

To:

Child/Adolescent
Day Treatment
Providers

HMOs and Other
Managed Care
Programs

Changes to local codes, paper claims, and prior authorization for child/adolescent day treatment, a HealthCheck Other Service, as a result of HIPAA

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/.

This *Wisconsin Medicaid and BadgerCare Update* introduces important changes to local codes, paper claims, and prior authorization (PA) for child/adolescent day treatment, a HealthCheck Other Service, effective October 2003, as a result of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). These changes include:

- Adopting a nationally recognized code to replace a currently used Wisconsin Medicaid local code.
- 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 important billing and prior authorization (PA) changes for child/adolescent day treatment, a HealthCheck Other Service. 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. These changes are *not* policy or coverage related (e.g., HealthCheck screen referral, PA, documentation requirements), but include:

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

Wisconsin Medicaid will adopt nationally recognized medical codes to replace the currently used Wisconsin Medicaid local code for child/adolescent day treatment services.

Procedure and modifier codes

Wisconsin Medicaid will adopt nationally recognized Healthcare Common Procedure

Coding System (HCPCS) code H2012 to replace currently used Wisconsin Medicaid local procedure code W7081 for child/adolescent day treatment services. Procedure code H2012 must be billed with HCPCS child/adolescent program modifier “HA.” Refer to Attachment 1 of this *Update* for a procedure code conversion chart.

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. Refer to Attachment 2 for a list of allowable POS codes for child/adolescent day treatment services.

Coverage for child/adolescent day treatment services

Medicaid coverage and documentation requirements for child/adolescent day treatment services will remain unchanged.

Revision of CMS 1500 paper claim instructions

With the implementation of HIPAA, Medicaid-certified child/adolescent day treatment providers 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 3 for the revised instructions. Attachment 4 is a sample of a claim for child/adolescent day treatment services that reflects 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).
- Place of service codes were revised (Element 24B).
- Type of service codes are no longer required (Element 24C).
- Up to four modifiers per procedure code may be entered (Element 24D).
- HealthCheck indicator “H” is no longer required (Element 24H).
- Spenddown amount should no longer be entered (Element 24K). Wisconsin Medicaid will automatically reduce the provider’s reimbursement by the recipient’s spenddown amount.

Medicaid coverage and documentation requirements for child/adolescent day treatment services remain unchanged.

Revision of prior authorization request forms and instructions

With the implementation of HIPAA, child/adolescent day treatment 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 5. A sample PA/RF is in Attachment 6.

Revisions made to the Prior Authorization Request Form

The following revisions were made to the PA/RF:

- Place of service codes were revised (Element 18).
- Type of service codes are no longer required.

Prior authorization attachments

The Prior Authorization/Child/Adolescent Day Treatment Attachment (PA/CADTA), HCF 11040, dated 06/03, has also been revised. The basic information requested on the form has not changed; only the format of the form has changed. Refer to Attachment 7 for a copy of

the completion instructions for the PA/CADTA. Attachment 8 is a copy of the PA/CADTA for providers to photocopy.

Obtaining prior authorization request forms

The PA/CADTA is available in a fillable Portable Document Format (PDF) from the forms page of the Wisconsin Medicaid Web site.

The PA/CADTA is 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/CADTA 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/CADTA or 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.

ATTACHMENT 1

Procedure code conversion chart for child/adolescent day treatment services

The following table lists the nationally recognized Healthcare Common Procedure Coding System (HCPCS) procedure code that providers will be required to use when submitting claims for child/adolescent day treatment services. 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).

Before HIPAA implementation	After HIPAA implementation	
Local procedure code	Replaced by HCPCS procedure code	Required modifier
W7081 Adolescent day treatment	H2012 Behavioral health day treatment, per hour	HA Child/adolescent program

ATTACHMENT 2

Place of service codes for child/adolescent day treatment services

The following table lists the place of service (POS) codes that providers will be required to use when submitting claims and prior authorization requests for child/adolescent day treatment services. 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).

Child/adolescent day treatment services may be provided in the following POS by certified child/adolescent day treatment programs only.

Code	Description
05	Indian Health Service Free-Standing Facility
06	Indian Health Service Provider-Based Facility
07	Tribal 638 Free-Standing Facility
08	Tribal 638 Provider-Based Facility
11	Office
22	Outpatient Hospital

ATTACHMENT 3

CMS 1500 claim form instructions for child/adolescent day treatment services

(For claims submitted after HIPAA implementation)

Use the following claim form completion instructions, *not* the claim form's printed descriptions, to avoid denial or inaccurate Medicaid 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

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, 1990, would be 02/03/90) or in MM/DD/YYYY format (e.g., February 3, 1990, would be 02/03/1990). 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 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.

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)

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

Element 19 — Reserved for Local Use (not required)

Element 20 — Outside Lab? (not required)

Element 21 — Diagnosis or Nature of Illness or Injury

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

Element 22 — Medicaid Resubmission (not required)

Element 23 — Prior Authorization Number

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 December 1, 8, 15, and 22, 2003, indicate 12/01/03 or 12/01/2003 in the “From” field and indicate 08/15/22 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 procedure.
- The charge for all procedures is identical. (Enter the total charge **per detail line** in Element 24F.)
- The number of services performed on each DOS is identical.
- All services have the same family planning indicator, if applicable.
- All services have the same emergency indicator, if applicable.

Element 24B — Place of Service

Enter the appropriate two-digit POS code for each service. See Attachment 2 of this *Wisconsin Medicaid and BadgerCare Update* for a list of allowable POS codes for child/adolescent day treatment services.

Element 24C — Type of Service (not required)

Element 24D — Procedures, Services, or Supplies

Enter the appropriate procedure code for the service provided.

Modifiers

Enter the appropriate modifier in the “Modifier” column of Element 24D.

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). Use the rounding guidelines listed below.

Minutes Billed	Quantity
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

Element 24H — EPSDT/Family Plan (not required)**Element 24I — EMG (not required)****Element 24J — COB (not required)****Element 24K — Reserved for Local Use (not required)****Element 25 — Federal Tax I.D. Number (not required)****Element 26 — Patient’s Account No. (not required)**

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

Element 27 — Accept Assignment (not required)**Element 28 — Total Charge**

Enter the total charges for this claim.

Element 29 — Amount Paid

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

Element 30 — Balance Due

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

Element 31 — Signature of Physician or Supplier

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

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

Element 32 — Name and Address of Facility Where Services Were Rendered (not required)**Element 33 — Physician’s, Supplier’s Billing Name, Address, ZIP Code, and Phone #**

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

ATTACHMENT 4

Sample CMS 1500 claim form for child/adolescent day treatment services

HEALTH INSURANCE CLAIM FORM												
<div style="display: flex; justify-content: space-between;"> PICA PICA </div>												
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 SEX MM DD YY M <input checked="" type="checkbox"/> F <input type="checkbox"/>							
5. PATIENT'S ADDRESS (No., Street) 609 Willow					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			ZIP CODE TELEPHONE (INCLUDE AREA CODE)		()					
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)					10. IS PATIENT'S CONDITION RELATED TO:							
a. OTHER INSURED'S POLICY OR GROUP NUMBER					a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO							
b. OTHER INSURED'S DATE OF BIRTH SEX MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>					b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input type="checkbox"/> NO _____							
c. EMPLOYER'S NAME OR SCHOOL NAME					c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO							
d. INSURANCE PLAN NAME OR PROGRAM NAME					10d. RESERVED FOR LOCAL USE							
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.												
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 <input type="checkbox"/>					15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY <input type="checkbox"/>							
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE					17a. I.D. NUMBER OF REFERRING PHYSICIAN							
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)					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY							
1. 296.33					20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO							
2. 300.30					22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.							
3. _____					23. PRIOR AUTHORIZATION NUMBER 1234567							
4. _____					24. A B C D E F G H I J K							
DATE(S) OF SERVICE From MM DD YY To MM DD YY		Place of Service	Type of Service	PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER		DIAGNOSIS CODE	\$ CHARGES	DAYS OR UNITS	EPST/ Family Plan	EMG	COB	RESERVED FOR LOCAL USE
1. 11: 07 03		22	H2012	HA		1	XXX XX	4.0				
2.												
3.												
4.												
5.												
6.												
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 \$		30. BALANCE DUE \$ XXX 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. Authorized MMDYY 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 PIN# GRP#						

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

ATTACHMENT 5

Prior Authorization Request Form (PA/RF) Completion Instructions for child/adolescent day treatment 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 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 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 the Prior Authorization/Child/ Adolescent Day Treatment Attachment (PA/CADTA) 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).

The words "HealthCheck Other Services" should be written **in red ink** across the top of the form. The quantity requested in Element 20 should be the total hours for the period requested and the charges in Element 21 should be the total charges for the number of hours in Element 20. **The appropriate *International Classification of Diseases, Ninth Edition, Clinical Modification (ICD-9-CM) diagnosis codes and descriptions* must be entered in Elements 10 and 13.**

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.*

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.

Element 3 — Processing Type

Enter the processing type “129 — Medical Day Treatment.” The processing type is a three-digit code used to identify a category of service requested. Prior authorization and requests will be returned without adjudication if no processing type is indicated.

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.

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 ICD-9-CM diagnosis code and description most relevant to the service/procedure requested.

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 relevant to the service/procedure requested, if applicable.

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 (not required)

Element 16 — Procedure Code

Enter the appropriate procedure code for each service requested.

Element 17 — Modifiers

Enter the modifier(s) corresponding to the procedure code listed.

Element 18 — POS

Enter the appropriate two-digit place of service code designating where the requested service would be provided.

Element 19 — Description of Service

Enter a written description corresponding to the appropriate Healthcare Common Procedure Coding System code for each service requested.

Element 20 — QR

Enter the appropriate quantity (e.g., number of services) requested for the procedure code listed.

Element 21 — Charge

Enter the usual and customary charge for each service requested. If the quantity is greater than “1,” multiply the quantity by the charge for each service 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 Charge

Enter the anticipated total charge for this request.

Element 23 — Signature — Requesting Provider

The original signature of the provider requesting this service 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 6

Sample Prior Authorization Request Form (PA/RF) for child/adolescent day treatment services

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

HealthCheck Other Services

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									
SECTION I — PROVIDER INFORMATION												
1. Name and Address — Billing Provider (Street, City, State, Zip Code)		2. Telephone Number — Billing Provider		3. Processing Type								
I.M. Provider 1 W. Wilson Anytown, WI 55555		(XXX) XXX-XXXX		129								
		4. Billing Provider's Medicaid Provider Number										
		12345678										
SECTION II — RECIPIENT INFORMATION												
5. Recipient Medicaid ID Number		6. Date of Birth — Recipient (MM/DD/YY)		7. Address — Recipient (Street, City, State, Zip Code)								
1234567890		MM/DD/YY		609 Willow Anytown, WI 55555								
8. Name — Recipient (Last, First, Middle Initial)		9. Sex — Recipient										
Recipient, Im A		<input checked="" type="checkbox"/> M <input type="checkbox"/> F										
SECTION III — DIAGNOSIS / TREATMENT INFORMATION												
10. Diagnosis — Primary Code and Description			11. Start Date — SOI	12. First Date of Treatment — SOI								
313.81 — oppositional disorder												
13. Diagnosis — Secondary Code and Description			14. Requested Start Date									
N/A												
15. Performing Provider Number	16. Procedure Code	17. Modifiers				18. POS	19. Description of Service		20. QR	21. Charge		
	H2012	HA				11	Behavioral health day treatment per hour		10	XXX.XX		
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									24. Date Signed			
<i>I.M. Provider</i>									MM/DD/YY			
FOR MEDICAID USE					Procedure(s) Authorized:			Quantity Authorized:				
<input type="checkbox"/> Approved <table style="width: 100%; margin-left: 100px;"> <tr> <td style="width: 50%; text-align: center;">Grant Date</td> <td style="width: 50%; text-align: center;">Expiration Date</td> </tr> </table>											Grant Date	Expiration Date
Grant Date	Expiration Date											
<input type="checkbox"/> Modified — Reason:												
<input type="checkbox"/> Denied — Reason:												
<input type="checkbox"/> Returned — Reason:												
SIGNATURE — Consultant / Analyst						Date Signed						

ATTACHMENT 7
Prior Authorization / Child / Adolescent
Day Treatment Attachment (PA/CADTA)
Completion Instructions

(A copy of the "Prior Authorization/Child/Adolescent Day Treatment Attachment [PA/CADTA] Completion Instructions" is located on the following pages.)

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WISCONSIN MEDICAID PRIOR AUTHORIZATION / CHILD / ADOLESCENT DAY TREATMENT ATTACHMENT (PA/CADTA) 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 the service-specific handbook for service restrictions and additional documentation requirements. Provide enough information for Wisconsin Medicaid medical consultants to make a reasonable judgement about the case.

Attach the completed Prior Authorization/Child/Adolescent Day Treatment Attachment (PA/CADTA), physician prescription, and evidence of a HealthCheck screen to the Prior Authorization Request Form (PA/RF) 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

GENERAL INSTRUCTIONS

The information contained in this PA/CADTA will be used to make a decision about the amount of child/adolescent day treatment which will be approved for Medicaid reimbursement. Complete each section as completely as possible. **Where noted in these instructions**, the provider may attach material that he or she may have in his or her records.

Initial Prior Authorization Request

Complete the PA/RF and the entire PA/CADTA and attach the HealthCheck referral and physician order. Label all attachments (e.g., "Day Treatment-Treatment Plan"). The initial authorization will be for a period of no longer than three months.

First Reauthorization

Complete the PA/RF and Sections I-III of the PA/CADTA. Attach a physician order for day treatment dated within one year of the date of receipt at Wisconsin Medicaid and a copy of the HealthCheck verification dated within one year of the beginning date of service (DOS) (these may be copies of those included with the initial authorization request). Attach a summary of the treatment to date, and a revised day treatment services treatment plan. Note progress on short- and long-term goals from the original plan. Be explicit in the summary as to the need for continued day treatment services. Authorization will be for a period of no longer than three months.

Second Reauthorization

Complete the PA/RF and Sections I-III of the PA/CADTA. Attach a copy of the physician order for day treatment and a copy of the HealthCheck verification dated within one year of the beginning DOS (these may be copies of those included with the previous authorization requests). Include an updated multi-agency treatment plan and an updated screening (the Achenbach Child Behavior Checklist or the Child and Adolescent Functional Assessment Scale [CAFAS]) using the same screening tool used for the initial request. Summarize the treatment since the previous authorization. The need for continued day treatment must be clearly documented. Where no change is noted in the treatment summary, justify the continued use of day treatment or note how changes in the treatment plan address the lack of progress. Specifically address aftercare planning. Authorization will be for a period of no longer than three months.

Subsequent Reauthorizations

Complete the PA/RF and Sections I-III of the PA/CADTA. Attach a copy of the physician order for day treatment and a copy of the HealthCheck verification dated within one year of the beginning DOS (these may be copies of those included with the previous authorization request). Attach a summary of the treatment since the previous authorization. Address why the recipient has not made transition to aftercare services. Strong justification will be required for day treatment services exceeding nine months per episode of treatment.

Please check the appropriate box at the top of the PA/CADTA to indicate whether this request is an initial, first reauthorization, second reauthorization, or subsequent reauthorization request. Make sure that the appropriate materials are included for the type of request indicated.

Multiple Services

When a recipient will require PA for other services concurrent to the child/adolescent day treatment (e.g., in-home treatment), a separate PA request must be submitted for those services along with the appropriate PA attachment and all required materials. The coordination of these concurrent services needs to be clearly indicated within the clinical documentation for all services. These other services must be identified on the multi-agency treatment plan(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, exactly as it appears on the recipient's Medicaid identification card.

Element 2 — Age — Recipient

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

Element 3 — Recipient Medicaid Identification Number

Enter the recipient's 10-digit Medicaid identification number exactly as it appears on the recipient's Medicaid identification card.

SECTION II — PROVIDER INFORMATION

Element 4 — Name — Day Treatment Provider

Enter the name of the Medicaid-certified day treatment program which will be billing for the services.

Element 5 — Day Treatment Provider's Medicaid Provider Number

Enter the eight-digit Medicaid provider number for the day treatment provider. Providers will be assigned a unique provider number for the child/adolescent day treatment program.

Element 6 — Name — Contact Person

Enter the name of a person who would be able to answer questions about this request.

Element 7 — Telephone Number — Contact Person

Enter the telephone number of the contact person.

SECTION III — DOCUMENTATION

Element 8

Indicate the date for which the provider wishes services to be first authorized and the end date for the authorization period. See the general instructions for information on the length of authorization that will be generally allowed. If the start date is prior to when this request will be received at Wisconsin Medicaid, clinical rationale must be provided justifying the need to start treatment prior to obtaining authorization. Requests may be backdated up to 10 working days on the initial authorization if this is requested and appropriate rationale is provided.

Element 9

Indicate the total number of hours for which the provider is requesting Medicaid reimbursement for this PA grant period. The total number of hours should equal the quantity requested in Element 20 of the PA/RF.

Element 10

Present or attach a summary of diagnostic assessment and differential diagnosis. Diagnoses on all five axes of the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) are required. The assessment should address the level of reality testing, thought processes, drive control, relational capacity, and defensive functioning. If not conducted by a psychiatrist or psychologist,* a psychiatrist or psychologist* must review and sign the summary and diagnosis. In some cases where the only, or primary, diagnosis is a conduct disorder, the request should provide sufficient justification for the appropriateness of day treatment. In those cases where the only, or primary, diagnosis is a psychoactive substance abuse disorder, requests will generally not be approved unless there is sufficient justification for the appropriateness of a mental health day treatment program. **Providers may attach copies of an existing assessment.**

Element 11

If the recipient is on medication, the treatment plan must include the name of the physician managing those medications. Present or attach a summary of the recipient's illness/treatment/medication history. For individuals with significant substance abuse problems, the multi-agency treatment plan should indicate how these will be addressed. **Providers may attach copies of illness/treatment/medication histories that are contained in their records.**

*One who is licensed in Wisconsin and listed, or eligible to be listed, in the national register of health care providers in psychology.

Element 12

- a. Complete the checklist for determining that an individual meets the criteria for severe emotional disturbance.

The following information defines the allowable conditions for b. and c. of the checklist.

- b. List the primary diagnosis and diagnosis code in the space provided. The individual must have one of the following DSM diagnoses:

Disorders usually first diagnosed in infancy, childhood, and adolescence include:

- Pervasive developmental disorders (coded on Axis II: 299.00; 299.10; 299.80).
- Attention-deficit and disruptive behavior disorders (312.81; 312.82; 312.89; 312.9; 313.81; 314.00; 314.01; 314.9).
- Feeding and eating disorders of infancy or early childhood (307.52; 307.53; 307.59).
- Tic disorders (307.20; 307.22; 307.23).
- Other disorders of infancy, childhood, or adolescence (307.3; 309.21; 313.23; 313.89).

Adult diagnostic categories appropriate for children and adolescents are:

- Substance-related disorders (303.90; 304.00-304.90; 305.00; 305.20-305.70; 305.90, except not caffeine intoxication).
- Schizophrenia and other psychotic disorders (293.81; 293.82; 295.10-295.40; 295.60-295.70; 295.90; 297.1; 297.3; 298.9).
- Mood disorders (293.83; 296.00-296.90; 300.4; 301.13; 311).
- Anxiety disorders (300.00-300.02; 300.21-300.23; 300.29; 300.3; 308.3; 309.81).
- Somatoform disorders (300.11; 300.81).
- Dissociative disorders (300.12-300.15; 300.6).
- Sexual and gender identity disorders (302.2-302.4; 302.6; 302.89; 302.9).
- Eating disorders (307.1; 307.51).
- Impulse-control disorders (312.30; 312.33; 312.34).
- Adjustment disorders (309.0; 309.24; 309.28; 309.3; 309.4; 309.9).
- Personality disorders coded on Axis II (301.0; 301.20-301.9).

- c. Check those boxes that apply. The individual must have one symptom or two functional impairments.

Symptoms

1. Psychoactive symptoms — Serious mental illness (e.g., schizophrenia) characterized by defective or lost contact with reality, often with hallucinations or delusions.
2. Suicidality — The individual must have made one attempt within the last three months or have significant ideation about or have made a plan for suicide within the past month.
3. Violence — The individual must be at risk for causing injury to persons or significant damage to property as a result of emotional disturbance.

Functional Impairments (compared to expected developmental level)

1. Functioning in self care — Impairment in self care is manifested by a person's consistent inability to take care of personal grooming, hygiene, clothes, and meeting of nutritional needs.
2. Functioning in community — Impairment in community function is manifested by a consistent lack of age-appropriate behavioral controls, decision making, judgment, and value system which results in potential involvement or involvement in the juvenile justice system.
3. Functioning in social relationships — Impairment of social relationships is manifested by the consistent inability to develop and maintain satisfactory relationships with peers and adults.
4. Functioning in the family — Impairment in family function is manifested by pattern of significantly disruptive behavior exemplified by repeated and/or unprovoked violence to siblings and/or parents, disregard for safety and welfare of self or others, e.g., fire setting, serious and chronic destructiveness, inability to conform to reasonable limitations, and expectations which may result in removal from the family or its equivalent.
5. Functioning at school / work — Impairment in any *one* of the following:
 - a) Impairment in functioning at school is manifested by the inability to pursue educational goals in a normal time frame, such as consistently failing grades, repeated truancy, expulsion, property damage, or violence towards others.
 - b) Meeting the definition of "child with exceptional educational needs: under ch. PI 11, Wis. Admin. Code, and s. 115.76(3) Wis. Stats.
 - c) Impairment at work is the inability to be consistently employed at a self-sustaining level, such as the inability to conform to work schedule, poor relationships with supervisor and other workers, or hostile behavior on the job.

d. Check those boxes that apply.

The individual is receiving services from two or more of the following service systems

- | | |
|---|---|
| <input type="checkbox"/> Mental health. | <input type="checkbox"/> Juvenile justice. |
| <input type="checkbox"/> Social services. | <input type="checkbox"/> Special education. |
| <input type="checkbox"/> Child protective services. | |

Eligibility criteria waived under certain circumstances:

- This individual would otherwise meet the definition of SED, but has not yet received services from more than one system, but, in the judgement of the medical consultant, would be likely to do so were the intensity of treatment requested not provided. Attach explanation.
- This individual would otherwise meet the definition of SED, but functional impairment has not persisted for six months, or the judgement of the medical consultant, the nature of the acute episode is such that impairment in functioning (as defined in the "Severe Emotional Disturbance Criteria Checklist," January 29, 1992) is likely to be evident without the intensity of treatment requested. Attach explanation.

Note: A Substance Abuse Assessment may be included. A Substance Abuse Assessment must be included if substance abuse related programming is part of the recipient's treatment program.

Element 13

Describe the treatment program which will be provided. Participation in specific groups/activities must be justified by the treatment plan. Attach a summary/description of groups or program components. The information presented should be adequate for determining that those services for which reimbursement are requested are Medicaid reimbursable.

Element 14

If not previously addressed, indicate the rationale for day treatment as opposed to other treatment modalities. Where less intensive outpatient (clinic) services have not been provided, discuss why not. Providers should present this justification in their own words and not assume that the consultants can infer this from other materials presented with the request.

Element 15

Indicate the expected duration of day treatment. Describe services expected to be rendered following completion of day treatment and transition plans. While providers are expected to indicate their expectations on the initial request, it is critical that plans for terminating day treatment be discussed in any requests for services at and beyond six months of treatment.

SECTION IV — ATTACHMENTS AND SIGNATURE

Element 16

The following materials must be attached and labeled.

- a. The request must include documentation that the recipient had a comprehensive HealthCheck screen within one year of the date the Child/Adolescent Day Treatment Attachment PA request is received at Wisconsin Medicaid. A HealthCheck Referral Form is no longer required for approval of a PA request. A PA request may be considered for approval so long as the PA request includes a statement or indication from the HealthCheck screener that a HealthCheck screen was performed. This must be signed and must show the date of the screen, which must be within one year of the date of receipt of the PA request.
- b. Attach a physician's prescription for day treatment services, signed by a physician, preferably a psychiatrist, dated within one year of date of receipt at Wisconsin Medicaid.
- c. The treatment team must complete a treatment plan covering their day treatment services. The plan must contain measurable goals, specific methods, and an expected time frame for achievement of the goals. The treatment plan must be tailored for the individual recipient.

The plan must clearly identify how specific program components relate to specific treatment goals. The methods allow for a clear determination that the services provided meet criteria for Medicaid covered services. Services which are primarily social or recreational in nature, educational services, and mealtimes are not reimbursable.

- d. The multi-agency treatment plan must be developed by representatives from all systems involved with the recipient (school, juvenile justice, social services, etc.). The plan must address the role of each system in the overall treatment and the major goals for each agency involved. Ideally, the plan should be signed by all participants, but to facilitate submission, the provider may document who was involved. Where some agency was not involved in the planning, the provider must document the reason and what attempts were made to include them. The plan should indicate why day treatment services are necessary and desirable. The individual who is coordinating the multi-agency planning should be clearly identified. A psychiatrist or psychologist* must sign either the multi-agency or day treatment plan (make sure the physician is identified as a psychiatrist). A model multi-agency treatment plan form is available on the forms page of the Wisconsin Medicaid Web site. To access the model plan form, 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.
- e. Providers must complete and attach the results of either the Achenbach Child Behavior Checklist or the CAFAS. Information about these screening instruments is available on the Internet under "Achenbach Behavior Checklist" and "Child and Adolescent Functional Assessment Scale."
- f. Submit a copy of a Substance Abuse Assessment where the psychiatric assessment indicates significant substance abuse problems and substance abuse-related services will be a part of the day treatment program. The assessment may be summarized in Section II-A of II-B as part of the psychiatric assessment or illness history. If the substance abuse problems will be addressed by some other agency, this should be indicated in the multi-agency treatment plan.

Element 17 — Signature — Day Treatment Program Director (Psychiatrist or Psychologist*)

The PA/CADTA request must be signed by the day treatment program director (psychologist or psychiatrist*).

Element 18 — Date Signed

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

* One who is licensed in Wisconsin and listed, or eligible to be listed, in the national register of healthcare providers in psychology.

ATTACHMENT 8
Prior Authorization / Child / Adolescent Day
Treatment Attachment (PA/CADTA)
(for photocopying)

(A copy of the "Prior Authorization/Child/Adolescent Day Treatment Attachment (PA/CADTA)" [for photocopying] is located on the following pages.)

**WISCONSIN MEDICAID
PRIOR AUTHORIZATION / CHILD / ADOLESCENT DAY TREATMENT ATTACHMENT
(PA/CADTA)**

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 Rd, Madison, WI 53784-0088.
Instructions: Type or print clearly. Before completing this form, read the Prior Authorization/Child/Adolescent Day Treatment Attachment (CADTA) Completion Instructions (HCF 11040A).

- Initial /Request First Reauthorization Second Reauthorization Subsequent Reauthorization

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 — Day Treatment Provider	5. Day Treatment Provider's Medicaid Provider Number
6. Name — Contact Person	7. Telephone Number — Contact Person

SECTION III — DOCUMENTATION

8. Indicate the requested start date and end date for this authorization period (if start date is prior to when request will be received by Wisconsin Medicaid, indicate rationale).
-
-
-
-
-
-
-
-
-
-
-
9. Indicate the number of hours of treatment to be provided over PA grant period. Indicate pattern of treatment, e.g., three hours per day, three days per week for eight weeks.
-

SECTION III — DOCUMENTATION (Continued)

The following additional information must be provided. If copies of existing records are attached to provide the information requested, **limit attachments to two pages for the psychiatric evaluation and illness / treatment history.** Highlighting relevant information is helpful. **Do not attach M-Team summaries, additional social service reports, court reports, or similar documents unless directed to do so following initial review of the documentation.**

-
10. Present a summary of the recipient's diagnostic assessment and differential diagnosis. **Diagnoses on all five axes of the most recent *Diagnostic and Statistical Manual of Mental Disorders (DSM)* are required.** If not conducted by a psychiatrist or psychologist*, a psychiatrist or psychologist* must review and sign the summary and diagnoses.

*One who is listed in Wisconsin and listed, or eligible to be listed, in the national register of health care providers in psychology.

SECTION III — DOCUMENTATION (Continued)

11. Present a summary of the recipient's illness / treatment / medication history and other significant background information.
Indicate why the provider thinks day treatment will produce positive change.

SECTION III — DOCUMENTATION (Continued)

12. Complete the checklist for determination that an individual meets the criteria for severe emotional disturbance (SED). Criteria for meeting the functional symptoms and impairments are found in the instructions. **The disability must be evidenced by a, b, c, and d listed below.**

a. **The individual must meet all three of the following:**

- Be under the age of 21.
- Have an emotional disability that has persisted for at least six months.
- That same disability must be expected to persist for a year or longer.

b. **A condition of SED** as defined by a mental or emotional disturbance listed in the most recent version of the American Psychiatric Association *Diagnostic and Statistical Manual of Mental Disorders*.

Primary Diagnosis

c. **Symptoms and functional impairments**

The individual must have one or two:

1. Symptoms (must have one)

- Psychotic symptoms.
- Suicidality.
- Violence.

2. Functional impairments (must have two)

- Functioning in self care.
- Functioning in the family.
- Functioning in the community.
- Functioning at school / work.
- Functioning in social relationships.

d. **The individual is receiving services from two or more of the following service systems.**

- Mental health.
- Juvenile justice.
- Social services.
- Special education.
- Child protective services.

Eligibility criteria waived under certain circumstances:

- This individual would otherwise meet the definition of SED, but has not yet received services from more than one system, but, in the judgement of the medical consultant, would be likely to do so were the intensity of treatment requested not provided. Attach explanation.
- This individual would otherwise meet the definition of SED, but functional impairment has not persisted for six months, or the judgement of the medical consultant, the nature of the acute episode is such that impairment in functioning (as defined in the "Severe Emotional Disturbance Criteria Checklist," January 29, 1992) is likely to be evident without the intensity of treatment requested. Attach explanation.

13. Describe the treatment program which will be provided. Attach a day treatment program schedule, if available. Summarize the proposed intervention in this section. The treatment plan should specify how program components relate to this specific client's treatment goals.

SECTION III — DOCUMENTATION (Continued)

14. Indicate the rationale for day treatment. Elaborate on this choice where prior outpatient (clinic) treatment is absent or limited. Why does the recipient need this level of intervention at this time?

15. Indicate the expected date for termination of day treatment. Describe anticipated service needs following completion of day treatment and transition plan.

SECTION IV — ATTACHMENTS AND SIGNATURE

16. Attach and **label** the following:

- a. Documentation that the recipient had a comprehensive HealthCheck screen within the past year. A copy of this documentation must be attached for reauthorizations. (A copy of the original documentation may be used.) **The initial request for these services must be received by Wisconsin Medicaid within one year of when the HealthCheck screen was dated.**
- b. A physician's prescription for day treatment services, signed by a physician, preferably a psychiatrist.
- c. A day treatment services treatment plan. Either treatment plan must be signed by a psychiatrist or psychologist.*
- d. A multi-agency treatment plan. The treatment plan must be signed by either a psychiatrist or psychologist.*
- e. Results of either the Achenbach Child Behavior Checklist **or** the Child and Adolescent Functional Assessment Scale (CAFAS).
- f. A Substance Abuse Assessment may be included. A Substance Abuse Assessment **must** be included if substance abuse-related programming is part of the recipient's treatment program.

I attest to the accuracy of the information on this PA request.

17. **SIGNATURE** — Day Treatment Program Director (Psychiatrist or Psychologist*)

18. Date Signed

* One who is licensed in Wisconsin and listed, or eligible to be listed, in the national register of health care providers in psychology.