan of care; An examination of body systems using standardized tests and measures in addressing a total of 3 or more elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions; An evolving clinical presentation with changing characteristics; and Clinical decision making of moderate complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 30 minutes are spent face-to-face with the patient and/or family.	
97163	Physical therapy evaluation: high complexity, requiring these components: A history of present problem with 3 or more personal factors and/or comorbidities that impact the plan of care; An examination of body systems using standardized tests and measures addressing a total of 4 or more elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions; A clinical presentation with unstable and unpredictable characteristics; and Clinical decision making of high complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 45 minutes are spent face-to-face with the patient and/or family.	Evaluation
97164	Re-evaluation of physical therapy established plan of care, requiring these components: An examination including a review of history and use of standardized tests and measures is required; and Revised plan of care using a standardized patient assessment instrument and/or measurable assessment of functional	Re-evaluation

The following codes will be considered as medically necessary when applicable criteria have been met. For services that are measured in 15-minute time units per the code descriptor, time must be documented. Units are required in addition to the code for billing with one unit equaling 15 minutes.		
Code	**Description**	**Notes**
	outcome Typically, 20 minutes are spent face-to-face with the patient and/or family.	
97165	Occupational therapy evaluation, low complexity, requiring these components: An occupational profile and medical and therapy history, which includes a brief history including review of medical and/or therapy records relating to the presenting problem; An assessment(s) that identifies 1-3 performance deficits (i.e., relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and Clinical decision making of low complexity, which includes an analysis of the occupational profile, analysis of data from problem-focused assessment(s), and consideration of a limited number of treatment options. Patient presents with no comorbidities that affect occupational performance. Modification of tasks or assistance (e.g., physical or verbal) with assessment(s) is not necessary to enable completion of evaluation component. Typically, 30 minutes are spent face-to-face with the patient and/or family.	Evaluation
97166	Occupational therapy evaluation, moderate complexity, requiring these components: An occupational profile and medical and therapy history, which includes an expanded review of medical and/or therapy records and additional review of physical, cognitive, or psychosocial history related to current functional performance; An assessment(s) that identifies 3-5 performance deficits (i.e., relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and Clinical decision making of moderate analytic complexity, which includes an analysis of the occupational profile, analysis	Evaluation

The following codes will be considered as medically necessary when applicable criteria have been met. For services that are measured in 15-minute time units per the code descriptor, time must be documented. Units are required in addition to the code for billing with one unit equaling 15 minutes.		
Code	**Description**	**Notes**
	of data from detailed assessment(s), and consideration of several treatment options. Patient may present with comorbidities that affect occupational performance. Minimal to moderate modification of tasks or assistance (e.g., physical or verbal) with assessment(s) is necessary to enable patient to complete evaluation component. Typically, 45 minutes are spent face-to-face with the patient and/or family.	
97167	Occupational therapy evaluation, high complexity, requiring these components: An occupational profile and medical and therapy history, which includes review of medical and/or therapy records and extensive additional review of physical, cognitive, or psychosocial history related to current functional performance; An assessment(s) that identifies 5 or more performance deficits (i.e., relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and Clinical decision making of high analytic complexity, which includes an analysis of the patient profile, analysis of data from comprehensive assessment(s), and consideration of multiple treatment options. Patient presents with comorbidities that affect occupational performance. Significant modification of tasks or assistance (e.g., physical or verbal) with assessment(s) is necessary to enable patient to complete evaluation component. Typically, 60 minutes are spent face-to-face with the patient and/or family.	Evaluation
97168	Re-evaluation of occupational therapy established plan of care, requiring these components: An assessment of changes in patient functional or medical status with	Re-evaluation

The following codes will be considered as medically necessary when applicable criteria have been met. For services that are measured in 15-minute time units per the code descriptor, time must be documented. Units are required in addition to the code for billing with one unit equaling 15 minutes.		
Code	**Description**	**Notes**
	revised plan of care; An update to the initial occupational profile to reflect changes in condition or environment that affect future interventions and/or goals; and A revised plan of care. A formal reevaluation is performed when there is a documented change in functional status or a significant change to the plan of care is required. Typically, 30 minutes are spent face-to-face with the patient and/or family.	
97530	Therapeutic activities, direct (one-on-one) patient contact (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, each 15 minutes	
97755	Assistive technology assessment (e.g., to restore, augment or compensate for existing function, optimize functional tasks and/or maximize environmental accessibility), direct one-on-one contact, with written report, each 15 minutes	
97760	Orthotic(s) management and training (including assessment and fitting when not otherwise reported), upper extremity(ies), lower extremity(ies) and/or trunk, initial orthotic(s) encounter, each 15 minutes	
97761	Prosthetic(s) training, upper and/or lower extremity(ies), initial prosthetic(s) encounter, each 15 minutes	
97763	Orthotic(s)/prosthetic(s) management and/or training, upper extremity(ies), lower extremity(ies), and/or trunk, subsequent	

The following codes will be considered as medically necessary when applicable criteria have been met. For services that are measured in 15-minute time units per the code descriptor, time must be documented. Units are required in addition to the code for billing with one unit equaling 15 minutes.		
Code	**Description**	**Notes**
	orthotic(s)/prosthetic(s) encounter, each 15 minutes	
G0151	Services performed by a qualified physical therapist in the home health or hospice setting, each 15 minutes	
G0152	Services performed by a qualified occupational therapist in the home health or hospice setting, each 15 minutes	

Policy Implementation/Update Information

This policy was originally implemented on February 01, 2025.

Date of Change	Effective Date	Overview of Change
October 17, 2024	February 01, 2025	New policy to clarify the corporate medical policy intent for therapy session maximum time limit.
May 01, 2025	August 01, 2025	Policy clarification statement added third bulleted language: • A therapy (Occupational or Physical) session is defined as up to one hour of PT services (including treatment and/or evaluation). • Billing cannot exceed one hour per session. • If an evaluation or re-evaluation is performed, there are no benefits for more than three timed code units performed at the same session
June 26, 2025	October 01, 2025	Clarified policy statement regarding definition of therapy session to include: Occupational & Physical Therapy Session is Defined: • An OT/PT session is defined as up to (4) units of OT/PT services (including treatment and/or evaluation). • Billing cannot exceed (4) units per session. • If an evaluation or re-evaluation is performed it

			cannot exceed (1) unit, therefore there are no benefits for more than (3) additional timed units performed at the same session.

Approved by **Update Approved: 07/10/2025**

Tom Weigel, MD, Chief Medical Officer