BADGERCARE+
BadgerCare Plus Information for Providers

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To: Federally Qualified Health Centers, Nursing Homes, Occupational Therapists, Physical Therapists, Physician Clinics, Physicians, Rehabilitation Agencies, Speech-Language Pathologists, Therapy Groups, HMOs and Other Managed Care Programs

Information on Plans of Care and the Coverage of Evaluations for Physical Therapy, Occupational Therapy, and Speech and Language Pathology Services

This *BadgerCare Plus Update* gives therapy providers information regarding documentation requirements related to plans of care and the coverage of evaluations, as identified in the Physical Therapy, Occupational Therapy, and Speech and Language Pathology Services Handbook published in January 2006.

Information in this *BadgerCare Plus Update* clarifies documentation requirements related to plans of care (POC) and coverage of evaluations identified in the Physical Therapy, Occupational Therapy, and Speech and Language Pathology Services Handbook published in January 2006. Information in this *Update* applies to the BadgerCare Plus Standard Plan and the BadgerCare Plus Benchmark Plan.

Plans of Care

Initial Evaluation and Plan of Care

For covered services, BadgerCare Plus accepts a signed and dated physician prescription for evaluation and treatment as the initial order for evaluation and as the initial POC for physical therapy (PT), occupational therapy (OT), and speech and language pathology (SLP) services. The prescription may be written by the physician or by the provider who makes a written record of the physician's verbal order. If the prescription is for evaluation and treatment, both are reimbursable on the initial date of service (DOS) when both are medically necessary.

If treatment begins on the same DOS as the evaluation, the providing therapist is required to either write or dictate an initial therapy POC by the close of business the day following the evaluation or by the close of business on the therapist's next scheduled work day. The prescribing physician is required to review, sign, and date the initial therapy POC promptly, but no later than 30 calendar days from the date the initial therapy POC was written or dictated.

If the physician wrote the prescription as "evaluation" or "evaluation only," reimbursement for treatment will not be allowable until the therapist writes or dictates a therapy POC and the physician reviews, signs, and dates the POC, or until the therapist has received a physician's verbal order to treat that has been reduced to writing. The prescribing physician is required to review, sign, and date the initial therapy POC promptly, but no later than 30 calendar days from the date the initial therapy POC was committed to writing or dictated.

Physician Review and Signature on Successive Plans of Care

All successive POC must be reduced to writing by the therapist and reviewed, signed, and dated by the prescribing physician at least every 90 days. The physician's signature and date on successive POC becomes the therapist's written order, and must be obtained prior to providing ongoing treatment. Should the severity of the member's condition require revision of the POC more frequently than every 90 days, the providing therapist is required to review and develop a new POC as frequently as the severity of the member's condition requires. BadgerCare Plus may deny or recoup reimbursement for services provided without a physician prescription or before a POC is established.

Frequently Asked Questions Regarding Evaluations

BadgerCare Plus covers evaluations for PT, OT, and SLP services when all applicable rules and regulations are met. The following questions and answers are offered to assist providers with information regarding BadgerCare Plus coverage of therapy evaluations:

Q: Does an evaluation need to be completed before submitting a prior authorization (PA) request?
A: Yes. BadgerCare Plus reviews both the PA request and the written report of the comprehensive evaluation submitted with the PA request to determine if the service is medically necessary. This is an exception to the general rule that PA should be granted before a service is performed. Refer to the Medicaid Physical Therapy, Occupational Therapy, and Speech and Language Pathology Services Handbook for PA procedures and forms.

Q: If a therapist has received a prescription to evaluate an individual, why might a PA request for the evaluation be denied?
A: BadgerCare Plus has a specific, legal definition of medical necessity. Although BadgerCare Plus requires that all services and equipment be prescribed by a physician, the physician's prescription alone does not meet BadgerCare Plus's specific, legal definition of medical necessity. Refer to HFS 101.03(96m), Wis. Admin. Code, and the Medicaid Physical Therapy, Occupational Therapy, and Speech and Language Pathology Services Handbook for examples of how the standards of medical necessity are applied to PA requests for therapy services.

The following are examples of evaluations that are not medically necessary. Prior Authorization requests for these evaluations would not be approved for reimbursement by BadgerCare Plus:

- *A screening could have provided the same conclusions and recommendations as a comprehensive evaluation.*
- *The professional skills of a PT, OT, or SLP provider were not required to perform the evaluation.* The information obtained from the therapy evaluation must justify that a therapist was required to perform the evaluation. The consultant reviewing the PA request may consider one or more of the following questions to determine if the professional skills of a PT, OT, or SLP provider were necessary:
  - ✓ What tests or measures were used in the therapy evaluation that led to conclusions that were not known about the member before the evaluation?
  - ✓ Why is the therapy evaluation required to be completed? What is the purpose of the evaluation?
  - ✓ Do other reports or medical records include the same information about the member?
  - ✓ Could the member's medical needs be met, or have they already been met, by a person other than a therapist?
- *The evaluation was completed solely because of a change in one of the following circumstances:*
  - ✓ The member's commercial health insurance coverage. BadgerCare Plus will not reimburse an evaluation when the evaluation was completed because Medicare coverage, or

coverage from any other pay source, has ended or changed.
  - ✓ The PT, OT, or SLP provider's employment status (e.g., business ownership). For example, if a therapist works for an agency and the agency is sold, providers will not be reimbursed because the services are being provided by a new agency when the therapist treating the member remains the same.
- *The reason for performing the evaluation was not medically necessary (e.g., an evaluation performed for the purpose of vocational training).* The requirement and purpose for performance of a service, such as a test or assessment, must be medically necessary, even if the professional skills of a therapist are needed to administer the service. A therapist may have special training or certification that allows the therapist to administer a particular test or assessment, but the need for the member to participate in the testing process must be medically necessary.

  If the reason for referral or the requested therapy services is not medically necessary or is noncovered, the evaluation will not be reimbursed. Examples include, but are not limited to, the following:
  - ✓ Therapy services for the member's participation in general gross motor activities, such as riding a bike or swimming, for the purpose of general health and wellness or weight loss.
  - ✓ Therapy services for a program that has been declared experimental in nature, such as auditory integration training services.
  - ✓ Assessments for the purpose of the member's participation in a vocational or recreational program, such as ergonomic evaluations, driving evaluations, or an evaluation to obtain a hunting license. Functional capacity evaluations are not covered by BadgerCare Plus.
  - ✓ Evaluations performed so that a member is able to participate in a program that would not be covered, such as computer or video training, or treatment interventions that may be considered alternative therapies, such as aquatic programs with marine mammals.
  - ✓ Evaluations completed solely to meet facility, agency, program, or clinic requirements (e.g., a therapy evaluation completed solely due to member age or at specified intervals of time).
- *The PT, OT, or SLP provider reports a change in the member's status, but the POC is not updated to reflect this change.* When a member is participating in a therapy program, the therapist continually assesses the member's condition and response to treatment interventions. If the member experiences a new illness or injury during the course of therapy, but the new diagnosis or clinical status does not result in significant changes to the therapy POC goals, providers will not be reimbursed for a therapy evaluation.

Note: Providers are reminded that a PA request for a therapy evaluation may also be denied for one of the following clerical reasons. The list includes examples that may be helpful to providers determining reimbursement of a therapy evaluation. Examples are included, but the basic policy reasons for which PA may also be denied are not limited to the following:
- ✓ The PA request was not received by BadgerCare Plus within 14 calendar days of the initial therapy evaluation. An approved PA request may be backdated to the date of the initial therapy evaluation if the PA request is received within the 14-day limit. PA requests for ongoing therapy may not be backdated.
- ✓ The evaluation was not completed by a provider who was Medicaid-certified on the date of service.
- ✓ The evaluation was not complete and comprehensive. If the therapy evaluation is a

summary of reports and records from other sources regarding the member's condition and status, the PA request may be denied or returned to the provider.

- ✓ The therapy evaluation was duplicative to another service. The standards of medical necessity stated in HFS 101.03(96m), Wis. Admin. Code, define a duplicative service as not being medically necessary. If a member is receiving other therapy services in another setting or from another provider, the medical need for a second provider must be supported. Pursuant to HFS 107.03 (12), Wis. Admin. Code, a therapy evaluation performed for the purpose of a second opinion is not covered.
- ✓ The member was not eligible for BadgerCare Plus on the DOS.

Q: Does BadgerCare Plus pay for screenings?
A: No. BadgerCare Plus does not reimburse therapy providers for screening services.

Q: Is a therapist able to bill the member if an evaluation is not paid by BadgerCare Plus?
A: A member may request a noncovered service, a covered service for which PA was denied (or modified), or a service that is not covered under the member's limited benefit category. The charge for the service may be collected from the member if the following conditions are met prior to the delivery of that service:

- The member accepts responsibility for payment.
- The provider and member make payment arrangements for the service.

Providers are strongly encouraged to obtain a written statement in advance documenting that the member has accepted responsibility for the payment of the service. For more information about collecting payment from members, refer to the Covered and Noncovered Services section of the All-Provider Handbook.

Additionally, the provider may not bill the member if the services are denied because of the provider's negligence to comply with BadgerCare Plus procedures, such as a PA request that is not received on time to backdate coverage to the date of the evaluation.

The *BadgerCare Plus Update* is the first source of program policy and billing information for providers. All information applies to Medicaid and BadgerCare Plus unless otherwise noted in the *Update*.

Wisconsin Medicaid and BadgerCare Plus are administered by the Division of Health Care Access and Accountability, Wisconsin Department of Health and Family Services, P.O. Box 309, Madison, WI 53701 - 0309.

For questions, call Provider Services at (800) 947-9627 or (608) 221-9883 or visit our Web site at *dhfs.wisconsin.gov/medicaid/*.

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