8 Physical Medicine

The relative value units in this section were determined uniquely for physical medicine services. Use the physical medicine conversion factor when determining fee amounts. The physical medicine conversion factor is not applicable to any other section.

The fee for a procedure or service in this section is determined by multiplying the relative value unit by the physical medicine conversion factor, subject to the ground rules, instructions, and definitions of the schedule. Conversion factors are located in the Introduction and General Guidelines section.

To ensure uniformity of billing when multiple services are rendered, each relative value unit is to be multiplied by the conversion factor separately. After which, charges for products may be added.

PHYSICAL MEDICINE GROUND RULES

The fees for physical medicine and physical or occupational therapy services are payable when services are rendered by a physician or a non-physician (duly licensed physical therapist [PT] or occupational therapist [OT]). When physical medicine treatment is rendered in the follow-up period of surgical or fracture care procedures, the treatment is not considered part of the global surgical fee. Physical medicine services are separately covered procedures when rendered during the follow-up period of any surgical service. When a patient is seen by a provider other than the surgeon prior to and during the implementation of a physical medicine program, and a history and physical examination is performed, a fee for an office visit is permitted. Definitions and rules pertaining to physical medicine services are as follows:

Note: Rules used by all providers in reporting their services are presented in the General Ground Rules in the Introduction and General Guidelines section.

1A. NYS Medical Treatment Guidelines

The recommendations of the NYS Medical Treatment Guidelines supersede the ground rule frequency limitation for services rendered to body parts covered by the NYS Medical Treatment Guidelines. The maximum reimbursement limitations per patient per day per accident or illness for modalities is 12.0 RVUs, re-evaluation plus modalities is 15.0 RVUs, and initial evaluation plus modalities is 18 RVUs. Treatment of work-related injuries should be in accordance with any applicable medical treatment guidelines adopted by the Chair of the Workers' Compensation Board. If there is a conflict between the fee schedule ground rules and the medical treatment guidelines, the guidelines will prevail. With limited exceptions that are clearly identified in the guidelines, treatment that correctly applies the treatment guidelines is pre-authorized regardless of the cost of the treatment. Treatment that is not a correct application of, or is outside or in excess of the treatment guidelines is not authorized unless the payer or Workers' Compensation Board has approved a variance.

1B. Supervision by Physician

When services are rendered by a registered physical therapist or occupational therapist under direct or indirect physician supervision, the supervision includes a periodic history and physical examination of the patient. The supervising physician should also oversee the written instructions for treatment for a given diagnosis. Written instructions should include precautions, goals, frequency, and modalities to be used.

2. Physical Medicine Utilization

Physical medicine services may not exceed 12 sessions/visits per patient per accident or illness or be rendered more than 180 days from the first session/visit.

3. Physical Medicine and Rehabilitation Program

If the provider deems that the patient's condition warrants a physical medicine and rehabilitation program and the referral is made during the follow-up period, no preauthorization from the insurance carrier is required for the referral.

4. Home Treatment

When treatment is rendered in a patient's home by a provider or self-employed therapist, add 50 percent to the listed value. Documentation explaining the necessity of home treatment instead of an office or outpatient treatment setting is required with the bill to the insurance carrier.

5. Referral and Authorization

Provider referring patients to a self-employed duly licensed and registered physical therapist (PT) or occupational therapist (OT) may include a directive indicating the treatment plan and duration but should not exceed 12 sessions/visits per patient per day or be rendered more than 180 days from the first session/visit.

Note: If prior authorization or the applicable MTG authorizes more than 12 sessions/visits or sessions/visits beyond 180 days from the first session/visit, the PT or OT does not need to obtain reauthorization until the previous authorization or MTG session/ visit limit is reached.

6. Report Requirements

Self-employed physical and occupational therapists shall submit OT/PT-4 reports as required by regulation.

7. Self-Employed Physical Therapist or Occupational Therapist

Self-employed physical or occupational therapists that render therapy during the follow-up period for fractures, dislocations, or other postoperative procedures shall be reimbursed for therapy during and after the follow-up period.

8. Initial Evaluation and Re-evaluation by a Self-employed Physical or Occupational Therapist

Self-employed physical therapists (PT) and occupational therapists (OT) may bill for an initial evaluation using CPT codes 97161–97163 and 97165–97167, respectively. The maximum number of RVUs (including treatment) per patient per day per accident or illness when billing for an initial evaluation shall be limited to 18. The following codes represent the treatments subject to this rule:

Evaluations shall include the following elements: history, examination, clinical testing, interpretation of data, clinical presentation, clinical decision making, and development of the plan of care with defined goals, appropriate interventions, and recommendations.

97010 97012 97014 97016 97018 97022 97024 97026 97028 97032 97033 97034 97035

9703697039 97110 97112 97113 97116 97124 97139 97140 97150 97530 97535 97537 97542

97760 97761 97762 97763

The maximum number of RVUs (including treatment) per person per day per accident or illness when billing for a re-evaluation shall be limited to 15. Re-evaluations using CPT codes 97164 (PT) and 97168 (OT) may be billed when any of the following applies:

A) If following discharge (for whatever reason), the patient is referred again for treatment with the same or similar condition of the same body part.

B) If there is a significant change in the patient's condition that warrants a revision of the treatment goals, intervention and/or the plan of care.

C) If it is medically necessary to provide re-evaluation services over and above those normally included during therapeutic treatment.