

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

Eligible Providers

To receive payment from ND Medicaid, the eligible servicing and billing provider National Provider Identifiers (NPI) must be enrolled with ND Medicaid on the date of service. Servicing providers acting as a locum tenens provider must be enrolled with 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 through the Automated Voice Response System by dialing 1.877.328.7098.

Refer to the [Member Eligibility Manual](#) for additional information regarding eligibility including information regarding limited coverage categories.

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.

The [Procedure Code Look-up Tool](#) can be used to identify if a procedure code is covered by ND Medicaid along with code specific details such as ORP requirements, Service Authorization requirements, and current rates.

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. The code descriptions below do not reflect full CPT® coding requirements. Please refer to the CPT® Codebook for service components.

Code	Description - ND Medicaid Notes
96127	Brief emotional or behavioral assessment with scoring and documentation, per standardized instrument. Limits do not apply.
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. Limits do not apply if done in conjunction with another service.
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.

Code	Description - ND Medicaid Notes
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.
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 (e.g., attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (e.g., 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.
97150* – Covered in schools for Individual Educational Program (IEP) services only	Group therapy services where a therapist provides care to two or more (maximum of 6) individuals simultaneously.
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.

Code	Description - ND Medicaid Notes
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.

*Counts against unit limits related to non-evaluation services.

#Counts against limits related to evaluation services.

With the exception of group therapy, ND Medicaid requires 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 July 1, 2025, 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 beyond 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 must 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 must 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;
- Explanation of lack of progress toward goal attainment since initial or previous plan of care update; and
- New, modified, or carried-over long-term and short-term goals based on progress or lack of progress.

Group Therapy – Covered in schools for IEP services only

Group therapy (2-6 members) supplements but does not replace individual therapy. Group therapy may not represent the entire care plan for any individual. The need for

group therapy must align with the American Physical Therapy Association guidelines and be documented in the Plan of Care and include the following:

- Justification for group (vs. individual) treatment for each treatment session;
- Specific goals targeted and how the group activity supports these goals;
- How the group activities use medically necessary skilled interventions and are supported by the member's established plan of care;
- Member's response to the group activities and related data;
- The members' participation or lack of participation in group activities;
- Percentage of treatment that group therapy represents; and
- Need for the continuation of group therapy.

Limits

Physical therapy evaluations are limited to one per calendar year. Physical therapy units are limited to:

- 60 units per calendar year for members age 21 and over.

For example, if a visit is 30 minutes, this equates to two (2) 15-minute timed units or one untimed or 30-minute unit. The initial units (60 for members age 21 and over) are available for physical therapy provided in any setting. Providers delivering therapy services to the member must coordinate with other facilities (i.e. schools and private agencies) to ensure all services align to provide the member with continuity of care and progress towards goals on the member's care plan without duplication.

It is the responsibility of the provider to confirm the availability of units through MMIS or by calling the Call Center at 701-328-7098 or 877-328-7098. If additional units over the limits are medically necessary for a member, the provider must submit a service authorization prior to performing additional services. Any additional units approved through a service authorization (SA) can only be utilized by the facility or provider who submitted the SA. Service authorizations may be approved for multiple agencies for a member if it is medically necessary.

Please see the [Service Authorization](#) section below for more information.

Note: A therapy units count obtained through ND Medicaid will only include adjudicated claims. Providers must also verify more recent therapy services with the member or member's guardian.

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:

- A specific International Classification of Diseases (ICD-10) code based medical diagnosis; and
- Specific interventions related to the diagnosis that:
 - Are focused on the documented limitations and issues that cause recurring developmental delays; and/or
 - 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. Providers must be prepared to show proof of collaboration without duplication of services.

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

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 [Outpatient Rehabilitation Therapy 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. Coordination is especially critical for children who are receiving services in multiple environments. Providers must be prepared to show proof of collaboration without duplication of services. Written parent consent is required prior to any exchange of information with medical providers.

Other service requirements

- Other health-related services must be authorized by an other 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:

- Additional evaluations,
- Reevaluations, and
- Therapy units that exceed the following limits:
 - For members age 21 and over:
 - 60 units per year.

The physical therapist must obtain an approved service authorization from ND Medicaid for the member prior to performing the requested services. To check a member's available therapy units, contact the Call Center at 701-328-7098 or 877-328-7098.

Note: A therapy units count obtained through ND Medicaid will only include adjudicated claims. Providers must also verify more recent therapy services with the member or member's guardian.

Service Authorization requirements include:

- A completed and current version of the [Service Limits Service Authorization Request](#) (SFN 481) with the corresponding order for services;
- A copy of the current physician signed plan of care;
- Short term and long-term goals and progress or lack of progress towards those goals and;
- All relevant progress notes.
 - If a member is getting therapy from multiple providers, including ABA services for Autism Spectrum Disorder, appropriate documentation is required showing collaboration without duplication of services.

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

- Medically necessary:
 - In addition to meeting the Medically Necessary requirements defined in North Dakota Administrative code 75-02-02-03.2(10), the services must meet the following requirements:
 - Require the judgement, knowledge and expertise of a qualified physical therapist due to the complexity of the situation; and
 - The services are accepted standards of medical practice specific and effective for the treatment of the member's condition; and
 - The services are provided with the expectation the member will improve in a reasonable and generally predictable period of time based on the ordering provider's assessment.
- Member compliance with home-based care plan elements between visits;
- Progress towards goal attainment since initial or previous plan of care update;
- Lack of progress toward goal attainment since initial or previous plan of care update;
- New, modified or carried-over goals based on progress or lack of progress towards initial goals; and
- Type, amount, duration, and frequency of continued therapy services:
 - The care plan should be based on the minimum amount of units required to meet the member's care plan goals.

Approved service authorizations will be for units to be utilized by the provider who submitted the service authorization. For example, if the school district submits the service authorization and is approved for more units, those services must be provided at the school and cannot be utilized by an alternative facility or provider. Service authorizations may be approved for multiple agencies for a member if it is medically necessary.

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.

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;
- Activities of daily living (ADLs) provided without the intent of member education and/or training 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;
- Acupuncture;
- Maintenance therapy;
- Meditation;
- Cupping; and
- Red light therapy, Photobimodulation (PBM), Low-level Laser Therapy(LLLT) or Cold Laser Therapy.

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. Additionally, the following must be documented:

- Time spent rendering a service for all time-based codes. Start and stop time is required for all time-based codes.

- Description of treatment/service provided. These records are used to decide medically necessary and correct billing.
- Dates of services provided.
- Dated signature, authenticated electronic or handwritten, of provider for each session. The use of signature stamps is not allowed.

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.

A unit of time is attained when the mid-point is passed. For example, a 15-minute unit is attained when 8 minutes have elapsed. A second 15-minute unit is attained when a total of 23 minutes has elapsed.

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.

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 and proof for denial of with ND Medicaid upon claim submission.

Contact

Medical Services

600 East Boulevard Ave

Bismarck, ND 58505-0250

Phone: (701) 328-2310

Email: dhsmedicalservices@nd.gov

Call Center

Phone: (701) 328-7098 or (877) 328-7098

Policy Updates

April 2025

- Format changes and clarifications added throughout the document.

February 2026

- Non-covered Services
 - Added cupping, red light therapy, Photobimodulation (PBM), Low-level Laser Therapy (LLLT) or Cold Laser Therapy
- Limits
 - Visits changed to units
 - Adult limits updated to account for visits to units change.

April 2026

- ADA updates made throughout document.