ForwardHealth
Wisconsin serving you

Update
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Affected Programs: BadgerCare Plus, Medicaid
To: Hospital Providers, HMOs and Other Managed Care Programs

Reminder: Claims for Outpatient Hospital Therapy Services Must Be Submitted Using a Professional Claim

Providers of outpatient hospital physical therapy (PT), occupational therapy (OT), and speech and language pathology (SLP) services are reminded to submit claims using a professional claim to receive reimbursement. Effective for claims processed on and after January 1, 2012, ForwardHealth will deny claims for outpatient hospital PT, OT, and SLP services submitted using an institutional claim.

Providers of outpatient hospital physical therapy (PT), occupational therapy (OT), and speech and language pathology (SLP) services are reminded to submit claims using an 837 Health Care Claim: Professional transaction or a 1500 Health Insurance Claim Form to receive reimbursement.

Effective for claims processed on and after January 1, 2012, regardless of the date of service (DOS), ForwardHealth will deny a claim — or the details on a claim — for outpatient hospital PT, OT, and SLP services submitted using an 837 Health Care Claim: Institutional transaction or a UB-04 Claim Form containing revenue codes 042X, 043X, or 044X.

For complete information on the program requirements for outpatient hospital PT, OT, and SLP services — including provider number, prior authorization (PA), allowable procedure codes, and claim submission requirements — providers may refer to the Therapies: Physical, Occupational, and Speech and Language Pathology service area of the Online Handbook on the ForwardHealth Portal at *www.forwardhealth.wi.gov/*.

Definition of Outpatient Hospital Therapy Services

As a reminder, outpatient hospital PT, OT, and SLP services refer to covered services provided by an approved hospital facility. Wisconsin Medicaid defines an "approved hospital facility" as the physical entity, surveyed and approved by the Department of Health Services, Division of Quality Assurance (DQA), under ch. 50, Wis. Stats. The DQA facility approval covers the building that the hospital identifies as constituting its operation.

Adjustments to Previously Submitted Outpatient Hospital Therapy Claims

Effective on and after January 1, 2012, providers will not be able to adjust claims for outpatient hospital PT, OT, and SLP services submitted on an institutional claim. If a provider submits an adjustment for an institutional claim that contains details for outpatient hospital therapy services, those details will deny. If the entire claim is for outpatient hospital therapy services, the entire claim will deny. The provider will then need to resubmit the services on a professional claim.

Exceptions

The requirement to submit claims for outpatient hospital therapy services on a professional claim does *not* apply to the following:

- Claims for PT, OT, and SLP evaluations and re-evaluations provided on the same DOS as an outpatient hospital specialty clinic visit.
- Claims for PT and OT services provided during an outpatient hospital (as defined above) cardiac rehabilitation visit, with cardiac rehabilitation team monitoring or physician electrocardiographic monitoring also provided.
- Provider-submitted Medicare crossover claims for outpatient hospital PT, OT, and SLP services previously submitted to Medicare on an institutional claim.

The exceptions noted above should be submitted using an institutional claim.

National Provider Identifier to Use

Providers are reminded to use their *hospital* National Provider Identifier (NPI) as the billing provider number on professional claims for outpatient hospital PT, OT, and SLP services.

Accurate Representation

Providers are responsible for ensuring that a certified therapy provider performed any outpatient hospital PT, OT, or SLP services being submitted on a claim. In addition, they are solely responsible for the truthfulness, accuracy, timeliness, and completeness of claims, cost reports, certification requirements, PA requests, or any supplemental information related to reimbursement for services (including the use of modifiers to identify therapy skilled professional services).

Fraud and Abuse

As stated in DHS 107.02(1)(a), Wis. Admin. Code, Wisconsin Medicaid may reject payment for a service if the claim, cost report, or PA request fails to meet program requirements or if the provider's supporting documentation does not support each claim, cost report, or PA request. Furthermore, under DHS 108.02(9), Wis. Admin. Code, it is Wisconsin Medicaid's responsibility to refer any provider to an appropriate law enforcement agency for willful misrepresentation. Wisconsin Medicaid has the right to audit and recover when documentation and medical recordkeeping requirements are not met per DHS 106.02(9)(e), (f), (g), Wis. Admin. Code.

Information Regarding Managed Care Organizations

This *ForwardHealth Update* contains fee-for-service policy and applies to services members receive on a fee-for-service basis only. For managed care policy, contact the appropriate managed care organization. Managed care organizations are required to provide at least the same benefits as those provided under fee-for-service arrangements.

The *ForwardHealth Update* is the first source of program policy and billing information for providers.

Wisconsin Medicaid, BadgerCare Plus, SeniorCare, and Wisconsin Chronic Disease Program are administered by the Division of Health Care Access and Accountability, Wisconsin Department of Health Services (DHS). The Wisconsin Well Woman Program is administered by the Division of Public Health, Wisconsin DHS.

For questions, call Provider Services at (800) 947-9627 or visit our Web site at *www.forwardhealth.wi.gov/*.

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