State Advocacy for Payment for Physical Therapist Services

An APTA State Advocacy Resource

APTA has developed these resources to help chapters advocate for legislation and regulations in their state that provide for fair payment and reduce administrative burden. You will find background on current issues, examples of positive state legislative actions, and templates for payment-related acts that chapters can use to propose legislation.

Current Trends in Payment

Multiple Procedure Payment Reduction

Under multiple procedure payment reduction, when multiple CPT procedure codes are billed to the same patient on the same day, the procedure with the highest practice expense value is reimbursed at 100%, and the practice expense values for additional codes are reduced, resulting in decreased payment for care provided by physical therapists and physical therapist assistants. APTA has opposed the MPPR policy at the federal level since CMS started applying it to "always therapy" services in 2011. The association continues to assert that it's a flawed policy because the practice expense values for physical medicine CPT codes already have been reduced to avoid duplication during the valuation process.

We are starting to see the application of MPPR to state programs such as Medicaid, which poses the threat of payment cuts to physical therapy and other health care services. We anticipate that MPPR will continue to be an issue as policymakers seek ways to "bend the health care cost curve."

Legislative action is one way to prevent the adoption of MPPR by other payers. Nebraska has passed legislation prohibiting the application of MPPR in its Medicaid program.

APTA Nebraska formed a coalition with state occupational therapists and speech-language pathologists to advocate for a bill that prohibits the application of MPPR to physical, occupational, and speech therapy services in the Nebraska Medicaid program to prevent insurers from applying it in the future.

After a coordinated lobbying campaign by PTs and PTAs, OTs and OTAs, and SLPs; strong legislative testimony; and withdrawal of a controversial amendment, the bill passed Nebraska's unicameral legislature unanimously and was signed into law by the governor in 2021.

For model language on prohibiting MPPR in state Medicaid programs, see Appendix A.

EFT Transactions and Virtual Credit Cards

Some insurance carriers are paying providers via electronic funds transfers or virtual credit cards, both of which can carry up to a 5% fee imposed on the provider. Alabama requires insurers to allow providers to opt out of payment via credit card, and Georgia prohibits insurers from paying via virtual credit cards. Connecticut enacted similar legislation in 2018 but only for dentists. Connecticut's statute requires insurers or any "entity that delivers, issues for delivery, renews, amends, or continues an individual or group health insurance policy" to allow dentists to refuse VCC payments. However, most states do not have restrictions on fees associated with this method of payment.

To avoid fees for EFT and virtual credit card payments, consider the following steps:

- Carefully review payer contracts and all amendments. At a minimum, review all contracts annually.
- Watch for updates to policies in payer newsletters.
- Pay attention to the presence or absence of language related to EFT transactions and virtual credit card transactions.
- Request a no-cost version of EFT transactions.
- Challenge virtual credit card payments and any associated fees.
- Check your state law regarding EFT transactions and virtual credit cards.
- Consult with an attorney for legal counsel and advice.

Prepayment Review

Prepayment claims reviews significantly delay payment. For example, providers in Maine were put on prepayment claims review, leading to delays of nine to 12 months. Thanks to advocacy by APTA Maine, the state became the first in the country to pass legislation that regulates prepayment review. The law, LD 1317, requires claims under prepayment review to be paid or denied within 30 days, prohibits the denial of a claim because of a correctable filing mistake, and requires commercial carriers to provide a process for appealing claim denials.

For model language on regulating insurance carrier practice, or facility-wide prepayment review, see Appendix B.

Prior Authorization

The Affordable Care Act's 8/20 rule, also known as the "Medical Loss Ratio," allows insurance carriers to include "quality assurance measures" as medical services spending, which has led to a significant increase in insurance carriers using third-party administrators to conduct prior authorization, utilization management, and concurrent review of therapy services. In response, several states are enacting legislation to put parameters and restrictions on prior authorization and other reviews by insurers.

For example, during the 2021 legislative session, APTA Oregon successfully advocated for passage of HB 2517, which requires all insurance carriers to report the number of prior authorizations requested, the number denied, and the number of denials overturned on appeal, and requires independent prior authorization review panels that include at least one clinician with the same or similar specialty as the requesting provider. Additionally, the new law requires that insurance carriers clearly post all prior authorization requirements on their websites, that clinical reviews be evidence-based, and that the reason for a denial be written in clear language. The bill models American Medical Association language for prior authorization and step therapy.

In 2023, Maine enacted legislation that prohibits insurers from requiring prior authorization for new episodes of care for the first 12 physical therapy, occupational therapy, or chiropractic visits (carriers can still retroactively deny claims determined not to be medically necessary, however). In addition, insurers will be required to appoint a qualified medical director to oversee prior authorization policies and to provide clear instruction to providers on how to obtain prior authorization when required.

For model language on prohibiting utilization management for therapy visits, see Appendix C and Appendix D.

Coverage and Payment Parity for Telehealth

During 2020 special sessions and 2021 regular sessions, states including Colorado (SB 20-212), Connecticut (HB 5596), Maryland (SB 3), and New Hampshire enacted legislation (HB 1623) requiring coverage and payment parity for physical therapist services delivered via telehealth. This ensures that providers are paid for treatment via telehealth on the same basis and at the same rate as if the services were provided in person.

Arkansas, Indiana, and Texas also enacted laws in 2021 to provide coverage of telehealth for PTs and other providers via telehealth. Most recently, Pennsylvania enacted legislation in 2024.

For model language on coverage and payment parity for telehealth, see Appendix E.

"Orange Envelope" Laws

Providers can easily miss important notices of material changes to insurer contracts, causing increased administrative burden, reduced payment for services, or both. Kentucky has enacted an "Orange Envelope" law requiring insurance carriers to furnish a 90-day notice of material changes to provider contracts that includes a proposed effective date, a detailed description of the proposed change, an opportunity for the provider to accept or opt-out of the change, and contact information if the provider wants to discuss the proposed changes with an insurance carrier representative. The law is named as such because the notice to participating providers must be in an orange-colored envelope with "ATTENTION! CONTRACT AMENDMENT ENCLOSED" printed on the envelope.

For model language on requiring notice of material changes to provider contracts, see Appendix F.

Provider Credentialing Laws

Credentialing is the process of becoming accepted into an insurance provider's preferred network. This process is important, as it helps insurance carriers determine that you're qualified to serve on their panels. Common problems with provider credentialing include long delays due to complex paperwork and verification processes, inconsistent standards across organizations, inaccurate or outdated information, difficulty keeping up with changing regulations, lack of standardization, and high administrative burden; all of which can lead to delays in patient access to care and potential revenue loss for healthcare providers

For model language on that requires health insurance carriers to follow specified guidelines regarding health care provider credentialing, see Appendix G.

Fair PT Copays

A number of APTA state chapters have been successful in passing fair PT copay legislation. Most recently, APTA West Virginia was successful in passing HB 2436, a significant change in regulations for insurers, mandating that carriers cannot charge copays, coinsurance, or office visit deductibles for physical therapy visits. In addition, the insurers must clearly state their physical therapy coverage policies, including coverage rates and terms and conditions.

See a sample of state laws on fair PT copays.

Last Updated: 1/15/2025
Contact: advocacy@apta.org

Appendix A

Model Language for an Act To Prohibit Multiple Procedure Payment Reduction in the Medicaid Program

Be it enacted by the People of the State of [STATE] as follows:

(1) For purposes of this section, multiple procedure payment reduction policy means a policy used in the federal Medicare program under Title XVIII of the federal Social Security Act for outpatient rehabilitation service codes where full payment is made for the unit or procedure with the highest rate and subsequent units and procedures are paid at a reduction of the published rates when more than one unit procedure is provided to the same patient on the same day.

(2) A multiple procedure payment reduction policy shall not be implemented under the Medicaid program as it applies to therapy services provided by physical therapy, occupational therapy, or speech-language pathology.

Appendix B

Model Language for an Act To Regulate Insurance Carrier Practice or Facility-wide Prepayment Review

Be it enacted by the People of the State of [STATE] as follows:

Definition of Practice or facility-wide prepayment review of providers: A practice or facility-wide prepayment review of the documentation or records of a provider conducted by a carrier for the purposes of identifying fraud, waste or abuse, determining whether the documentation is appropriate or adequate to support a claim for covered health care services or determining whether health care services are or were medically necessary health care as a condition of payment must be conducted in accordance with the following requirements:

A. When a carrier subjects a provider or facility to a practice or facility-wide prepayment review, the carrier shall provide a process to allow claims and documentation to be submitted to the carrier electronically for purposes of proving timely filing and tracking the carrier's compliance with time limits in other applicable laws.

B. Claims subject to a practice or facility-wide prepayment review must be paid or disputed within 30 days. Any claim that is not disputed or paid within 30 days by the carrier is overdue and subject to interest.

C. Any records of an enrollee reviewed as part of a practice or facility-wide prepayment review must be reviewed by the same reviewer to the extent possible. The reviewer who performs the practice or facility-wide prepayment review is the primary contact person for the provider related to an audit, review, denial or nonpayment of a claim. Any practice or facility-wide prepayment review that involves clinical or professional judgement must be conducted by or in consultation with a clinical peer.

D. A carrier may not apply additional or different documentation standards beyond the standards set by the professional association of the provider subject to practice or facility-wide

prepayment review if those standards are publicly available or made available to the carrier. This paragraph does not prohibit carriers from establishing or applying medical policies or clinical guidelines to determine whether a service is a covered benefit and medically necessary health care. This paragraph does not apply to claims submitted by a hospital or other health care facility.

E. A carrier may not deny payment of a claim for covered health care services by a provider solely on the basis of a minor documentation error or omission, including, but not limited to, misspelling, use of an abbreviation or a correctable error, unless the carrier affords the provider or enrollee the opportunity to resubmit the claim to correct the identified error.

F. If a carrier requires additional information as part of a practice or facility-wide prepayment review of a claim for covered health care services by a provider, the carrier shall inform the provider with reasonable specificity of the information needed by the carrier to adjudicate the claim.

G. Additional information required by a carrier is considered timely filed by the provider if submitted within 30 days from the date the provider received notice from the carrier of the errors, omissions or additional information needed.

H. A carrier shall provide information on how a provider may appeal the denial of a claim, including the mailing or e-mail address or fax number where an appeal should be sent, on its publicly accessible website or in a provider manual.

I. A carrier shall provide an opportunity to appeal the results of an audit leading to the provider being put on a practice or facility-wide prepayment review.

J. A carrier may not audit a provider or require that a provider's claims be subject to practice or facility-wide prepayment review as retribution for raising contract disputes.

For the purposes of this subsection, "practice or facility-wide prepayment review" means a manual review or audit process of all, or substantially all, of a provider's claims by a carrier or the carrier's agent

Appendix C

Model Language for an Act To Prohibit Utilization Management for Certain Therapy Visits

Be it enacted by the People of the State of [STATE] as follows:

(1) A health carrier or its contracted entity that imposes different prior authorization standards and criteria for a covered service among tiers of contracting providers of the same licensed profession in the same health plan shall inform an enrollee which tier an individual provider or group of providers is in by posting the information on its web site in a manner accessible to both enrollees and providers.

(2)(a) A health carrier or its contracted entity may not require utilization management or review of any kind including, but not limited to, prior, concurrent, or postservice authorization for an initial evaluation and management visit and up to six treatment visits with a contracting provider in a new episode of care for each of the following: physical therapy, occupational therapy, or speech and hearing therapies. Visits for which utilization management or review is prohibited under this section are subject to quantitative treatment limits of the health plan.

This section may not be interpreted to limit the ability 10 of a health plan to require a referral or prescription for the therapies listed in this section.

(b) For visits for which utilization management or review is prohibited under this section, a health carrier or its contracted entity may not:

(i) Deny or limit coverage on the basis of medical necessity or

appropriateness; or

(ii) Retroactively deny care or refuse payment for the visits.

(3) A health carrier shall post on its web site and provide upon the request of a covered person or contracting provider any prior authorization standards, criteria, or information the carrier uses for medical necessity decisions.

(4) A health care provider with whom a health carrier consults regarding a decision to deny, limit, or terminate a person's covered health care services must hold a license, certification, or registration, in good standing and must be in the same or related health field as the health care provider being reviewed or of a specialty whose practice entails the same or similar covered health care service.

(5) A health carrier may not require a provider to provide a discount from usual and customary rates for health care services not covered under a health plan, policy, or other agreement, to which the provider is a party.

(6) Nothing in this section prevents a health carrier from denying coverage based on insurance fraud.

For purposes of this section:

(a) "New episode of care" means treatment for a new condition or diagnosis for which the enrollee has not been treated by a provider of the same licensed profession within the previous ninety days and is not currently undergoing any active treatment.

(b) "Contracting provider" does not include providers employed within an integrated delivery system operated by a carrier licensed under chapter [NUMBER] of [NUMBER].

Appendix D

Model Language for an Act on Prior Authorization for Certain Therapy Visits

Be it enacted by the People of the State of [STATE] as follows:

1. Prior authorization for new episode of care prohibited for 12 visits. A carrier may not require prior authorization for rehabilitative or habilitative services, including, but not limited to, physical therapy, for the first 12 visits of each new episode of care. For purposes of this subsection, "new episode of care" means treatment for a new or recurring condition for which an insured has not been treated by the provider within the previous 90 days. After the 12 visits of each new episode of care, a carrier may not require prior authorization more frequently than every 6 visits or every 30 days, whichever time period is longer.

2. Prior authorization for chronic pain prohibited for 90 days. A carrier may not require prior authorization for physical medicine or rehabilitation services provided to patients with chronic pain for the first 90 days following diagnosis in order to provide the necessary nonpharmacologic management of the pain. After the first 90 days following a chronic pain diagnosis, a carrier may not require prior authorization more frequently than every 6 visits or every 30 days, whichever time period is longer. For purposes of this subsection, “chronic pain” means pain that persists or recurs for more than 3 months.

3. Response time; additional information. A carrier shall respond to a prior authorization request for services or visits in an ongoing plan of care under this section within 24 hours. If a carrier requires more information to make a decision on the prior authorization request, the carrier shall notify the patient and the provider within 24 hours of the initial request with the information that is needed to complete the prior authorization request, including but not limited to the specific tests and measures needed from the patient and provider. A carrier shall make a decision on the prior authorization request within 24 hours of receiving the requested information.

4. Approval of prior authorization. This subsection governs circumstances in which a prior authorization for covered services under this section is deemed to be approved by a carrier. A prior authorization is deemed to be approved if a carrier:

A. Fails to timely answer a prior authorization request in accordance with subsection 3, including due to a failure of the carrier's prior authorization platform or process; or

B. Informs a provider that prior authorization is not required orally, via an online platform or program, through the patient's health plan documents or by any other means.

5. Retroactive authorization. A carrier shall provide a procedure for providers and insureds to obtain retroactive authorization for services under this section that are medically necessary covered benefits. A carrier may not deny coverage for medically necessary services under this section only for failure to obtain a prior authorization, if a medical necessity determination can be made after the services have been provided and the services would have been covered benefits if prior authorization had been obtained.

6. Appeal. A carrier's failure to approve a prior authorization for all services or visits in a plan of care under this section is subject to the same appeal rights as a denial under the bureau's rule regarding health plan accountability and the provider's network agreement with the carrier, if any.

7. Intent. Nothing in this section is intended to prohibit a carrier from performing a retrospective medical necessity review.

Appendix E

Model Language for an Act on Coverage and Payment Parity for Physical Therapy Delivered Via Telehealth

Definition of Telehealth

Telehealth is the use of information and communications technologies to provide and support clinical health care, patient and professional health-related education and advice, public health, health promotion activities, health administration, consultation, and research. Technologies include but are not limited to videoconferencing, the internet, store-and-forward imaging, streaming media, and terrestrial and wireless communications and others as further established by rule.

Telehealth Coverage and Reimbursement

1. Generally. A health benefit plan shall pay for covered services provided via telehealth to an insured person.
2. Equivalent coverage and payment. Telehealth coverage and payment shall be equivalent to the coverage and payment for the same service provided in person unless the telehealth provider and the health benefit plan contractually agree to an alternative payment rate for telehealth services.
3. Deductibles, copayments, and coinsurance. Benefits for a service provided as telehealth may be made subject to a deductible, copayment, or coinsurance. A deductible, copayment, or coinsurance applicable to a particular service provided through telecommunications technology shall not exceed the deductible, copayment, or coinsurance required by the health benefit plan for the same service when provided in person.
4. Prohibition on annual dollar maximum. A health benefit plan shall not impose an annual dollar maximum on coverage for health care services covered under the health benefit plan that are provided as telehealth, other than an annual dollar maximum that applies to the same services when provided in person by the same provider.

5. Licensure. A health benefit plan shall require a health care professional to be licensed, or otherwise permitted, in [STATE] in order to be eligible to receive payment for telehealth services.

6. Network arrangements. Payment made under this section shall be consistent with any provider network arrangements that have been established for the health benefit plan.

Prohibitions and Limitations

1. A health benefit plan shall not:

    a. Require a previously established in-person relationship or the provider to be physically present with a patient or client, unless the provider determines that it is necessary to perform that service in person.
    b. Require prior authorization, medical review, or administrative clearance for telehealth that would not be required if that service were provided in person.
    c. Require demonstration that it is necessary to provide services to a patient or client as telehealth.
    d. Require a provider to be employed by another provider or agency in order to provide telehealth services that would not be required if that service were provided in person.
    e. Restrict or deny coverage based solely on the communication technology or application used to provide the telehealth service.
    f. Impose specific requirements or limitations on the technologies used to provide telehealth services.
    g. Impose additional certification, location, or training requirements as a condition of payment for telehealth services.
    h. Require a provider to be part of a telehealth network.

2. Nothing in this section shall be construed to require a health benefit plan to:

    a. Provide coverage for telehealth services that are not medically necessary.

b. Reimburse any fees charged by a telehealth facility for transmission of a telehealth encounter.

Claims Forms and Records

The department shall promulgate an administrative regulation in accordance with [STATE LAW] to designate the claim forms and records required to be maintained in accordance with this section

Appendix F

Model Language for an Act Regarding Proposed Material Changes to Insurance Contracts

Be it enacted by the People of the State of [STATE] as follows:

(1) As used in this section, unless the context requires otherwise:

(a) "Material change" means a change to a contract, the occurrence and timing of which is not otherwise clearly identified in the contract, that decreases the health care provider's payment or compensation or changes the administrative procedures in a way that may reasonably be expected to significantly increase the provider's administrative expense, and includes any changes to provider network requirements, or inclusion in any new or modified insurance products; and

(b) "Participating provider" means a provider that has entered into an agreement with an insurer to provide health care services.

(2) Each insurer offering a health benefit plan shall establish procedures for changing an existing agreement with a participating provider that shall include the requirements of this section.

(3) If an insurer offering a health benefit plan makes any material change to an agreement it has entered into with a participating provider for the provision of health care services, the insurer shall provide the participating provider with at least ninety (90) days' notice of the material change. The notice of a material change required under this section shall:

a) Provide the proposed effective date of the change;

b) Include a description of the material change;

c) Include a statement that the participating provider has the option to either accept or reject the proposed material change in accordance with this section;

d) Provide the name, business address, telephone number, and electronic mail address of a representative of the insurer to discuss the material change, if requested by the participating provider;

e) Provide notice of the opportunity for a meeting using real-time communication to discuss the proposed changes if requested by the participating provider. For purposes of this paragraph, "real-time communication" means any mode of telecommunications in which all users can exchange information instantly or with negligible latency and includes the use of traditional telephone, mobile telephone, teleconferencing, and videoconferencing. If requested by the provider, the opportunity to communicate to discuss the proposed changes may occur via electronic mail instead of real-time communication; and

f) Provide notice that upon three (3) material changes in a twelve (12) month period, the provider may request a copy of the contract with material changes consolidated into it. Provision of the copy of the contract by the insurer shall be for informational purposes only and shall have no effect on the terms and conditions of the contract.

(4) If a material change relates to the participating provider's inclusion in any new or modified insurance products, or proposes changes to the participating provider's membership networks:

(a) The material change shall only take effect upon the acceptance of the participating provider, evidenced by a written signature; and

(b) The notice of the proposed material change shall be sent by certified mail, return receipt requested.

(5) For any other material change not addressed in subsection (4) of this section:

1. The material change shall take effect on the date provided in the notice unless the participating provider objects to the change in accordance with this paragraph;

2. A participating provider who objects under this paragraph shall do so in writing and the written protest shall be delivered to the insurer within thirty (30) days of the participating provider's receipt of notice of the proposed material change;
3. Within thirty (30) days following the insurer's receipt of the written objection, the insurer and the participating provider shall confer in an effort to reach an agreement on the proposed change or any counterproposals offered by the participating provider; and
4. If the insurer and participating provider fail to reach an agreement during the thirty (30) day negotiation period described in subparagraph 3. of this paragraph, then thirty (30) days shall be allowed for the parties to unwind their relationship, provide notice to patients and other affected parties, and terminate the contract pursuant to its original terms. The notice of proposed material change shall be sent in an orange-colored envelope with the phrase "ATTENTION! CONTRACT AMENDMENT ENCLOSED!" in no less than fourteen (14) point boldface Times New Roman font printed on the front of the envelope. This color of envelope shall be used for the sole purpose of communicating proposed material changes and shall not be used for other types of communication from an insurer.
5. If an insurer issuing a health benefit plan makes a change to an agreement that changes an existing prior authorization, precertification, notification, or referral program, or changes an edit program or specific edits, the insurer shall provide notice of the change to the participating provider at least fifteen (15) days prior to the change.
6. Any notice required to be mailed pursuant to this section shall be sent to the participating provider's point of contact, as set forth in the provider agreement. If no point of contact is set forth in the provider agreement, the insurer shall send the requisite notice to the provider's place of business addressed to the provide.

Appendix G

Model Language for an Act to Regulate Provider Credentialing

Be it enacted by the People of the State of [STATE] as follows:

Section 1

Definitions.

(a) As used in this chapter:

(i) "Applicant" means a health care provider who submits an application to a health carrier to become credentialed as a participating health care provider in one (1) or more of the health carrier's provider networks;

(ii) "Application" means an applicant's most recent application to become credentialed by a health carrier as a participating health care provider in one (1) or more of the health carrier's provider networks;

(iii) "Completed credentialing application" means a credentialing application that is free of defects and contains all of the information that, when later supplemented by verification and documentation gathered by the health carrier during the primary source verification process, is necessary for the health carrier to make a credentialing decision;

(iv) "Credentialing" means the process by which a health carrier or its designee collects information concerning an applicant, assesses whether the applicant satisfies the requirements to become a participating health care provider in one (1) or more of the health carrier's provider networks, verifies all information submitted by the applicant and approves or denies the applicant's application;

(v) "Health carrier" means as defined by <insert statutory reference> and shall not mean pharmacy benefit managers.

Health care provider credentialing requirements;

(a) Within seven (7) calendar days after a health carrier receives an application for credentialing, the health carrier shall provide the applicant notice of receipt of the application in written or electronic form and contact information for the person reviewing the application. After receiving an application, a health carrier shall determine whether the application is complete. If the health carrier determines that the application is incomplete, the health carrier shall notify the applicant in writing or by electronic means that the application is incomplete within fifteen (15) calendar days after the date the health carrier received the application. The notice shall describe the items that are required to complete the application. The health care provider shall submit a completed credentialing application within fifteen (15) calendar days of receiving the notice. Failure of the health care provider to submit a completed credentialing application within fifteen (15) days of receiving the notice shall restart the timelines in this subsection.

(b) A health carrier shall conclude the process of credentialing an applicant within thirty (30) calendar days after the health carrier receives the applicant's application. The thirty (30) calendar day period shall pause if a health care provider receives notification that their application is incomplete and shall resume after the health carrier verifies that the health care provider has resubmitted a completed credentialing application. A health carrier shall provide each applicant written or electronic notice of the outcome of the applicant's credentialing at the conclusion of the credentialing process.

(c) If an applicant becomes credentialed as a participating health care provider in a health carrier's network and a fully executed contract between the health care provider and the health carrier is in effect prior to covered services being provided, the health carrier shall reimburse the applicant for all covered reimbursable health care services provided by the applicant beginning with the date the health carrier received a completed credentialing application from the applicant, unless otherwise preempted by federal law.

Section 2. The department of insurance shall promulgate rules providing for a uniform credentialing application that shall be used by applicants and health carriers. Dental and vision insurance are exempt from using the uniform application.

Section 3. Nothing in this act shall require a health carrier to violate or fail to meet a standard or requirement of a nationally recognized accrediting entity.

Section 4. This act shall apply to applications for credentialing submitted to health carriers on or after <insert date>.