Agenda

1. Recipient Eligibility & Eligibility Inquiry Tool
2. Covered Services & Limitations & Service Limit Tool
3. Diagnosis Look-Up Tool
4. Online Portal Claim Submission
5. Medicaid Resources
## Physical Therapy Services: Eligible Recipients

<table>
<thead>
<tr>
<th>Coverage Type</th>
<th>Coverage Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid/CHIP Full Coverage</td>
<td>Medically necessary services covered in accordance with the limitations described in this chapter.</td>
</tr>
<tr>
<td>Qualified Medicare Beneficiary – Coverage Limited (73)</td>
<td>Coverage restricted to co-payments and deductibles on Medicare A and B covered services.</td>
</tr>
<tr>
<td>Medicaid – Pregnancy Related Coverage Only (77)</td>
<td>Coverage restricted to pregnancy related services only including medical issues that can harm the life of the mother or baby.</td>
</tr>
<tr>
<td>Unborn Children Prenatal Care Program (79)</td>
<td>Coverage restricted to pregnancy related services only including medical issues that can harm the life of the mother or baby.</td>
</tr>
</tbody>
</table>
Medicaid Portal Eligibility Look Up Tool

Eligibility Inquiry

Searches are limited to 1 month at a time when Health Benefit Plan Coverage is selected. All other searches are limited up to 6 months at a time. Search spans can be up to 3 years in the past. If no date is selected, results will be displayed for the current date through the end of the current month.

Note: Up to 5 recipients can be searched at a time.

- **Cost Share Type**: Select
- **Dates of Service**: From [ ] To [ ]

Search Option #1: Recipient ID [ ]

Search Option #2: Recipient First Name [ ] Recipient Last Name [ ]

3 out of 4 are required for a search.

Last 4 of SSN [ ] Date of Birth [ ]
Medicaid Portal Eligibility Look Up Tool

<table>
<thead>
<tr>
<th>Insured Information</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Recipient ID:</td>
<td>[Redacted]</td>
</tr>
<tr>
<td>Gender: F</td>
<td>[Redacted]</td>
</tr>
<tr>
<td>Date of Birth:</td>
<td>[Redacted]</td>
</tr>
<tr>
<td>Address: Mitchell, SD, 57301-3790</td>
<td>[Redacted]</td>
</tr>
<tr>
<td>Phone: (605) 996-7526</td>
<td>[Redacted]</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Eligibility</th>
<th>Dates are valid for current query.</th>
</tr>
</thead>
<tbody>
<tr>
<td>21 - Active Coverage: Medicaid - Full Coverage</td>
<td></td>
</tr>
<tr>
<td>Eligibility: 6/28/2022 - 6/30/2022</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Primary Care Provider/Health Home Provider</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care Location</td>
<td>Primary Care Provider</td>
</tr>
<tr>
<td>MITCHELL CLINIC LTD</td>
<td>RASMUSSEN, PAUL</td>
</tr>
<tr>
<td>818 W HAVENS AVE</td>
<td></td>
</tr>
<tr>
<td>MITCHELL, SD 57301-3830</td>
<td></td>
</tr>
<tr>
<td>(605) 996-7526</td>
<td></td>
</tr>
</tbody>
</table>

* Cost share amounts exceeding $0.00 apply to non-PCP/HH provider visits only.

<table>
<thead>
<tr>
<th>Cost Share</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Dates: 6/28/2022 - 6/30/2022</td>
<td>Service Type: Physician Services</td>
</tr>
</tbody>
</table>

* Non-covered charges are patient’s responsibility.
Covered Services and Limitations

• Enrollment
  • Services are covered for licensed, enrolled providers.
  • Licensed physical therapy assistants are not eligible to enroll, but services provided by them can be billed by an enrolled therapist.

• Ordering of Services
  • Physical therapy outpatient therapy services must be ordered by a physician, physician assistant, or nurse practitioner through a written prescription.
  • The order is valid for one year. If services are needed past one year a new order must be written.
  • For recipients in the Primary Care Provider (PCP) or in the Health Home (HH) program, the order must be made by the recipient’s PCP or HH provider. If the ordering provider is someone other than the recipient’s PCP or HH provider, a PCP or HH referral is required.
Covered Services and Limitations

• Written Care Plan
  • Services must be directly and specifically related to an active written care plan that is established by the ordering provider or by the physical therapist who will provide the services.
  • If the plan is developed by a physical therapist, it must be certified by the ordering provider.
    ➢ Certification should occur as soon as possible and within 30 days of initiating therapy.
    ➢ The certification must include the ordering provider’s full name and signature on the care plan that contains the diagnosis and level of treatment intensity.
    ➢ The care plan must be certified by the ordering provider and recertified after one year of treatment.
    ➢ The care plan must be recertified within 30 days of a significant change in the care plan or a significant change in the recipient’s condition.
    ➢ When the care plan is recertified, the plan or other documentation in the recipient’s record must indicate the continued need for therapy services.
    ➢ The provider who recertifies the plan must sign the care plan.
    ➢ The care plan must include the following: diagnoses, long-term goals, and type, amount, duration, and frequency of therapy services.
Covered Services and Limitations

• Medical Necessity
  • In addition to meeting the medical necessity requirements in ARSD 67:16:01:06.02, the services must meet the following requirements:
    ➢ The judgment, knowledge, and skills of a qualified physical, occupational or speech therapist are required due to the complexity and sophistication of the condition;
    ➢ The services are considered under accepted standards of medical practice to be specific and effective treatment for the patient’s condition;
    ➢ The services are reasonable and necessary to the treatment of the patient’s condition; and
    ➢ Services are provided with the expectation that the patient will improve significantly in a reasonable and generally predictable period of time, based on the physician’s assessment of the patient’s restorative potential after any needed consultation with a qualified therapist.
Covered Services and Limitations

• **Assistant Supervision**
  - Assistant services must be performed by or under the supervision of a physical therapist.
  - Supervision must be provided in accordance with the applicable licensure provisions in [SDCL Ch. 36-10](#) or the applicable regulations in the state the services are provided in if the services are provided outside of South Dakota.

• **Assistant Billing**
  - Services provided by an assistant are required to be billed by the supervising therapist using the HM modifier. The HM modifier will reduce the allowed payment; services are reimbursed at 90 percent of the regular rate.
  - South Dakota Medicaid recommends the supervising therapist review and sign documentation for submitted claims. The supervising therapist's NPI must be listed in box 24J or the 837P equivalent.
Covered Services and Limitations

• Co-Treatment
  • Co-treatment is appropriate when coordination between the two disciplines will benefit the recipient, not simply for scheduling convenience.
    
    Example: A recipient may address cognitive goals for sequencing as part of a speech-language pathology (SLP) treatment session while the physical therapist (PT) is training the recipient to use a wheelchair, or a recipient may address ADL goals for increasing independence as part of an occupational therapist (OT) treatment session while the PT addresses balance retraining with the recipient to increase independence with mobility.
  
  • Documentation should clearly indicate the rationale for co-treatment and state the goals that will be addressed through this method of intervention.
  • Co-treatment sessions should be documented as such by each practitioner, stating which goals were addressed and the progress made.
  • Co-treatment should be limited to two disciplines providing interventions during one treatment session.
  • Providers must split the time between therapy disciplines for billing purposes when two or more therapy disciplines deliver services to a recipient in the same block of time.
Covered Services and Limitations

• Maintenance Therapy
  • South Dakota Medicaid does not cover therapy services if they are maintenance in nature, unless therapy services are needed to sustain a level of function or if the member's condition would otherwise digress.
  • The recipient’s care plan must clearly document the need for these services, including attempts to resolve treatment.
  • The services must be medically necessary, and physician ordered.

• Birth to Three and School Districts
  • Refer to the Birth to Three and School Districts manuals
Covered Services and Limitations

• Non-Covered Therapy Services
  • Acupuncture;
  • Exercises a recipient can do on his or her own at home;
  • Masseur or masseuse services;
  • Dry needling;
  • Equestrian/hippotherapy; and
  • Services related to activities for the general good and welfare of patients, such as general exercises to promote overall fitness and flexibility and activities to provide diversion or general motivation.
Documentation Requirements

• Therapy documentation
  • Therapists must complete a progress report note at minimum after every 90 days for restorative therapy. The notes must include:
    ➢ An evaluation of progress toward current goals;
    ➢ A professional judgment and continued goals;
    ➢ Any modification of goals and/or treatment, if necessary; and
    ➢ Termination of services, if necessary

• Time-Based Therapy Codes
  • Time-based therapy codes require a start and stop time to be maintained as part of the recipient’s medical record.
Reimbursement and Coverage Updates

- Physical Therapy Services rates were updated July 1, 2022:
  - Highly utilized physical therapy CPT codes received a targeted rate increase and a 6 percent inflationary increase.
  - Other codes received a 6 percent inflationary increase.
  - HM modifier for assistants was changed from a 50% of the allowable payment to 90% of the allowable payment.
- Self care management, CPT Code 97535, is covered as of July 1, 2022.
Reimbursement and Claims

• **Reimbursement and Billing**
  - The maximum allowable rates for physical therapy services are listed on our fee schedules page: https://dss.sd.gov/medicaid/providers/feeschedules/.
  - Providers should bill for services at their usual and customary rate.

• **Nursing Facility**
  - Therapy services are included in a nursing facility’s per diem if provided by a facility employee or by a consultant who is under contract with the facility and are not separately billable to South Dakota Medicaid.
  - Therapy services provided by someone other than a facility employee or a licensed therapist who has a contract with the facility to provide the therapy are separately reimbursable.

• **Unlisted Procedure**
  - When billing CPT code 97799, unlisted physical medicine service, the provider must submit documentation as to what service was provided.
  - Claims submitted without documentation will be denied.
Diagnosis Look Up Tool

The Diagnosis Look-up Tool can be used by providers to identify the circumstances when a diagnosis code is payable by South Dakota Medicaid. Providers should review all fields to determine if a code is payable. The status indicated on the tool is not a guarantee of payment. Claims may deny for other reasons such as system edits or failure to meet South Dakota Medicaid coverage criteria. A description of the fields is provided below.

**Diagnosis Code:** This is the ICD-10 diagnosis code.

**Diagnosis Description:** This is a description of the diagnosis code.

**Billing Status**
- **Primary:** This code may be listed first on a claim. Multiple primary codes may be listed.
- **Secondary:** This code may not be listed first on the claim and must be billed in conjunction with a primary code. Multiple secondary codes may be listed.
- **Not Covered:** This code is not billable per ICD-10 rules or South Dakota Medicaid coverage criteria.
Medical Portal Claims Submission

Submit New CMS 1500

The numbering system of this submission form relates to the CMS-1500 claim form. Please refer to the billing manual found at dss.sd.gov/medicaid/providers for additional information about billing requirements.

Denotes required field. A record can only be saved if all required fields have been completed.

1. SELECT CLAIM TYPE
   - Select Type

1a. INSURED'S I.D. NUMBER
2. PATIENT'S NAME
3. PATIENT'S BIRTH DATE
4. PATIENT'S ADDRESS

9. OTHER INSURED'S NAME
9a. OTHER INSURED'S POLICY OR GROUP NUMBER
9d. OTHER INSURED PLAN NAME OR PROGRAM NAME

11d. IS THERE ANOTHER HEALTH BENEFIT PLAN

33. BILLING PROVIDER ZIP CODE
33a. BILLING PROVIDER NPI
33b. BILLING PROVIDER TAXONOMY

PATIENT'S SEX

a. EMPLOYMENT?
   - YES
   - NO
b. AUTO ACCIDENT?
   - YES
   - NO
c. OTHER ACCIDENT?
   - YES
   - NO

Save
Top Ten Denial Reasons

<table>
<thead>
<tr>
<th>Denial Code</th>
<th>Denial Code Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>352</td>
<td>PRIMARY CARE/HEALTH HOME NPI INCORRECT</td>
</tr>
<tr>
<td>27</td>
<td>DENIED FOR INVALID PROVIDER/NPI NOT ON FILE</td>
</tr>
<tr>
<td>35</td>
<td>RECIPIENT ELIGIBLE FOR MEDICARE BENEFITS</td>
</tr>
<tr>
<td>900</td>
<td>EXACT DUPLICATE OF PEND/PD CLM - DO NOT RESUBMIT</td>
</tr>
<tr>
<td>774</td>
<td>CLAIM EXCEEDS 6 MONTH LIMIT</td>
</tr>
<tr>
<td>348</td>
<td>MULTIPLE NPI MATCH TAXONOMY/ZIP+4 REQUIRED</td>
</tr>
<tr>
<td>91</td>
<td>RECIPIENT HAS PRIVATE HEALTH INSURANCE</td>
</tr>
<tr>
<td>24</td>
<td>REFERRING PHYSICIAN NPI NOT ON FILE</td>
</tr>
<tr>
<td>961</td>
<td>INCORRECT SUBMISSION MEDICAID IN BLOCK 1 MUST BE MARKED</td>
</tr>
<tr>
<td>47</td>
<td>PROCEDURE/NDC NOT COVERED BY MEDICAID</td>
</tr>
</tbody>
</table>
Medicaid Resources

Fee Schedule
• https://dss.sd.gov/docs/medicaid/providers/feeschedules/Chiropractic_latest.pdf

Diagnosis Look Up Tool
• https://dss.sd.gov/medicaid/providers/diagnosistool.aspx

Provider Manuals
• https://dss.sd.gov/medicaid/providers/billingmanuals/

Medicaid Online Portal
• The Medicaid Online Portal allows providers to verify eligibility and recipient cost shares, submit claims, view and download remittance advices, and look up service limits.
  o https://dss.sd.gov/ocp/Account/Login?ReturnUrl=%2focp%

Portal CMS-1500 Claim Submission Guide
• https://dss.sd.gov/docs/medicaid/portal/Portal_CMS_1500_Submission_Guide.pdf