THERAPY SERVICES

ELIGIBLE PROVIDERS

In order to receive payment, all eligible servicing and billing providers' National Provider Identifiers (NPI) must be enrolled with South Dakota Medicaid. Servicing providers acting as a locum tenens provider must enroll in South Dakota Medicaid and be listed on the claim form. Please refer to the provider enrollment chart for additional details on enrollment eligibility and supporting documentation requirements.

South Dakota Medicaid has a streamlined enrollment process for eligible ordering, referring, and attending providers that may require no action on the part of the provider as submission of claims constitutes agreement to the South Dakota Medicaid Provider Agreement.

Occupational Therapy

Occupational therapy (OT) services may be provided by an occupational therapist licensed under SDCL 36-31 or an occupational therapy assistant (OTA) licensed under SDCL 36-31. Occupational therapy assistants may provide approved tasks under an enrolled supervising OT, but are not eligible to enroll with South Dakota Medicaid. Services provided by students are not covered.

Physical Therapy

Physical therapy (PT) services may be provided by a physical therapist licensed under SDCL 36-10 or a physical therapist assistant (PTA) licensed under SDCL 36-10. Physical therapy assistants may provide approved tasks under an enrolled supervising PT, but are not eligible to enroll with South Dakota Medicaid. Services provided by students are not covered.

Speech Therapy

Speech therapy services may be provided by a physician, speech-language pathologist (SLP) licensee under SDCL Ch. 36-37 or out-of-state equivalent, provisional speech-language pathologist licensee under SDCL Ch. 36-37, limited speech-language pathologist licensee under SDCL Ch. 36-37(when services are rendered in a school setting), or a speech-language pathologist assistant (SLPA) licensee under SDCL Ch. 36-37. SLPAs may provide services under an enrolled supervising speech-language pathologist but are not eligible to enroll. Services provided by students are not covered.

ELIGIBLE RECIPIENTS

Providers are responsible for checking a recipient's Medicaid ID card and verifying eligibility before providing services. Eligibility can be verified using South Dakota Medicaid's online portal.
The following recipients are eligible for medically necessary services covered in accordance with the limitations described in this chapter:

Coverage Type	Coverage Limitations
Medicaid/CHIP Full Coverage	Medically necessary services covered in accordance with the limitations described in this chapter.
Qualified Medicare Beneficiary – Coverage Limited (73)	Coverage restricted to copay, coinsurance, and deductibles on Medicare A and B covered services.
Unborn Children Prenatal Care Program (79)	Coverage restricted to pregnancy related services only including medical issues that can harm the life of the mother or baby.

Refer to the Recipient Eligibility manual for additional information regarding eligibility including information regarding limited coverage aid categories.

COVERED SERVICES AND LIMITS

General Coverage Principles

Providers should refer to the General Coverage Principles manual for basic coverage requirements all services must meet. These coverage requirements include:

- The provider must be properly enrolled;
- Services must be medically necessary;
- The recipient must be eligible; and
- If applicable, the service must be prior authorized.

The manual also includes non-discrimination requirements providers must abide by.

Occupational, Physical, and Speech Therapy Covered Services

Outpatient therapy services must be ordered by a physician, physician assistant, or nurse practitioner through a written prescription and provided by a provider referenced in the Eligible Providers section. The order is valid for one year. If services are needed past one year, a new order must be written. For recipients in a Care Management program, the order must be made by the recipient's Care Management provider. If the ordering provider is someone other than the recipient's Care Management provider, a Care Management referral is also required. Please refer to the Referrals manual for additional information.

Written Care Plan

The services must be directly and specifically related to an active written care plan that is established by the ordering provider or by the occupational therapist, physical therapist, or speech therapist who will provide the services. If the plan is developed by an OT, PT, or SLP 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 recertified after one year if continued services are needed. If there is a significant change in the care plan or a significant change in the recipient's condition the care plan must be recertified within 30 days. 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 treatment goals; and
- Type, amount (number of times in a day), duration (number of weeks or number of treatment sessions), and frequency (number of times in a week) of therapy services.

If a recipient is receiving treatment in multiple disciplines (such as OT, PT, and/or SLP), there must be a plan of care for each specialty and each therapist must independently establish the impairment or dysfunction to be treated and the associated goals.

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 recipient's condition;
- The services are reasonable and necessary to the treatment of the recipient's condition; and
- Services are provided with the expectation that the recipient will improve significantly in a reasonable and generally predictable period of time, based on the ordering provider's assessment of the patient's restorative potential after any needed consultation with a qualified PT, OT, or SLP.

Co-Treatment

Co-treatment may be appropriate when practitioners from different professional disciplines can effectively address their treatment goals while the patient is engaged in a single therapy session. For example, a recipient may address cognitive goals for sequencing as part of a SLP treatment session while the PT is training the recipient to use a wheelchair, or a recipient may address activities of daily living goals for increasing independence as part of an OT treatment session while the PT addresses balance retraining with the recipient to increase independence with mobility.

- Co-treatment is appropriate when coordination between the two disciplines will benefit the recipient, not simply for scheduling convenience.
- 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.

Maintenance Therapy

South Dakota Medicaid does not cover therapy services if they are maintenance in nature. However, if therapy services are needed to sustain a level of function or if the member's condition would otherwise

digress, the services may be covered by South Dakota Medicaid. 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 ordered by the physician, physician assistant, or nurse practitioner.

Supervision

The services of an assistant must be performed by or under the supervision of a PT, OT, or SLP. Supervision must be provided in accordance with the applicable licensure provisions including SDCL Ch. 36-10, SDCL Ch. 36-31, and SDCL 36-37-20 or the applicable regulations in the state the services are provided in if the services are provided outside of South Dakota.

CPT Code 92507

Effective for claims with dates of service on and after July 1, 2025, South Dakota Medicaid will no longer treat CPT code 92507 as a 15-minute time-based code for all providers with the exception of school districts when billed on a CMS 1500. In alignment with standard coding guidance, providers must only bill one (1) unit per member per day. Additional units billed for the same member on the same day will be denied, regardless of the session length.

Outpatient Hospitals

For outpatient hospitals billing on a UB-04 CPT code 92507 is considered an encounter code for services rendered on the date of service.

Speech Generating Device

The recipient's SLP must obtain prior authorization from South Dakota Medicaid before an augmentative communication device or a modification to a previously authorized device is provided. Providers should refer to the DMEPOS Manual for prior authorization form and criteria.

Telemedicine

Refer to the Telemedicine manual regarding therapy services that may be provided via telemedicine.

Birth to Three and School Districts Services

Providers should refer to the Birth to Three manual and to the School Districts manual for additional guidance if applicable.

Home Health Agency Services

Providers should refer to the Home Health Agency manual for home health agency services guidance.

NON-COVERED SERVICES

General Non-Covered Services

Providers should refer to ARSD 67:16:01:08 or the General Coverage Principles manual for a general list of services that are not covered by South Dakota Medicaid.

Non-covered Therapy Services

South Dakota Medicaid does not cover the following services:

- Acupuncture;
- Exercises a recipient can do independently at home;
- Massage 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

General Requirements
Providers must keep legible medical and financial records that fully justify and disclose the extent of services provided and billed to South Dakota Medicaid. These records must be retained for at least 6 years after the last date a claim was paid or denied. Please refer to the Documentation and Record Keeping manual for additional requirements.

Therapy Documentation
Therapists must document the recipient's progress towards meeting therapy goals. The therapist must also document the ordering provider's order. Treatment notes must be updated in the recipient's file after every visit. The treatment must indicate what took place at the appointment, how much time was spent performing the services, and any observations the therapist made while working with the recipient.

Therapists must complete a progress report note at minimum after every 90 days for restorative therapy. The note must include:

- An evaluation of progress toward current goals;
- A professional judgment about 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 medical record.

REIMBURSEMENT AND CLAIM INSTRUCTIONS

Timely Filing
South Dakota Medicaid must receive a provider's completed claim form within 6 months following the month the service was provided. Requests for reconsiderations will only be considered if they are received within the timely filing period or within 3 months of the date a claim was denied. The time limit may be waived or extended by South Dakota Medicaid in certain circumstances. Providers should refer to the General Claim Guidance manual for additional information.

Third-Party Liability
Medicaid recipients may have one or more additional source of coverage for health services. South Dakota Medicaid is generally the payer of last resort. Providers must pursue the availability of third-party payment sources and should use the Medicare Crossover or Third-Party Liability billing instructions when applicable. Providers should refer to the General Claim Guidance manual for additional information.

Reimbursement
A claim for therapy services must be submitted at the provider's usual and customary charge. Payment for therapy services is limited to the lesser of the provider's usual and customary charge or the fee contained on South Dakota Medicaid's Physician Services Nonlaboratory Procedures fee schedule.

Assistants
Services provided by an assistant are required to be billed by the supervising therapist using the HM modifier for an SLPA, CO modifier for an OTA, and CQ modifier for a PTA. Assistants are reimbursed at 90 percent of the allowable therapist rate.

Outpatient Hospital
Therapy services provided in Ambulatory Payment Classification (APC) hospitals are paid at the APC fee schedule rate. Services provided in non-APC hospitals are reimbursed according to the hospital's standard reimbursement methodology.

Nursing Facility
If therapy services are provided by a facility employee or by a therapist under contract with the facility, the reimbursement for the service is included in a nursing facility's per diem. These services are not separately billable to South Dakota Medicaid.

Services are separately reimbursable if the therapy is provided by a therapist who is not a facility employee and does not have a contract with the facility to provide therapy.

Claims Instructions
Claims for OT, PT, or SLP services should be submitted on the CMS 1500 claim form, through the Medicaid Online Portal, or via an 837P electronic. If the services are provided in an outpatient hospital, it must be billed on a UB-04 or via an 837I transaction. Detailed claim form instructions are available on our website.

Assistants
Services provided by an assistant are required to be billed by the supervising therapist using the HM modifier for an SLPA, CO modifier for an OTA, and CQ modifier for a PTA. 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.

Co-Treatment

When billing for co-treatment, 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. The total time billed should not exceed the actual length of time spent with the patient. For example, a PT and an OT work together for 30 minutes with one recipient on transfer activities. The PT and PT can each bill 15 minutes. Alternatively, the total 30 minutes could be billed by either the PT or the OT, but not both.

Time Based Codes

Please refer to the General Claim Guidance manual for additional guidance regarding billing time based codes.

Unlisted Procedure

If billing CPT code 97799, unlisted physical medicine service, the provider must submit documentation regarding the service provided. Claims submitted without documentation will be denied.

School District and Birth to Three Services

Please refer to the School District manual or Birth to Three manual for claim instructions.

REFERENCES

- Administrative Rule of South Dakota (ARSD)
- South Dakota Medicaid State Plan
- Code of Federal Regulations

QUICK ANSWERS

1. **Is dry needling a covered service?**

   No, dry needling is not covered by South Dakota Medicaid.

2. **Are respiratory care practitioners eligible to enroll with South Dakota Medicaid?**

   No, respiratory care practitioners are not eligible to enroll.

3. **If I provide services as part of a Medicare certified home health agency, do I need to enroll?**

   Yes, eligible providers must enroll with South Dakota Medicaid in this circumstance. All eligible providers must be listed on the claim form when they provide services.

4. **Can speech therapy be provided via telemedicine?**

Yes, speech therapy services may be provided via telemedicine once an initial in-person contact has been completed. An in-person contact must occur every 90 days thereafter. The telemedicine service must be provided by means of "real-time" interactive telecommunications system.

5. **How do I bill for group speech therapy CPT code 92508?**

   Providers should submit a claim for each individual Medicaid recipient that received therapy services. Providers must only bill one (1) unit per member per day. Additional units billed for the same member on the same day will be denied, regardless of the session length.

6. **Can therapy services be provided via telemedicine?**

   Yes, refer to the Telemedicine manual regarding therapy services that may be provided via telemedicine.

7. **Do I need to list the ordering, referring, and prescribing (ORP) provider NPI on the claim when billing OT, PT, or SLP therapy services for a recipient who does not have a Care Management provider?**

   Yes, all therapy service claims must include an ORP NPI on the claim.