PHYSICAL THERAPY

ND Medicaid covers 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.

COVERED SERVICES

Physical therapy requires an order (prescription) for evaluation and treatment from a physician or practitioner of the healing arts allowed to prescribe under their scope of practice according to state law.

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 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 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.

Physical therapy services provided to a resident in a nursing facility, «swing bed, or hospital» are not separately billable. «Physical therapy is separately billable for ICF/IID residents.» ND Medicaid pays for physical therapy through the rate established for these facilities.

The following is a list of ND Medicaid covered CPT® codes:

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.»
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
97761	Training in use of prosthesis for arms and/or legs, per 15 minutes

«*These 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.

^Code description does not reflect full CPT® coding requirements. Please reference the CPT Codebook for service components. »

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 incorporated into 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 relatively short 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 typically also establish short-term goals, such as goals for a week or month of therapy, to help track progress toward the goal for the episode of care.

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.

SERVICE AUTHORIZATIONS
Members are limited to one evaluation per year which does not require a service authorization. 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.

ND Medicaid will not cover services exceeding the limit provided without a service authorization.

Service Authorization Requirements

The physical therapist must submit a service authorization prior to the member's receipt of services requiring authorization. Therapists must:

- Complete and submit a Service Limits Service Authorization Request (SFN 481) to ND Medicaid along with a copy of the current plan of care and relevant progress notes.
  - SFN 481 is available at https://www.nd.gov/eforms/.

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 toward goal attainment;
- Type, amount, duration, and frequency of continued therapy services; and
- Reasonableness of new, modified or carried-over goals.

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 prior service authorization request. Retroactive authorization requests are reviewed and decided upon internally on a case-by-case basis.

NONCOVERED SERVICES

- Physical therapy provided without an order from a physician or licensed practitioner of the healing arts;
- 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;
- 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 is allowed when delivered 1) collaboratively pursuant to an existing Plan of Care or therapy series or 2) by a school district as specified in the member's Individualized Education Plan (IEP). Therapy received outside of an IEP cannot duplicate therapy received through the member's IEP.»
- 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;
- Masseur or masseuse services;
- Unattended electrical stimulation;
- Unattended modalities;
- Graded motor imagery; guided visualization, or any other visualization therapy;
- Dry needling;
- Kinesio Taping;
- Acupuncture;
- Maintenance therapy.
- Any codes or procedures not listed in the table of covered services above are subject to denial, audit, and recoupment.

«DOCUMENTATION REQUIREMENTS

See the Documentation Guidelines for Medicaid Services found in the Provider Information policy.

DEFINITIONS

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

BILLING GUIDELINES

Practitioners: 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.