PEIA PPB Plan
Massage Therapy Policy

Approved and Issued By:

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Massage Therapy benefits are available under the PEIA PPB benefit plan for the services of a Massage Therapist. The details of this benefit are outlined below.

EFFECTIVE DATE: Coverage for Massage Therapy became effective March 11, 1992, with an annual benefit maximum of $750.00. As of July 1, 1999, Massage Therapy services were included in the "Outpatient Therapy" benefit with a combined annual maximum of $1,000 per patient. Effective July 1, 2005, PEIA implemented a 20 visit maximum number of visits for "Outpatient Therapy" services.

The revision of the licensing requirement is effective July 1, 2013. See item 13 below for details.

BENEFIT MAXIMUMS: All covered massage therapy services provided by a licensed Massage Therapist are applied toward the 20-visit benefit maximum for outpatient therapy services. Services included in the outpatient therapy benefit maximum are; physical, occupational, massage, vision, and speech therapy and chiropractic services. As of July 1, 2012, acupuncture services are not covered by PEIA. The 20-visit limit is a per member, per plan year maximum. Coverage may be extended beyond the 20 visit limit for members in case management due to a catastrophic illness or injury, if approved in advance by HealthSmart Care Management Solutions.

COVERAGE: Services determined to be medically necessary and which meet Plan guidelines are covered as follows:

PEIA PPB Plans A, B, and D

- The first 20 visits are covered with a $10 copayment per visit, plus deductible and coinsurance.

- If additional visits (more than 20) are medically necessary and approved by HealthSmart Care Management Solutions, the copayment is $25 per visit and the deductible and coinsurance apply.

PEIA PPB Plan C---High Deductible Health Plan

- The first 20 visits are subject to the combined medical and prescription drug deductible and, once the deductible is met, these visits are covered at 80% of the allowed amount for in-network services.
- If additional visits (more than 20) are medically necessary and approved by HealthSmart Care Management Solutions, once the deductible is met they are covered at 80% of the allowed amount.

PLAN GUIDELINES: PEIA requires that all massage therapists follow appropriate "Medical Massage Treatment Guidelines." Following are the general guidelines required of the massage therapist:

1. The therapist must have a written order for treatment on file (no verbal orders) from a physician;

2. There are 3 zones of the body - the upper extremities, the lower extremities and the trunk (including the head and neck regions). Each zone of the body can only have 2 units (15 minutes) of ANY manual therapy per day with a maximum of 4 units;

3. PTs, Chiropractors and Massage therapists cannot use the same CPT code on the same day;

4. A treatment unit is 15 minutes;

5. Treatment should always stop once patient has reached MMI (maximum medical improvement);

    a. "Maximum medical improvement" means a condition that has become static or stabilized during a period of time sufficient to allow optimal recovery, and one that is unlikely to change in spite of further medical or surgical therapy.

6. Massage therapists must have an evaluation on file, treatment notes for every session and a treatment plan on file for every patient. The treatment plan and physician's prescription must be submitted with the initial claim;

7. Massage therapists must bill the proper CPT code for the services they provide - recognized codes are 97124 and 97140. Massage therapists cannot charge for any service not manually provided (ultrasound, etc);

8. Diagnosis codes must match the prescription sent by the ordering physicians. If a doctor orders massage therapy for a stiff neck, and the patient comes to

the massage therapist complaining of a stiff neck, shoulder pain and numbness and tingling going down the arm, the massage therapist must contact the doctor office, tell them of the complaints not on the order and ask if the ordering physician wants to re-evaluate their patient, leave the order as it stands, or send a new order to cover treatment for the areas not listed on the original order. A copy of the prescription, along with the treatment plan, must be submitted with the initial claim. If the treatment plan is changed, it must be sent to HealthSmart with the initial claim for the new treatment plan. If it is for visits over the 20-visit maximum, it should be sent to HealthSmart Care Management Solutions.

9. Only "acute" treatment is covered (**maintenance treatment is NOT covered**);

10. Each treatment session must be billed separately on a CMS 1500 claim form;

11. The charge per unit must be consistent with the charges billed to non-PEIA patients;

12. Malpractice insurance is required (minimum of $2 million per occurrence); and

13. Therapist must be:
    - licensed or certified under the law of the jurisdiction in which the care is rendered;
    - providing treatment within the scope or limitation of the license or certification;
    - not under sanction by Medicare, Medicaid or both. Services of providers under sanction will be denied for the duration of the sanction; and
    - not excluded by PEIA due to adverse audit findings.

Effective July 1, 2013, PEIA is removing the requirement for National Certification.

BILLING FOR SERVICES: Providers must follow PEIA billing procedures and guidelines for PEIA PPB Plan members.

PROHIBITION OF BALANCE BILLING: The PEIA PPB Plan is governed in part by the Omnibus Health Care Act which was enacted by the West Virginia Legislature in April 1989. This Law requires that any West Virginia health care provider who treats a PEIA PPB Plan participant must accept assignment of benefits and cannot balance bill the participant for any portion of charges over and above the PEIA fee allowance or for any discount amount applied to a provider's charge or payment. This is known as the "prohibition of balance billing."

The prohibition of balance billing applies when services are provided in West Virginia and when the PEIA PPB Plan is the primary payor. When the PPB Plan is the secondary payor, the provider will follow the rules and limitations of the primary payer. When PEIA is the primary payor, the member is always responsible for deductibles, coinsurance amounts, copayments and for non-covered services, unless otherwise covered by another insurer.

WHO TO CALL: Providers with questions regarding benefits or to check the status of a claim should call HealthSmart at 888-440-7342 and choose option 1.

To request additional services beyond the 20-visit maximum, call HealthSmart Care Management Solutions at 888-440-7342 and choose option 1, than option 4.

Original Effective Date: November 7, 2002
Revision Date: December 11, 2002 (revised)
Revision Date: August 4, 2004 (2nd revision)
Revision Date: March 23, 2012 (revision for July 2012 benefit update)
Revision Date: May 16, 2013 (revision for July 2013 update to licensing requirement)