



PHYSICAL THERAPY

This document is subject to change. Please check our web site for updates.

This provider manual outlines policy and claims submission guidelines for claims submitted to the North Dakota Health Enterprise MMIS.

This document covers services provided by a physical therapist who is enrolled with North Dakota (ND) Medicaid.

A physical therapist is an individual who has graduated from an approved School of Physical Therapy or has equivalent training and is licensed to practice physical therapy in the state in which the individual provides services.

GENERAL INFORMATION

Physical therapy departments and their personnel must adhere to the “APTA Standards for Physical Therapy Services and Physical Therapy Practitioners”, the “North Dakota Physical Therapy Practice Act established in ND Century Code 43-26.1 and the NDPTA Guidelines for Physical Therapists”.

Physical therapy services consist of evaluation and re-evaluation, treatment planning, provision of treatments, instruction and consultative services.

Physical therapy services must relate directly and specifically to a written treatment regimen that is reviewed and revised as medically necessary by the member’s physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law and meets primary care provider requirements, if applicable.

The following must be documented in the member’s plan of care:

- The member’s medical diagnosis and any contraindications to treatment;
- A description of the member’s functional status;
- The objectives of the rehabilitative and therapeutic service;
- A description of the member’s progress toward the objectives.

Physical therapy services must be prescribed and a plan of care must be signed by the member's physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law, and meet primary care provider requirements if applicable. Recertification of the treatment plan must occur at 60-day subsequent intervals from the date of the initial evaluation or encounter. Subsequent recertification must occur at 60-day intervals throughout the course of treatment. The Department requires a copy of the recertification when the provider is requesting encounters which are over the service limits. In all situations, a copy of the recertification must be kept by the provider for auditing purposes.

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 qualified physical therapist.

Restorative physical therapy must be medically necessary, ordered by a physician, anticipated to result in substantial improvement of the member within a predictable period of time, generally not exceeding 90 days.

Physical therapy considered rehabilitative is typically provided for members with conditions due to congenital abnormality, trauma, deprivation, or diseases that interrupt or delay the sequence and rate of normal growth, development, and maturation. Medicaid does not cover these services if they are maintenance in nature. However, if they were needed to sustain a level of function or the member's condition would digress, the services would be covered by ND Medicaid. The services must be medically necessary and physician ordered.

Physical therapy is limited to 15 visits per calendar year. Prior authorization is required for visits exceeding this limit.

The following is a list of ND Medicaid covered CPT codes for restorative and rehabilitative services:

97001	Physical therapy evaluation	1 unit
97002	Physical therapy re-evaluation	1 unit
97010	Application of a modality to one or more areas; hot or cold packs	1 unit
97022	Application of a modality to one or more areas; whirlpool	1 unit
97032	Application of modality to one or more areas; electrical stimulation (manual), each 15 minutes	15 min./1 unit
97035	Application of modality to one or more areas; ultrasound, each 15 minutes	15 min./1 unit
97110	Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility	15 min./1 unit
97112	Therapeutic procedure, one or more areas, each 15 minutes;	15 min./1 unit

	neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities	
97113	Aquatic therapy with therapeutic exercises	15 min./1 unit
97116	Therapeutic procedure, one or more areas, each 15 minutes; gait training (includes stair climbing)	15 min./1 unit
97761	Prosthetic training, upper and/or lower extremity(s), each 15 minutes	15 min./1 unit
97530	Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes	15 min./1 unit
G0151	Services of physical therapist in home health setting, each 15 minutes	15 min./1 unit
All other services for physical therapy and rehabilitation are non-covered by ND Medicaid.		

SERVICE AUTHORIZATIONS

A service authorization is required for services exceeding the limit of 15 visits per calendar year. The provider must complete and submit **SFN 481** to ND Medicaid, prior to the member's receipt of additional services. The form is available at www.nd.gov/dhs/services/medicalserv/medicaid/online-forms.html.

Information needed is:

- Prior short-term goals;
- Prior long-term goals;
- Progress since previous update;
- New short-term goals;
- New long-term goals.

Upon receipt of the information, ND Medicaid will evaluate the treatment plan for the following:

- Accomplishment of prior goals;
- Progress;
- Reasonable new goals;
- Maintenance care.

If the services are determined necessary to sustain a level of function or the member's condition would digress, the services would be covered by ND Medicaid. The services must be medically necessary and physician ordered.

NON-COVERED SERVICES

- Physical therapy that is provided without a prescription from a physician;
- Services for contracture that are not severe and 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;
- Bowel and bladder retraining programs;
- Arts and crafts activities for the purpose of recreation;
- Services that are not medically necessary;
- Services that are not documented in the member's health care record;
- Services that are not part of the member's plan of care or are specified in a plan of care that is not reviewed and revised as medically necessary as part of a re-certification process;
- Services that are not designed to improve or maintain the functional status of a member with a physical impairment;
- Services by more than one provider of the same type for the same diagnosis unless the service is provided by the school district as specified in the member's individualized education plan;
- A rehabilitative and therapeutic service that is denied Medicare payment because of the provider's failure to comply with Medicare requirements;
- Physical therapy services provided in a nursing facility or ICF/MR. Medicaid pays for those service through the rate established for the facility;
- Maintenance therapy.

BILLING GUIDELINES

Providers must bill for services using the North Dakota Web Portal using the electronic claims submission web pages or Electronic Data Exchange transaction. The claim must include a valid National Provider Identification number (NPI) and taxonomy code.