

To:  
 Counties Certified  
 for Outpatient  
 Mental Health/  
 Substance  
 Abuse Services  
 in the Home  
 and Community  
 County  
 Departments of  
 Community  
 Programs  
 County Human  
 Service  
 Departments  
 County Mental  
 Health  
 Coordinators  
 County Social  
 Service  
 Departments  
 County Substance  
 Abuse  
 Coordinators  
 County/Tribal  
 Aging Units  
 Tribal Human  
 Service  
 Facilitators  
 HMOs and Other  
 Managed Care  
 Programs

## Changes to local codes and paper claims for outpatient mental health and substance abuse services in the home or community as a result of HIPAA

This *Wisconsin Medicaid and BadgerCare Update* introduces important changes to local codes and paper claims for outpatient mental health and substance abuse services in the home or community, effective October 2003, as a result of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA).

These changes include:

- Adopting nationally recognized codes to replace currently used Wisconsin Medicaid local codes.
- Revising CMS 1500 paper claim instructions.

A separate *Update* will notify providers of the specific effective dates for the various changes.

### Changes as a result of HIPAA

This *Wisconsin Medicaid and BadgerCare Update* introduces important billing changes for outpatient mental health and substance abuse services in the home or community. These changes will be implemented in October 2003 as a result of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). A separate *Update* will notify providers of the specific effective dates for the various changes. These changes are not policy

or coverage related (e.g., documentation requirements), but include:

- Adopting nationally recognized procedure codes, place of service (POS) codes, and modifiers to replace currently used Wisconsin Medicaid local codes.
- Revising CMS 1500 paper claim instructions.

*Note:* Use of the national codes that will replace Wisconsin Medicaid local codes or revised paper claim instructions prior to implementation dates may result in claim denials. Specific implementation dates will be published in a separate *Update*.

### Adoption of nationally recognized codes

Wisconsin Medicaid will adopt nationally recognized codes to replace currently used Wisconsin Medicaid local codes for outpatient mental health and substance abuse services in the home or community.

### Allowable procedure codes

Wisconsin Medicaid will adopt *Current Procedural Terminology* (CPT) and Healthcare Common Procedure Coding System (HCPCS) procedure codes to replace currently used local (“W”) procedure codes for outpatient mental health and substance abuse services in the home

or community. Refer to Attachment 1 of this *Update* for a procedure code conversion chart. Refer to Attachment 2 for a complete list of Medicaid-covered procedure codes for outpatient mental health and substance abuse services in the home or community and related policies. Providers will be required to use the appropriate procedure code that describes the service performed.

*Note:* All providers of outpatient mental health and substance abuse services in the home or community will be required to choose the CPT or the HCPCS procedure code that most accurately reflects the time spent on the service provided as specified in the procedure code description. For procedure codes that do not indicate a time increment in their description, providers will be required to choose the time increment from the rounding guidelines in Attachment 3.

### *Modifiers*

All providers of outpatient mental health and substance abuse services in the home or community will be required to indicate two nationally recognized modifiers in Element 24D of the CMS 1500 claim form for each procedure code indicated.

One of the modifiers is used to identify the professional level of the provider performing each procedure for reimbursement purposes. For example, modifier “HO” would indicate a Master’s degree level psychotherapist performed the service.

The second required modifier is used to identify that outpatient mental health or substance abuse services have been performed in the home or community. This modifier (“UC”) is the same for all providers and *must* be used with *all* procedure codes.

A list of modifiers and corresponding descriptions are included in Attachments 1 and 2. All modifiers that begin with a “U” (“UA,” “UB,” “UC”) are state-defined national modifiers that maintain the listed descriptions for this provider type *only*. Modifiers that begin with an “H” (“HN,” “HO,” “HP”) are defined nationally for all provider types.

### *Type of service codes*

Type of service codes will no longer be required on Medicaid claims.

### *Place of service codes*

Nationally recognized two-digit POS codes will replace the one-digit Wisconsin Medicaid POS codes used currently. Refer to Attachment 4 for a list of allowable POS codes for outpatient mental health and substance abuse services in the home or community.

### *Claim sort indicator*

All providers of outpatient mental health and substance abuse services in the home or community will be required to indicate claim sort indicator “P” in Element 1 of the CMS 1500 claim form.

### *Coverage for outpatient mental health and substance abuse services in the home or community remains unchanged*

Medicaid coverage and documentation requirements for outpatient mental health and substance abuse services in the home or community will remain unchanged. Refer to outpatient mental health and substance abuse services in the home or community *Updates* for complete Medicaid policies and procedures.

### **Revision of CMS 1500 paper claim instructions**

With the implementation of HIPAA, Medicaid-certified providers of outpatient mental health and substance abuse services in the home or community will be required to follow the revised

**N**nationally recognized two-digit POS codes will replace the one-digit Wisconsin Medicaid POS codes used currently.

instructions for the CMS 1500 paper claim form in this *Update*, even though the actual CMS 1500 claim form is not being revised at this time. Refer to Attachment 5 for the revised instructions. Attachment 6 is a sample of a claim for clinics that *are not* “biller only” and Attachment 7 is a sample for clinics that *are* “biller only.” Both samples reflect the changes to the billing instructions.

*Note:* In some instances, paper claim instructions will be different from electronic claim instructions. Providers should refer to their software vendor’s electronic billing instructions for completing electronic claims.

#### *Revisions made to the CMS 1500 claim form instructions*

Revisions made to the instructions for the CMS 1500 paper claim include the following:

- Only claim sort indicator “P” should be entered (Element 1).
- Other insurance indicators were revised (Element 9).
- Place of service codes were revised (Element 24B).
- Type of service codes are no longer required (Element 24C).
- A modifier must be entered for each procedure code (Element 24D).
- Spenddown amount should no longer be entered (Element 24K). Wisconsin Medicaid will automatically reduce the provider’s reimbursement by the recipient’s spenddown amount.

#### **General HIPAA information**

Refer to the following Web sites for more HIPAA-related information:

- [www.cms.gov/hipaa/](http://www.cms.gov/hipaa/) — Includes links to the latest HIPAA news and federal Centers for Medicare and Medicaid Services HIPAA-related links.

- [aspe.hhs.gov/admsimp/](http://aspe.hhs.gov/admsimp/) — Contains links to proposed and final rules, links to download standards and HIPAA implementation guides, and frequently asked questions regarding HIPAA and the Administrative Simplification provisions.
- [www.dhfs.state.wi.us/hipaa/](http://www.dhfs.state.wi.us/hipaa/) — Contains Wisconsin Department of Health and Family Services HIPAA-related publications, a list of HIPAA acronyms, links to related Web sites, and other valuable HIPAA information.

#### **Information regarding Medicaid HMOs**

This *Update* contains Medicaid fee-for-service information and applies to providers of services to recipients who have fee-for-service Medicaid. Since HIPAA impacts all health care payers, it is important to know that HIPAA changes, including changes from local procedure codes to national procedure codes, will also have an impact on Medicaid HMOs. For questions related to Medicaid HMOs or managed care HIPAA-related changes, contact the appropriate managed care organization.

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

Although the *Update* refers to Medicaid recipients, all information applies to BadgerCare recipients also.

Wisconsin Medicaid and BadgerCare are administered by the Division of Health Care Financing, 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 [www.dhfs.state.wi.us/medicaid/](http://www.dhfs.state.wi.us/medicaid/).

# ATTACHMENT 1

## Procedure code conversion chart for outpatient mental health and substance abuse services in the home or community

The following chart lists procedure codes and modifiers that providers in outpatient mental health and substance abuse clinics will be required to use when submitting claims. A separate *Wisconsin Medicaid and BadgerCare Update* will notify providers of the specific effective dates for Wisconsin Medicaid's implementation of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). Refer to Attachment 2 of this *Update* or *Current Procedural Terminology (CPT)* and *Healthcare Common Procedure Coding System (HCPCS)* procedure code books for a complete description of these codes.

Professional level modifiers		
Modifier	Description	Providers
<b>HN</b>	Bachelors degree level	Alcohol and other drug abuse (AODA) counselor (counselors that have less credentials than a Master's level psychotherapist)
<b>HO</b>	Masters degree level	Master's level psychotherapist (Master's level psychotherapists are Master's-level mental health professionals with 3,000 hours of supervised experience or are listed in an appropriate national registry as stated in HFS 61.96, Wis. Admin. Code. This includes registered nurses with a Master's degree in psychiatric-mental health nursing or community mental health nursing from a graduate school of nursing accredited by the National League for Nursing.)
<b>HP</b>	Doctoral level	Psychologist, Ph.D.
<b>UA</b>	MD, Psychiatrist	Psychiatrist billing mental health and substance abuse services Physician billing substance abuse services Physician assistant billing pharmacologic management
<b>UB</b>	APNP — Psychiatric specialty	Advanced Practice Nurse Prescriber (APNP) — Master's level registered nurse, only those with an APNP — psychiatric specialty billing pharmacologic management

Other required modifier	
Modifier	Description
<b>UC</b>	Required for <i>all</i> outpatient mental health and substance abuse services provided in the home or community

### Psychiatric diagnostic or evaluative interview procedures

Before HIPAA implementation	After HIPAA implementation		
Local procedure code and description	Nationally recognized procedure code(s)	Professional level modifier(s)*	UC modifier
<p><b>W7400</b> Psychiatric diagnostic interview exam — home or community by Psychiatrist</p> <p><b>W7401</b> Psychiatric diagnostic interview exam — home or community by Ph.D.</p> <p><b>W7402</b> Psychiatric diagnostic interview exam — home or community by Master's</p>	<p>Psychiatry: <b>90801, 90802</b></p>	<p><b>UA</b> <b>HP</b> <b>HO</b></p>	<p><b>required</b></p>

\*Select the appropriate modifier that describes the individual provider performing the service.

## Psychiatric therapeutic procedures (individual/family)

In reporting mental health or substance abuse, the appropriate code is chosen on the basis of the type of psychotherapy (interactive versus insight oriented), the face-to-face time spent with the patient during psychotherapy and whether evaluation and management services are furnished on the same date of service as psychotherapy.

Before HIPAA implementation	After HIPAA implementation			
Local procedure code and description	CPT procedure code	HCPCS procedure code	Professional level modifier(s)*	UC modifier
<b>W7403</b> Individual psychotherapy/substance abuse therapy — home or community by Psychiatrist	Office or Other Outpatient Facility Psychotherapy: <b>90804, 90805, 90806, 90807, 90808, 90809, 90810, 90811, 90812, 90813, 90814, 90815</b>  Other Psychotherapy: <b>90845, 90846, 90847, 90849, 90875, 90876, 90880, 90887, 90899</b>	<b>H0022</b> Alcohol and/or drug intervention service  <b>T1006</b> Alcohol and/or substance abuse services, family/couple counseling	<b>UA</b>	<b>required</b>
<b>W7404</b> Individual psychotherapy/substance abuse therapy — home or community by Ph.D.	Office or Other Outpatient Facility Psychotherapy: <b>90804, 90806, 90808, 90810, 90812, 90814</b>  Other Psychotherapy: <b>90845, 90846, 90847, 90849, 90875, 90876, 90880, 90887, 90899</b>	<b>H0022</b> Alcohol and/or drug intervention service  <b>T1006</b> Alcohol and/or substance abuse services, family/couple counseling	<b>HP</b>	<b>required</b>
<b>W7405</b> Individual psychotherapy/substance abuse therapy — home or community by Master's	Office or Other Outpatient Facility Psychotherapy: <b>90804, 90806, 90808, 90810, 90812, 90814</b>  Other Psychotherapy: <b>90845, 90846, 90847, 90849, 90875, 90876, 90880, 90887, 90899</b>	<b>H0022</b> Alcohol and/or drug intervention service  <b>T1006</b> Alcohol and/or substance abuse services, family/couple counseling	<b>HO</b>	<b>required</b>
<b>W7406</b> Individual substance abuse therapy — home or community by AODA Counselor	None	<b>H0022</b> Alcohol and/or drug intervention service  <b>T1006</b> Alcohol and/or substance abuse services, family/couple counseling	<b>HN</b>	<b>required</b>
<b>W7407</b> Individual substance abuse therapy — home or community by MD other than Psychiatrist	None	<b>H0022</b> Alcohol and/or drug intervention service  <b>T1006</b> Alcohol and/or substance abuse services, family/couple counseling	<b>UA</b>	<b>required</b>

\*Select the appropriate modifier that describes the individual provider performing the service.

## Psychiatric therapeutic procedures (group)

Before HIPAA implementation	After HIPAA implementation			
Local procedure code and description	CPT procedure code	HCPCS procedure code	Professional level modifier(s)*	UC modifier
<p><b>W7408</b> Group psychotherapy/substance abuse therapy – home or community by Psychiatrist</p> <p><b>W7409</b> Group psychotherapy/substance abuse therapy – home or community by Ph.D.</p> <p><b>W7410</b> Group psychotherapy/substance abuse therapy – home or community by Master's</p> <p><b>W7411</b> Group psychotherapy/substance abuse therapy – home or community by AODA Counselor</p> <p><b>W7412</b> Group psychotherapy/substance abuse therapy – home or community by MD other than Psychiatrist</p>	<p><b>90853</b> Group psychotherapy (other than of a multiple-family group)</p> <p><b>90857</b> Interactive group psychotherapy</p>	<p><b>H0005</b> Alcohol and/or drug services; group counseling by a clinician</p>	<p><b>UA</b> <b>HP</b> <b>HO</b> <b>HN</b></p>	<p><b>required</b></p>

## Other psychiatric services or procedures

Before HIPAA implementation	After HIPAA implementation		
Local procedure code and description	CPT procedure code	Professional level modifier(s)*	UC modifier
<p><b>W7413</b> Pharmacologic management – home or community by Psychiatric Advanced Practice Nurse Prescriber (APNP), Physician Assistants, and Psychiatrists (quantity of 1.0 = 15 minutes)</p>	<p><b>90862</b> Pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy</p>	<p><b>UA</b> <b>UB</b></p>	<p><b>required</b></p>
<p><b>W7414</b> Pharmacologic management – home or community by Psychiatric Nurse (quantity of 1.0 = 15 minutes)</p>	<p><b>90862</b> Pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy</p>	<p><b>HO</b></p>	<p><b>required</b></p>

\*Select the appropriate modifier that describes the individual provider performing the service.

## ATTACHMENT 2

# Outpatient mental health and substance abuse services in the home or community procedure codes

The procedure codes listed in this attachment will be allowable to those providers who provide mental health and substance abuse services in the home or community after implementation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Not all providers may be reimbursed for all mental health or substance abuse services. To determine which certified providers may be reimbursed for a particular service, please consult the charts in this attachment. A separate *Wisconsin Medicaid and BadgerCare Update* will notify providers of the specific effective dates for Wisconsin Medicaid's implementation of HIPAA.

Refer to Attachment 4 of this *Update* for a list of allowable place of service (POS) codes and descriptions.

Professional level modifiers		
Modifier	Description	Providers
HN	Bachelors degree level	Alcohol and other drug abuse (AODA) counselor (counselors that have less credentials than a Master's level psychotherapist)
HO	Masters degree level	Master's level psychotherapist (Master's level psychotherapists are Master's-level mental health professionals with 3,000 hours of supervised experience or are listed in an appropriate national registry as stated in HFS 61.96, Wis. Admin. Code. This includes registered nurses with a Master's degree in psychiatric-mental health nursing or community mental health nursing from a graduate school of nursing accredited by the National League for Nursing.)
HP	Doctoral level	Psychologist, PhD
UA	MD, Psychiatrist	Psychiatrist billing mental health and substance abuse services Physician billing substance abuse services Physician assistant billing pharmacologic management
UB	APNP — Psychiatric specialty	Advanced Practice Nurse Prescriber (APNP) — Master's level registered nurse, only those with an APNP — psychiatric specialty billing pharmacologic management

Other required modifier	
Modifier	Description
UC	Required for <i>all</i> outpatient mental health and substance abuse services provided in the home or community

### Psychiatry procedure codes

#### Psychiatric diagnostic or evaluative interview procedures

Procedure code	Description	Certified providers who may perform service	Modifiers (required)	Allowable POS
90801	Psychiatric diagnostic interview examination (quantity of 1.0 = 1 hour)	Master's degree level	HO, UC	04, 12, 15, 34, 99
		Doctoral level	HP, UC	
		Psychiatrist	UA, UC	
90802	Interactive psychiatric diagnostic interview examination using play equipment, physical devices, language interpreter, or other mechanisms of communication (quantity of 1.0 = 1 hour)	Master's degree level	HO, UC	04, 12, 15, 34, 99
		Doctoral level	HP, UC	
		Psychiatrist	UA, UC	

#### Psychiatric therapeutic procedures: office or other outpatient facility — *insight oriented, behavior modifying and/or supportive psychotherapy*

Procedure code	Description	Certified providers who may perform service	Modifiers (required)	Allowable POS
90804	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient;	Master's degree level	HO, UC	04, 12, 15, 34, 99
		Doctoral level	HP, UC	
		Psychiatrist	UA, UC	
90805	with medical evaluation and management services	Psychiatrist	UA, UC	04, 12, 15, 34, 99
90806	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient;	Master's degree level	HO, UC	04, 12, 15, 34, 99
		Doctoral level	HP, UC	
		Psychiatrist	UA, UC	
90807	with medical evaluation and management services	Psychiatrist	UA, UC	04, 12, 15, 34, 99
90808	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 75 to 80 minutes face-to-face with the patient;	Master's degree level	HO, UC	04, 12, 15, 34, 99
		Doctoral level	HP, UC	
		Psychiatrist	UA, UC	
90809	with medical evaluation and management services	Psychiatrist	UA, UC	04, 12, 15, 34, 99

**Psychiatric therapeutic procedures: office or other outpatient facility — interactive psychotherapy**

Procedure code	Description	Certified providers who may perform service	Modifiers (required)	Allowable POS
90810	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient;	Master's degree level	HO, UC	04, 12, 15, 34, 99
		Doctoral level	HP, UC	
		Psychiatrist	UA, UC	
90811	with medical evaluation and management services	Psychiatrist	UA, UC	04, 12, 15, 34, 99
90812	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient;	Master's degree level	HO, UC	04, 12, 15, 34, 99
		Doctoral level	HP, UC	
		Psychiatrist	UA, UC	
90813	with medical evaluation and management services	Psychiatrist	UA, UC	04, 12, 15, 34, 99
90814	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 75 to 80 minutes face-to-face with the patient;	Master's degree level	HO, UC	04, 12, 15, 34, 99
		Doctoral level	HP, UC	
		Psychiatrist	UA, UC	
90815	with medical evaluation and management services	Psychiatrist	UA, UC	04, 12, 15, 34, 99

**Psychiatric therapeutic procedures: other psychotherapy**

Procedure code	Description	Certified providers who may perform service	Modifiers (required)	Allowable POS
90845	Psychoanalysis (quantity of 1.0 = 60 minutes)	Master's degree level	HO, UC	04, 12, 15, 34, 99
		Doctoral level	HP, UC	
		Psychiatrist	UA, UC	
90846	Family psychotherapy (without the patient present) (quantity of 1.0 = 60 minutes)	Master's degree level	HO, UC	04, 12, 15, 34, 99
		Doctoral level	HP, UC	
		Psychiatrist	UA, UC	
90847	Family psychotherapy (conjoint psychotherapy) (with patient present) (quantity of 1.0 = 60 minutes)	Master's degree level	HO, UC	04, 12, 15, 34, 99
		Doctoral level	HP, UC	
		Psychiatrist	UA, UC	
90849	Multiple-family group psychotherapy (quantity of 1.0 = 60 minutes)	Master's degree level	HO, UC	04, 12, 15, 34, 99
		Doctoral level	HP, UC	
		Psychiatrist	UA, UC	
90853	Group psychotherapy (other than of a multiple-family group) (quantity of 1.0 = 60 minutes)	Master's degree level	HO, UC	04, 12, 15, 34, 99
		Doctoral level	HP, UC	
		Psychiatrist	UA, UC	
90857	Interactive group psychotherapy (quantity of 1.0 = 60 minutes)	Master's degree level	HO, UC	04, 12, 15, 34, 99
		Doctoral level	HP, UC	
		Psychiatrist	UA, UC	

**Psychiatric therapeutic procedures: other psychiatric services or procedures**

Procedure code	Description	Certified providers who may perform service	Modifiers (required)	Allowable POS
90862	Pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy (quantity of 1.0 = 15 minutes)	Master's level psychiatric nurse	HO, UC	04, 12, 15, 34, 99
		Psychiatric APNP	UB, UC	
		Psychiatrist	UA, UC	
90875	Individual psychophysiological therapy incorporating biofeedback training by any modality (face-to-face with the patient), with psychotherapy (eg, insight oriented, behavior modifying or supportive psychotherapy); approximately 20-30 minutes	Master's degree level	HO, UC	04, 12, 15, 34, 99
		Doctoral level	HP, UC	
		Psychiatrist	UA, UC	
90876	approximately 45-50 minutes	Master's degree level	HO, UC	04, 12, 15, 34, 99
		Doctoral level	HP, UC	
		Psychiatrist	UA, UC	
90880	Hypnotherapy (quantity of 1.0 = 60 minutes)	Master's degree level	HO, UC	04, 12, 15, 34, 99
		Doctoral level	HP, UC	
		Psychiatrist	UA, UC	
90887	Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient (quantity of 1.0 = 60 minutes)	Master's degree level	HO, UC	04, 12, 15, 34, 99
		Doctoral level	HP, UC	
		Psychiatrist	UA, UC	
90899	Unlisted psychiatric service or procedure (quantity of 1.0 = 60 minutes)	Master's degree level	HO, UC	04, 12, 15, 34, 99
		Doctoral level	HP, UC	
		Psychiatrist	UA, UC	

## Substance abuse treatment procedure codes

### Substance abuse therapeutic procedures

Procedure code	Description	Certified providers who may perform service	Modifiers (required)	Allowable POS
H0005	Alcohol and/or drug services; group counseling by a clinician (quantity of 1.0 = 60 minutes)	Bachelor's degree level	HN, UC	04, 12, 15, 34, 99
		Master's degree level	HO, UC	
		Doctoral level	HP, UC	
		Psychiatrist	UA, UC	
H0022	Alcohol and/or drug intervention service (planned facilitation) (quantity of 1.0 = per person in group per 60 minutes)	Bachelor's degree level	HN, UC	04, 12, 15, 34, 99
		Master's degree level	HO, UC	
		Doctoral level	HP, UC	
		Psychiatrist	UA, UC	
T1006	Alcohol and/or substance abuse services, family/couple counseling (quantity of 1.0 = 60 minutes)	Bachelor's degree level	HN, UC	04, 12, 15, 34, 99
		Master's degree level	HO, UC	
		Doctoral level	HP, UC	
		Psychiatrist	UA, UC	

## ATTACHMENT 3

# Rounding guidelines for outpatient mental health and substance abuse services in the home or community

Providers should use the following rounding guidelines *only* when 1.0 unit of service is equal to one hour. Providers should follow the time specified in the procedure code description for all other codes.

Mental health and substance abuse outpatient services	
Time (minutes)	Unit(s) billed
1-6	.1
7-12	.2
13-18	.3
19-24	.4
25-30	.5
31-36	.6
37-42	.7
43-48	.8
49-54	.9
55-60	1.0
Etc.	Etc.

## ATTACHMENT 4

# Place of service codes for outpatient mental health and substance abuse services in the home or community

The following table lists the place of service (POS) codes that providers will be required to use when submitting claims after implementation of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). A future *Wisconsin Medicaid and BadgerCare Update* will notify providers of the specific effective dates for Wisconsin Medicaid's implementation of HIPAA.

POS code	Description
04	Homeless Shelter
12	Home
15	Mobile Unit
34	Hospice
99	Other Place of Service

# ATTACHMENT 5

## CMS 1500 claim form instructions for outpatient mental health and substance abuse services in the home or community

(For claims submitted after HIPAA implementation)

Use the following claim form completion instructions, *not* the element descriptions printed on the claim form, to avoid denied claims or inaccurate claim payment. Complete all required elements as appropriate. Do not include attachments unless instructed to do so.

Wisconsin Medicaid recipients receive a Medicaid identification card upon being determined eligible for Wisconsin Medicaid. Always verify a recipient's eligibility before providing nonemergency services by using the Eligibility Verification System (EVS) to determine if there are any limitations on covered services and to obtain the correct spelling of the recipient's name. Refer to the Provider Resources section of the All-Provider Handbook or the Medicaid Web site at [www.dhfs.state.wi.us/medicaid/](http://www.dhfs.state.wi.us/medicaid/) for more information about the EVS.

### **Element 1 – Program Block/Claim Sort Indicator**

Enter claim sort indicator "P" in the Medicaid check box for the service billed.

### **Element 1a – Insured's I.D. Number**

Enter the recipient's 10-digit Medicaid identification number. Do not enter any other numbers or letters. Use the Medicaid identification card or the EVS to obtain the correct identification number.

### **Element 2 – Patient's Name**

Enter the recipient's last name, first name, and middle initial. Use the EVS to obtain the correct spelling of the recipient's name. If the name or spelling of the name on the Medicaid identification card and the EVS do not match, use the spelling from the EVS.

### **Element 3 – Patient's Birth Date, Patient's Sex**

Enter the recipient's birth date in MM/DD/YY format (e.g., February 3, 1955, would be 02/03/55) or in MM/DD/YYYY format (e.g., February 3, 1955, would be 02/03/1955). Specify whether the recipient is male or female by placing an "X" in the appropriate box.

### **Element 4 – Insured's Name (not required)**

### **Element 5 – Patient's Address**

Enter the complete address of the recipient's place of residence, if known.

### **Element 6 – Patient Relationship to Insured (not required)**

### **Element 7 – Insured's Address (not required)**

### **Element 8 – Patient Status (not required)**

### **Element 9 – Other Insured's Name**

Commercial health insurance must be billed prior to submitting claims to Wisconsin Medicaid, unless the service does not require commercial health insurance billing as determined by Wisconsin Medicaid.

If the EVS indicates that the recipient has dental ("DEN") or has no commercial health insurance, leave Element 9 blank.

If the EVS indicates that the recipient has Wausau Health Protection Plan (“HPP”), BlueCross & BlueShield (“BLU”), Wisconsin Physicians Service (“WPS”), Medicare Supplement (“SUP”), TriCare (“CHA”), Vision only (“VIS”), a health maintenance organization (“HMO”), or some other (“OTH”) commercial health insurance, **and** the service requires other insurance billing according to the Coordination of Benefits section of the All-Provider Handbook, then one of the following three other insurance (OI) explanation codes **must** be indicated in the **first** box of Element 9. The description is not required, nor is the policyholder, plan name, group number, etc. (Elements 9a, 9b, 9c, and 9d are not required.)

Code	Description
OI-P	PAID in part or in full by commercial health insurance or commercial HMO. In Element 29 of this claim form, indicate the amount paid by commercial health insurance to the provider or to the insured.
OI-D	DENIED by commercial health insurance or commercial HMO following submission of a correct and complete claim, or payment was applied towards the coinsurance and deductible. Do not use this code unless the claim was actually billed to the commercial health insurer.
OI-Y	YES, the recipient has commercial health insurance or commercial HMO coverage, but it was not billed for reasons including, but not limited to: <ul style="list-style-type: none"> <li>✓ The recipient denied coverage or will not cooperate.</li> <li>✓ The provider knows the service in question is not covered by the carrier.</li> <li>✓ The recipient’s commercial health insurance failed to respond to initial and follow-up claims.</li> <li>✓ Benefits are not assignable or cannot get assignment.</li> <li>✓ Benefits are exhausted.</li> </ul>

*Note:* The provider may not use OI-D or OI-Y if the recipient is covered by a commercial HMO and the HMO denied payment because an otherwise covered service was not rendered by a designated provider. Services covered by a commercial HMO are not reimbursable by Wisconsin Medicaid except for the copayment and deductible amounts. Providers who receive a capitation payment from the commercial HMO may not bill Wisconsin Medicaid for services that are included in the capitation payment.

**Element 10 – Is Patient’s Condition Related to (not required)**

**Element 11 – Insured’s Policy, Group, or FECA Number (not required)**

**Elements 12 and 13 – Authorized Person’s Signature (not required)**

**Element 14 – Date of Current Illness, Injury, or Pregnancy (not required)**

**Element 15 – If Patient Has Had Same or Similar Illness (not required)**

**Element 16 – Dates Patient Unable to Work in Current Occupation (not required)**

**Elements 17 and 17a – Name and I.D. Number of Referring Physician or Other Source (not required)**

For outpatient mental health and substance abuse services in the home or community, the prescribing physician’s name and Universal Provider Identification Number, eight-digit Medicaid provider number, or license number is required for all services *except* evaluation (90801 and 90802). If a psychiatrist is the referring or prescribing provider *and* the performing provider, the psychiatrist’s name and provider number must be entered in this element.

**Element 18 – Hospitalization Dates Related to Current Services (not required)**

**Element 19 – Reserved for Local Use (not required)**

## Element 20 – Outside Lab? (not required)

## Element 21 – Diagnosis or Nature of Illness or Injury

Enter the *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis code for each symptom or condition related to the services provided. List the primary diagnosis first. Etiology (“E”) and manifestation (“M”) codes may not be used as a primary diagnosis. The diagnosis description is not required.

## Element 22 – Medicaid Resubmission (not required)

## Element 23 – Prior Authorization Number (not required)

## Element 24A – Date(s) of Service

Enter the month, day, and year for each service using the following guidelines:

- When billing for one date of service (DOS), enter the date in MM/DD/YY or MM/DD/YYYY format in the “From” field.
- When billing for two, three, or four DOS on the same detail line, enter the first DOS in MM/DD/YY or MM/DD/YYYY format in the “From” field and enter subsequent DOS in the “To” field by listing **only** the date(s) of the month. For example, for DOS January 12 through 15, 2003, enter 01/12/03 or 01/12/2003 in the “From” field and enter 13/14/15 in the “To” field.

It is allowable to enter up to four DOS per line if:

- All DOS are in the same calendar month.
- All services are billed using the same procedure code and modifier, if applicable.
- All services have the same place of service (POS) code.
- All services were performed by the same provider.
- The same diagnosis is applicable for each service.
- The charge for all services is identical. (Enter the total charge **per detail line** in Element 24F.)
- The number of services performed on each DOS is identical.
- All services have the same family planning indicator, if applicable.
- All services have the same emergency indicator, if applicable.

## Element 24B – Place of Service

Enter the appropriate two-digit POS code for each service.

## Element 24C – Type of Service (not required)

## Element 24D – Procedures, Services, or Supplies

Enter the single most appropriate five-character procedure code. Wisconsin Medicaid denies claims received without an appropriate procedure code.

### Modifiers

Enter the appropriate modifier in the “Modifier” column of Element 24D. Please note that Wisconsin Medicaid has not adopted all modifiers.

## Element 24E – Diagnosis Code

Enter the number (1, 2, 3, or 4) that corresponds to the appropriate ICD-9-CM diagnosis code listed in Element 21.

## Element 24F – \$ Charges

Enter the total charge for each line item. Providers are required to bill Wisconsin Medicaid their usual and customary charge. The usual and customary charge is the provider’s charge for providing the same service to persons not entitled to Medicaid benefits.

## Element 24G – Days or Units

Enter the appropriate number of units for each line item. Always use a decimal (e.g., 2.0 units).

### **Element 24H – EPSDT/Family Plan (not required)**

### **Element 24I – EMG**

Enter an “E” for each procedure code performed as an emergency, regardless of the POS. If the procedure is not an emergency, leave this element blank.

### **Element 24J – COB (not required)**

### **Element 24K – Reserved for Local Use**

When the billing provider (Element 33) is a county-owned clinic (not a “biller only” provider), leave this element blank.

When the billing provider (Element 33) is a “biller only” provider, indicate the performing provider’s individual eight-digit provider number.

Any other information entered in this element may cause claim denial.

### **Element 25 – Federal Tax I.D. Number (not required)**

### **Element 26 – Patient’s Account No. (not required)**

Optional — Providers may enter up to 20 characters of the patient’s internal office account number. This number will appear on the Remittance and Status Report and/or the 835 Health Care Claim Payment/Advice transaction.

### **Element 27 – Accept Assignment (not required)**

### **Element 28 – Total Charge**

Enter the total charges for this claim.

### **Element 29 – Amount Paid**

Enter the actual amount paid by commercial health insurance. (If the dollar amount indicated in Element 29 is greater than zero, “OI-P” must be indicated in Element 9.) If the commercial health insurance denied the claim, enter "000." Do **not** enter Medicare-paid amounts in this field.

### **Element 30 – Balance Due**

Enter the balance due as determined by subtracting the amount paid in Element 29 from the amount in Element 28.

### **Element 31 – Signature of Physician or Supplier**

The provider or the authorized representative must sign in Element 31. The month, day, and year the form is signed must also be entered in MM/DD/YY or MM/DD/YYYY format.

*Note:* The signature may be a computer-printed or typed name and date or a signature stamp with the date.

### **Element 32 – Name and Address of Facility Where Services Were Rendered (not required)**

### **Element 33 – Physician’s, Supplier’s Billing Name, Address, ZIP Code, and Phone #**

Enter the name of the provider submitting the claim and the complete mailing address. The minimum requirement is the provider’s name, street, city, state, and Zip code. At the bottom of Element 33, enter the billing provider’s eight-digit Medicaid provider number.

This is the county or tribal agency responsible for the local matching funds.

# ATTACHMENT 6

Sample CMS 1500 claim form for outpatient mental health and substance abuse services in the home or community — county owned clinics (not a "biller only" provider)

HEALTH INSURANCE CLAIM FORM									
1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/>					1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)				
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <b>Recipient, Im A.</b>					3. PATIENT'S BIRTH DATE <b>MM DD YY</b> M <input type="checkbox"/> F <input checked="" type="checkbox"/>				
5. PATIENT'S ADDRESS (No., Street) <b>609 Willow St</b>					7. INSURED'S ADDRESS (No., Street)				
CITY <b>Anytown</b> STATE <b>WI</b>					8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>				
ZIP CODE <b>55555</b> TELEPHONE (Include Area Code) <b>(XXX) XXX-XXXX</b>					9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) <b>OI-P</b>				
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) <b>OI-P</b>					10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) _____ c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO				
a. OTHER INSURED'S POLICY OR GROUP NUMBER					11. INSURED'S POLICY GROUP OR FECA NUMBER				
b. OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>					a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>				
c. EMPLOYER'S NAME OR SCHOOL NAME					b. EMPLOYER'S NAME OR SCHOOL NAME				
d. INSURANCE PLAN NAME OR PROGRAM NAME					c. INSURANCE PLAN NAME OR PROGRAM NAME				
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.  SIGNED _____ DATE _____					13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.  SIGNED _____				
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY					15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY				
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE <b>I.M. Referring/Prescribing</b>					17a. I.D. NUMBER OF REFERRING PHYSICIAN <b>12345678</b>				
19. RESERVED FOR LOCAL USE					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY				
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE) 1. <b>290</b> 3. _____ 2. _____ 4. _____					20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO				
24. A DATE(S) OF SERVICE To B Place of Service C Type of Service D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E DIAGNOSIS CODE F \$ CHARGES G DAYS OR UNITS H EPSDT Family Plan I EMG J COB K RESERVED FOR LOCAL USE					22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.				
25. FEDERAL TAX I.D. NUMBER SSN EIN					23. PRIOR AUTHORIZATION NUMBER				
26. PATIENT'S ACCOUNT NO. <b>1234JED</b>					27. ACCEPT ASSIGNMENT? (For gov't. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO				
28. TOTAL CHARGE \$ <b>XXX XX</b>					29. AMOUNT PAID \$ <b>XX XX</b>				
29. AMOUNT PAID \$ <b>XX XX</b>					30. BALANCE DUE \$ <b>XX XX</b>				
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) <b>I.M. Provider</b> MM/DD/YY SIGNED _____ DATE _____					32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)				
32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)					33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # <b>I.M. Billing</b> <b>1 W. Williams</b> PIN# _____ GRP# _____				

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

# ATTACHMENT 7

Sample CMS 1500 claim form for outpatient mental health and substance abuse services in the home or community — "biller only" providers

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION

HEALTH INSURANCE CLAIM FORM																													
1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA BLK LUNG (SSN) <input type="checkbox"/> OTHER (ID) <input type="checkbox"/>					1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) <b>1234567890</b>																								
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <b>Recipient, Im A.</b>					3. PATIENT'S BIRTH DATE MM DD YY <b>MM DD YY</b> M <input type="checkbox"/> F <input checked="" type="checkbox"/>																								
4. INSURED'S NAME (Last Name, First Name, Middle Initial)					5. PATIENT'S ADDRESS (No., Street) <b>609 Willow St</b>																								
6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>					7. INSURED'S ADDRESS (No., Street)																								
CITY <b>Anytown</b>			STATE <b>WI</b>		8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>			CITY		STATE																			
ZIP CODE <b>55555</b>			TELEPHONE (Include Area Code) <b>(XXX) XXX-XXXX</b>		Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>			ZIP CODE		TELEPHONE (INCLUDE AREA CODE)																			
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) <b>OI-P</b>					10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) _____ c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO					11. INSURED'S POLICY GROUP OR FECA NUMBER																			
a. OTHER INSURED'S POLICY OR GROUP NUMBER					a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>					SEX																			
b. OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>					b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) _____					d. EMPLOYER'S NAME OR SCHOOL NAME																			
c. EMPLOYER'S NAME OR SCHOOL NAME					c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO					c. INSURANCE PLAN NAME OR PROGRAM NAME																			
d. INSURANCE PLAN NAME OR PROGRAM NAME					10d. RESERVED FOR LOCAL USE					d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i>																			
<b>READ BACK OF FORM BEFORE COMPLETING &amp; SIGNING THIS FORM.</b>																													
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.  SIGNED _____ DATE _____					13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.  SIGNED _____																								
14. DATE OF CURRENT: <input type="checkbox"/> ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY					15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY					16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY																			
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE <b>I.M. Referring/Prescribing</b>					17a. I.D. NUMBER OF REFERRING PHYSICIAN <b>12345678</b>					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																			
19. RESERVED FOR LOCAL USE					20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES					22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.																			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)					23. PRIOR AUTHORIZATION NUMBER																								
1. <b>290</b>					3. _____																								
2. _____					4. _____																								
A DATE(S) OF SERVICE From To			B Place of Service		C Type of Service		D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER			E DIAGNOSIS CODE		F \$ CHARGES		G DAYS OR UNITS		H EPSTD Family Plan		I EMG		J COB		K RESERVED FOR LOCAL USE							
1 12 02 03			12				90801 UA UC			1		XX XX		1.0								24681012							
2 12 15 03			12				90806 UA UC			1		XX XX		1.0								64295318							
3 12 22 03 29			12				90857 HO UC			1		XX XX		2.0								52623789							
4																													
5																													
6																													
25. FEDERAL TAX I.D. NUMBER SSN EIN					26. PATIENT'S ACCOUNT NO. <b>1234JED</b>					27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO					28. TOTAL CHARGE \$ <b>XXX XX</b>					29. AMOUNT PAID \$ <b>XX XX</b>					30. BALANCE DUE \$ <b>XX XX</b>				
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) <b>I.M. Provider</b> MM/DD/YY SIGNED _____ DATE _____										32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)										33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # <b>I.M. Billing</b> <b>1 W. Williams</b> <b>Anytown, WI 55555</b> <b>87654321</b> PIN# _____ GRP# _____									

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)