

To:
AODA Counselors
County Mental Health Coordinators
County Substance Abuse Coordinators
Master's Level Psychotherapists
Outpatient Mental Health/ Substance Abuse Clinics
Psychiatrists
Psychologists
HMOs and Other Managed Care Programs

Changes to local codes, paper claims, and prior authorization for outpatient mental health and substance abuse services as a result of HIPAA

This *Wisconsin Medicaid and BadgerCare Update* introduces important changes to local codes, paper claims, and prior authorization (PA) for outpatient mental health and substance abuse services 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.
- Revising Medicaid PA request forms and instructions.

A future *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 billing and prior authorization (PA) changes for outpatient mental health and substance abuse services. These changes will be implemented in October 2003, as a result of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). A future *Update* will notify providers of the specific effective dates for the various changes. This applies to psychiatrists and Ph.D. psychologists in private practice as well as alcohol and other

drug abuse (AODA) counselors, Master's level providers, physicians, and Ph.D. psychologists in private and county-owned mental health and substance abuse clinics. These changes are not policy or coverage related (e.g., PA requirements, documentation requirements), but include:

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

Note: Use of the national codes that will replace Wisconsin Medicaid local codes, revised paper claim instructions, or revised PA forms and instructions prior to implementation dates may result in claim denials and returned PA requests. Specific implementation dates will be published in a future *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.

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

Refer to Attachment 3 for revised outpatient mental health and substance abuse services maximum allowable fees and copayment rates. Keep in mind that the maximum allowable fees listed in Attachment 3 are the proposed fees effective July 1, 2002, and may be subject to change. Wisconsin Medicaid will notify providers if the fees change from those printed in this *Update*.

Note: All outpatient mental health and substance abuse providers will be required to choose the CPT or HCPCS procedure code that most accurately reflects the time spent on the service provided specified in the procedure code description. For procedure codes that do not indicate a time increment, providers will be required to choose the time increment from the rounding guidelines in Attachment 4.

Modifiers

All providers of outpatient mental health and substance abuse services will be required to indicate a nationally recognized modifier in Element 24D of the CMS 1500 claim form for each procedure performed. A modifier is used to identify the professional level of the provider performing each procedure performed for reimbursement purposes. For example, modifier

“HO” will indicate a Master’s degree level psychotherapist performed the service. A list of modifiers and corresponding descriptions is included in Attachments 1, 2, and 3.

Performing providers — reminder

Private clinics are reminded that they are required to indicate a performing provider number on a claim. The performing provider number (Element 24K) and the appropriate modifier (Element 24D) are required.

Though county-owned clinics are currently not required to indicate a performing provider number in Element 24K on a claim, Wisconsin Medicaid encourages them to do so if the provider is individually Medicaid-certified. (Providers in county-owned clinics are not required to be individually Medicaid-certified but counties are encouraged to have staff be individually certified.)

Type of service codes

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

Place of service codes

Nationally recognized two-digit POS codes will replace the one-digit Wisconsin Medicaid POS codes used currently. Refer to Attachment 5 for a list of allowable POS codes for outpatient mental health and substance abuse services.

Coverage for outpatient mental health and substance abuse services remains unchanged

Medicaid coverage and documentation requirements for outpatient mental health and substance abuse services will remain unchanged. Refer to the Mental Health and Alcohol and Other Drug Abuse Services Handbook and other *Updates* for complete Medicaid policies and procedures.

Nnationally recognized two-digit POS codes will replace the one-digit Wisconsin Medicaid POS codes used currently.

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

Revision of CMS 1500 paper claim instructions

With the implementation of HIPAA, Medicaid-certified providers of outpatient mental health and substance abuse services will be required to follow the revised 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 6 for the revised instructions. Attachments 7 and 8 are samples of claims that 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:

- Other insurance indicators were revised (Element 9).
- Medicare disclaimer codes were revised (Element 11).
- 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.

Revision of prior authorization request forms, attachments, and instructions

With the implementation of HIPAA, outpatient mental health and substance abuse services providers will be required to use the revised Prior Authorization Request Form (PA/RF), HCF 11018, dated 06/03. Instructions for

completion of this revised form are located in Attachment 9. Sample PA/RFs are in Attachments 10-12.

Revisions made to the Prior Authorization Request Form

The following revisions were made to the PA/RF:

- Requested start date field added (Element 14).
- Space for performing provider number added for each service/procedure (Element 15).
- Space added for additional modifiers (Element 17).
- Place of service codes were revised (Element 18).
- Type of service codes are no longer required.

Revised prior authorization attachments

Wisconsin Medicaid has revised PA attachments. The basic information requested on the attachments has not changed; only the format of the attachments has changed. The following PA attachments have been revised:

- Prior Authorization/Psychotherapy Attachment (PA/PSYA), HCF 11031, dated 06/03. Refer to Attachment 13 for PA/PSYA Completion Instructions and Attachment 14 for a sample PA/PSYA (for photocopying).
- Prior Authorization/Substance Abuse Attachment (PA/SAA), HCF 11032, dated 06/03. (The PA/SAA replaces the Prior Authorization/Alcohol and Other Drug Abuse Attachment. Wisconsin Medicaid updated the name of this attachment to comply with industry standards.) Refer to Attachment 15 for PA/SAA Completion Instructions and Attachment 16 for a sample PA/SAA (for photocopying).
- Prior Authorization/Evaluation and Testing Attachment (PA/ETA), HCF 11033, dated 06/03. Refer to Attachment 17 for PA/ETA

Completion Instructions and Attachment 18
for a sample PA/ETA (for photocopying).

Obtaining prior authorization request forms and attachments

The PA/PSYA, PA/SAA, and PA/ETA are available in a fillable Portable Document Format (PDF) from the forms page of the Wisconsin Medicaid Web site. (Providers cannot obtain copies of the PA/RF from the Medicaid Web site since each form has a unique preprinted PA number on it.) To access the PA/PSYA, PA/SAA, or PA/ETA and other Medicaid forms, follow these instructions:

1. Go to www.dhfs.state.wi.us/medicaid/.
2. Choose “Providers” from the options listed in the Wisconsin Medicaid main menu.
3. Select “Provider Forms” under the “Provider Publications and Forms” topic area.

The fillable PDF may be accessed using Adobe Acrobat Reader® and may be completed electronically. Providers may then include the printed version of the attachment with the PA/RF. To use the fillable PDF, click on the dash-outlined boxes to enter information. Press the “Tab” key to move from one box to the next.

To request paper copies of the PA/PSYA, PA/AA, PA/ETA, or the PA/RF, call Provider Services at (800) 947-9627 or (608) 221-9883. Questions about the forms may also be directed to Provider Services at the telephone numbers previously mentioned.

In addition, all PA forms and attachments are available by writing to Wisconsin Medicaid. Include a return address, the name of the form, and the HCF number of the form (if applicable) and send the request to:

Wisconsin Medicaid
Form Reorder
6406 Bridge Rd
Madison WI 53784-0003

General HIPAA information

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

- 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/ — 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/ — 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 Medicaid Web site provides instructions on how to obtain Adobe Acrobat Reader® at no charge from the Adobe® Web site at www.adobe.com/. Adobe Acrobat Reader® does not allow users to save completed fillable PDFs to their computer. Refer to the Adobe® Web site for more information on fillable PDFs.

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/.

ATTACHMENT 1

Procedure code conversion chart for outpatient mental health and substance abuse services

The following chart lists procedure codes and modifiers that psychiatrists and Ph.D. psychologists in private practice and *all* outpatient mental health and substance abuse clinics will be required to use when submitting claims. A future *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 Attachments 2 or 3 of this *Update* or to *Current Procedural Terminology (CPT)* and Healthcare Common Procedure Coding System (HCPCS) for a complete description of these codes.

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, Ph.D.
UA	MD, Psychiatrist	Psychiatrist billing mental health and substance abuse services Physician billing substance abuse services Physician assistant billing substance abuse services
UB	APNP — Psychiatric specialty	Advanced Practice Nurse Prescriber (APNP) — Master's level registered nurse, only those with an APNP — psychiatric specialty billing pharmacologic management
U8	Physician assistant	Physician assistant billing pharmacologic management

Psychiatric diagnostic or evaluative interview procedures

Before HIPAA implementation	After HIPAA implementation	
Local procedure code and description	Nationally recognized procedure code(s)	Allowable modifier(s)*
W8931 Psychiatric evaluation — Ph.D. W8932 Psychiatric evaluation — Master's-level therapist W8933 Psychiatric evaluation — Psychiatrist	Psychiatry: 90801, 90802	HO HP UA
W8987 Limitation — Exceeded Psychotherapy/substance abuse (AODA) diagnostic interview examination (quantity of 1 = 1 hour)	Limitation Exceeded (Psychotherapy): H0046 Limitation Exceeded (Substance Abuse): H0047	HO HP UA

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

Psychiatric therapeutic procedures (individual/family)

In reporting psychotherapy, the appropriate code is chosen on the basis of the type of psychotherapy (interactive versus insight oriented), the place of service (office versus inpatient), 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(s)	Allowable modifier(s)*
<p>W8927 Individual/Family psychotherapy — Ph.D.</p>	<p>Office or Other Outpatient Facility Psychotherapy: 90804, 90806, 90808, 90810, 90812, 90814</p> <p>Inpatient Hospital, Partial Hospital, or Residential Care Facility Psychotherapy: 90816, 90818, 90821, 90823, 90826, 90828</p> <p>Other Psychotherapy: 90845, 90846, 90847, 90865, 90875, 90876, 90880, 90887, 90899</p>	<p>HP</p>
<p>W8928 Individual/Family psychotherapy — Master's-level therapist</p>	<p>Office or Other Outpatient Facility Psychotherapy: 90804, 90806, 90808, 90810, 90812, 90814</p> <p>Inpatient Hospital, Partial Hospital, or Residential Care Facility Psychotherapy: 90816, 90818, 90821, 90823, 90826, 90828</p> <p>Other Psychotherapy: 90845, 90846, 90847, 90875, 90876, 90880, 90887, 90899</p>	<p>HO</p>
<p>W8930 Individual/Family psychotherapy — Psychiatrist</p>	<p>Office or Other Outpatient Facility Psychotherapy: 90804, 90805, 90806, 90807, 90808, 90809, 90810, 90811, 90812, 90813, 90814, 90815</p> <p>Inpatient Hospital, Partial Hospital, or Residential Care Facility Psychotherapy: 90816, 90817, 90818, 90819, 90821, 90822, 90823, 90824, 90826, 90827, 90828, 90829</p> <p>Other Psychotherapy: 90845, 90846, 90847, 90865, 90870, 90871, 90875, 90876, 90880, 90887, 90899</p>	<p>UA</p>

*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	Allowable modifier(s) *
<p>W8934 Group psychotherapy — Ph.D.</p> <p>W8935 Group psychotherapy — Master's-level therapist</p> <p>W8936 Group psychotherapy — Psychiatrist</p>	<p>Multiple-family group psychotherapy: 90849</p> <p>Group psychotherapy (other than of a multiple-family group): 90853</p> <p>Interactive group psychotherapy: 90857</p>	<p>HP HO UA</p>

Other psychiatric services or procedures

Before HIPAA implementation	After HIPAA implementation	
Local procedure code and description	CPT procedure code	Allowable modifier(s) *
<p>W8937 Psychiatry medication management (Medication check) — Master's-level Psychiatric Nurse (quantity of 1.0 = 15 minutes)</p>	<p>Pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy 90862</p>	<p>HO</p>
<p>W8938 Psychiatry medication management (Medication check) — Nurse Practitioners, Physician Assistants, and Psychiatrists (quantity of 1.0 = 15 minutes)</p>	<p>Pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy 90862</p>	<p>UA UB U8</p>

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

Substance abuse treatment procedures

Before HIPAA implementation	After HIPAA implementation	
Local procedure code and description	HCPCS procedure code and description	Allowable Modifier(s) *
<p>W8968 Individual substance abuse (AODA) therapy (quantity of 1 = 60 minutes)</p>	<p>Alcohol and/or drug intervention service (planned facilitation): H0022</p>	<p>HN HO HP UA</p>
<p>W8969 Group substance abuse therapy (quantity of 1 = 60 minutes)</p>	<p>Alcohol and/or drug services; group counseling by a clinician: H0005</p>	
<p>W8970 Family substance abuse (AODA) therapy (quantity of 1 = 60 minutes)</p>	<p>Alcohol and/or substance abuse services, family/couple counseling: T1006</p>	
<p>W8972 Individual/Family AODA — Ph.D.</p> <p>W8973 Individual/Family AODA — MS</p> <p>W8974 Individual/Family AODA — MD</p> <p>W8975 Individual/Family AODA — Other</p>	<p>Individual — Alcohol and/or drug intervention service (planned facilitation): H0022</p> <p>Family — Alcohol and/or substance abuse services, family/couple counseling: T1006</p>	
<p>W8976 Group AODA — Ph.D.</p> <p>W8977 Group AODA — MS</p> <p>W8978 Group AODA — MD</p> <p>W8979 Group AODA — Other</p>	<p>Alcohol and/or drug services; group counseling by a clinician: H0005</p>	

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

ATTACHMENT 2

Outpatient mental health and substance abuse services procedure codes

The procedure codes listed in this Attachment will be allowable to those providers who provide mental health evaluations, psychotherapy, and substance abuse services in outpatient settings after implementation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This includes psychiatrists and Ph.D. psychologists in private practice and all outpatient mental health or substance abuse clinics (for services provided by psychiatrists, Ph.D. psychologists, Master's-level psychotherapists, and alcohol and other drug abuse [AODA] counselors). Not all providers may be reimbursed for all outpatient 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 future *Wisconsin Medicaid and BadgerCare Update* will notify providers of the specific effective dates for Wisconsin Medicaid's implementation of HIPAA.

Refer to Attachment 5 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, Ph.D.
UA	MD, Psychiatrist	Psychiatrist billing mental health and substance abuse services Physician billing substance abuse services Physician assistant billing substance abuse services
UB	APNP — Psychiatric specialty	Advanced Practice Nurse Prescriber (APNP) — Master's level registered nurse, only those with an APNP — psychiatric specialty billing pharmacologic management
U8	Physician assistant	Physician assistant billing pharmacologic management

Psychiatry procedure codes

Psychiatric diagnostic or evaluative interview procedures

Procedure code	Description	Certified providers who may perform service	Modifier (required)	Limitations	Allowable ICD-9-CM diagnoses	Allowable POS
90801	Psychiatric diagnostic interview examination (quantity of 1.0 = 1 hour)	Master's degree level	HO	Any additional hours beyond six hours of a combination of 90801 and 90802 in a two-year period accumulates toward the prior authorization (PA) threshold.**	All	03, 11, 21*, 22, 23, 31, 32, 51*, 54, 61*
		Doctoral level	HP			
		Psychiatrist	UA			
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	Any additional hours beyond six hours of a combination of 90801 and 90802 in a two-year period accumulates toward the PA threshold.**	All	03, 11, 21*, 22, 23, 31, 32, 51*, 54, 61*
		Doctoral level	HP			
		Psychiatrist	UA			
H0046	Mental health services, not otherwise specified (Wisconsin Medicaid: Limitation — Exceeded; Psychotherapy diagnostic interview examination [quantity of 1.0 = 1 hour])	Master's degree level	HO	Accumulates toward the 15-hour/\$500 calendar-year threshold beyond which PA is required (except for inpatient hospital).	All	03, 11, 21*, 22, 23, 31, 32, 51*, 54, 61*
		Doctoral level	HP			
		Psychiatrist	UA			

*The POS codes "21," "51," and "61" are not allowable for Master's level providers. Payment is included in the hospital's Medicaid diagnosis-related group (DRG) reimbursement.

**Diagnostic interview examinations beyond this limit must be billed under H0046, which accumulates toward the 15-hour/\$500 calendar year threshold beyond which PA is required.

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	Modifier (required)	Limitations	Allowable ICD-9-CM diagnoses	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	Accumulates toward the 15-hour/\$500 calendar-year threshold beyond which PA is required.	290-316	03, 11, 22, 23
		Doctoral level	HP			
		Psychiatrist	UA			
90805	with medical evaluation and management services	Psychiatrist	UA	Accumulates toward the 15-hour/\$500 calendar-year threshold beyond which PA is required.	290-316	03, 11, 22, 23
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	Accumulates toward the 15-hour/\$500 calendar-year threshold beyond which PA is required.	290-316	03, 11, 22, 23
		Doctoral level	HP			
		Psychiatrist	UA			
90807	with medical evaluation and management services	Psychiatrist	UA	Accumulates toward the 15-hour/\$500 calendar-year threshold beyond which PA is required.	290-316	03, 11, 22, 23
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	Accumulates toward the 15-hour/\$500 calendar-year threshold beyond which PA is required.	290-316	03, 11, 22, 23
		Doctoral level	HP			
		Psychiatrist	UA			
90809	with medical evaluation and management services	Psychiatrist	UA	Accumulates toward the 15-hour/\$500 calendar-year threshold beyond which PA is required.	290-316	03, 11, 22, 23

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

Procedure code	Description	Certified providers who may perform service	Modifier (required)	Limitations	Allowable ICD-9-CM diagnoses	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	Accumulates toward the 15-hour/\$500 calendar-year threshold beyond which PA is required.	290-316	03, 11, 22, 23
		Doctoral level	HP			
		Psychiatrist	UA			
90811	with medical evaluation and management services	Psychiatrist	UA	Accumulates toward the 15-hour/\$500 calendar-year threshold beyond which PA is required.	290-316	03, 11, 22, 23
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	Accumulates toward the 15-hour/\$500 calendar-year threshold beyond which PA is required.	290-316	03, 11, 22, 23
		Doctoral level	HP			
		Psychiatrist	UA			
90813	with medical evaluation and management services	Psychiatrist	UA	Accumulates toward the 15-hour/\$500 calendar-year threshold beyond which PA is required.	290-316	03, 11, 22, 23
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	Accumulates toward the 15-hour/\$500 calendar-year threshold beyond which PA is required.	290-316	03, 11, 22, 23
		Doctoral level	HP			
		Psychiatrist	UA			
90815	with medical evaluation and management services	Psychiatrist	UA	Accumulates toward the 15-hour/\$500 calendar-year threshold beyond which PA is required.	290-316	03, 11, 22, 23

Psychiatric therapeutic procedures: inpatient hospital or residential care facility — *insight oriented, behavior modifying, and/or supportive psychotherapy* Wisconsin Medicaid covers “partial hospital” services under a separate benefit — Day Treatment/Day Hospital services (HFS 107.13[4], Wis. Admin. Code).

Procedure code	Description	Certified providers who may perform service	Modifier (required)	Limitations	Allowable ICD-9-CM diagnoses	Allowable POS
90816	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 20 to 30 minutes face-to-face with the patient;	Master's degree level	HO	Accumulates toward the 15-hour/\$500 calendar-year threshold beyond which PA is required (except for inpatient hospital).	290-316	21*, 31, 32, 51*, 54, 61*
		Doctoral level	HP			
		Psychiatrist	UA			
90817	with medical evaluation and management services	Psychiatrist	UA	Accumulates toward the 15-hour/\$500 calendar-year threshold beyond which PA is required (except for inpatient hospital).	290-316	21*, 31, 32, 51*, 54, 61*
90818	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 45 to 50 minutes face-to-face with the patient;	Master's degree level	HO	Accumulates toward the 15-hour/\$500 calendar-year threshold beyond which PA is required (except for inpatient hospital).	290-316	21*, 31, 32, 51*, 54, 61*
		Doctoral level	HP			
		Psychiatrist	UA			
90819	with medical evaluation and management services	Psychiatrist	UA	Accumulates toward the 15-hour/\$500 calendar-year threshold beyond which PA is required (except for inpatient hospital).	290-316	21*, 31, 32, 51*, 54, 61*
90821	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 75 to 80 minutes face-to-face with the patient;	Master's degree level	HO	Accumulates toward the 15-hour/\$500 calendar-year threshold beyond which PA is required (except for inpatient hospital).	290-316	21*, 31, 32, 51*, 54, 61*
		Doctoral level	HP			
		Psychiatrist	UA			
90822	with medical evaluation and management services	Psychiatrist	UA	Accumulates toward the 15-hour/\$500 calendar-year threshold beyond which PA is required (except for inpatient hospital).	290-316	21*, 31, 32, 51*, 54, 61*

Psychiatric therapeutic procedures: inpatient hospital or residential care facility — *interactive psychotherapy*

See HFS 107.13, Wis. Admin. Code, for the Medicaid policy on partial hospital/day treatment services. Wisconsin Medicaid covers “partial hospital” services under a separate benefit — Day Treatment/Day Hospital services. (Continued on next page)

Procedure code	Description	Certified providers who may perform service	Modifier (required)	Limitations	Allowable ICD-9-CM diagnoses	Allowable POS
90823	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient hospital, partial hospital or residential care setting, approximately 20 to 30 minutes face-to-face with the patient;	Master's degree level	HO	Accumulates toward the 15-hour/\$500 calendar-year threshold beyond which PA is required (except for inpatient hospital).	290-316	21*, 31, 32, 51*, 54, 61*
		Doctoral level	HP			
		Psychiatrist	UA			
90824	with medical evaluation and management services	Psychiatrist	UA	Accumulates toward the 15-hour/\$500 calendar-year threshold beyond which PA is required (except for inpatient hospital).	290-316	21*, 31, 32, 51*, 54, 61*
90826	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient hospital, partial hospital or residential care setting, approximately 45 to 50 minutes face-to-face with the patient;	Master's degree level	HO	Accumulates toward the 15-hour/\$500 calendar-year threshold beyond which PA is required (except for inpatient hospital).	290-316	21*, 31, 32, 51*, 54, 61*
		Doctoral level	HP			
		Psychiatrist	UA			

*The POS codes "21," "51," and "61" are not allowable for Master's level providers. Payment is included in the hospital's Medicaid DRG reimbursement.

Psychiatric therapeutic procedures: inpatient hospital or residential care facility — interactive psychotherapy

See HFS 107.13, Wis. Admin. Code, for the Medicaid policy on partial hospital/day treatment services. Wisconsin Medicaid covers "partial hospital" services under a separate benefit — Day Treatment/Day Hospital services. (Continued from previous page)

Procedure code	Description	Certified providers who may perform service	Modifier (required)	Limitations	Allowable ICD-9-CM diagnoses	Allowable POS
90827	with medical evaluation and management services	Psychiatrist	UA	Accumulates toward the 15-hour/\$500 calendar-year threshold beyond which PA is required (except for inpatient hospital).	290-316	21*, 31, 32, 51*, 54, 61*
90828	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient hospital, partial hospital or residential care setting, approximately 75 to 80 minutes face-to-face with the patient;	Master's degree level	HO	Accumulates toward the 15-hour/\$500 calendar-year threshold beyond which PA is required (except for inpatient hospital).	290-316	21*, 31, 32, 51*, 54, 61*
		Doctoral level	HP			
		Psychiatrist	UA			
90829	with medical evaluation and management services	Psychiatrist	UA	Accumulates toward the 15-hour/\$500 calendar-year threshold beyond which PA is required (except for inpatient hospital).	290-316	21*, 31, 32, 51*, 54, 61*

Psychiatric therapeutic procedures: other psychotherapy

Procedure code	Description	Certified providers who may perform service	Modifier (required)	Limitations	Allowable ICD-9-CM diagnoses	Allowable POS
90845	Psychoanalysis (quantity of 1.0 = 60 minutes)	Master's degree level	HO	Accumulates toward the 15-hour/\$500 calendar-year threshold beyond which PA is required (except for inpatient hospital).	290-316	03, 11, 21*, 22, 23, 31, 32, 51*, 54, 61*
		Doctoral level	HP			
		Psychiatrist	UA			
90846	Family psychotherapy (without the patient present) (quantity of 1.0 = 60 minutes)	Master's degree level	HO	Accumulates toward the 15-hour/\$500 calendar-year threshold beyond which PA is required (except for inpatient hospital).	290-316	03, 11, 21*, 22, 23, 31, 32, 51*, 54, 61*
		Doctoral level	HP			
		Psychiatrist	UA			
90847	Family psychotherapy (conjoint psychotherapy) (with patient present) (quantity of 1.0 = 60 minutes)	Master's degree level	HO	Accumulates toward the 15-hour/\$500 calendar-year threshold beyond which PA is required (except for inpatient hospital).	290-316	03, 11, 21*, 22, 23, 31, 32, 51*, 54, 61*
		Doctoral level	HP			
		Psychiatrist	UA			
90849	Multiple-family group psychotherapy (quantity of 1.0 = 60 minutes)	Master's degree level	HO	Accumulates toward the 15-hour/\$500 calendar-year threshold beyond which PA is required (except for inpatient hospital).	290-316	03, 11, 22, 23, 31, 32, 54
		Doctoral level	HP			
		Psychiatrist	UA			
90853	Group psychotherapy (other than of a multiple-family group) (quantity of 1.0 = 60 minutes)	Master's degree level	HO	Accumulates toward the 15-hour/\$500 calendar-year threshold beyond which PA is required.	290-316	03, 11, 22, 23, 31, 32, 54
		Doctoral level	HP			
		Psychiatrist	UA			
90857	Interactive group psychotherapy (quantity of 1.0 = 60 minutes)	Master's degree level	HO	Accumulates toward the 15-hour/\$500 calendar-year threshold beyond which PA is required.	290-316	03, 11, 22, 23, 31, 32, 54
		Doctoral level	HP			
		Psychiatrist	UA			

*The POS codes "21," "51," and "61" are not allowable for master's level providers. Payment is included in the hospital's Medicaid DRG reimbursement.

Psychiatric therapeutic procedures: other psychiatric services or procedures

Procedure code	Description	Certified providers who may perform service	Modifier (required)	Limitations	Allowable ICD-9-CM diagnoses	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	Limited to two units per date of service (DOS) and four units per month.**	290-316	03, 11, 22, 23, 31, 32, 54, 99
		Psychiatric APNP	UB			
		Physician Assistant	U8			
		MD, Psychiatrist	UA			
90865	Narcosynthesis for psychiatric diagnostic and therapeutic purposes (eg, sodium amobarbital [Amytal] interview) (quantity of 1.0 = 60 minutes)	Doctoral level	HP	Accumulates toward the 15-hour/\$500 calendar-year threshold beyond which PA is required (except for inpatient hospital).	290-316	03, 11, 22, 23, 31, 32, 54
		Psychiatrist	UA			
90870	Electroconvulsive therapy (includes necessary monitoring); single seizure	Psychiatrist	UA		290-316	03, 11, 21, 22, 23, 51, 61
90871	multiple seizures, per day	Psychiatrist	UA		290-316	03, 11, 21, 22, 23, 51, 61
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	Accumulates toward the 15-hour/\$500 calendar-year threshold beyond which PA is required (except for inpatient hospital).	290-316	03, 11, 21*, 22, 23, 31, 32, 51*, 54, 61*
		Doctoral level	HP			
		Psychiatrist	UA			
90876	approximately 45-50 minutes	Master's degree level	HO	Accumulates toward the 15-hour/\$500 calendar-year threshold beyond which PA is required (except for inpatient hospital).	290-316	03, 11, 21*, 22, 23, 31, 32, 51*, 54, 61*
		Doctoral level	HP			
		Psychiatrist	UA			
90880	Hypnotherapy (quantity of 1.0 = 60 minutes)	Master's degree level	HO	Accumulates toward the 15-hour/\$500 calendar-year threshold beyond which PA is required (except for inpatient hospital).	290-316, except 305.1	03, 11, 21*, 22, 23, 31, 32, 51*, 54, 61*
		Doctoral level	HP			
		Psychiatrist	UA			
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	Accumulates toward the 15-hour/\$500 calendar-year threshold beyond which PA is required (except for inpatient hospital).	290-316	03, 11, 21*, 22, 23, 31, 32, 51*, 54, 61*
		Doctoral level	HP			
		Psychiatrist	UA			
90899** and ***	Unlisted psychiatric service or procedure (quantity of 1.0 = 60 minutes)	Master's degree level	HO	Accumulates toward the 15-hour/\$500 calendar-year threshold beyond which PA is required (except for inpatient hospital).	290-316	03, 11, 21*, 22, 23, 31, 32, 51*, 54, 61*
		Doctoral level	HP			
		Psychiatrist	UA			

*The POS codes "21," "51," and "61" are not allowable for Master's level providers. Payment is included in the hospital's Medicaid DRG reimbursement.

**This code is to be used by all providers only when greater than 90 minutes of individual psychotherapy is provided on one day. Bill the total time (quantity of 1.0 = 60 minutes). It is not to be used for group psychotherapy. Submit with documentation showing medical necessity.

***Not payable in conjunction with 90804-90819, 90821-90824, 90826-90829, 90845, or 90875-90876 by the same provider on same DOS.

Substance abuse treatment procedure codes

Substance abuse therapeutic procedures

H0005	Alcohol and/or drug services; group counseling by a clinician (quantity of 1.0 = 60 minutes)	Bachelor's degree level	HN	Accumulates toward the 15-hour/\$500 calendar-year threshold beyond which PA is required.	290-316	03, 11, 22, 23, 31, 32, 54
		Master's degree level	HO			
		Doctoral level	HP			
		MD, Psychiatrist	UA			
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	Accumulates toward the 15-hour/\$500 calendar-year threshold beyond which PA is required (except for inpatient hospital).	290-316	03, 11, 21*, 22, 23, 31, 32, 51*, 54, 61*
		Master's degree level	HO			
		Doctoral level	HP			
		MD, Psychiatrist	UA			
T1006	Alcohol and/or substance abuse services, family/couple counseling (quantity of 1.0 = 60 minutes)	Bachelor's degree level	HN	Accumulates toward the 15-hour/\$500 calendar-year threshold beyond which PA is required.	290-316	03, 11, 21*, 22, 23, 31, 32, 51*, 54, 61*
		Master's degree level	HO			
		Doctoral level	HP			
		MD, Psychiatrist	UA			
H0047	Alcohol and/or other drug abuse services, not otherwise specified (Wisconsin Medicaid: Limitation — Exceeded; Substance Abuse diagnostic interview examination [quantity of 1.0 = 1 hour])	Master's degree level	HO	Accumulates toward the 15-hour/\$500 calendar-year threshold beyond which PA is required (except for inpatient hospital).	All	03, 11, 21*, 22, 23, 31, 32, 51*, 54, 61*
		Doctoral level	HP			
		MD, Psychiatrist	UA			

*The POS codes "21," "51," and "61" are not allowable for Master's or Bachelor's level providers. Payment is included in the hospital's Medicaid DRG reimbursement.

ATTACHMENT 3

Outpatient mental health and substance abuse services maximum allowable fees and copayment rates

The procedure codes listed in this Attachment will be allowable to those providers who provide mental health evaluations, psychotherapy, and substance abuse services in outpatient settings after implementation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This includes psychiatrists and Ph.D. psychologists in private practice and all outpatient mental health or substance abuse clinics (for services provided by psychiatrists, Ph.D. psychologists, Master's-level psychotherapists, and alcohol and other drug abuse [AODA] counselors). Not all providers may be reimbursed for all outpatient 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. Maximum allowable fees listed in this Attachment are the proposed fees effective July 1, 2002, and may be subject to change. Wisconsin Medicaid will notify providers if the fees change from those printed in this *Wisconsin Medicaid and BadgerCare Update*.

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, Ph.D.
UA	MD, Psychiatrist	Psychiatrist billing mental health and substance abuse services Physician billing substance abuse services Physician assistant billing substance abuse services
UB	APNP — Psychiatric specialty	Advanced Practice Nurse Prescriber (APNP) — Master's level registered nurse, only those with an APNP — psychiatric specialty billing pharmacologic management
U8	Physician assistant	Physician assistant billing pharmacologic management

Psychiatry procedure codes

Psychiatric diagnostic or evaluative interview procedures

Procedure code	Description	Certified providers who may perform service	Modifier (required)	Maximum Allowable Fee effective July 1, 2002	Copayment
90801	Psychiatric diagnostic interview examination (quantity of 1.0 = 1 hour)	Master's degree level	HO	\$55.00	\$3.00
		Doctoral level	HP	\$65.00	\$3.00
		Psychiatrist	UA	\$80.13	\$3.00
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	\$55.00	\$3.00
		Doctoral level	HP	\$65.00	\$3.00
		Psychiatrist	UA	\$80.13	\$3.00
H0046	Mental health services, not otherwise specified (Wisconsin Medicaid: Limitation — Exceeded; Psychotherapy diagnostic interview examination [quantity of 1.0 = 1 hour])	Master's degree level	HO	\$55.00	\$3.00
		Doctoral level	HP	\$65.00	\$3.00
		Psychiatrist	UA	\$80.13	\$3.00

Psychiatric therapeutic procedures: office or other outpatient facility — *insight oriented, behavior modifying, and/or supportive psychotherapy* Wisconsin Medicaid covers "partial hospital" services under a separate benefit — Day Treatment/Day Hospital services (HFS 107.13[4], Wis. Admin. Code).

Procedure code	Description	Certified providers who may perform service	Modifier (required)	Maximum Allowable Fee effective July 1, 2002	Copayment
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	\$27.50	\$2.00
		Doctoral level	HP	\$32.50	\$2.00
		Psychiatrist	UA	\$40.06	\$2.00
90805	with medical evaluation and management services	Psychiatrist	UA	\$40.06	\$2.00
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	\$55.00	\$3.00
		Doctoral level	HP	\$65.00	\$3.00
		Psychiatrist	UA	\$80.13	\$3.00
90807	with medical evaluation and management services	Psychiatrist	UA	\$80.13	\$3.00
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	\$82.50	\$3.00
		Doctoral level	HP	\$97.50	\$3.00
		Psychiatrist	UA	\$120.19	\$3.00
90809	with medical evaluation and management services	Psychiatrist	UA	\$120.19	\$3.00

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

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	\$27.50	\$2.00
		Doctoral level	HP	\$32.50	\$2.00
		Psychiatrist	UA	\$40.06	\$2.00
90811	with medical evaluation and management services	Psychiatrist	UA	\$40.06	\$2.00
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	\$55.00	\$3.00
		Doctoral level	HP	\$65.00	\$3.00
		Psychiatrist	UA	\$80.13	\$3.00
90813	with medical evaluation and management services	Psychiatrist	UA	\$80.13	\$3.00
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	\$82.50	\$3.00
		Doctoral level	HP	\$97.50	\$3.00
		Psychiatrist	UA	\$120.19	\$3.00
90815	with medical evaluation and management services	Psychiatrist	UA	\$120.19	\$3.00
90816	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 20 to 30 minutes face-to-face with the patient;	Master's degree level	HO	\$27.50	\$2.00
		Doctoral level	HP	\$32.50	\$2.00
		Psychiatrist	UA	\$40.06	\$2.00
90817	with medical evaluation and management services	Psychiatrist	UA	\$40.06	\$2.00
90818	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 45 to 50 minutes face-to-face with the patient;	Master's degree level	HO	\$55.00	\$3.00
		Doctoral level	HP	\$65.00	\$3.00
		Psychiatrist	UA	\$80.13	\$3.00
90819	with medical evaluation and management services	Psychiatrist	UA	\$80.13	\$3.00
90821	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 75 to 80 minutes face-to-face with the patient;	Master's degree level	HO	\$82.50	\$3.00
		Doctoral level	HP	\$97.50	\$3.00
		Psychiatrist	UA	\$120.19	\$3.00
90822	with medical evaluation and management services	Psychiatrist	UA	\$120.19	\$3.00

Psychiatric therapeutic procedures: inpatient hospital or residential care facility — interactive psychotherapy
 See HFS 107.13, Wis. Admin. Code, for the Medicaid policy on partial hospital/day treatment services. Wisconsin Medicaid covers “partial hospital” services under a separate benefit — Day Treatment/Day Hospital services.

Procedure code	Description	Certified providers who may perform service	Modifier (required)	Maximum Allowable Fee effective July 1, 2002	Copayment
90823	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient hospital, partial hospital or residential care setting, approximately 20 to 30 minutes face-to-face with the patient;	Master's degree level	HO	\$27.50	\$2.00
		Doctoral level	HP	\$32.50	\$2.00
		Psychiatrist	UA	\$40.06	\$2.00
90824	with medical evaluation and management services	Psychiatrist	UA	\$40.06	\$2.00
90826	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient hospital, partial hospital or residential care setting, approximately 45 to 50 minutes face-to-face with the patient;	Master's degree level	HO	\$55.00	\$3.00
		Doctoral level	HP	\$65.00	\$3.00
		Psychiatrist	UA	\$80.13	\$3.00
90827	with medical evaluation and management services	Psychiatrist	UA	\$80.13	\$3.00
90828	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient hospital, partial hospital or residential care setting, approximately 75 to 80 minutes face-to-face with the patient;	Master's degree level	HO	\$82.50	\$3.00
		Doctoral level	HP	\$97.50	\$3.00
		Psychiatrist	UA	\$120.19	\$3.00
90829	with medical evaluation and management services	Psychiatrist	UA	\$120.19	\$3.00

Psychiatric therapeutic procedures: other psychotherapy

90845	Psychoanalysis (quantity of 1.0 = 60 minutes)	Master's degree level	HO	\$55.00	\$3.00
		Doctoral level	HP	\$65.00	\$3.00
		Psychiatrist	UA	\$80.13	\$3.00
90846	Family psychotherapy (without the patient present) (quantity of 1.0 = 60 minutes)	Master's degree level	HO	\$55.00	\$3.00
		Doctoral level	HP	\$65.00	\$3.00
		Psychiatrist	UA	\$80.13	\$3.00
90847	Family psychotherapy (conjoint psychotherapy) (with patient present) (quantity of 1.0 = 60 minutes)	Master's degree level	HO	\$55.00	\$3.00
		Doctoral level	HP	\$65.00	\$3.00
		Psychiatrist	UA	\$80.13	\$3.00
90849	Multiple-family group psychotherapy (quantity of 1.0 = 60 minutes)	Master's degree level	HO	\$61.41	\$3.00
		Doctoral level	HP	\$72.30	\$3.00
		Psychiatrist	UA	\$90.16	\$3.00
90853	Group psychotherapy (other than of a multiple-family group) (quantity of 1.0 = 60 minutes)	Master's degree level	HO	\$11.26	\$1.00
		Doctoral level	HP	\$13.82	\$1.00
		Psychiatrist	UA	\$20.23	\$1.00
90857	Interactive group psychotherapy (quantity of 1.0 = 60 minutes)	Master's degree level	HO	\$11.26	\$1.00
		Doctoral level	HP	\$13.82	\$1.00
		Psychiatrist	UA	\$20.23	\$1.00

Psychiatric therapeutic procedures: other psychiatric services or procedures (Continued on next page)

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	\$15.75	
		Psychiatric APNP	UB	\$31.68	
		Physician Assistant	U8	\$28.51	
		MD, Psychiatrist	UA	\$31.68	
90865	Narcosynthesis for psychiatric diagnostic and therapeutic purposes (eg, sodium amobarbital [Amytal] interview) (quantity of 1.0 = 60 minutes)	Doctoral level	HP	\$65.00	\$3.00
		Psychiatrist	UA	\$80.13	\$3.00

Psychiatric therapeutic procedures: other psychiatric services or procedures (Continued from previous page)

Procedure code	Description	Certified providers who may perform service	Modifier (required)	Maximum Allowable Fee effective July 1, 2002	Copayment
90870	Electroconvulsive therapy (includes necessary monitoring); single seizure	Psychiatrist	UA	\$132.80	\$3.00
90871	multiple seizures, per day	Psychiatrist	UA	\$132.80	\$3.00
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	\$27.50	\$2.00
		Doctoral level	HP	\$32.50	\$2.00
		Psychiatrist	UA	\$40.06	\$2.00
90876	approximately 45-50 minutes	Master's degree level	HO	\$55.00	\$3.00
		Doctoral level	HP	\$65.00	\$3.00
		Psychiatrist	UA	\$80.13	\$3.00
90880	Hypnotherapy (quantity of 1.0 = 60 minutes)	Master's degree level	HO	\$55.00	\$3.00
		Doctoral level	HP	\$65.00	\$3.00
		Psychiatrist	UA	\$80.13	\$3.00
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	\$55.00	\$3.00
		Doctoral level	HP	\$65.00	\$3.00
		Psychiatrist	UA	\$80.13	\$3.00
90899** and ***	Unlisted psychiatric service or procedure (quantity of 1.0 = 60 minutes)	Master's degree level	HO	Individually Considered	\$3.00
		Doctoral level	HP	Individually Considered	\$3.00
		Psychiatrist	UA	Individually Considered	\$3.00

**This code is to be used by all providers only when greater than 90 minutes of individual psychotherapy is provided on one day. Bill the total time (quantity of 1.0 = 60 minutes). It is not to be used for group psychotherapy. Submit with documentation showing medical necessity.

***Not payable in conjunction with 90804-90819, 90821-90824, 90826-90829, 90845, or 90875-90876 by the same provider on the same date of service.

Substance abuse treatment procedure codes

Substance abuse therapeutic procedures

H0005	Alcohol and/or drug services; group counseling by a clinician (quantity of 1.0 = 60 minutes)	Bachelor's degree level	HN	\$8.45	\$0.50
		Master's degree level	HO	\$11.26	\$1.00
		Doctoral level	HP	\$13.82	\$1.00
		MD, Psychiatrist	UA	\$20.23	\$1.00
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	\$31.96	\$2.00
		Master's degree level	HO	\$55.00	\$3.00
		Doctoral level	HP	\$65.00	\$3.00
		MD, Psychiatrist	UA	\$80.13	\$3.00
T1006	Alcohol and/or substance abuse services, family/couple counseling (quantity of 1.0 = 60 minutes)	Bachelor's degree level	HN	\$31.96	\$2.00
		Master's degree level	HO	\$55.00	\$3.00
		Doctoral level	HP	\$65.00	\$3.00
		MD, Psychiatrist	UA	\$80.13	\$3.00
H0047	Alcohol and/or other drug abuse services, not otherwise specified (Wisconsin Medicaid: Limitation — Exceeded; Substance Abuse diagnostic interview examination [quantity of 1.0 = 1 hour])	Master's degree level	HO	\$55.00	\$3.00
		Doctoral level	HP	\$65.00	\$3.00
		MD, Psychiatrist	UA	\$80.13	\$3.00

ATTACHMENT 4

Rounding guidelines for outpatient mental health and substance abuse services

The following table illustrates the rules of rounding and gives the appropriate billing unit for all services *except* pharmacologic management and electroconvulsive therapy.* Providers should use these 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.

Outpatient mental health and substance abuse 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.

The following table illustrates the rules of rounding and gives the appropriate billing unit for pharmacologic management. Providers should use these rounding guidelines only when 1.0 unit of service is equal to 15 minutes. Providers should follow the time specified in the procedure code description for all other codes.

Pharmacologic management rounding guidelines	
Time (minutes)	Unit(s) billed
1-3	.2
4-6	.4
7-9	.6
10-12	.8
13-15	1.0
16-18	1.2
19-21	1.4
22-24	1.6
25-27	1.8
28-30	2.0
Etc.	Etc.

*Electroconvulsive therapy reimbursement is made on a daily basis; therefore, there are no rounding guidelines for this service.

ATTACHMENT 5

Place of service codes for outpatient mental health and substance abuse services

The table below 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
03	School
11*	Office
21**	Inpatient Hospital
22	Outpatient Hospital
23	Emergency Room — Hospital
31	Skilled Nursing Facility
32	Nursing Facility
51**	Inpatient Psychiatric Facility
54	Intermediate Care Facility/Mentally Retarded
61**	Comprehensive Inpatient Rehabilitation Facility
99***	Other Place of Service

* Services provided in an office setting have to be performed in the office of a Medicaid-certified mental health and/or substance abuse outpatient clinic.

**Services provided to a hospital inpatient by master's level psychotherapists or alcohol and other drug abuse (AODA) counselors are not separately reimbursable as mental health or substance abuse professional services. Group therapy and medication management are not separately reimbursable by any provider as professional mental health or substance abuse services when provided to a hospital inpatient.

***Only for pharmacologic management in community-based residential facilities.

ATTACHMENT 6

CMS 1500 claim form instructions for outpatient mental health and substance abuse services

(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/ for more information about the EVS.

Element 1 — Program Block/Claim Sort Indicator

County-owned outpatient mental health and substance abuse services clinics

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

Psychiatrists and Ph.D. psychologists in private practice and privately owned outpatient mental health and substance abuse services clinics (by alcohol and other drug abuse [AODA] counselors, master's level providers, physicians, and Ph.D. psychologists)

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”) insurance only 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"> ✓ The recipient denied coverage or will not cooperate. ✓ The provider knows the service in question is not covered by the carrier. ✓ The recipient’s commercial health insurance failed to respond to initial and follow-up claims. ✓ Benefits are not assignable or cannot get assignment. ✓ Benefits are exhausted.

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

Use the **first** box of this element for Medicare information. (Elements 11a, 11b, 11c, and 11d are not required.) Submit claims to Medicare before submitting claims to Wisconsin Medicaid.

Outpatient mental health and substance abuse services providers are *not* required to be Medicare enrolled to provide Medicare-covered services for dual entitlees. Dual entitlees are those recipients covered under both Medicare and Wisconsin Medicaid.

Element 11 should be left blank when one or more of the following statements is true:

- Medicare never covers the procedure in any circumstance.
- Wisconsin Medicaid indicates the recipient does not have any Medicare coverage, including Medicare Cost (“MCC”) or Medicare + Choice (“MPC”), for the service provided. For example, the service is covered by Medicare Part A, but the recipient does not have Medicare Part A.
- Wisconsin Medicaid indicates that the provider is not Medicare enrolled.
- Medicare has allowed the charges. In this case, attach the Explanation of Medicare Benefits, but do not indicate on the claim form the amount Medicare paid.

If none of the previous statements are true, a Medicare disclaimer code is necessary. The following Medicare disclaimer codes may be used when appropriate:

Code	Description
M-5	<p>Provider is not Medicare certified. This code may be used when providers are identified in Wisconsin Medicaid files as being Medicare certified, but are billing for dates of service (DOS) before or after their Medicare certification effective dates. Use M-5 in the following instances:</p> <p><i>For Medicare Part A (all three criteria must be met):</i></p> <ul style="list-style-type: none"> ✓ The provider is identified in Wisconsin Medicaid files as certified for Medicare Part A, but the provider was not certified for the date the service was provided. ✓ The recipient is eligible for Medicare Part A. ✓ The procedure provided is covered by Medicare Part A. <p><i>For Medicare Part B (all three criteria must be met):</i></p> <ul style="list-style-type: none"> ✓ The provider is identified in Wisconsin Medicaid files as certified for Medicare Part B, but the provider was not certified for the date the service was provided. ✓ The recipient is eligible for Medicare Part B. ✓ The procedure provided is covered by Medicare Part B.
M-7	<p>Medicare disallowed or denied payment. This code applies when Medicare denies the claim for reasons related to policy (not billing errors), or the recipient's lifetime benefit, spell of illness, or yearly allotment of available benefits is exhausted. Use M-7 in the following instances:</p> <p><i>For Medicare Part A (all three criteria must be met):</i></p> <ul style="list-style-type: none"> ✓ The provider is identified in Wisconsin Medicaid files as certified for Medicare Part A. ✓ The recipient is eligible for Medicare Part A. ✓ The service is covered by Medicare Part A but is denied by Medicare Part A due to frequency limitations, diagnosis restrictions, or the service is not payable due to benefits being exhausted. <p><i>For Medicare Part B (all three criteria must be met):</i></p> <ul style="list-style-type: none"> ✓ The provider is identified in Wisconsin Medicaid files as certified for Medicare Part B. ✓ The recipient is eligible for Medicare Part B. ✓ The service is covered by Medicare Part B but is denied by Medicare Part B due to frequency limitations, diagnosis restrictions, or the service is not payable due to benefits being exhausted.
M-8	<p>Noncovered Medicare service. This code may be used when Medicare was not billed because the service is not covered in this circumstance. Use M-8 in the following instances:</p> <p><i>For Medicare Part A (all three criteria must be met):</i></p> <ul style="list-style-type: none"> ✓ The provider is identified in Wisconsin Medicaid files as certified for Medicare Part A. ✓ The recipient is eligible for Medicare Part A. ✓ The service is usually covered by Medicare Part A but not in this circumstance (e.g., recipient's diagnosis). <p><i>For Medicare Part B (all three criteria must be met):</i></p> <ul style="list-style-type: none"> ✓ The provider is identified in Wisconsin Medicaid files as certified for Medicare Part B. ✓ The recipient is eligible for Medicare Part B. ✓ The service is usually covered by Medicare Part B but not in this circumstance (e.g., recipient's diagnosis).

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, the prescribing physician's name and Universal Provider Identification Number (UPIN), eight-digit Medicaid provider number, or license number is required for all services *except* evaluation (90801 and 90802) and mental health services/substance abuse services, not otherwise specified (H0046 and H0047). 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

If a provider bills an unlisted (or not otherwise specified) procedure code (90899 — Unlisted psychiatric service or procedure), a description of the procedure must be indicated in this element. If Element 19 does not provide enough space for the procedure description, or if a provider is billing multiple unlisted procedure codes, documentation must be attached to the claim describing the procedure(s). In this instance, indicate “See Attachment” in Element 19.

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. Refer to Attachment 2 of this *Wisconsin Medicaid and BadgerCare Update* for allowable diagnosis codes.

Element 22 — Medicaid Resubmission (not required)

Element 23 — Prior Authorization Number

Enter the seven-digit prior authorization (PA) number from the approved Prior Authorization Request Form (PA/RF). Services authorized under multiple PA requests must be billed on separate claim forms with their respective PA numbers. Wisconsin Medicaid will only accept one PA number per claim.

Element 24A — Date(s) of Service

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

- When billing for one 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.

Element 24B — Place of Service

Enter the appropriate two-digit POS code for each service. Refer to Attachment 5 of this *Update* for allowable POS codes for outpatient mental health and substance abuse services.

Notes: Services provided to a hospital inpatient recipient by Master's level psychotherapists or AODA counselors are not separately reimbursable as mental health/substance abuse professional services.

Group therapy and medication management services are not separately reimbursable by any provider as professional mental health or substance abuse services when provided to a hospital inpatient recipient.

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). Refer to Attachment 4 for rounding guidelines.

Element 24H — EPSDT/Family Plan (not required)**Element 24I — EMG (not required)****Element 24J — COB (not required)**

Element 24K — Reserved for Local Use

Private outpatient mental health and substance abuse clinics

Enter the eight-digit Medicaid provider number of the performing provider for each procedure. When submitting claims for pharmacologic management (90862 — medication check) performed by a registered nurse other than a Master's level psychiatric nurse, enter the eight-digit Medicaid provider number of the supervising physician if the Master's level psychiatric nurse is *not* individually Medicaid certified. Enter the Medicaid provider number of the Master's level psychiatric nurse if the nurse is separately Medicaid certified. Any other information entered in this element may cause claim denial.

County-owned outpatient mental health and substance abuse clinics

Though county-owned outpatient mental health and substance abuse services clinics are *not* required to indicate a performing provider number in this element, Wisconsin Medicaid encourages them to do so if the provider is individually Medicaid certified. Providers in county-owned clinics are not required to be individually Medicaid certified but counties are encouraged to have staff be individually certified.

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)

If the services were provided to a recipient in a nursing facility (POS code "31," "32," or "54"), indicate the nursing home's Medicaid provider number.

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.

ATTACHMENT 7

Sample CMS 1500 claim form for outpatient mental health services in a private clinic

CARRIER
PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION

HEALTH INSURANCE CLAIM FORM																																																																																																																										
1. MEDICARE <input type="checkbox"/> MEDICAID <input 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) 1234567890																																																																																																																					
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Recipient, Im A.					3. PATIENT'S BIRTH DATE MM DD YY MM DD YY SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>																																																																																																																					
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9d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. RESERVED FOR LOCAL USE			c. INSURANCE PLAN NAME OR PROGRAM NAME																																																																																																																					
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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.					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 _____ DATE _____					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 I.M. Referring/Prescribing					17a. I.D. NUMBER OF REFERRING PHYSICIAN 12345678																																																																																																																					
19. RESERVED FOR LOCAL USE					16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION 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)					20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO																																																																																																																					
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25. FEDERAL TAX I.D. NUMBER SSN EIN			26. PATIENT'S ACCOUNT NO. 1234JED		27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ XXX XX		29. AMOUNT PAID \$ XX XX		30. BALANCE DUE \$ XX XX																																																																																																															
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.) I.M. Provider 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 # I.M. Billing 1 W. Williams Anytown, WI 55555 76543210 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)

ATTACHMENT 8

Sample CMS 1500 claim form for outpatient mental health services in a county-owned clinic

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) 1234567890					
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Recipient, Im A.					3. PATIENT'S BIRTH DATE MM DD YY MM DD YY SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>					
5. PATIENT'S ADDRESS (No., Street) 609 Willow St					6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>					
CITY Anytown			STATE WI		7. INSURED'S ADDRESS (No., Street)			CITY STATE		
ZIP CODE 55555		TELEPHONE (Include Area Code) (xxx) xxx-xxxx			8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>		9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) OI-P			
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) OI-P		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO			11. INSURED'S POLICY GROUP OR FECA NUMBER M-7					
a. OTHER INSURED'S POLICY OR GROUP NUMBER		b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO			a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>					
b. OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>		c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO			b. EMPLOYER'S NAME OR SCHOOL NAME					
c. EMPLOYER'S NAME OR SCHOOL NAME		10d. RESERVED FOR LOCAL USE			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>					
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			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 I.M. Referring/Prescribing			17a. I.D. NUMBER OF REFERRING PHYSICIAN 12345678			18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY				
19. RESERVED FOR LOCAL USE			20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO			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) 1. 296.35			23. PRIOR AUTHORIZATION NUMBER			24. PROCEDURE(S) OF SERVICE, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER				
24. DATE(S) OF SERVICE From To MM DD YY MM DD YY			25. FEDERAL TAX I.D. NUMBER SSN EIN			26. PATIENT'S ACCOUNT NO. 1234JED		27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO		
24. DATE(S) OF SERVICE From To MM DD YY MM DD YY			28. TOTAL CHARGE \$ XXX XX			29. AMOUNT PAID \$ XX XX		30. BALANCE DUE \$ XX XX		
24. DATE(S) OF SERVICE From To MM DD YY MM DD YY			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.) I.M. Provider 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 # I.M. Billing 1 W. Williams Anytown, WI 55555 87654321 P# _____ GRP# _____	

CARRIER
PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION

ATTACHMENT 9

Prior Authorization Request Form (PA/RF) Completion Instructions for outpatient mental health and substance abuse services

(For prior authorization requests submitted after HIPAA implementation)

Wisconsin Medicaid requires information to enable Medicaid to authorize and pay for medical services provided to eligible recipients.

Recipients are required to give providers full, correct, and truthful information for the submission of correct and complete claims for Medicaid reimbursement. This information will include, but is not limited to, information concerning eligibility status, accurate name, address, and Medicaid identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to Medicaid administration such as determining eligibility of the applicant or processing provider claims for reimbursement. The Prior Authorization Request Form (PA/RF) is used by Wisconsin Medicaid and is mandatory when requesting PA. Failure to supply the information requested by the form may result in denial of Medicaid payment for the services.

Providers may submit PA requests, along with all applicable service-specific attachments, including the Prior Authorization/Psychotherapy Attachment (PA/PSYA), Prior Authorization/Substance Abuse Attachment (PA/SAA), or Prior Authorization/Evaluation and Testing Attachment (PA/ETA) by fax to Wisconsin Medicaid at (608) 221-8616; or, providers may submit PA requests with attachments to:

Wisconsin Medicaid
Prior Authorization
Ste 88
6406 Bridge Rd
Madison WI 53784-0088

The provision of services that are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s).

SECTION I — PROVIDER INFORMATION

Element 1 — Name and Address — Billing Provider

Enter the name and complete address (street, city, state, and Zip code) of the billing provider. The name listed in this element must correspond with the Medicaid provider number listed in Element 4. *No other information should be entered in this element, since it also serves as a return mailing label.* Nonbilling performing providers (Master's degree psychotherapists or alcohol and other drug abuse [AODA] counselors) must indicate the clinic name and number as the billing provider.

Element 2 — Telephone Number — Billing Provider

Enter the telephone number, including the area code, of the office, clinic, facility, or place of business of the billing provider. Nonbilling performing providers (Master's degree psychotherapists or AODA counselors) must indicate the clinic telephone number.

Element 3 — Processing Type

The processing type is a three-digit code used to identify a category of service requested. Enter one of the following processing types:

- 126 — Psychotherapy.
- 128 — Substance Abuse Services (other than Day Treatment).

Element 4 — Billing Provider's Medicaid Provider Number

Enter the eight-digit Medicaid provider number of the billing provider. The provider number in this element must match the provider name listed in Element 1. Nonbilling performing providers (Master's degree psychotherapists or AODA counselors) must indicate the eight-digit Medicaid provider number of the clinic.

SECTION II — RECIPIENT INFORMATION

Element 5 — Recipient Medicaid ID Number

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

Element 6 — Date of Birth — Recipient

Enter the recipient's date of birth in MM/DD/YY format (e.g., September 8, 1966, would be 09/08/66).

Element 7 — Address — Recipient

Enter the complete address of the recipient's place of residence, including the street, city, state, and Zip code. If the recipient is a resident of a nursing home or other facility, include the name of the nursing home or facility.

Element 8 — Name — Recipient

Enter the recipient's last name, followed by his or her 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 9 — Sex — Recipient

Enter an "X" in the appropriate box to specify male or female.

SECTION III — DIAGNOSIS / TREATMENT INFORMATION

Element 10 — Diagnosis — Primary Code and Description

Enter the appropriate *International Classification of Diseases, Ninth Edition, Clinical Modification* (ICD-9-CM) diagnosis code and description most relevant to the service/procedure requested. A diagnosis code is not required on PA requests for psychiatric evaluation or diagnostic tests.

Element 11 — Start Date — SOI (not required)

Element 12 — First Date of Treatment — SOI (not required)

Element 13 — Diagnosis — Secondary Code and Description

Enter the appropriate secondary ICD-9-CM diagnosis code and description additionally descriptive of the recipient's clinical condition. A diagnosis code is not required on PA requests for psychiatric evaluation or diagnostic tests.

Element 14 — Requested Start Date

Enter the requested start date for service(s) in MM/DD/YY format, if a specific start date is requested. If backdating is requested, include the clinical rationale for starting before PA was received. Backdating is not allowed on subsequent PA requests.

Element 15 — Performing Provider Number

(For private mental health and substance abuse clinics only.) Enter the eight-digit Medicaid provider number of the provider who will be providing the service, only if this number is different from the billing provider number listed in Element 4.

Element 16 — Procedure Code

Enter the appropriate *Current Procedural Terminology* code or Healthcare Common Procedure Coding System code for each service/procedure/item requested.

Element 17 — Modifiers

Enter the modifier(s) corresponding to the procedure code listed if a modifier is required by Wisconsin Medicaid.

Element 18 — POS

Enter the appropriate place of service (POS) code designating where the requested service/procedure/item would be provided/performed/dispensed. Refer to Attachment 5 of this *Update* for a list of allowable POS codes.

Element 19 — Description of Service

Enter a written description corresponding to the appropriate procedure code for each service/procedure/item requested.

Element 20 — QR

Enter the appropriate quantity (e.g., number of services, days' supply) requested for the procedure code listed. Refer to Attachment 4 for rounding guidelines.

Element 21 — Charge

Enter your usual and customary charge for each service/procedure/item requested. If the quantity is greater than "1.0," multiply the quantity by the charge for each service/procedure/item requested. Enter that total amount in this element.

Note: The charges indicated on the request form should reflect the provider's usual and customary charge for the procedure requested. Providers are reimbursed for authorized services according to *Terms of Provider Reimbursement* issued by the Department of Health and Family Services.

Element 22 — Total Charges

Enter the anticipated total charge for this request.

Element 23 — Signature — Requesting Provider

The original signature of the provider requesting/performing/dispensing this service/procedure/item must appear in this element.

Element 24 — Date Signed

Enter the month, day, and year the PA/RF was signed (in MM/DD/YY format).

Do not enter any information below the signature of the requesting provider — this space is reserved for Wisconsin Medicaid consultants and analysts.

ATTACHMENT 10

Sample Prior Authorization Request Form (PA/RF) for psychotherapy services

DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Health Care Financing
HCF 11018 (Rev. 06/03)

STATE OF WISCONSIN
HFS 106.03(4), Wis. Admin. Code

WISCONSIN MEDICAID PRIOR AUTHORIZATION REQUEST FORM (PA/RF)

Providers may submit prior authorization (PA) requests by fax to Wisconsin Medicaid at (608) 221-8616; or, providers may send the completed form with attachments to: Wisconsin Medicaid, Prior Authorization, Suite 88, 6406 Bridge Road, Madison, WI 53784-0088. **Instructions:** Type or print clearly. Before completing this form, read your service-specific Prior Authorization Request Form (PA/RF) Completion Instructions.

FOR MEDICAID USE — ICN	AT	Prior Authorization Number 1234567
-------------------------------	----	--

SECTION I — PROVIDER INFORMATION		
1. Name and Address — Billing Provider (Street, City, State, Zip Code) I.M. Provider 1 W. Williams Anytown, WI 55555	2. Telephone Number — Billing Provider (XXX) XXX-XXXX 87654321	3. Processing Type 126
4. Billing Provider's Medicaid Provider Number 87654321		

SECTION II — RECIPIENT INFORMATION		
5. Recipient Medicaid ID Number 1234567890	6. Date of Birth — Recipient (MM/DD/YY) MM/DD/YY	7. Address — Recipient (Street, City, State, Zip Code) 1234 Street St. Anytown, WI 55555
8. Name — Recipient (Last, First, Middle Initial) Recipient, Ima A.		9. Sex — Recipient <input type="checkbox"/> M <input checked="" type="checkbox"/> F

SECTION III — DIAGNOSIS / TREATMENT INFORMATION									
10. Diagnosis — Primary Code and Description 296.3 Major depressive disorder					11. Start Date — SOI		12. First Date of Treatment — SOI		
13. Diagnosis — Secondary Code and Description 309.00 Adjustment reaction					14. Requested Start Date MM/DD/YY				
15. Performing Provider Number	16. Procedure Code	17. Modifiers				18. POS	19. Description of Service	20. QR	21. Charge
98765432*	90845	HP				11	Individual psychotherapy	6	XXX.XX
98765432*	90847	HP				11	Family psychotherapy	13	XXX.XX
<i>*Note: Only private clinics are required to indicate a performing provider number.</i>									

An approved authorization does not guarantee payment. Reimbursement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after the authorization expiration date. Reimbursement will be in accordance with Wisconsin Medicaid payment methodology and policy. If the recipient is enrolled in a Medicaid HMO at the time a prior authorized service is provided, Medicaid reimbursement will be allowed only if the service is not covered by the HMO.	22. Total Charges XXX.XX
--	------------------------------------

23. SIGNATURE — Requesting Provider <div style="text-align: center; font-family: cursive; font-size: 1.2em;">I.M. Provider</div>	24. Date Signed MM/DD/YY
---	------------------------------------

FOR MEDICAID USE	Procedure(s) Authorized:	Quantity Authorized:
<input type="checkbox"/> Approved		
<div style="text-align: center;"> Grant Date Expiration Date </div>		
<input type="checkbox"/> Modified — Reason:		
<input type="checkbox"/> Denied — Reason:		
<input type="checkbox"/> Returned — Reason:		
SIGNATURE — Consultant / Analyst		Date Signed

ATTACHMENT 13
Prior Authorization / Psychotherapy Attachment (PA/PSYA)
Completion Instructions

(A copy of the "Prior Authorization/Psychotherapy Attachment [PA/PSYA] Completion Instructions" is located on the following pages.)

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WISCONSIN MEDICAID PRIOR AUTHORIZATION / PSYCHOTHERAPY ATTACHMENT (PA/PSYA) COMPLETION INSTRUCTIONS

Wisconsin Medicaid requires information to enable Medicaid to authorize and pay for medical services provided to eligible recipients.

Recipients are required to give providers full, correct, and truthful information for the submission of correct and complete claims for Medicaid reimbursement. This information should include, but is not limited to, information concerning eligibility status, accurate name, address, and Medicaid identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to Medicaid administration such as determining eligibility of the applicant, processing prior authorization (PA) requests, or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of PA or Medicaid payment for the services.

The use of this form is voluntary and providers may develop their own form as long as it includes all the information and is formatted exactly like this form. If necessary, attach additional pages if more space is needed. Providers should refer to their service-specific handbook for service restrictions and additional documentation requirements. Provide enough information for Wisconsin Medicaid medical consultants to make a reasonable judgment about the case.

Attach the completed Prior Authorization/Psychotherapy Attachment (PA/PSYA) to the Prior Authorization Request Form (PA/RF) and physician prescription (if necessary) and send it to Wisconsin Medicaid. Providers may submit PA requests by fax to Wisconsin Medicaid at (608) 221-8616. Providers who wish to submit PA requests by mail may do so by submitting them to the following address:

Wisconsin Medicaid
Prior Authorization
Ste 88
6406 Bridge Rd
Madison WI 53784-0088

The provision of services that are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s).

GENERAL INSTRUCTIONS

The information contained in the PA/PSYA is used to make a decision about the amount and type of psychotherapy that is approved for Wisconsin Medicaid reimbursement. Thoroughly complete each section and include any material that would be helpful to understand the necessity of the services being requested. Where noted in these instructions, material from personal records may be substituted for the information requested on the form.

When submitting the initial PA request for a particular individual, complete the entire PA request. For continuing PA on the same individual, it is not necessary to rewrite Elements 1-18, unless new information has caused a change in any of the information in these elements (e.g., a different diagnosis, belief that intellectual functioning is, in fact, significantly below average). When there has been no change to the information in Elements 1-18, submit a photocopy of Elements 1-18 along with updated information in Elements 19-36. Medical consultants reviewing the PA requests have a file containing the previous requests, but they must base their decisions on the clinical information submitted, so it is important to present all current relevant clinical information. For example, a depressed person may overeat or eat too little, or may sleep a lot or very little; therefore, recording simply that the recipient is depressed does not present the relevant clinical picture. The documentation should include details on the signs and symptoms the recipient presents due to the diagnosis.

Prior authorization for psychotherapy is not granted when another provider already has an approved PA for psychotherapy services for the same recipient. In these cases, Wisconsin Medicaid recommends that the recipient request that previous providers notify Wisconsin Medicaid that they have discontinued treatment with this recipient. The recipient may also submit a signed statement of his or her desire to change providers and include the date of the change. The new provider's PA may not overlap with the previous provider's PA.

SECTION I — RECIPIENT INFORMATION

Element 1 — Name — Recipient

Enter the recipient's last name, followed by his or her first name and middle initial. Use the Eligibility Verification System (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 2 — Age — Recipient

Enter the age of the recipient in numerical form (e.g., 16, 21, 60).

Element 3 — Recipient Medicaid Identification Number

Enter the recipient's 10-digit Medicaid identification number. Do not enter any other numbers or letters.

SECTION II — PROVIDER INFORMATION

Element 4 — Name — Performing Provider

Enter the name of the therapist who will be providing treatment.

Element 5 — Performing Provider's Medicaid Provider Number (not required)

Enter the eight-digit Medicaid provider number of the performing provider.

Element 6 — Telephone Number — Performing Provider

Enter the telephone number, including the area code, of the office, clinic, facility, or place of business of the billing provider.

Element 7 — Discipline — Performing Provider

Enter the discipline (credentials) of the therapist who will be providing treatment. The discipline should correspond with the name listed in Element 4.

Element 8 — Name — Prescribing Provider

Enter the name of the physician who wrote the prescription for psychotherapy.

Element 9 — Prescribing Provider's Medicaid Provider Number

Enter the eight-digit Medicaid provider number of the physician who wrote the prescription for psychotherapy.

SECTION III — DOCUMENTATION

Element 10 — Diagnosis

Enter the diagnosis codes and descriptions from the most recent version of the Diagnostic and Statistical Manual of Mental Disorders (DSM), using all five axes.

Element 11 — Date Treatment Began

Enter the date of the first treatment by this provider.

Element 12 — Diagnosed by

Indicate the procedure(s) used to make the diagnosis.

Element 13 — Consultation

Indicate whether there was a consultation done with respect to the recipient's diagnosis and/or treatment needs. Indicate why the consultation was needed.

Element 14 — Results of Consultation

Summarize the results of this consultation or attach a copy of the consultant's report.

Element 15 — Presenting Symptoms

Enter the presenting symptoms and indicate the degree of severity. This information may be provided as a part of an intake summary that may be attached to this request form.

Elements 16-17 — Intellectual Functioning

Indicate whether intellectual functioning is significantly below average (e.g., an I.Q. below 80). If "yes," indicate the I.Q. or intellectual functional level.

Element 18 — Historical Data

This information may be submitted in the form of an intake summary, case history, or mental status exam as long as all information relevant to the request for treatment authorization is included.

Element 19 — Present GAF (DSM)

Enter the global assessment of functioning scale score from the most recent version of the DSM. For continuing PA requests, indicate whether the recipient is progressing in treatment, using measurable indicators when appropriate.

Element 20 — Present Mental Status Symptomatology

Indicate the recipient's current mental status and symptoms. For continuing authorization requests, indicate the progress that has been made since the beginning of treatment or since the previous authorization. This information may be supplied in the form of an intake summary or a treatment summary as long as the summary presents a crystallization of the progress to date. It is not acceptable to send progress notes which do not summarize the progress to date.

Element 21 — Updated / Historical Data

For continuing requests, indicate any new information about the recipient's history which may be relevant to determine the need for continued treatment.

Element 22 — Treatment Modalities

Indicate the treatment modalities to be used.

Element 23 — Number of Minutes Per Session

Indicate the length of session for each modality.

Elements 24-25 — Frequency of Requested Sessions and Total Number of Sessions Requested

If requesting sessions more frequently than once per week, please indicate why they are needed. If a series of treatments that are not regular is anticipated (e.g., frequent sessions for a few weeks, with treatment tapering off thereafter), indicate the total number of hours of treatment requested, the time period over which the treatment is requested, and the expected pattern of treatment. The total hours must match the quantity(ies) indicated on the PA/RF.

Example: A provider requests 15 hours of treatment over a 12-week period. The recipient attends a one and one-half hour group every other week (six groups for a total of nine hours). There are one-hour weekly individual sessions for four weeks and every other week for the following four weeks (six individual sessions for a total of six hours).

Element 26 — Psychoactive Medication

Indicate all the medications the recipient is taking which may affect the recipient's symptoms that are being treated. Indicate whether a medication review has been done in the past three months.

Element 27 — Rationale for Further Treatment

Indicate the symptoms or problems in functioning that require further treatment. If recipient has not progressed in treatment thus far, indicate reasons for believing that continued treatment is helping.

Element 28 — Goals / Objectives of Treatment

Summarize current goals/objectives of treatment. A treatment plan may be attached in response to this item.

Element 29 — Steps to Termination

Providers should indicate how they are preparing the recipient for termination. When available, indicate a planned date of termination.

Element 30 — Family Members

Adequate justification is required if an individual provider provides services to more than one family member in individual psychotherapy.

Element 31 — Signature — Performing Provider

Wisconsin Medicaid requires the performing provider's signature to process the PA request. Read the Prior Authorization Statement before dating and signing the attachment.

Element 32 — Date Signed

Enter the month, day, and year the PA/PSYA was signed by the performing provider (in MM/DD/YYYY format).

Element 33 — Signature — Recipient (optional)

Signature indicates the recipient has read the form. Signature is optional.

Element 34 — Date Signed

Enter the month, day, and year the PA/PSYA was signed by the recipient (in MM/DD/YYYY format).

Element 35 — Signature — Supervising Provider

Signature required only if the performing provider is not a physician or psychologist.

Element 36 — Date Signed

Enter the month, day, and year the PA/PSYA was signed by the supervising provider (in MM/DD/YYYY format).

Other Required Information

In addition to the above information, Wisconsin Medicaid requires the following to process the PA request:

- Attach a copy of the signed and dated prescription for psychotherapy.* The initial prescription must be dated within three months of receipt by Wisconsin Medicaid. Subsequent prescriptions must be dated within 12 months of receipt by Wisconsin Medicaid.

* If the performing provider is a physician, a prescription need not be attached.

ATTACHMENT 14
Prior Authorization / Psychotherapy Attachment (PA/PSYA)
(for photocopying)

(A copy of the "Prior Authorization/Psychotherapy Attachment [PA/PSYA]" [for photocopying] is located on the following pages.)

**WISCONSIN MEDICAID
 PRIOR AUTHORIZATION / PSYCHOTHERAPY ATTACHMENT (PA/PSYA)**

Providers may submit prior authorization (PA) requests by fax to Wisconsin Medicaid at (608) 221-8616; or, providers may send the completed form with attachments to: Wisconsin Medicaid, Prior Authorization, Suite 88, 6406 Bridge Road, Madison, WI 53784-0088.
Instructions: Type or print clearly. Before completing this form, read the Prior Authorization/Psychotherapy Attachment (PA/PSYA) Completion Instructions (HCF 11031A).

SECTION I — RECIPIENT INFORMATION

1. Name — Recipient (Last, First, Middle Initial)	2. Age — Recipient
3. Recipient Medicaid Identification Number	

SECTION II — PROVIDER INFORMATION

4. Name — Performing Provider	5. Performing Provider's Medicaid Provider Number (optional)
6. Telephone Number — Performing Provider	7. Discipline — Performing Provider
8. Name — Prescribing Provider	9. Prescribing Provider's Medicaid Provider Number

SECTION III — DOCUMENTATION

10. Diagnosis

Axis I a) _____

b) _____

Axis II _____

Axis III _____

Axis IV (optional) 1 2 3 4 5 6 7 8 9 0

Axis V (past year) (optional) _____

11. Date Treatment Began	12. Diagnosed by: <input type="checkbox"/> Clinical Exam <input type="checkbox"/> Psychological Testing <input type="checkbox"/> Other (specify) _____
13. Consultation <input type="checkbox"/> Yes <input type="checkbox"/> No	14. Results of Consultation

Continued

SECTION III — DOCUMENTATION (Continued)

15. Presenting Symptoms

Severity: Mild Moderate Severe

16. Is the recipient's intellectual functioning significantly below average?

Yes No

17. If "yes" to Element 16, what is the recipient's I.Q. score or intellectual functioning level?

18. Historical Data

Give relevant social and school history including development (if under 18), treatment history, past mental status, diagnosis(es), etc. (Attach additional sheets if necessary.)

19. Present GAF (DSM)

Is the recipient progressing in treatment? Yes No

If no, explain.

Continued

SECTION III — DOCUMENTATION (Continued)

20. Present Mental Status / Symptomatology (include progress since treatment was initiated, or since last authorization)

21. Updated / Historical Data (family dynamics, living situation, etc.)

22. Treatment Modalities

- Psychodynamic Behavior Modification Biofeedback Play Therapy
- Other (specify) _____

23. Number of Minutes Per Session

Individual _____ Group _____ Family _____

24. Frequency of Requested Sessions

- Monthly Twice / month Once / week
- Other (specify) _____

25. Total Number of Sessions Requested

26. Psychoactive Medication? Yes No

Has there been a medication check in the past three months? Yes No

If yes, names and dosage(s) _____

27. Rationale for Further Treatment

SECTION III — DOCUMENTATION (Continued)

28. Goals / Objectives of Treatment

29. What steps have been taken to prepare recipient for termination of treatment?

30. Does the provider see other family members in a separate process? If yes, give rationale for seeing multiple family members.

31. **SIGNATURE** — Performing Provider

32. Date Signed

33. **SIGNATURE** — Recipient (optional)

34. Date Signed

35. **SIGNATURE** — Supervising Provider

36. Date Signed

ATTACHMENT 15
Prior Authorization / Substance Abuse Attachment (PA/SAA)
Completion Instructions

(A copy of the "Prior Authorization/Substance Abuse Attachment [PA/SAA] Completion Instructions" is located on the following pages.)

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WISCONSIN MEDICAID PRIOR AUTHORIZATION / SUBSTANCE ABUSE ATTACHMENT (PA/SAA) COMPLETION INSTRUCTIONS

Wisconsin Medicaid requires information to enable Medicaid to authorize and pay for medical services provided to eligible recipients.

Recipients are required to give providers full, correct, and truthful information for the submission of correct and complete claims for Medicaid reimbursement. This information should include, but is not limited to, information concerning eligibility status, accurate name, address, and Medicaid identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to Medicaid administration such as determining eligibility of the applicant, processing prior authorization (PA) requests, or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of PA or Medicaid payment for the services.

The use of this form is voluntary and providers may develop their own form as long as it includes all the information and is formatted exactly like this form. If necessary, attach additional pages if more space is needed. Providers should refer to their service-specific handbook for service restrictions and additional documentation requirements. Provide enough information for Wisconsin Medicaid medical consultants to make a reasonable judgment about the case.

Attach the completed Prior Authorization/Substance Abuse Attachment (PA/SAA) to the Prior Authorization Request Form (PA/RF) and physician prescription (if necessary) and send it to Wisconsin Medicaid. Providers may submit PA requests by fax to Wisconsin Medicaid at (608) 221-8616. Providers who wish to submit PA requests by mail may do so by submitting them to the following address:

Wisconsin Medicaid
Prior Authorization
Ste 88
6406 Bridge Rd
Madison WI 53784-0088

The provision of services that are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s).

SECTION I — RECIPIENT INFORMATION

Element 1 — Name — Recipient

Enter the recipient's last name, followed by his or her first name and middle initial. Use the Eligibility Verification System (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 2 — Age — Recipient

Enter the age of the recipient in numerical form (e.g., 16, 21, 60).

Element 3 — Recipient Medicaid Identification Number

Enter the recipient's 10-digit Medicaid identification number. Do not enter any other numbers or letters.

SECTION II — PROVIDER INFORMATION

Element 4 — Name and Credentials — Performing Provider

Enter the name and credentials of the therapist who will be providing treatment.

Element 5 — Performing Provider's Medicaid Provider Number (not required)

Enter the eight-digit Medicaid provider number of the performing provider.

Element 6 — Telephone Number — Performing Provider

Enter the performing provider's telephone number, including area code.

Element 7 — Name — Referring / Prescribing Provider

Enter the name of the provider referring/prescribing treatment.

Element 8 — Referring / Prescribing Provider’s Medicaid Provider Number

Enter the referring/prescribing provider’s eight-digit provider number, if available. The remaining portion of this attachment is to be used to document the medical necessity for the service requested.

SECTION III — TYPE OF TREATMENT REQUESTED

Element 9

Designate the type of treatment requested (e.g., primary intensive outpatient treatment, aftercare/follow-up service, or affected family member/codependency treatment). Identify the types of sessions, duration, and schedule. The total hours must match the quantities indicated in Element 20 of the PA/RF.

If a certified psychotherapist is requesting specific psychotherapy services for the substance abuse-affected recipient that are not represented by the categories of treatment listed, complete the Prior Authorization/Psychotherapy Attachment (PA/PSYA).

SECTION IV — DOCUMENTATION

Element 10

Indicate if the recipient was in primary substance abuse treatment in the last 12 months. If “yes,” provide dates, problem(s), outcome, and provider of service.

Element 11

Enter the dates of diagnostic evaluation(s) or medical examination(s) in MM/DD/YY format.

Element 12

Specify diagnostic procedures employed.

Element 13

Provide current primary and secondary diagnosis (refer to the current Diagnostic and Statistical Manual of Mental Disorders) codes and descriptions.

Element 14

Describe the recipient’s current clinical problems and relevant history. Include substance abuse history.

Element 15

Describe the recipient’s family situation. Describe how family issues are being addressed and if family members are involved in treatment. If family members are not involved in treatment, specify why not.

Element 16

Provide a detailed description of treatment objectives and goals.

Element 17

Describe expected outcome of treatment (include use of self-help groups if appropriate).

SECTION V — SIGNATURES

Element 18 — Signature — Recipient or Representative (optional)

Signature of the recipient or representative indicates the recipient has read the attached request for PA of substance abuse and agrees that it will be sent to Wisconsin Medicaid for review. The recipient’s signature is optional.

Element 19 — Date Signed

Enter the month, day, and year the PA/SAA is signed (in MM/DD/YY format) by the recipient or representative.

Element 20 — Relationship (if representative)

Include representative’s relationship to recipient, if applicable, when a representative signs.

Element 21 — Signature — Performing Provider

Wisconsin Medicaid requires the performing provider’s signature to process the PA request. Read the Prior Authorization Statement before dating and signing the attachment.

Element 22 — Date Signed

Enter the month, day, and year the PA/SAA is signed (in MM/DD/YY format) by the performing provider.

Element 23 — Discipline of Performing Provider

Enter the discipline of the performing provider.

Element 24 — Performing Provider's Medicaid Provider Number

Enter the performing provider's Medicaid provider number.

Element 25 — Signature — Supervising Provider

Signature required only if the performing provider is not a physician or psychologist.

Element 26 — Date Signed

Enter the month, day, and year the PA/SAA was signed (in MM/DD/YY format) by the supervising provider, if applicable.

Other Information

- Providers may attach copies of assessments, treatment summaries, treatment plans, or other documentation in response to the information requested on the form. Providers are responsible for ensuring that the information attached adequately responds to what is requested.
- Attach a copy of the signed and dated prescription for substance abuse services (unless a physician is the performing provider). The initial prescription must be signed and dated within three months of receipt by Wisconsin Medicaid. Subsequent prescriptions must be dated within twelve months of receipt by Wisconsin Medicaid.
- The attachment must be signed and dated by the provider requesting/providing the service.

ATTACHMENT 16
Prior Authorization / Substance Abuse Attachment (PA/SAA)
(for photocopying)

(A copy of the "Prior Authorization/Substance Abuse Attachment [PA/SAA]" [for photocopying] is located on the following pages.)

**WISCONSIN MEDICAID
PRIOR AUTHORIZATION / SUBSTANCE ABUSE ATTACHMENT (PA/SAA)**

Providers may submit prior authorization (PA) requests and attachments by fax to Wisconsin Medicaid at (608) 221-8616; or, providers may send the completed form with attachments to: Wisconsin Medicaid, Prior Authorization, Suite 88, 6406 Bridge Road, Madison, WI 53784-0088. **Instructions:** Type or print clearly. Before completing this form, read the Prior Authorization/Substance Abuse Attachment (PA/SAA) Completion Instructions (HCF 11032A).

SECTION I — RECIPIENT INFORMATION

1. Name — Recipient (Last, First, Middle Initial)	2. Age — Recipient
---	--------------------

3. Recipient Medicaid Identification Number

SECTION II — PROVIDER INFORMATION

4. Name and Credentials — Performing Provider

5. Performing Provider's Medicaid Provider Number (not required)	6. Telephone Number — Performing Provider
--	---

7. Name — Referring / Prescribing Provider	8. Referring / Prescribing Provider's Medicaid Provider Number
--	--

SECTION III — TYPE OF TREATMENT REQUESTED

9.

Primary Intensive Outpatient Treatment

- Individual Group Family
- Number of minutes per session _____ Individual _____ Group _____ Family
- Sessions will be Twice / month Once / month Once / week Other (specify) _____
- Requesting _____ hours per week, for _____ weeks
- Anticipating beginning treatment date _____
- Estimated intensive treatment termination date _____
- Attach a copy of treatment design, which includes the following:
 - a) Schedule of treatment (day, time of day, length of session, and service to be provided during that time).
 - b) Description of aftercare / follow-up component.

Aftercare / Follow-Up Service

- Individual Group Family
- Number of minutes per session _____ Individual _____ Group _____ Family
- Sessions will be Twice / month Once / month Once / week Other (specify) _____
- Requesting _____ hours per week, for _____ weeks
- Estimated discharge date from this component of care _____

Continued

SECTION III — TYPE OF TREATMENT REQUESTED (Continued)

- Affected Family Member / Codependency Treatment
 - Individual Group Family
 - Number of minutes per session _____ Individual _____ Group _____ Family
 - Sessions will be Twice / month Once / month Once / week Other (specify) _____
 - Requesting _____ hours per week, for _____ weeks
 - Anticipating beginning treatment date _____
 - Estimated affected family member / codependency treatment termination date _____
 - Attach a copy of treatment design, which includes the following:
 - a) Schedule of treatment (day, time of day, length of session, and service to be provided during that time)
 - b) Description of aftercare / follow-up component

SECTION IV — DOCUMENTATION

10. Was the recipient in primary substance abuse treatment in the last 12 months? Yes No Unknown
If "yes," provide dates, problem(s), outcome, and provider of service.

11. Enter the dates of diagnostic evaluation(s) or medical examination(s).

12. Specify diagnostic procedures employed.

Continued

SECTION IV — DOCUMENTATION (Continued)

13. Provide current primary and secondary diagnosis (refer to the current Diagnostic and Statistical Manual of Mental Disorders) codes and descriptions.

14. Describe the recipient's current clinical problems and relevant history. Include substance abuse history.

15. Describe the recipient's family situation. Include how family issues are being addressed and if family members are involved in treatment. If family members are not involved in treatment, specify why not.

16. Provide a detailed description of treatment objectives and goals.

Continued

SECTION IV — DOCUMENTATION (Continued)

17. Describe expected outcome of treatment (include use of self-help groups if appropriate).

SECTION V — SIGNATURES

I have read the attached request for PA of substance abuse services and agree that it will be sent to Wisconsin Medicaid for review.

18. SIGNATURE — Recipient or Representative (optional)	19. Date Signed
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20. Relationship (if representative)

Attach a photocopy of the physician's prescription for treatment. The prescription must be signed and dated within three months of receipt by Wisconsin Medicaid (initial request) or within 12 months of receipt by Wisconsin Medicaid (subsequent request). (Physician providers need not attach a prescription unless treatment is prescribed by another physician).

21. SIGNATURE — Performing Provider	22. Date Signed
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23. Discipline of Performing Provider	24. Performing Provider's Medicaid Provider Number
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25. SIGNATURE — Supervising Provider	26. Date Signed
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ATTACHMENT 17
Prior Authorization / Evaluation and Testing Attachment (PA/ETA)
Completion Instructions

(A copy of the "Prior Authorization/Evaluation and Testing Attachment [PA/ETA] Completion Instructions" is located on the following pages.)

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**WISCONSIN MEDICAID
PRIOR AUTHORIZATION / EVALUATION AND TESTING ATTACHMENT (PA/ETA)
COMPLETION INSTRUCTIONS**

Wisconsin Medicaid requires information to enable Medicaid to authorize and pay for medical services provided to eligible recipients.

Recipients are required to give providers full, correct, and truthful information for the submission of correct and complete claims for Medicaid reimbursement. This information will include, but is not limited to, information concerning eligibility status, accurate name, address, and Medicaid identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to Medicaid administration such as determining eligibility of the applicant, processing prior authorization (PA) requests, or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of PA or Medicaid payment for the services.

The use of this form is voluntary and providers may develop their own form as long as it includes all the information and is formatted exactly like this form. If necessary, attach additional pages if more space is needed. Providers should refer to their service-specific handbook for service restrictions and additional documentation requirements. Provide enough information for Wisconsin Medicaid medical consultants to make a reasonable judgment about the case.

Attach the completed Prior Authorization/Evaluation and Testing Attachment (PA/ETA) to the Prior Authorization Request Form (PA/RF) and physician prescription (if necessary) and send it to Wisconsin Medicaid. Providers may submit PA requests by fax to Wisconsin Medicaid at (608) 221-8616. Providers who wish to submit PA requests by mail may do so by submitting them to the following address:

Wisconsin Medicaid
Prior Authorization
Ste 88
6406 Bridge Rd
Madison WI 53784-0088

The provision of services that are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s).

SECTION I — RECIPIENT INFORMATION

Element 1 — Name — Recipient

Enter the recipient's last name, followed by his or her first name and middle initial. Use the Eligibility Verification System (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 2 — Age — Recipient

Enter the age of the recipient in numerical form (e.g., 16, 21, 60).

Element 3 — Recipient Medicaid Identification Number

Enter the recipient's 10-digit Medicaid identification number. Do not enter any other numbers or letters.

SECTION II — PROVIDER INFORMATION

Element 4 — Name and Credentials — Performing Provider

Enter the name and credentials of the therapist who will be performing the evaluation or testing.

Element 5 — Performing Provider's Medicaid Provider Number

Enter the eight-digit Medicaid provider number of the performing provider. (Not required for providers in 51.42 Board-operated clinics.)

Element 6 — Telephone Number — Performing Provider

Enter the performing provider's telephone number, including area code.

SECTION III — DOCUMENTATION

Element 7

Document the type of evaluation being requested and why it is needed. For instance, the evaluation may be a competency examination or it may be necessitated by the need to confirm a diagnosis. If the recipient was referred for evaluation, indicate who made the referral and why. Indicate how the results of the evaluation or testing will be used. Indicate how the recipient will benefit (e.g., indicate if the evaluation might be used to place the recipient in a less restrictive setting, or to obtain guardianship which would be in the recipient's best interests). Providers requesting retroactive authorization must document the emergency situation or the court order that justifies such a request and indicate the initial date of service.

Element 8

Indicate the specific tests, instruments, or procedures which will be used to conduct the testing or evaluation. These tests, instruments, or procedures must be those accepted as standard of practice for the psychiatrist/psychologists (e.g., proposed psychological testing instruments should be listed in the latest edition of the Mental Measurements Handbook).

Element 9

The provider needs to indicate what other evaluations or testing they are aware of that have been done on the recipient in the past two years and why the current request is not duplicative. Where possible, attach copies of the evaluations, tests, or summaries of their results.

A physician's prescription is not required for these evaluations and testing services.

Element 10 — Signature — Performing Provider

Enter the signature of the performing provider.

Element 11 — Date Signed

Enter the month, day, and year the PA/ETA was signed (in MM/DD/YYYY format).

Element 12 — Signature — Recipient (optional)

Enter the signature of the recipient.

Element 13 — Date Signed

Enter the month, day, and year the PA/ETA was signed (in MM/DD/YYYY format).

ATTACHMENT 18
Prior Authorization / Evaluation and Testing Attachment (PA/ETA)
(for photocopying)

(A copy of the "Prior Authorization/Evaluation and Testing Attachment [PA/ETA]"
[for photocopying] is located on the following pages.)

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**WISCONSIN MEDICAID
PRIOR AUTHORIZATION / EVALUATION AND TESTING ATTACHMENT (PA/ETA)**

Providers may submit prior authorization (PA) requests by fax to Wisconsin Medicaid at (608) 221-8616; or, providers may send the completed form with attachments to: Wisconsin Medicaid, Prior Authorization, Suite 88, 6406 Bridge Road, Madison, WI 53784-0088.

Instructions: Type or print clearly. Before completing this form, read the Prior Authorization/Evaluation and Testing Attachment (PA/ETA) Completion Instructions (HCF 11033A).

SECTION I — RECIPIENT INFORMATION

1. Name — Recipient (Last, First, Middle Initial)

2. Age — Recipient

3. Recipient Medicaid Identification Number

SECTION II — PROVIDER INFORMATION

4. Name and Credentials — Performing Provider

5. Performing Provider's Medicaid Provider Number

6. Telephone Number — Performing Provider

SECTION III — DOCUMENTATION

7. Indicate the type of evaluation being requested and why this evaluation is needed (if this was a referral, indicate who made the referral). Be specific as to how the recipient will benefit from this evaluation.

SECTION III — DOCUMENTATION (Continued)

8. Indicate the techniques or instruments that will be used to conduct the evaluation.

9. Indicate other evaluations in which the provider is aware of that have been conducted on this recipient in the past two years. Indicate why requested evaluation does not duplicate earlier evaluations.

10. SIGNATURE — Performing Provider	11. Date Signed
12. SIGNATURE — Recipient (optional)	13. Date Signed