ForwardHealth
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Update
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Affected Programs: BadgerCare Plus, Medicaid
To: Hospital Providers, Occupational Therapists, Physical Therapists, Rehabilitation Agencies, Speech-Language Pathologists, Speech and Hearing Clinics, Therapy Groups, HMOs and Other Managed Care Programs

Prior Authorization No Longer Required for Evaluations or Re-Evaluations for Occupational Therapy, Physical Therapy, and Speech-Language Pathology

This *ForwardHealth Update* establishes new policy for evaluations and re-evaluations for occupational therapy (OT), physical therapy (PT), and speech-language pathology (SLP) services, in addition to clarifying evaluation documentation.

Overview of New Coverage Policy

Effective for dates of service (DOS) on and after January 1, 2018:

- Prior authorization (PA) will no longer be required for reimbursement of OT, PT, or SLP evaluations or re-evaluations.
- Professional providers may bill therapy evaluations and re-evaluations provided in outpatient hospital specialty clinics with the appropriate *Current Procedural Terminology* (CPT) code representing the service on a professional claim format.

PA No Longer Required for Evaluations or Re-Evaluations

Effective for DOS on and after January 1, 2018, PA will no longer be required for reimbursement of OT, PT, or SLP evaluations or re-evaluations.

Previously approved PA requests for DOS on and after January 1, 2018, will not require any action by providers. Providers must follow billing requirements that are applicable for the DOS.

Therapy providers are required to continue following all other current coverage policy, including, but not limited to, modifier usage and evaluation and re-evaluation coverage policy as outlined in the Covered and Noncovered Services section of the Therapies: Physical, Occupational, and Speech and Language Pathology service area of the ForwardHealth Online Handbook, as well as wheelchair evaluation coverage policy as outlined in the Wheelchair Evaluations topic (topic #1777) in the Wheelchairs and Wheelchair Accessories chapter of the Covered and Noncovered Services section of the Durable Medical Equipment service area of the Online Handbook.

Note: The PA requirement change discussed in this *Update* does not apply to therapy evaluations billed by a home health agency under the home health benefit. Home health providers should continue to follow the home health policy outlined in the Home Health service area of the Online Handbook.

Documentation Requirements for Evaluations and Re-Evaluations

In the member's medical record, PT, OT, and SLP providers are required to include a written report of the member's evaluation and evaluation documentation. The evaluation documentation must be available upon request. The member's medical record must include the following:

- Assessment of the member's condition and recommendations for therapy intervention
- Baseline measurements that establish a performance or ability level using units of objective measurement that can be consistently applied when reporting subsequent status of the member's progress
- Chronological history of treatment provided for the diagnosis
- Diagnosis(es) with date(s) of onset, current medical status, and functional status of the member
- List of other PT, OT, and SLP service providers who are currently treating the member to the extent known by the evaluating PT, OT, or SLP provider
- Procedures to be used in treatment. Providers may identify procedures with the applicable CPT code(s)
- Goals of treatment
- Previous level of function and change in medical status since previous PA requests if performing a re-evaluation
- Reason for the referral
- Recommended frequency and duration of treatment
- Test charts or forms used in the evaluation, if applicable
- Underlying conditions or impairments to be treated

PA Request Submission for Treatment Services

Submission of a signed and dated evaluation and/or re-evaluation therapy report will be required for PA requests for OT, PT, and SLP treatment.

New Claim Submission Requirements

Effective January 1, 2018, therapy evaluations and re-evaluations provided in outpatient hospital specialty clinics should be billed with the appropriate professional CPT procedure code representing the service on a professional claim format. ForwardHealth had previously instructed professional providers to bill therapy evaluations and re-evaluations provided in outpatient hospital specialty clinics under CPT procedure code 99366 (Medical team conference with interdisciplinary team of health care professionals, face-to-face with patient and/or family, 30 minutes or more, participation by nonphysician qualified health care professional).

Information Regarding Managed Care Organizations

This *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 (MCO). MCOs 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 Medicaid Services, the Wisconsin Department of Health Services (DHS). The Wisconsin AIDS Drug Assistance Program and the Wisconsin Well Woman Program are administered by the Division of Public Health, DHS.

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

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This *Update* was issued on 12/21/2017 and information contained in this *Update* was incorporated into the Online Handbook on 01/04/2018.