wisconsin Medicaid update and BadgerCare

July 2003 ● No. 2003-71
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Wisconsin Medicaid and BadgerCare Information for Providers

To:

Adult Mental Health Day Treatment Providers

HMOs and Other Managed Care Programs

Changes to local codes, paper claims, and prior authorization for adult mental health day treatment 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 adult mental health day treatment (formerly referred to as medical day treatment) 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 important billing and prior authorization (PA) changes for adult mental health day treatment, formerly referred to as medical day treatment services. For these services, "adult" is defined as a recipient age 18 or older. 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., PA requirements, documentation requirements), but include:

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

Wisconsin Medicaid will adopt nationally recognized medical codes to replace currently used Wisconsin Medicaid local codes for adult mental health day treatment services.

Allowable procedure codes and modifiers

Wisconsin Medicaid will adopt Healthcare Common Procedure Coding System (HCPCS)

procedure codes to replace currently used Wisconsin Medicaid local procedure codes (W8910-W8914) for adult mental health day treatment services. Currently used procedure codes W8988 and W8989 have been eliminated. Refer to Attachment 1 of this *Update* for the allowable procedure and diagnosis codes. Providers will be required to use the appropriate HCPCS procedure code that describes the service performed.

Modifiers

Providers will be required to use nationally recognized HCPCS modifiers "HE" to indicate "mental health program" and "U6" to indicate "functional assessment." Modifier code "U6" is a national modifier defined by Wisconsin Medicaid as a functional assessment for adult mental health day treatment.

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 adult mental health day treatment services.

Coverage for adult mental health day treatment services

Medicaid coverage and documentation requirements for adult mental health day treatment services remain unchanged. Refer to the Medical Day Treatment handbook and *Updates* for complete Medicaid policies and procedures.

Revision of CMS 1500 paper claim instructions

With the implementation of HIPAA, Medicaid-certified adult mental health 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 adult mental health 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.

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

Revisions made to the CMS 1500 claim form instructions

Revisions made to the CMS 1500 paper claim form instructions 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).
- Up to four modifiers per procedure code may be entered (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 and instructions

With the implementation of HIPAA, adult mental health 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:

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

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

Prior authorization attachments

The Prior Authorization/Adult Mental Health Day Treatment Attachment (PA/AMHDTA), HCF 11038, 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/AMHDTA. Attachment 8 is a copy of the PA/AMHDTA for providers to photocopy.

Obtaining Prior Authorization Request Forms

The PA/AMHDTA 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/AMHDTA 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/AMHDTA 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/admnsimp/* — 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.

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* 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 adult mental health day treatment services

The following table lists the nationally recognized procedure codes and modifiers that providers will be required to use when submitting claims for adult mental health 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 description	**Replaced by HCPCS* procedure code**	**Program modifier code**	**Service modifier code**	**ICD-9-CM** Diagnosis code restrictions**
W8910 Day treatment Inpatient recipient — 1 hour	**H2012** Behavioral health day treatment Per hour	**HE** Mental health program	None	295-302.9 306-309.9 311-316
W8911 Day treatment Outpatient recipient — 1 hour				
W8912 Day treatment Nursing home recipient — 1 hour				
W8913 Functional assessment Positive day treatment — 1 hour	**H2012** Behavioral health day treatment Per hour	**HE** Mental health program	**U6** Functional assessment	Diagnosis code required, but no restrictions.
W8914 Functional assessment Negative day treatment — 1 hour				
W8988 Limitation exceeded Functional assessment Positive day treatment — 1 hour	Has been eliminated			
W8989 Limitation exceeded Functional assessment Negative day treatment — 1 hour	Has been eliminated			

*HCPCS = Healthcare Common Procedure Coding System.
**ICD-9-CM = *International Classification of Diseases, Ninth Revision, Clinical Modification*

ATTACHMENT 2
Place of service codes
for adult mental health day treatment 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.

Adult mental health day treatment services may be provided in the following POS by certified mental health 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
50	Federally Qualified Health Center
71	State or Local Public Health Clinic
72	Rural Health Clinic

ATTACHMENT 3
CMS 1500 claim form instructions for adult mental health 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 obtain the correct spelling of the recipient's name and correct Medicaid identification number. 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, 1955, would be 02/03/55) or in MM/DD/YYYY format (e.g., February 3, 1955, would be 02/03/1955). Specify whether the recipient is male or female by placing an "X" in the appropriate box.

Element 4 — Insured's Name (not required)

Element 5 — Patient's Address

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

Element 6 — Patient Relationship to Insured (not required)

Element 7 — Insured's Address (not required)

Element 8 — Patient Status (not required)

Element 9 — Other Insured's Name

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

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

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

Code	Description
OI-P	PAID 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: ✓ 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	**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: *For Medicare Part A (all three criteria must be met):* ✓ 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. *For Medicare Part B (all three criteria must be met):* ✓ 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	**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: *For Medicare Part A (all three criteria must be met):* ✓ 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. *For Medicare Part B (all three criteria must be met):* ✓ 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	**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: *For Medicare Part A (all three criteria must be met):* ✓ 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). *For Medicare Part B (all three criteria must be met):* ✓ 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

Enter the referring physician's name and six-character Universal Provider Identification Number (UPIN). If the UPIN is not available, enter the eight-digit Medicaid provider number or the license number of the referring physician.

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. Refer to Attachment 1 of this *Wisconsin Medicaid and BadgerCare Update* for a list of diagnosis code restrictions.

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, 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 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 HealthCheck or 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 for a list of allowable POS codes.

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(s) (up to four per procedure code) in the "Modifier" column of Element 24D. Please note that Wisconsin Medicaid has not adopted all national 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, time units, qualifying circumstance units, or other services billed for each line item. Always use a decimal (e.g., 2.0 units).

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

Leave this element blank.

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 provider's name (exactly as indicated on the provider's notification of certification letter) and address of the billing provider. At the bottom of Element 33, enter the billing provider's eight-digit Medicaid provider number.

ATTACHMENT 4
Sample CMS 1500 claim form
for adult mental health day treatment services

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE ☐ (Medicare #) | MEDICAID ☐ (Medicaid #) | CHAMPUS ☐ (Sponsor's SSN) | CHAMPVA ☐ (VA File #) | GROUP HEALTH PLAN ☐ (SSN or ID) | FECA BLK LUNG ☐ (SSN) | OTHER ☐ (ID)

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 [X] F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 609 Willow

6. PATIENT RELATIONSHIP TO INSURED: Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street):

CITY: Anytown | STATE: WI

8. PATIENT STATUS: Single ☐ Married ☐ Other ☐ | Employed ☐ Full-Time Student ☐ Part-Time Student ☐

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): OI-P

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: M-8

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) ☐ YES ☐ NO

a. INSURED'S DATE OF BIRTH MM DD YY | SEX: M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY | SEX: M ☐ F ☐

b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? ☐ YES ☐ NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO *If yes*, return to and complete item 9 a-d.

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.

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: MM DD YY ◀ ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: I.M. Referring MD

17a. I.D. NUMBER OF REFERRING PHYSICIAN: 12345678

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 296.5
2. ____.__
3. ____.__
4. ____.__

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1	11 07 03		22		H2012	HE U6	1	XX XX	1.0				
2	11 11 03		11		H2012	HE	1	XX XX	1.5				
3	11 14 03	21 28	11		H2012	HE	1	XX XX	3.0				
4													
5													
6													

25. FEDERAL TAX I.D. NUMBER SSN EIN ☐ ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ 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. Authorized MMDDYY

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

(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 5
Prior Authorization Request Form (PA/RF) Completion Instructions for adult mental health 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/Adult Mental Health Day Treatment Attachment (PA/AMHDTA) 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.*

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 processing type "129" for Mental Health Day Treatment Services. The processing type is a three-digit code used to identify a category of service requested.

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 *International Classification of Diseases, Ninth Edition, Clinical Modification* (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 (not required)
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 Healthcare Common Procedure Coding System (HCPCS) 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 code designating where the requested service/procedure/item would be provided/performed/dispensed.

Element 19 — Description of Service
Enter a written description corresponding to the appropriate HCPCS code for each service/procedure/item requested.

Element 20 — QR
Enter the appropriate quantity requested for the procedure code listed.

Element 21 — Charge
Enter the provider's usual and customary charge for each service/procedure/item requested. If the quantity is greater than "1," 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 6
Sample Prior Authorization Request Form (PA/RF) for adult mental health day treatment 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

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 **00000026**	

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) **Recipient, Im A**	9. Sex — Recipient ☒ M ☐ F	

SECTION III — DIAGNOSIS / TREATMENT INFORMATION

10. Diagnosis — Primary Code and Description	11. Start Date — SOI	12. First Date of Treatment — SOI
295.32 — Schizophrenia, paranoid type		
13. Diagnosis — Secondary Code and Description **301.0 — Paranoid personality disorder**	14. Requested Start Date	

15. Performing Provider Number	16. Procedure Code	17. Modifiers 1	2	3	4	18. POS	19. Description of Service	20. QR	21. Charge
	H2012	**HE**				**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.M. Provider	**MM/DD/YY**

FOR MEDICAID USE

Procedure(s) Authorized:

Quantity Authorized:

☐ Approved

Grant Date _____ Expiration Date _____

☐ Modified — Reason:

☐ Denied — Reason:

☐ Returned — Reason:

SIGNATURE — Consultant / Analyst _____ Date Signed _____

ATTACHMENT 7
Prior Authorization / Adult Mental Health Day Treatment Attachment (PA/AMHDTA) Completion Instructions

(A copy of the "Prior Authorization/Adult Mental Health Day Treatment Attachment [PA/AMHDTA] Completion Instructions" is located on the following pages.)

DEPARTMENT OF HEALTH AND FAMILY SERVICES **STATE OF WISCONSIN**
Division of Health Care Financing
HCF 11038A (Rev. 06/03)

WISCONSIN MEDICAID
PRIOR AUTHORIZATION / ADULT MENTAL HEALTH DAY TREATMENT ATTACHMENT (PA/AMHDTA) 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 judgement about the case.

Attach the completed Prior Authorization/Adult Mental Health Day Treatment Attachment (PA/AMHDTA) 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 name (including last name, 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, 21, 60).

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 and Credentials — Requesting / Performing Provider
Enter the name and credentials of the therapist who will be providing treatment.

Element 5 — Requesting / Performing Provider's Medicaid Provider No. (not required)

Element 6 — Telephone Number — Requesting / 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 No.
Enter the referring/prescribing provider's eight-digit provider number.

SECTION III — DOCUMENTATION

Per HFS 101.03(37), Wis. Admin. Code, "Adult Mental Health Day Treatment" is described by the following definition:

> "Day treatment" or "day hospital" means a non-residential program in a medically supervised setting that provides case management, medical care, psychotherapy and other therapies, including recreational, physical, occupational and speech therapies, and follow-up services, to alleviate problems related to mental illness or emotional disturbances.
>
> **Note:** Day treatment services are provided by an interdisciplinary team on a routine, continuous basis for a scheduled portion of a 24-hour day and may include structural rehabilitative activities including training in basic living skills, interpersonal skills and problem-solving skills.

Element 9
Enter the number of hours requested per week.

Element 10
Enter the estimated final treatment date.

Element 11
Indicate if the recipient has had previous day treatment at the provider's facility or elsewhere.

Element 12
Describe evaluation, including date(s), tests used, and results.

Element 13
Attach page 1 of the recipient's most recent Functional Assessment Scales. (Functional Assessment must be signed and dated within three months of receipt by Wisconsin Medicaid.)

Element 14
Indicate if the recipient's intellectual functioning is below average.

Element 15
Provide a brief history pertinent to requested services (Include psycho-social history, hospitalization history, family history, living situation history, etc.).

Element 16
Describe progress/status since treatment began or was last authorized, if applicable.

Element 17
Specify overall character of service to be provided.

> **Rehabilitation.** This category is used for all of the target adult mental health day treatment population who may benefit by **intensive** adult mental health day treatment.
>
> **Maintenance.** This category is for those recipients, who by diagnosis and history, are suffering from a **chronic mental disorder** as indicated by diagnosis, signs of illness for two or more years, and past intensive adult mental health day treatment that has already been tried for six months or more with no apparent change in functional assessment and/or narrative history. The major goal of treatment here is to **maintain** the individual in the community and prevent hospitalization.
>
> **Stabilization.** This category is for those recipients in the target population who decompensate and/or have an acute exacerbation of a chronic condition. The goal in this category is to increase structure, stabilize the recipient, prevent harm to self and/or others, and/or prevent hospitalization. Decompensation would be indicated by a recent hospitalization (i.e., within the last 30 days), and/or other acceptable signs of clear deterioration (in level and course of functioning).

Element 18
Identify measurable treatment goals.

Element 19
Attach a specific schedule of activities, including date, time of day, length of session, and service to be provided.

Element 20
Estimate the recipient's rehabilitation potential for employment (competitive, supported, sheltered, etc.), social interaction, and independent living.

Element 21 — Signature — Recipient or Representative
Enter the signature of the recipient or representative.

Element 22 — Date Signed
Enter the month, day, and year the PA/AMHDTA was signed (in MM/DD/YY format) by the recipient or representative.

Element 23 — Relationship (if representative)
Include relationship to recipient (if a representative signs).

Element 24 — Signature — Prescribing Physician
Enter the signature of the prescribing physician.

Element 25 — Date Signed
Enter the month, day, and year the PA/AMHDTA was signed (in MM/DD/YY format) by the prescribing physician.

Element 26 — Signature — Therapist Providing Treatment
Enter the signature of the therapist providing treatment.

Element 27 — Date Signed
Enter the month, day, and year the PA/AMHDTA was signed (in MM/DD/YY format) by the therapist providing the treatment.

Element 28 — Signature — 51.42 Board Director / Designee
Enter the signature of the 51.42 board director or designee.

Element 29 — Date Signed
Enter the month, day, and year the PA/AMHDTA was signed (in MM/DD/YY format) by the 51.42 board director/designee.

ATTACHMENT 8
Prior Authorization / Adult Mental Health Day Treatment Attachment (PA/AMHDTA) (for photocopying)

(A copy of the "Prior Authorization/Adult Mental Health Day Treatment Attachment [PA/AMHDTA]" [for photocopying] may be found on the following pages.)

DEPARTMENT OF HEALTH AND FAMILY SERVICES **STATE OF WISCONSIN**
Division of Health Care Financing
HCF 11038 (Rev. 06/03)

WISCONSIN MEDICAID

PRIOR AUTHORIZATION / ADULT MENTAL HEALTH DAY TREATMENT ATTACHMENT (PA/AMHDTA)

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 PA/AMHDTA Completion Instructions (HCF 11038A).

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 — Requesting / Performing Provider

5. Requesting / Performing Provider's Medicaid Provider No.	6. Telephone Number — Requesting / Performing Provider
7. Name — Referring / Prescribing Provider	8. Referring / Prescribing Provider's Medicaid Provider No.

SECTION III — DOCUMENTATION

9. Number of hours per week requested	10. Estimated final treatment date

11. Has the recipient had previous adult mental health day treatment at the provider's facility or elsewhere?

❑ Yes ❑ No ❑ Unknown

If "Yes," list dates and locations.

12. Evaluation(s). Include date(s), tests used, and results.

Continued

SECTION III — DOCUMENTATION (Continued)

13. Attach page 1 of the recipient's most recent Functional Assessment Scales. (Functional Assessment must be signed and dated within three months of receipt by Wisconsin Medicaid.)

14. Is the recipient's intellectual functioning below average? ❑ Yes ❑ No
If "yes," what is the recipient's IQ score or intellectual functioning level, and how was this measured?

15. Provide a brief history pertinent to requested services (Include psycho-social history, hospitalization history, family history, living situation history, etc.).

16. Describe progress / status since treatment began or was last authorized, if applicable.

Continued

SECTION III — DOCUMENTATION (Continued)

17. Specify overall character of service to be provided.

❑ Rehabilitation ❑ Maintenance ❑ Stabilization

18. Identify measurable treatment goals.

19. Attach a specific schedule of activities, including date, time of day, length of session, and service to be provided.

20. Estimate the recipient's rehabilitation potential for employment (competitive, supported, sheltered, etc.), social interaction, and independent living.

Continued

SECTION III — DOCUMENTATION (Continued)

I have read the attached requests for PA of adult mental health day treatment services and agree that it will be sent to Wisconsin Medicaid for review.

21. **SIGNATURE** — Recipient or Representative	22. Date Signed
23. Relationship (if representative)	
24. **SIGNATURE** — Prescribing Physician	25. Date Signed
26. **SIGNATURE** — Therapist Providing Treatment	27. Date Signed
28. **SIGNATURE** — 51.42 Board Director / Designee	29. Date Signed