PHYSICAL THERAPY

PURPOSE

ND Medicaid covers medically necessary physical therapy provided to a member by a physical therapist or a physical therapy assistant under the supervision of a licensed, qualified, and enrolled physical therapist.

APPLICABILITY

ELIGIBILE PROVIDERS

To receive payment from ND Medicaid, the eligible servicing and billing provider National Provider Identifiers (NPI) must be enrolled on the date of service with ND Medicaid. Servicing providers acting as a locum tenens provider must enroll in ND Medicaid and be listed on the claim form. Please refer to provider enrollment for additional details on enrollment eligibility and supporting documentation requirements.

Physical Therapy services can be provided by the following enrolled providers as allowed by their scope of their licensure:

- Physical therapist licensed under North Dakota Century Code 43-26.1-04.

ELIGIBLE MEMBERS

Providers are responsible for verifying a member's eligibility before providing services. Eligibility can be verified using the ND Medicaid MMIS Portal or through the Automated Voice Response System by dialing 1.877.328.7098.

COVERED SERVICES AND LIMITS

GENERAL PROVIDER POLICIES

The General Provider Policies details basic coverage requirements for all services. Basic coverage requirements include:

- The provider must be enrolled in ND Medicaid;
- Services must be medically necessary;
- The member must be eligible on the date of service; and
- If applicable, the service has an approved service authorization.

PHYSICAL THERAPY COVERED SERVICES

Physical therapy services must be of a level of complexity and sophistication, or the condition of the member must be of a nature that requires the judgment, knowledge, and skills of a physical therapist. Physical therapy includes services that address an individual's deficits in physical performance, motor skills, cognitive skills, sensory integrative skills, preventive skills, therapeutic adaptations, and activities of daily living.

Physical therapy provided on an ongoing basis to maximize the member's functional level is covered for members who have:

- experienced trauma;
- a chronic condition; or
- a condition due to congenital abnormality, deprivation, or disease that interrupts or delays the sequence and rate of normal growth, development, and maturation.

ND Medicaid covers the following CPT© codes; codes not specifically listed are not covered by ND Medicaid:

Code	Description[1] | *ND Medicaid Notes*
96127	Brief emotional or behavioral assessment with scoring and documentation, per standardized instrument.
97039, 97139 & 97799	Unlisted modality, procedure, or service. *These codes always require service authorization and will not be considered for services identified as noncovered in this chapter.*
97010	Application of hot or cold packs to 1 or more areas
97022	Application of whirlpool therapy to 1 or more areas
97032	Application of electrical stimulation to 1 or more areas, each 15 minutes
97035	Application of ultrasound to 1 or more areas, each 15 minutes
97110	Therapeutic exercise to develop strength, endurance, range of motion, and flexibility (one or more areas), each 15 minutes.
97112	Neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities (one or more areas), each 15 minutes.

[1] Code description does not reflect full CPT© coding requirements. Please reference the CPT Codebook for service components

Code	Description[1] | *ND Medicaid Notes*
97113	Water pool therapy with therapeutic exercises to 1 or more areas, each 15 minutes
97116	Gait training (includes stair climbing), each 15 minutes
97129	Therapeutic interventions that focus on cognitive function (eg, attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (eg, managing time or schedules, initiating, organizing, and sequencing tasks), direct (one-on-one) patient contact; initial 15 minutes. Code may only be reported once per day.
97130	Each additional 15 minutes. Use in conjunction with 97129.
97140	Manual (physical) therapy techniques to 1 or more regions, each 15 minutes
97530	Therapeutic activities, direct (one-on-one) patient contact (use of dynamic activities to improve functional performance), each 15 minutes.
97161	Physical therapy evaluation: low complexity, typically 20 minutes
97162	Physical therapy evaluation: moderate complexity, typically 30 minutes
97163	Physical therapy evaluation: high complexity, typically 45 minutes
97164	Re-evaluation of physical therapy plan of care, typically 20 minutes. Face-to-face service.
97542	Wheelchair management, 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	Training in use of prosthesis for arms and/or legs, per 15 minutes
97763	Orthotic(s)/prosthetic(s) management and/or training, upper extremity(ies), lower extremity(ies), and/or trunk, subsequent orthotic(s)/prosthetic(s) encounter, each 15 minutes

Covered services require direct (one-on-one) contact with the patient by the provider (constant attendance). Coverage for these codes indicates the provider is performing the modality and cannot be performing another procedure at the same time. Only the

actual time of the provider's direct contact with the patient, providing services requiring the skills of a therapist, is covered.

Physical Therapy Assistants
Effective for dates of service 07/01/2025 and forward, ND Medicaid will require services rendered by a certified physical therapy assistant (PTA) to be identified on the claim line using the CQ modifier. The PTA must be listed as the rendering/servicing provider in the medical records. The medical records must contain the signature of both the supervising provider and the rendering provider.

The supervising provider NPI and taxonomy must be listed as the rendering (CMS 1500 claim form or 837p) or attending (UB 04 claim form or 837i) provider on the claim.

ORDERS FOR CARE

Physical therapy requires an order (prescription) for evaluation and treatment from a physician or other licensed practitioner (OLP) allowed to prescribe under their scope of practice according to state law. An order is valid for one (1) year. If continued services are needed past one year, a new order must be written.

PLAN OF CARE

Physical therapy services must be provided in accordance with a documented plan of care that is dated and signed by the physical therapist responsible for oversight of the plan.

The initial plan of care shall contain, at minimum:

- Diagnosis;
- A description of the member's functional status;
- The objectives of the physical therapy services;
- Short-term treatment goals;
- Long-term treatment goals; and
- Type, amount, duration, and frequency of therapy services.

The plan of care shall be consistent with the related evaluation which is considered part of the plan. The plan should provide for treatment in the most efficient and effective manner and anticipate progress toward achieving the treatment goals within a medically reasonable amount of time, generally not to exceed 90 days. Long-term treatment goals should be developed for the entire episode of care in the current setting. When the

episode is anticipated to be long enough to require more than one certification, the long-term goals may be specific to the part of the episode that is being certified. Goals should be measurable and pertain to identified functional impairments. Therapists must establish and update short and long-term goals, based on member progress, to track the episode of care. The recipient's care plan must clearly document the need for these services, including attempts to resolve treatment.
The physical therapist must update the plan of care within 90 days of the initial evaluation or first therapeutic encounter; and each 90-day interval throughout the course of treatment. With each 90-day interval, the plan of care must be certified (signed and dated) by the ordering or referring provider who has knowledge of the need for and supports ongoing therapy services for the member.

Updates to the plan of care must include:

- Prior short-term goals;
- Prior long-term goals;
- Explanation of progress toward goal attainment since initial or previous plan of care update;
- New, modified, or carried-over short-term goals; and
- New, modified, or carried-over long-term goals.

LIMITATIONS

Physical therapy evaluations are limited to one per calendar year. Physical therapy is limited to 30 visits per calendar year for members age 21 and over. Providers should confirm a member's use of the 30 visits prior to providing care.

MAINTENANCE THERAPY

ND Medicaid does not cover maintenance therapy. If therapy services are needed to sustain a level of function or if the member's condition would otherwise deteriorate, services may be covered by ND Medicaid. The member's plan of care must clearly document the need for services, including attempts to resolve and reduce treatment. The plan of care must include member therapy activities to facilitate progress and prevent deterioration of skills outside of the therapy appointment.
Physical therapy must be supported by documentation that is based on the medical diagnosis and appropriate developmental milestones and contains the following criteria:

1. A specific International Classification of Diseases (ICD-10) code based medical diagnosis; and
2. Specific interventions related to the diagnosis that

a. Are focused on the documented limitations and issues that cause recurring developmental delays; and/or
b. Address issues in other areas of development or difficulty with certain skills that are being addressed through continued care

Treatment for conditions which are not supported by a specific ICD-10 or current diagnosis where recipients can reasonably be expected to spontaneously improve with age and development do not meet the need for ongoing therapy.

DUPLICATE THERAPY

ND Medicaid does not cover duplication of services. Members may receive physical therapy services from more than one provider when:

- The care is delivered collaboratively, pursuant to an already existing Plan of Care; or
- The services are delivered by a school district as specified in the member's Individualized Education Plan (IEP). Therapy services received outside of an IEP cannot duplicate therapy services received through the member's IEP.

When multiple providers are delivering therapy services, the providers must collaborate to ensure that services are not duplicative and are delivered according to the plan of care.

SERVICES DELIVERED TO AN INPATIENT OR RESIDENT IN A FACILITY

Physical therapy services provided to a resident staying at a nursing facility, swing bed, or inpatient hospital are not separately billable. ND Medicaid pays for physical therapy through the rate established for these facilities. Physical therapy is separately billable for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) residents.

INDIVIDUALIZED EDUCATION PLAN (IEP) SERVICES

IEP REQUIREMENTS

Physical Therapy services provided as directed by an IEP must be:

- Authorized or prescribed and outlined in the student's IEP;
- Updated on the student's IEP as services start or stop;
- Billed by a public school or special education unit; and
- Documented in accordance with PT documentation requirements;

The services are delivered by a school district as specified in the member's Individualized Education Plan (IEP). Therapy services received outside of an IEP cannot duplicate therapy services received through the member's IEP. When multiple providers are delivering therapy services, the providers must collaborate to ensure that services are not duplicative and are delivered according to the plan of care.

Other service requirements

- Other health-related services must be authorized by a licensed practitioner (OLP) of the healing arts operating within their scope of practice;
- ND Medicaid will not directly pay private schools for IEP-related services.

SERVICE AUTHORIZATION REQUIREMENTS

ND Medicaid requires a service authorization for services exceeding ND Medicaid limits. Service authorizations are required for:

- Additional evaluations,
- Reevaluations, and
- Therapy visits that exceed the limit of 30 visits per calendar year for members ages 21 and over.

The physical therapist must obtain an approved service authorization from ND Medicaid for the member prior to performing the requested services. A service authorization requires:

- A completed Service Limits Service Authorization Request (SFN 481) with the corresponding order for services;
- A copy of the current plan of care and;
- All relevant progress notes.

Upon receipt of the complete service authorization request, including the current plan of care and progress notes, ND Medicaid will evaluate the request for additional services for the following:

- Medical necessity;
- Progress towards goals;
- Type, amount, duration, and frequency of continued therapy services; and
- Reasonableness of new, modified or carried-over goals.

Service authorizations for new evaluations or reevaluations may not be approved when a member has missed appointments or fails to follow through with the recommended plan of care.

RETROACTIVE AUTHORIZATION

To be eligible for retroactive authorization consideration, all requirements for service authorization must be met, and ND Medicaid must receive the retroactive authorization request no later than 90 days from the date the service. The physical therapy provider must demonstrate good cause for the failure to secure the required service authorization prior to performing the services. Retroactive authorization requests are reviewed and decided upon internally on a case-by-case basis. Frequent requests for retroactive authorization may be considered abuse of the program.

NON-COVERED SERVICES

GENERAL NON-COVERED SERVICES

The Noncovered Services Policy contains a general list of services that are not covered by North Dakota Medicaid.

PHYSICAL THERAPY NON-COVERED SERVICES

Non-covered physical therapy services include:

- Physical therapy provided without an order from a physician or other licensed practitioner;
- Services for contracture that do not interfere with the member's functional status;
- Ambulation of a member who has an established gait pattern;
- Services for conditions of chronic pain that do not interfere with the member's functional status and that can be maintained by routine nursing measures;
- Services for activities of daily living when performed by the therapist, therapist assistant, or therapy aide;
- Services including athletic training, sports improvement, recreational activity improvement, recovery or for the purpose of a return to sport;
- Arts and crafts activities for the purpose of recreation;
- Services that are not part of the member's plan of care or are specified in a plan of care but are not reviewed and revised as medically necessary;
- Services that are not designed to improve or to prevent the digression of the functional status of a member with a physical impairment;
- Duplicate therapy

- A rehabilitative and therapeutic service that is denied for Medicare or private health insurance payment because of the provider's failure to comply with Medicare or private health insurance requirements;
- Massage services;
- Unattended electrical stimulation;
- Unattended modalities;
- Guided motor imagery; guided visualization, or any other visualization therapy;
- Dry needling;
- Kinesio Taping; and
- Acupuncture.

DOCUMENTATION REQUIREMENTS

GENERAL REQUIREMENTS

Providers must keep legible medical and financial records that fully justify and disclose the extent of services provided and billed to ND Medicaid. Records must be retained for at least 7 years after the last date the claim was paid or denied. Providers must follow the documentation requirements in the Provider Requirements Policy.

Documentation must be unique, and specific to the date of service provided, be representative of what the therapist has provided, and must support the procedures that are billed to ND Medicaid. For Plan of Care requirements see the "Plan of Care" section above.

REIMBURSEMENT METHODOLOGY AND CLAIM INSTRUCTIONS

TIMELY FILING

ND Medicaid must receive an original Medicaid primary claim within one hundred eighty (180) days from the date of service. The time limit may be waived or extended by ND Medicaid in certain circumstances. The Timely Filing Policy contains additional information.

THIRD-PARTY LIABILITY

Medicaid members may have one or more additional source of coverage for health services. ND Medicaid is generally the payer of last resort. Providers must pursue the availability of third-party payment sources. The Third Party Liability Policy contains additional information.

CLIENT SHARE (RECIPIENT LIABILITY)

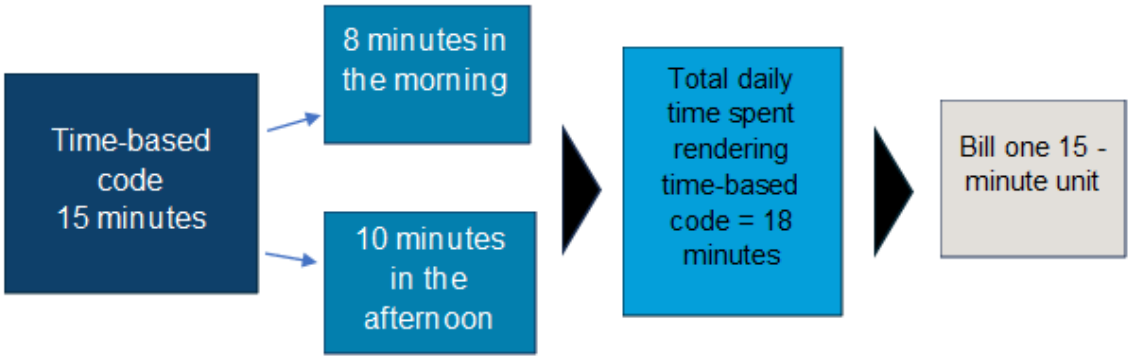
Client share (recipient liability) is the monthly amount a member must pay toward the cost of medical services before the Medicaid program will pay for services received. The Client Share Policy contains additional information.

REIMBURSEMENT

A claim for services must be submitted at the provider's usual and customary charge. Payment for services is limited to the lesser of the provider's usual and customary charge or the ND Medicaid calculated reimbursement.

Physical therapy services are reimbursed according to the ND Medicaid fee schedule. Fees are calculated based on the relative value unit (RVU) and the ND Medicaid conversion factor.

When billing for one code that is billed in units (i.e. 15 minutes) throughout a day, report the total amount of units on one claim line.



CLAIM FORM

CLINIC BASED SERVICES

Physical therapy services must be billed using the CMS 1500 claim form or 837P.

OUTPATIENT HOSPITAL BASED SERVICES

Physical therapy services must be billed using the UB 04 claim form or 837i.

CLAIM REQUIREMENTS

The supervising provider NPI and taxonomy must be listed as the rendering (CMS 1500 claim form or 837p) or attending (UB 04 claim form or 837i) provider on the claim when services are provided by a Physical Therapy Assistant (PTA).

Claims must be coded and billed to the highest degree of specificity based on CPT©/HCPCS/ICD-10-CM rules, guidelines, and definitions.

OUTPATIENT HOSPITAL BASED SERVICES

Providers must bill the appropriate revenue code and CPT© code.

DEFINITIONS

Duplicate therapy – means therapy and/or treatment provided by more than one provider of the same type for the same diagnosis.

REFERENCES

- North Dakota Administrative Code
- North Dakota Century Code
- Code of Federal Regulations

RELATED POLICIES

- Occupational Therapy
- Speech Language Pathology

FREQUENTLY ASKED QUESTIONS

Q: Can therapy students bill for services?

A: Services provided by students enrolled in a medical training program may be billed under the supervising provider if:

- The provider provides direct supervision of the student for the duration of the time services are being provided to the member. Direct supervision means that the supervising provider may immediately intervene in service delivery as necessary.
- There are no more than six (6) students providing services to every one (1) direct supervising provider.

- There is a contract with the education institution, or the education institution has a policy in place outlining the requirements for supervision of students providing services to Medicaid members. The policy or contract must be provided to ND Medicaid upon request.
- The supervising provider is responsible for:
  - satisfying all applicable state law and regulatory supervision requirements; and
  - patient care provided by a student.
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Q: Why is ND Medicaid requiring claims be billed with the therapy assistant modifier CQ?

A: ND Medicaid is requiring the use of modifier CQ, for services provided by the therapy assistant to add transparency and understanding of who is providing services to our members.

Q: Are providers required to request additional services from the primary payor once they have exhausted the primary insurance benefit limits?

A: Yes, providers are expected to request additional visits from the primary insurance and follow any requirements set forth by the primary insurance.

Q: If the primary insurance does not recognize and pay assistants, can we bill ND Medicaid as primary?

A: No, primary requirements must be followed, and the patient should not be scheduled with that provider type.

Q: Does ND Medicaid automatically pay as primary when TPL benefits have been exhausted, and the primary doesn't extend benefits?

A: No, ND Medicaid does not automatically become the primary pay. The provider must take the appropriate steps to obtain additional benefits from the primary payor and share the reason for non-coverage with ND Medicaid upon claim submission.

CONTACT

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POLICY UPDATES

April 2025

Section	Summary
	Format changes and clarifications added throughout.

July 2025

Section	Summary
Eligible Providers	PTAs removed from eligible providers.
Covered Services	Additional information on how to bill for PTA services.
FAQs	Section added