wisconsin Medicaid update
and BadgerCare

July 2003 ● No. 2003-72
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Wisconsin Medicaid and BadgerCare Information for Providers

To:
Nursing Homes
Occupational Therapists
Physical Therapists
Rehabilitation Agencies
Speech and Hearing Clinics
Speech-Language Pathologists
Therapy Groups
HMOs and Other Managed Care Programs

Changes to local codes, paper claims, and prior authorization for physical therapy, occupational therapy, and speech and language pathology 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 physical therapy (PT), occupational therapy (OT), and speech and language pathology (SLP) 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 physical therapy (PT), occupational therapy (OT), and speech and language pathology (SLP) services. These changes will be implemented in October 2003 as a result of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). A future *Update* will notify providers of the specific effective dates for the various changes. These changes are not policy or coverage related (e.g., PA requirements, documentation requirements), but include:

- Adopting nationally recognized 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 codes

Wisconsin Medicaid will adopt nationally recognized medical codes to replace currently used Wisconsin Medicaid local codes for PT, OT, and SLP services.

Allowable procedure codes

Medicaid-certified PT, OT, and SLP providers should continue to use the *Current Procedural Terminology* procedure codes that they use currently. Providers should continue to refer to their service-specific *Updates* and handbooks for nationally recognized procedure codes that Wisconsin Medicaid covers.

Modifiers

Wisconsin Medicaid will adopt nationally recognized Healthcare Common Procedure Coding System (HCPCS) modifiers to replace currently used Wisconsin Medicaid local modifiers ("PT," "OT," and "GS") for PT and OT services. Refer to Attachment 1 of this *Update* for a modifier conversion chart. Physical therapy and OT providers will be required to use the appropriate HCPCS modifier or modifiers that describe the service performed; these modifiers do not apply to SLP services.

Birth to 3 Natural Environment Enhanced Reimbursement

Wisconsin Medicaid will require the "TL" modifier for services that meet the criteria for the *natural environment enhanced reimbursement when providing services to children in the Birth to 3 (B-3) Program.* Providers submitting claims that meet the criteria for the natural environment enhanced reimbursement when providing services to children in the B-3 Program will be required to use a combination of the "TL" modifier and one of the following national POS codes: "04," "12," and "99."

Type of service codes

Type of service codes will no longer be required on Medicaid claims or 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 PT, OT, and SLP services.

Coverage for physical therapy, occupational therapy, and speech and language pathology services

Medicaid coverage and documentation requirements for PT, OT, and SLP services will remain unchanged. Refer to the Physical Therapy and Occupational Therapy Handbook, Speech and Language Pathology Handbook, and *Updates* for complete Medicaid policies and procedures.

Physical therapy and OTproviders will be required to use the appropriate HCPCS modifier or modifiers that describe the service performed; these modifiers do not apply to SLP services.

Revision of CMS 1500 paper claim instructions

With the implementation of HIPAA, Medicaid-certified PT, OT, and SLP 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. Attachments 4-7 are samples of claims for PT, OT, and SLP services that reflect the changes to the billing instructions.

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

Revisions made to the CMS 1500 claim form instructions

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

- Other insurance indicators were revised (Element 9).
- Medicare disclaimer codes were revised (Element 11).
- Place of service codes were revised (Element 24B).
- Type of service codes are no longer required (Element 24C).
- Up to four modifiers per procedure code may be entered (Element 24D).
- HealthCheck indicators "H" and "B" are not required (Element 24H).
- Wisconsin Medicaid will no longer accept mother/baby claims. Refer to the June 2003 *Update* (2003-29), titled "Wisconsin Medicaid no longer reimburses claims for newborns under the mother's identification number," for more information.

The PA/TA, PA/B3, and PA/SOIA are available in a fillable Portable Document Format (PDF) from the forms page of the Wisconsin Medicaid Web site.

Revision of prior authorization request forms and instructions

With the implementation of HIPAA, PT, OT, and SLP 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 8. Sample PA/RFs are in Attachments 9-13.

Revisions made to the Prior Authorization Request Form

The following revisions were made to the PA/RF:

- Requested start date field added (Element 14).
- Space for performing provider number added for each service/procedure (Element 15). Rehabilitation agencies do not indicate a performing provider number.
- Space added for additional modifiers (Element 17).
- Place of service codes were revised (Element 18).
- Type of service codes are no longer required.

Prior authorization attachments

The Prior Authorization/Therapy Attachment (PA/TA), HCF 11008, dated 06/03; Prior Authorization/Birth to 3 Therapy Attachment (PA/B3), HCF 11011, dated 01/03; and Prior Authorization/Spell of Illness Attachment (PA/SOIA), HCF 11039, dated 06/03; have also been revised. The basic information requested on the PA/TA and the PA/B3 has not changed; only the format of the forms has changed. However, the information requested on the PA/SOIA has changed. Refer to the July 2003 *Update* (2003-79), titled "Changes to spell of illness prior authorization," to learn more about the changes. Refer to Attachments 14-18 for completion instructions and forms for providers to photocopy for the PA/TA, PA/B3, and PA/SOIA.

Obtaining Prior Authorization Request Forms

The PA/TA, PA/B3, and PA/SOIA are available in a fillable Portable Document Format (PDF) from the forms page of the Wisconsin Medicaid Web site. (Providers cannot obtain copies of the PA/RF from the Medicaid Web site since each form has a unique preprinted PA number on it.) To access the PA/TA, PA/B3, PA/SOIA, 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/TA, PA/B3, PA/SOIA, 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

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/*.

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.

* 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
Modifier chart for physical therapy, occupational therapy, and speech and language pathology services

The table below lists the Healthcare Common Procedure Coding System (HCPCS) modifiers that providers will be required to use when submitting claims for physical therapy (PT), occupational therapy (OT), and speech and language pathology (SLP) 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**	
Provider	**Local modifier or POS* code**	**Local modifier or POS code description**	**HCPCS modifier**	**HCPCS modifier description**
OT	OT	Occupational therapy	GO	Services delivered [personally by an occupational therapist or] under an outpatient occupational therapy plan of care
PT	PT	Physical therapy	GP	Services delivered [personally by physical therapist or] under an outpatient physical therapy plan of care
PT and OT	GS	Therapy assistant under general supervision	TF	Intermediate level of care
PT, OT, and SLP	Birth to 3 services billed with POS code "0" or "4"	Birth to 3 services provided in a natural environment	TL**	Early intervention/individualized family service plan (IFSP)

*POS = Place of service

**The "TL" modifier can only be used in conjunction with POS codes "04," "12," and "99."

ATTACHMENT 2
Place of service codes for physical therapy, occupational therapy, and speech and language pathology services

The table below lists the place of service (POS) codes that providers will be required to use when submitting claims after the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) implementation.

POS code	POS code description
04*	Homeless Shelter
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
12*	Home
15	Mobile Unit
20	Urgent Care Facility
21**	Inpatient Hospital
22**	Outpatient Hospital
31	Skilled Nursing Facility
32	Nursing Facility
33	Custodial Care Facility
34	Hospice
50	Federally Qualified Health Center
54	Intermediate Care Facility/Mentally Retarded
71	State or Local Public Health Clinic
72	Rural Health Clinic
99*	Other Place of Service

*Place of service codes "04," "12," and "99" are eligible for the natural environment enhanced reimbursement when providing services to children in the Birth to 3 Program.

**Place of service codes "21" and "22" are allowable for speech and language pathology services only.

ATTACHMENT 3
CMS 1500 claim form instructions for physical therapy, occupational therapy, and speech and language pathology services

(For claims submitted after HIPAA implementation)

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

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

Element 1 — Program Block/Claim Sort Indicator

Enter claim sort indicator "T" for physical therapy (PT), occupational therapy (OT), and speech and language pathology (SLP) services or "M" for rehabilitation agency services 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). Specify whether the recipient is male or female by placing an "X" in the appropriate box.

Element 4 — Insured's Name (not required)

Element 5 — Patient's Address

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

Element 6 — Patient Relationship to Insured (not required)

Element 7 — Insured's Address (not required)

Element 8 — Patient Status (not required)

Element 9 — Other Insured's Name

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

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

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

Code	Description
OI-P	PAID in part or in full by commercial health insurance or commercial HMO. In Element 29 of this claim form, indicate the amount paid by commercial health insurance to the provider or to the insured.
OI-D	DENIED by commercial health insurance or commercial HMO following submission of a correct and complete claim, or payment was applied towards the coinsurance and deductible. Do not use this code unless the claim was actually billed to the commercial health insurer.
OI-Y	YES, the recipient has commercial health insurance or commercial HMO coverage, but it was not billed for reasons including, but not limited to: ✓ 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

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

Element 20 — Outside Lab? (not required)

Element 21 — Diagnosis or Nature of Illness or Injury

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

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 procedure using the following guidelines:

- When billing for one DOS, enter the date in MM/DD/YY 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 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 procedures have the same place of service (POS) code.
- All procedures 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.

Element 24B — Place of Service

Enter the appropriate two-digit POS code for each service. Refer to Attachment 2 of this *Wisconsin Medicaid and BadgerCare Update* for a list of allowable POS codes for PT, OT, and SLP services.

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 (up to four per procedure code) modifier(s) 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 for each line item. Always use a decimal (e.g., 1.0 units). Physical therapy, OT, and SLP services must be billed following the conversion of therapy treatment time guidelines; providers should refer to the Physical Therapy and Occupational Therapy Handbook and the Speech and Language Pathology Services Handbook.

Element 24H — EPSDT/Family Plan (not required)

Element 24I — EMG (not required)

Element 24J — COB (not required)

Element 24K — Reserved for Local Use

Enter the eight-digit Medicaid provider number of the performing provider for each procedure if that number is different than the billing provider number in Element 33. Any other information entered in this element may cause claim denial.

Note: Rehabilitation agencies do not indicate a performing provider number.

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 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)

Enter the name and address of the facility where the services were provided only when submitting claims for POS codes "31" or "32." It is not necessary to add any information in this element for any other POS.

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. Minimum requirement is the provider's name, address, 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 physical therapy services

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE [ ] (Medicare #) MEDICAID [T] (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 St

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-7

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: IM Referring MD

17a. I.D. NUMBER OF REFERRING PHYSICIAN: B12345

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. 436.
2. 437.0
3. .
4. .

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 1234567

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 01 04 05	06 10	11		97116	GP	1	XX XX	6.0				12345678
2 02 20 05		11		97110	GP	2	XX XX	1.5				12345678
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) 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.)

J.M. Authorized MM/DD/YY

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

I.M. Therapist
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
Sample CMS 1500 claim form
for occupational therapy services

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #) | MEDICAID T (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 ☐ F X

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

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

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 ☐

CITY | STATE

ZIP CODE: 55555 | TELEPHONE (Include Area Code): (XXX) XXX-XXXX

Employed ☐ Full-Time Student ☐ Part-Time Student ☐

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-7

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: IM Referring

17a. I.D. NUMBER OF REFERRING PHYSICIAN: B12345

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. 436 3. ____

2. 437.0 4. ____

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 1234567

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 10 20 04	23 27	11		97150	GO TF	1	XX XX	6.0				12345678
2 10 23 04		12		97110	GO TF TL	2	XX XX	1.0				12345678
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) 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.)

J.M. authorized MM/DD/YY

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

Therapy Group
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 6
Sample CMS 1500 claim form
for speech and language pathology 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 ☐ F ☒

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

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

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):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: M-7

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

17a. I.D. NUMBER OF REFERRING PHYSICIAN

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. 436.__
2. 437.0
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 12 04 04	07 10	11		92507		1	XX XX	3.0				12345678
2 12 07 04		11		92508		1	XX XX	1.0				12345678
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) ☐ YES ☐ NO

28. TOTAL CHARGE: $ XXX XX

29. AMOUNT PAID: $ 00.00

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.)

D.M. authorized MM/DD/YY

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

I.M. Pathologist
1 W. Williams
Anytown, WI 55555

PIN# 87654321 GRP#

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) *PLEASE PRINT OR TYPE*

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

ATTACHMENT 7
Sample CMS 1500 claim form
for rehabilitation agency 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 ☐ F ☒

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

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

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 ☐

CITY: STATE:

ZIP CODE: 55555 TELEPHONE (Include Area Code): (XXX) XXX-XXXX

Employed ☐ Full-Time Student ☐ Part-Time Student ☐

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-7

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

17a. I.D. NUMBER OF REFERRING PHYSICIAN

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. 436.
2. 437.0
3. .
4. .

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 1234567

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 05 04	06 14	11		97116	GP TF	1	XX XX	6.0				
2 12 10 04		11		97110	GP TF	2	XX XX	1.0				
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) 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.)

J.M. Authorized MM/DD/YY

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

Rehabilitation Agency
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 8
Prior Authorization Request Form (PA/RF) Completion Instructions for physical therapy, occupational therapy, and speech and language pathology 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/Therapy Attachment (PA/TA), Prior Authorization/Birth to 3 Therapy Attachment (PA/B3), or Prior Authorization/Spell of Illness Attachment (PA/SOIA), as applicable, 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 the appropriate three-digit processing type from the list below. The processing type is a three-digit code used to identify the category of service requested. Use processing type "999" (Other) only if the requested category of service is not found in the list below. Prior authorization and spell of illness (SOI) requests will be returned without adjudication if no processing type is indicated.

111 — Physical Therapy (PT)
112 — Occupational Therapy (OT)
113 — Speech and Language Pathology (SLP)
114 — SOI for PT
115 — SOI for OT
116 — SOI for SLP
160 — Birth to 3 (B-3) for PT
161 — B-3 for OT
162 — B-3 for SLP
999 — Other (use only if the requested category or service is not listed above)

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
Do not complete this element unless requesting an SOI. Enter the date of onset for the SOI in MM/DD/YY format.

Element 12 — First Date of Treatment — SOI
Do not complete this element unless requesting an SOI. Enter the date of the first treatment for the SOI in MM/DD/YY format.

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. If requesting an SOI, leave this element blank.

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 requesting an SOI, leave this element blank.

Element 15 — Performing Provider Number
Enter the eight-digit Medicaid provider number of the provider who will be performing the service, *only* if this number is different from the billing provider number listed in Element 4. If the treating therapist is the therapy assistant, enter the provider number of the supervising therapist. Rehabilitation agencies do not indicate a performing provider number.

Element 16 — Procedure Code
Enter the appropriate procedure code for each service/procedure requested. If requesting a B-3 service, leave this element blank.

Element 17 — Modifiers
Enter the "GP" modifier for PT services and the "GO" modifier for OT services. No modifier is needed for SLP services. Do not enter the "TF" modifier or the "TL" modifier.

Element 18 — POS
Enter the appropriate place of service (POS) code designating where the requested service/procedure would be provided/performed. Refer to Attachment 2 of this *Wisconsin Medicaid and BadgerCare Update* for a list of allowable POS codes for PT, OT, and SLP services.

Element 19 — Description of Service
Enter the written description corresponding to the appropriate procedure code for each service/procedure requested. If requesting a B-3 service, enter "Birth to 3" and the therapy discipline as the description (e.g., "Birth to 3 occupational therapy services" for OT services).

Element 20 — QR
Enter the appropriate quantity requested for each procedure code listed. If requesting an SOI or a B-3 service, leave this element blank.

Element 21 — Charge
Enter the usual and customary charge for each procedure code listed. If the quantity is greater than "1," multiply the quantity by the charge for each service/procedure requested. Enter that total amount in this element. If requesting an SOI or a B-3 service, leave this element blank.

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. If requesting an SOI or a B-3 service, leave this element blank.

Element 23 — Signature — Requesting Provider
The original signature of the provider requesting/performing this service/procedure 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 9
Sample Prior Authorization Request Form (PA/RF) for physical therapy services

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

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

WISCONSIN MEDICAID
PRIOR AUTHORIZATION REQUEST FORM (PA/RF)

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

FOR MEDICAID USE — ICN	AT	Prior Authorization Number
		1234567

SECTION I — PROVIDER INFORMATION

1. Name and Address — Billing Provider (Street, City, State, Zip Code)	2. Telephone Number — Billing Provider	3. Processing Type
Therapy Group **1 W. Williams** **Anytown, WI 55555**	**(XXX) XXX-XXXX**	**111**
	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) **Recipient, Ima**	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
436 CVA		
13. Diagnosis — Secondary Code and Description **437.0 Cerebral atherosclerosis**	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
87654321	**97116**	**GP**				**11**	**Gait training/transferring 15 min x 3/wk x 11 wk**	**33**	**XXX.XX**
87654321	**97110**	**GP**				**11**	**Strengthening exercises 15 min x 3/wk x 11 wk**	**33**	**XXX.XX**
87654321	**97032**	**GP**				**11**	**E Stim**	**33**	**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 ***I. M. Provider***

24. Date Signed **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 10
Sample Prior Authorization Request Form (PA/RF) for occupational therapy services

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

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

WISCONSIN MEDICAID
PRIOR AUTHORIZATION REQUEST FORM (PA/RF)

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

FOR MEDICAID USE — ICN	AT	Prior Authorization Number
		1234567

SECTION I — PROVIDER INFORMATION

1. Name and Address — Billing Provider (Street, City, State, Zip Code)	2. Telephone Number — Billing Provider	3. Processing Type
Therapy Group **1 W. Williams** **Anytown, WI 55555**	**(XXX) XXX-XXXX**	**112**
	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) **Recipient, Ima**	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
436 CVA		
13. Diagnosis — Secondary Code and Description **437.0 Cerebral atherosclerosis**	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
87654321	**97110**	**GO**				**11**	**Strengthening exercises 15 min x 3/wk x 11 wk**	**33**	**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 11
Sample Prior Authorization Request Form (PA/RF) for speech and language pathology services

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

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

WISCONSIN MEDICAID
PRIOR AUTHORIZATION REQUEST FORM (PA/RF)

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

FOR MEDICAID USE — ICN	AT	Prior Authorization Number
		1234567

SECTION I — PROVIDER INFORMATION

1. Name and Address — Billing Provider (Street, City, State, Zip Code)	2. Telephone Number — Billing Provider	3. Processing Type
I.M. Billing **1 W. Williams** **Anytown, WI 55555**	**(XXX) XXX-XXXX**	**113**
	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, Ima	❑ M ☒ F	

SECTION III — DIAGNOSIS / TREATMENT INFORMATION

10. Diagnosis — Primary Code and Description	11. Start Date — SOI	12. First Date of Treatment — SOI
315.31 Language Delays		
13. Diagnosis — Secondary Code and Description	14. Requested Start Date	
783.4 Developmental Delays	**MM/DD/YY**	

15. Performing Provider Number	16. Procedure Code	17. Modifiers 1	2	3	4	18. POS	19. Description of Service	20. QR	21. Charge
87654321	**92506**					**11**	**Speech/Language Evaluation**	**1**	**XXX.XX**
87654321	**92507**					**11**	**Speech/Language Therapy**	**17**	**XXX.XX**
87654321	**92508**					**11**	**Group Speech/Language Therapy**	**17**	**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 12
Sample Prior Authorization Request Form (PA/RF) to be submitted with the Prior Authorization / Birth to 3 Attachment (PA/B3)

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

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

WISCONSIN MEDICAID
PRIOR AUTHORIZATION REQUEST FORM (PA/RF)

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

FOR MEDICAID USE — ICN	AT	Prior Authorization Number
		1234567

SECTION I — PROVIDER INFORMATION

1. Name and Address — Billing Provider (Street, City, State, Zip Code)	2. Telephone Number — Billing Provider	3. Processing Type
Therapy Group **1 W. Williams** **Anytown, WI 55555**	**(XXX) XXX-XXXX**	**161**
	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, Ima	❑ M ☒ F	

SECTION III — DIAGNOSIS / TREATMENT INFORMATION

10. Diagnosis — Primary Code and Description	11. Start Date — SOI	12. First Date of Treatment — SOI
783.4 Developmental delays		
13. Diagnosis — Secondary Code and Description	14. Requested Start Date	
	MM/DD/YY	

15. Performing Provider Number	16. Procedure Code	17. Modifiers 1	2	3	4	18. POS	19. Description of Service	20. QR	21. Charge
87654321		**GO**				**12**	**Birth to 3 occupational therapy services**		

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**	

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 13
Sample Prior Authorization Request Form (PA/RF) to be submitted with the Prior Authorization / Spell of Illness Attachment (PA/SOIA)

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

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

WISCONSIN MEDICAID
PRIOR AUTHORIZATION REQUEST FORM (PA/RF)

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

FOR MEDICAID USE — ICN	AT	Prior Authorization Number
		1234567

SECTION I — PROVIDER INFORMATION

1. Name and Address — Billing Provider (Street, City, State, Zip Code)	2. Telephone Number — Billing Provider	3. Processing Type
Therapy Group **1 W. Williams** **Anytown, WI 55555**	**(XXX) XXX-XXXX** 4. Billing Provider's Medicaid Provider Number **12345678**	**116**

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, Ima	❑ M ☒ F	

SECTION III — DIAGNOSIS / TREATMENT INFORMATION

10. Diagnosis — Primary Code and Description	11. Start Date — SOI	12. First Date of Treatment — SOI
436 CVA	**MM/DD/YY**	**MM/DD/YY**
13. Diagnosis — Secondary Code and Description	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
87654321	**92526**					**11**	**dysphagia therapy**		
87654321	**92507**					**11**	**speech therapy**		

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**

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 14
Prior Authorization / Therapy Attachment (PA/TA) Completion Instructions

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

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DEPARTMENT OF HEALTH AND FAMILY SERVICES **STATE OF WISCONSIN**
Division of Health Care Financing (800) 947-9627
HCF 11008A (Rev. 06/03)

WISCONSIN MEDICAID
PRIOR AUTHORIZATION / THERAPY ATTACHMENT (PA/TA) 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 on this form and is formatted exactly like this form. If necessary, attach additional pages if more space is needed. 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.

Each provider must submit sufficient detailed information. Sufficient detailed information on a PA request means enough clinical information regarding the recipient to meet Wisconsin Medicaid's definition of "medically necessary." "Medically necessary" is defined in HFS 101.03(96m), Wis. Admin. Code. Each PA request is unique, representing a specific clinical situation. Therapists typically consider a number of issues that influence a decision to proceed with therapy treatment at a particular frequency to meet a particular goal. Those factors that influence treatment decisions should be documented on the PA request. Medicaid therapy consultants will consider documentation of those same factors to determine whether or not the request meets Wisconsin Medicaid's definition of "medically necessary." Medicaid consultants cannot "fill in the blanks" for a provider if the documentation is insufficient or unclear. The necessary level of detail may vary with each PA request and within the various sections of a PA request.

These directions are formatted to correspond to each required element on the Prior Authorization/Therapy Attachment (PA/TA). The **bold** headings directly reflect the name of the element on the PA/TA. The proceeding text reflects instructions, hints, examples, clarification, etc., that will help the provider document medical necessity in sufficient detail.

Attach the completed PA/TA 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

SECTION I — RECIPIENT / PROVIDER INFORMATION

Enter the following information into the appropriate box:

Element 1 — Name — Recipient
Enter the recipient's last name, first name, and middle initial. Use Wisconsin Medicaid's Eligibility Verification System (EVS) to obtain the correct spelling of the recipient's name. If the name or the spelling of the name on the Medicaid identification card and the EVS do not match, use the spelling from the EVS. Refer to the Provider Resources section of the All-Provider Handbook for ways to access the EVS.

Element 2 — Recipient Medicaid ID Number
Enter the recipient's 10-digit Medicaid identification number. Do not enter any other numbers or letters.

Element 3 — Age — Recipient
Enter the age of the recipient in numerical form (e.g., 16, 21, 60).

Element 4 — Name and Credentials — Therapist
Enter the treating therapist's name and credentials. If the treating therapist is a therapy assistant, enter the name of the supervising therapist and the name of the therapy assistant.

Element 5 — Therapist's Medicaid Provider No.
Enter the treating therapist's eight-digit Medicaid provider number. If the treating therapist is the therapy assistant, enter the provider number of the supervising therapist. Rehabilitation agencies do not indicate a performing provider number.

Element 6 — Telephone No. — Therapist
Enter the treating therapist's telephone number, including area code and extension (if applicable). If the treating therapist is a therapy assistant, enter the telephone number of the supervising therapist.

Element 7 — Name — Referring / Prescribing Physician
Enter the referring or prescribing physician's name.

Be sure:
- The recipient's name corresponds with the Medicaid identification number listed.
- The recipient's Medicaid identification number has 10 digits.
- The recipient is currently Medicaid eligible.
- The provider's name and Medicaid identification number match.
- The provider's Medicaid number has eight digits.

Note: All of the information in this section must be complete, accurate, and exactly the same as the information from Medicaid's EVS and on the PA/RF before the PA request is forwarded to a Medicaid consultant. *Incomplete or inaccurate information will result in a returned PA request.*

Element 8 — Requesting PA for Physical Therapy, Occupational Therapy, Speech and Language Pathology
Check the appropriate box on the PA/TA for the type of therapy service being requested.

Element 9 — Total Time Per Day Requested
Enter the anticipated number of minutes a typical treatment session will require. It is expected the requested minutes per session will be consistent with the recipient's history, age, attention span, cognitive ability, medical status, treatment goals, procedures, rehabilitation potential, and any other intervention the recipient receives. Intensity of intervention is determined by rate of change, rather than level of severity.

Element 10 — Total Sessions Per Week Requested
Enter the number of treatment days per week requested. It is expected the requested number of treatment days per week will be consistent with the recipient's history, medical status, treatment goals, rehabilitation potential, and any other intervention the recipient receives. Intensity of intervention is determined by rate of change, rather than level of severity.

Element 11 — Total Number of Weeks Requested
Enter the number of weeks requested. The requested duration should be consistent with the recipient's history, medical status, treatment goals, rehabilitation potential, and any other intervention the recipient receives. The requested duration should correspond to the number of weeks required to reach the goals identified in the plan of care. Intensity of intervention is determined by rate of change, rather than level of severity.

Element 12 — Requested Start Date
Enter the requested grant date for this PA request in MM/DD/YYYY format.

SECTION II — PERTINENT DIAGNOSES / PROBLEMS TO BE TREATED

Element 13 — Provide a description of the recipient's current treatment diagnosis, any underlying conditions, and problem(s) to be treated, including dates of onset.

Indicate the pertinent medical diagnoses that relate to the reasons for providing therapy for the recipient at this time AND any underlying conditions that may affect the plan of care or outcome (e.g., dementia, cognitive impairment, medications, attention deficits). Include dates of onset for all diagnoses. If the date of onset is unknown, state "unknown."

If this documentation is on a previous PA request and is still valid, indicate "this documentation may be found on PA No. XXXXXXX." Providers should review this information for accuracy each time that they submit a PA request.

Note: Avoid copying the same information on subsequent PA requests without verifying that the information continues to be accurate. A PA request may be returned if it appears as if there has been no change documented under Section II, but other sections of the PA suggest there have been some changes to the recipient's medical/functional condition/need.

Example 1: A recipient without cognitive impairment may attain a goal to learn a task in one to three visits. However, achieving the same treatment goal for a cognitively impaired recipient may require additional visits. Knowledge of the recipient's cognitive abilities is critical to understanding the need for the requested additional visits.

Example 2: When the recipient has a medical diagnosis, such as Parkinson's disease or a pervasive developmental disorder, it is necessary to document the medical diagnosis *as well as* the problem(s) being treated. Listing the problem(s) to be treated without a medical diagnosis, or vice versa, is insufficient.

SECTION III — BRIEF PERTINENT MEDICAL / SOCIAL INFORMATION

Element 14 — Include referral information, living situation, previous level of function, any change in medical status since previous PA request(s), and any other pertinent information.

The Medicaid consultant needs to understand the complete "picture" of the recipient and take into consideration the recipient's background, personal needs, status, change in status, etc. Sufficient, but pertinent, documentation of a recipient's medical/social status may include:

- Conditions that may affect the recipient's outcome of treatment.
- Evidence that this recipient will benefit from therapy at this time.
- Reasons why a Medicaid-reimbursed service is being requested at this time (this is helpful when this is not a new diagnosis or is a continuing episode of care for this recipient).

The provider's documentation must include the factors considered when developing the recipient's plan of care. Such factors may be:

- Reasons for referral.
- Referral source (e.g., a second opinion, nursing having difficulty with carry-over program, school therapist referred because school does not have equipment to make orthotics).
- Reason(s) the recipient's medical needs are not met under current circumstances.
- Recent changes (e.g., change in medical status, change in living status) with reference dates.
- Recipient's goal (e.g., recipient's motivation to achieve a new goal may have changed).
- Recipient's living situation.
- Residence (e.g., nursing home vs. independent living).
- Caregiver (who is providing care [specific name not required], how frequently available, ability to follow through with instructions, etc.).
- If caregiver is required — the level of assistance required, the amount of assistance required, the type of assistance required.
- Degree of family support.
- Equipment and/or environmental adaptations used by the recipient.
- Brief history of the recipient's previous functional status.
- Prior level of function.
- Level of function after last treatment episode with reference dates.
- Cognition/behavior/compliance.
- Any other pertinent information that indicates a need for therapy services at this time.

SECTION IV — PERTINENT THERAPY INFORMATION

Element 15 — Document the chronological history of treatment provided for the treatment diagnoses (identified under Section II), dates of those treatments, and the recipient's functional status following those treatments.

Summarize previous episodes of care, if applicable, in the chart provided in this section. If this is a new patient, include history taken from the recipient, recipient's caregivers, or patient file. Include knowledge of other therapy services provided to the recipient (e.g., if requesting a PA for speech and language pathology, include any occupational therapy or physical therapy the recipient may have received as well). Be concise, but informative.

Element 16 — List other service providers that are currently accessed by the recipient for those treatment diagnoses identified under Section II (i.e., home health, school, behavior management, home program, dietary services, therapies). Briefly document the coordination of the therapy treatment plan with these other service providers. Documentation may include telephone logs, summarization of conversations or written communication, copies of plans of care, staffing reports, or received written reports.

Document the coordination of the therapy treatment plan with other service providers that may be working to achieve the same, or similar, goals for the recipient. If there are no other providers currently treating the recipient, indicate "not applicable" in the space provided.

Element 17 — Check the appropriate box (on the PA/TA) and circle the appropriate form, if applicable:

- ❑ **The current Individualized Education Program (IEP) / Individualized Family Service Plan (IFSP) / Individual Program Plan (IPP) is attached to this PA request.**
- ❑ **The current IEP / IFSP / IPP is attached to PA number_____.**
- ❑ **There is no IEP / IFSP / IPP because _____.**
- ❑ **Cotreatment with another therapy provider is within the plan of care.**
- ❑ **Referenced report(s) is attached (list any report[s])_____.**

The IEP, IFSP, and IPP are reports used as follows:

- Individualized Education Plan — A written plan for a 3- to 21-year-old child who receives exceptional education services in school.
- Individualized Family Service Plan — A written plan for a 0- to 3-year-old child who receives therapy services through the Birth to 3 Program.
- Individualized Program Plan — A written active treatment plan for individuals who reside in an Intermediate Care Facility for the Mentally Retarded.

Submission of the IEP, IFSP, and IPP with the PA request is required if the recipient is receiving services that require one of the above written plans.

This section is included as a quick reference to remind providers to attach the necessary documentation materials to the PA request and to remind providers to document cotreatment, if applicable, in their plan of care.

Cotreatment is when two therapy types provide their respective services to one recipient during the same treatment session. For example, occupational therapists and physical therapists treat the recipient at the same time or occupational therapists and speech-language pathologists treat the recipient at the same time. It is expected that the medical need for cotreatment be documented in both providers' plans of care and that *both* PA requests are submitted *in the same envelope*.

Other "referenced reports" may be swallow studies, discharge summaries, surgical reports, dietary reports, or psychology reports. These reports should be submitted with the PA request when the information in those reports influenced the provider's treatment decision making and were referenced elsewhere in the PA request. Prior authorization requests submitted without the required or referenced documentation attached to the PA request will be returned to the provider.

SECTION V — EVALUATION (COMPREHENSIVE RESULTS OF FORMAL / INFORMAL TESTS AND MEASUREMENTS THAT PROVIDE A BASELINE FOR THE RECIPIENT'S FUNCTIONAL LIMITATIONS)

Element 18 — Attach a copy of the initial evaluation or the most recent evaluation or re-evaluation, *or* indicate with which PA number this information was previously submitted.

- ❑ **Comprehensive initial evaluation attached. Date of initial comprehensive evaluation _____.**
- ❑ **Comprehensive initial evaluation submitted with PA number _____.**
- ❑ **Current re-evaluation attached. Date of most current evaluation or re-evaluation(s) _____.**
- ❑ **Current re-evaluation submitted with PA number _____.**

A copy of the comprehensive evaluation for the current episode of care (for the current problem being treated) must be included with the PA request or submitted previously with another PA request, regardless of when treatment was initiated, and regardless of the reimbursement source at the time of the comprehensive evaluation. An evaluation defining the recipient's overall functional abilities and limitations with baseline measurements, from which a plan of care is established, is necessary for the Medicaid consultant to understand the recipient's needs and the request.

The initial evaluation must:

(1) Establish a baseline for identified limitations — Provide baseline measurements that establish a performance (or ability) level, *using units of objective measurement that can be consistently applied when reporting subsequent status*. It is very important to use consistent units of measurement throughout documentation, or be able to explain why the units of measurement changed.

Example 1: If the functional limitation is "unable to brush teeth," the limiting factor may be due to strength, range of motion, cognition, sensory processing, or equipment needs. The baseline should establish the status of identified limiting factors. Such factors may include:

- Range of motion measurements in degrees.
- Eye-hand coordination as measured by a testing tool or units of speed and accuracy.
- Oral sensitivity as measured by an assessment tool or type of reaction to specific kinds of textures or temperatures at specific oral cavity/teeth location.
- Grasp deficits including type of grasp and grip strength.

Later on, subsequent progress must be described using the same terms (e.g., grip strength increased by 2 pounds).

Example 2: If the functional limitation is "unable to sit long enough to engage in activities," indicate "the recipient can short sit for two minutes, unsupported, before losing his balance to the left." Later on, progress can be documented in terms of time.

(2) Relate the functional limitations to an identified deficit — The evaluation must be comprehensive enough that another, independent clinician would reasonably reach the same conclusion regarding the recipient's functional limitation.

Example 1: The recipient is referred to therapy because "she doesn't eat certain types of foods." The evaluation should clearly indicate the reason for not eating those certain foods. A deficit has not been identified if testing indicates the recipient only eats Food "B." Some deficit examples (for not eating a variety of foods) are: cleft palate, oral defensiveness, lip closure, tongue mobility, an aversion to food, aspiration, attention span, recipient is G-tube fed and is therefore not hungry. The identified deficit must be objectively measured and quantified (i.e., a baseline — see above).

Example 2: The recipient is referred to therapy because "he cannot go up and down stairs safely." The evaluation should clearly indicate the reasons for this functional limitation. A deficit has not been identified if the results of testing indicate the recipient can only step up three inches. Strength, range of motion, balance, sensory processing, motivation, etc., must be assessed and documented to identify the deficit causing the functional limitation (i.e., objectively tested, measured, and quantified on the evaluation).

A re-evaluation is the process of performing selected tests and measures (after the initial evaluation) in the targeted treatment area(s) to evaluate progress, functional ability, treatment effectiveness, and/or to modify or redirect intervention. The re-evaluation must be submitted with the PA request whenever it is necessary to update the recipient's progress/condition. Using the same tests and measurements as used in the initial evaluation is essential to reviewing status/progress. If new tests or measurements are used in the re-evaluation, explain why a different measurement tool was used.

SECTION VI — PROGRESS

Element 19 — Describe progress in specific, measurable, objective, and functional terms (using consistent units of measurement) that are related to the goals / limitations, *since treatment was initiated or last authorized.*

(If this information is concisely written in other documentation prepared for the provider's/therapist's records, attach and write "see attached" in the space provided.)

Document the goal or functional limitation in the left column on the PA/TA. Indicate the corresponding status for that goal or limitation *as of the previous PA request or since treatment was initiated (whichever is most recent)* in the middle column on the PA/TA. Indicate the corresponding status of that goal or limitation *as of the date of the current PA request* (do not use "a month ago" or "when last seen" or "when last evaluated") in the third column of the PA/TA. Progress relates to the established baseline, previous goals, and identified limitations. Use the same tests and measurements as those units of measurement used in the baseline description.

The following information is necessary to evaluate the medical necessity of the PA request:

- Progress documented in specific, measurable, and objective terms.
- Use of words that are specific, measurable, or objective and words such as: better, improved, calmer, happier, pleasant, less/more, not as good, not as reliable, longer, more prolonged, and "goal not met," are not specific, measurable, or objective. These do not convey to the Medicaid consultant if or how much progress has been achieved. The following examples are specific, measurable, and objective:
  Example 1: Strength increased from *poor* to *fair*, as determined with a Manual Muscle Test.
  Example 2: Speech intelligibility improved from 30% to 70%, per standardized measurement.

- Consistent use of the same tests and measurements and units of measurement.
  Example: A progress statement that notes the recipient can now eat hamburgers does not correlate to his goal of articulation and the baseline established for articulation.
- *Progress must demonstrate the recipient has learned new skills and therefore has advanced or improved in function* ***as a result of*** *treatment intervention.* "If treatment of underlying factors, such as increase in endurance, strength or range of motion or decrease in pain does not improve the performance of functional activities, then improvement is not considered to be significant" (Acquaviva, p. 85).

  "Significant functional progress: Must result from treatment rather from maturation or other uncontrolled factors, must be real, not random, must be important, not trivial" (Bain and Dollaghan).

- Significant functional progress must have been demonstrated within the past six months for continued therapy PA approval. Prior authorization requests for treatment when the recipient has not advanced or improved function within six months cannot be approved, HFS 107.16(3)(e)1, HFS 107.17(3)(e)1, and HFS 107.18(3)(e)1, Wis. Admin. Code.
- Prior authorization requests for maintenance therapy must demonstrate the functional purpose (medical necessity) of treatment, as "progress" is not necessarily applicable to maintenance programs. The Medicaid consultant will look for evidence that there is a continued functional purpose for the recipient as a result of skilled therapeutic intervention, in accordance with the Wisconsin Administrative Code and applicable *Wisconsin Medicaid and BadgerCare Updates*.

SECTION VII — PLAN OF CARE

Element 20 — Identify the specific, measurable, objective, and functional goals for the recipient (to be met by the end of this PA request) and both of the following:
(1) Indicate the therapist-required skills / treatment techniques that will be used to meet each goal.
(2) Designate (with an asterisk[*]) which goals are reinforced in a carry-over program.

(If the plan of care is concisely written in other documentation prepared for the recipient's records, attach and write "see attached" in the space provided.)

Examples for this section include:
1. GOAL: Client will be 80% intelligible in conversation as judged by an unfamiliar listener.
   Plan of care: Oral motor exercises, environmental cues, articulation skills.
2. GOAL: Client will increase vocabulary with five new words as reported by parent.
   Plan of care: Sing songs, read books, and use adjectives and adverbs in conversation.*
3. GOAL: Client will ascend stairs reciprocally without assistance.
   Plan of care: Gastrocnemius and gluteus medius strengthening.
4. GOAL: Client will transfer into and out of tub with verbal cues.
   Plan of care: Prepare bathroom and client for transfer; provide consistent verbal cues as rehearsed in PT.*
5. GOAL: Client will demonstrate ability to button ½-inch button on dress shirt independently using any pinch pattern.
   Plan of care: Graded finger grasp/pinch strengthening, eye-hand coordination, and bilateral hand use.
6. GOAL: Client will catch/throw a 10" ball.
   Plan of care: Practice play catch while sitting using a variety of objects, e.g., Nerf® ball, plastic ball, beach ball, volleyball, or balloon.*

It is very important to:
- Use consistent units of measurement.
- Document those elements of a treatment plan that only a skilled therapist could implement (e.g., 1, 3, and 5 above).
- Designate (with an asterisk [*]) those goals or interventions the provider has instructed other caregivers or the recipient to incorporate into the recipient's usual routine in his or her usual environment (such as 2, 4, and 6 above where kicking a ball, jumping, throwing a ball, building endurance, rote activities, who/what/where questions, using appropriate pronouns, choosing new foods, etc., are part of the overall plan of care).
- Write goals consistent with functional limitations and identified deficit as described in the evaluation and status statements (Section V) or progress section (Section VI).

Example: The evaluation identified the functional limitation and deficits corresponding to the above examples. Examples of limitations and deficits may include:
1. The client is not intelligible in conversation due to poor tongue control.
2. The 24-month-old client cannot express his needs because he has the vocabulary of a 16-month-old.
3. The client cannot get to his bedroom independently because of *poor* muscle strength.
4. The client cannot safely get into the bathtub because he has poor short-term memory and is easily distractible.
5. The client cannot dress independently because of decreased fine-motor skills as tested on the Peabody and he lacks all functional pinch patterns.
6. The client cannot use hands/arms bilaterally because of poor left upper-extremity proximal stability.

SECTION VIII — REHABILITATION POTENTIAL

Element 21 — Complete the following sentences based upon the professional assessment.

(1) Upon discharge from this episode of care, the recipient will be able to

Describe what the recipient will be able to *functionally do* at the end of this episode of care (not necessarily the end of the PA request) based upon the professional assessment. Discharge planning begins at the initial evaluation. At the initial evaluation the therapist should be able to determine the amount/type of change the recipient is capable of making based upon all the factors presented at the evaluation. Statements such as "will be age appropriate," "will resume prior level of function," "will have effects of multiple sclerosis minimized," or "will eat all foods" are vague and frequently are not achievable with the patient population therapists encounter. More recipient-specific or definitive statements of prognosis would be the following examples:

- "Return to home to live with spouse support."
- "Communicate basic needs and wants with her peers."
- "Go upstairs to his bedroom by himself."
- "Get dressed by herself."
- "Walk in the community with stand-by assistance for safety."
- "Walk to the dining room with or without assistive device and the assistance of a nurse's aide."
- "Swallow pureed foods."

(2) Upon discharge from this episode of care, the recipient may continue to require the following supportive services

Indicate what community or therapy services the recipient may continue to require at the end of this episode of care. Examples include:

- "Range of motion program by caregivers."
- "Infrequent (be specific) screening by therapist to assure maintenance of skills."
- "A communication book."
- "Behavior management services."
- "Dietary consultation."
- "Supervision of (a task) by a caregiver."

(3) The recipient / recipient's caregivers support the therapy plan of care by the following activities and frequency of carryover

Describe what activities the recipient and/or caregivers do or do not do with the recipient that will affect the outcome of treatment.

(4) It is estimated this episode of care will end (provide approximate end time)

Establish an anticipated time frame for the recipient to meet his or her realistic functional goals (e.g., two weeks, two months, two years).

These specific questions are asked to avoid one-word responses (e.g., "good"). Information beyond a one-word response provides the Medicaid consultant with additional detail that supports the justification that therapy services are necessary to meet the recipient's goals. Wisconsin Medicaid recognizes that the statements in this section are considered professional judgments and may not reflect the actual outcome of treatment.

Element 22 — SIGNATURE — Providing Therapist
The providing therapist's signature is required at the end of the PA/TA.

Element 23 — Date Signed
Enter the month, day, and year the PA/TA was signed (in MM/DD/YYYY format) by the providing therapist.

Element 24 — SIGNATURE — Recipient or Recipient Caregiver (optional)
The recipient's or recipient caregiver's signature is optional at this time, but is encouraged (as a means to review what has been requested on the recipient's behalf on the PA request).

Element 25 — Date Signed
Enter the month, day, and year the PA/TA was signed (in MM/DD/YYYY format) by the recipient or recipient's caregiver (if applicable).

If the required documentation is missing from the request form, the request will be returned to the provider for the missing information.

REMINDER: The PA/RF must be filled out completely (i.e., all sections completed). Attach the completed PA/TA and any other documentation to the PA/RF.

REFERENCES

Bain and Dollaghan (1991). Language, Speech and Hearing Services in Schools, 13

Acquaviva, J.D., ed. (1992). Effective Documentation for Occupational Therapy. Rockville, Maryland, The American Occupational Therapy Association, Inc.

Moyers, P.A. (1999). “The Guide to Occupational Therapy Practice.” American Journal of Occupational Therapy (Special Issue), 53 (3)

American Physical Therapy Association, 2001, Guide to Physical Therapist Practice, Physical Therapy, 81 (1)

American Physical Therapy Association, 1997, Guide to Physical Therapist Practice, Physical Therapy, 77 (11)

American Speech-Language and Hearing Association, 1997, Cardinal Documents

American Occupational Therapy Association Standards of Practice

American Physical Therapy Association Standards of Practice

American Speech-Language and Hearing Association Standards of Practice

Wisconsin Administrative Code

ATTACHMENT 15
Prior Authorization / Therapy Attachment (PA/TA) (for photocopying)

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

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DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Health Care Financing
HCF 11008 (Rev. 06/03)

STATE OF WISCONSIN
(800) 947-9627

WISCONSIN MEDICAID

PRIOR AUTHORIZATION / THERAPY ATTACHMENT (PA/TA)

Providers may submit prior authorization (PA) requests by fax to Wisconsin Medicaid at (608) 221-8616; or, providers may send the completed form with attachments to: Wisconsin Medicaid, Prior Authorization, Suite 88, 6406 Bridge Road, Madison, WI 53784-0088.
Instructions: Type or print clearly. Before completing this form, read the Prior Authorization/Therapy Attachment (PA/TA) Completion Instructions (HCF 11008A).

SECTION I — RECIPIENT / PROVIDER INFORMATION

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

4. Name and Credentials — Therapist	5. Therapist's Medicaid Provider No.	6. Telephone No. — Therapist

7. Name — Referring / Prescribing Physician	8. Requesting PA for ❑ Physical Therapy ❑ Occupational Therapy ❑ Speech and Language Pathology

9. Total Time Per Day Requested	10. Total Sessions Per Week Requested

11. Total Number of Weeks Requested	12. Requested Start Date

SECTION II — PERTINENT DIAGNOSES / PROBLEMS TO BE TREATED

13. Provide a description of the recipient's current treatment diagnosis, any underlying conditions, and problem(s) to be treated, including dates of onset.

SECTION III — BRIEF PERTINENT MEDICAL / SOCIAL INFORMATION

14. Include referral information, living situation, previous level of function, any change in medical status since previous PA request(s), and any other pertinent information.

SECTION IV — PERTINENT THERAPY INFORMATION

15. Document the chronological history of treatment provided for the diagnoses (identified under Section II), dates of those treatments, and the recipient's functional status following those treatments.

Provider Type (e.g., occupational therapy, physical therapy, speech and language pathology)	Dates of Treatment	Functional Status After Treatment

Continued

SECTION IV — PERTINENT THERAPY INFORMATION (Continued)

16. List other service providers that are currently accessed by the recipient for those treatment diagnoses identified under Section II (i.e., home health, school, behavior management, home program, dietary services, therapies). Briefly document the coordination of the therapy treatment plan with these other service providers. Documentation may include telephone logs, summarization of conversations or written communication, copies of plans of care, staffing reports, or received written reports.

17. Check the appropriate box and circle the appropriate form, if applicable.

- ❑ The current Individualized Education Program (IEP) / Individualized Family Service Plan (IFSP) / Individual Program Plan (IPP) is attached to this PA request.
- ❑ The current IEP / IFSP / IPP is attached to PA number _____.
- ❑ There is no IEP / IFSP / IPP because _____
  _____.
- ❑ Cotreatment with another therapy provider is within the plan of care.
- ❑ Referenced report(s) is attached (list any report[s]) _____.

SECTION V — EVALUATION (COMPREHENSIVE RESULTS OF FORMAL / INFORMAL TESTS AND MEASUREMENTS THAT PROVIDE A BASELINE FOR THE RECIPIENT'S FUNCTIONAL LIMITATIONS)

18. Attach a copy of the initial evaluation or the most recent evaluation or re-evaluation, **or** indicate with which PA number this information was previously submitted.

- ❑ Comprehensive initial evaluation attached. Date of initial comprehensive evaluation _____.
- ❑ Comprehensive initial evaluation submitted with PA number _____.
- ❑ Current re-evaluation attached. Date of most current evaluation or re-evaluation(s) _____.
- ❑ Current re-evaluation submitted with PA number _____.

SECTION VI — PROGRESS

19. **INSTRUCTIONS:** Describe progress in specific, measurable, objective, and functional terms (using consistent units of measurement) that are related to the goals / limitations, *since treatment was initiated or last authorized*.

Goal / Limitation	Previous Status / Date (MM/DD/YY)	Status as of Date of PA Request / Date (MM/DD/YY)

(If this information is concisely written in other documentation prepared for the provider's/therapist's records, attach and write "see attached" in the space above.)

Continued

SECTION VII — PLAN OF CARE

20. Identify the specific, measurable, objective, and functional goals for the recipient (to be met by the end of this PA request) and both of the following:
    (1) Indicate the therapist-required skills / treatment techniques that will be used to meet each goal.
    (2) Designate (with an asterisk [*]) which goals are reinforced in a carry-over program.

(If the plan of care is concisely written in other documentation prepared for the recipient's records, attach and write "see attached" in the space above.)

SECTION VIII — REHABILITATION POTENTIAL

21. Complete the following sentences based upon the professional assessment.
    (1) Upon discharge from this episode of care, the recipient will be able to

    (2) Upon discharge from this episode of care, the recipient may continue to require the following supportive services

    (3) The recipient / recipient's caregivers support the therapy plan of care by the following activities and frequency of carryover

    (4) It is estimated this episode of care will end (provide approximate end time)

22. SIGNATURE — Providing Therapist	23. Date Signed
24. SIGNATURE — Recipient or Recipient Caregiver (optional)	25. Date Signed

ATTACHMENT 16
Prior Authorization / Birth to 3 Attachment (PA/B3) (for photocopying)

(A copy of the "Prior Authorization/Birth to 3 Attachment [PA/B3]" [for photocopying] is located on the following page.)

DEPARTMENT OF HEALTH AND FAMILY SERVICES **STATE OF WISCONSIN**
Division of Health Care Financing
HCF 11011 (Rev. 01/03)

WISCONSIN MEDICAID
PRIOR AUTHORIZATION / BIRTH TO 3 THERAPY ATTACHMENT (PA/B3)

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 on this form and is formatted exactly like this form. If necessary, attach additional pages if more space is needed.

REMINDER TO PROVIDERS
Providers are reminded that all services must meet the rules and regulations of Wisconsin Medicaid as found in HFS 101-108, Wis. Admin. Code. Providers are further reminded that PA does not guarantee payment for the service.

SUBMITTING PRIOR AUTHORIZATION REQUESTS
Attach the completed Prior Authorization/Birth to 3 Therapy Attachment (PA/B3) 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

Name — Recipient (Last, First, Middle Initial)	Recipient Medicaid Identification Number
Name — Therapist (Last, First, Middle Initial)	Therapist's or Rehabilitation Agency's Medicaid Provider Number

By my signature below, I hereby attest that:

- I am providing an evaluation completed for the purpose of determining the recipient's eligibility for the Birth to 3 (B-3) Program or for the purpose of initiating and/or providing therapy services as part of the Individualized Family Service Plan (IFSP) developed for the recipient.

OR

- I am providing ongoing therapy services and I certify that all of the following are true:
  - √ The IFSP for the child named above was or will be developed and implemented in accordance with the requirements set forth in HFS 90, Wis. Admin. Code.
  - √ The therapy services I am providing to the recipient named above are as stated in the child's current and valid IFSP.
  - √ The frequency and duration of services I am providing to the child named above reflects the frequency and duration of services listed in the recipient's IFSP.
  - √ The recipient of the services is enrolled in a B-3 Program for all dates of service and is younger than three years of age.
  - √ I am a therapist employed by a B-3 Program or am under agreement with a B-3 agency to provide B-3 services.
  - √ The therapy services provided meet all the applicable rules and regulations as stated in HFS 101-108, Wis. Admin. Code, and *Wisconsin Medicaid and BadgerCare Updates*.
  - √ I understand that I am required to maintain a record of services provided to the child named above, per HFS 106, Wis. Admin. Code.

SIGNATURE — Therapist	Date Signed (MM/DD/YYYY)

ATTACHMENT 17
Prior Authorization / Spell of Illness Attachment (PA/SOIA) Completion Instructions

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

DEPARTMENT OF HEALTH AND FAMILY SERVICES **STATE OF WISCONSIN**
Division of Health Care Financing
HCF 11039A (Rev. 06/03)

WISCONSIN MEDICAID
PRIOR AUTHORIZATION / SPELL OF ILLNESS ATTACHMENT (PA/SOIA) 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 the Prior Authorization/Spell of Illness Attachment (PA/SOIA) is voluntary when requesting spell of illness (SOI). Providers may develop their own form as long as it includes all the information on this form and is formatted exactly like this form. Failure to supply the information requested by the form may result in denial of Medicaid payment for the services.

Attach the completed PA/SOIA 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

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

An SOI ends when the maximum allowable treatment days have been used or when the physical therapy (PT), occupational therapy (OT), or speech and language pathology (SLP) services are no longer required, whichever comes first. If, near the end of the maximum allowable treatment days, the skills of a PT, OT, or SLP provider are still needed, the provider should submit the PA/RF and the Prior Authorization/Therapy Attachment (PA/TA) to continue services.

SECTION I — RECIPIENT INFORMATION

Element 1 — Name — Recipient
Enter the recipient's last name, followed by his or her first name and middle initial. Use the Eligibility Verification System (EVS) to obtain the correct spelling of the recipient's name. If the name or spelling of the name on the Medicaid identification card and the EVS do not match, use the spelling from the EVS.

Element 2 — Age — Recipient
Enter the age of the recipient in numerical form (e.g., 16, 21, 60).

Element 3 — Recipient Medicaid Identification Number
Enter the recipient's 10-digit Medicaid identification number. Do not enter any other numbers or letters in this field.

SECTION II — PROVIDER INFORMATION

Element 4 — Name and Credentials — Therapist
Enter the name and credentials of the primary therapist participating in therapy services for the recipient. If the performing provider is a therapy assistant, enter the name of the supervising therapist.

Element 5 — Therapist's Medicaid Provider Number
Enter the performing provider's eight-digit provider number. If the performing provider is a therapy assistant, enter the provider number of the supervising therapist. Rehabilitation agencies do not indicate a performing provider.

Element 6 — Telephone Number — Therapist
Enter the performing provider's telephone number, including the area code, of the office, facility, or place of business. If the performing provider is a therapy assistant, enter the telephone number of the supervising therapist.

Element 7 — Name — Prescribing Physician
Enter the name of the prescribing physician.

SECTION III — DOCUMENTATION

Element 8
Enter an "X" in the appropriate box to indicate a PT, OT, or SLP SOI request.

Element 9 — Requested Start Date
Enter the requested start date for service(s) in MM/DD/YY format (e.g., June 30, 2003, would be 06/30/03).

Element 10 — Primary *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) Diagnosis Code or ICD-9-CM Surgical Procedure Code
Enter the appropriate primary ICD-9-CM diagnosis code or surgical procedure code.

Element 11
Enter an "X" in the appropriate box to indicate "yes" or "no" in response to each statement. Only one of "A" through "F" must be marked "yes" in addition to "G" for SOI approval. Otherwise, the PT, OT, or SLP provider should submit the PA/RF and the PA/TA.

Element 12 — Signature — Therapist Providing Evaluation / Treatment
The signature of the therapist providing evaluation/treatment must appear in the space provided.

Element 13— Date Signed
Enter the month, day, and year the PA/SOIA was signed in MM/DD/YY format.

ATTACHMENT 18
Prior Authorization / Spell of Illness Attachment (PA/SOIA) (for photocopying)

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

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DEPARTMENT OF HEALTH AND FAMILY SERVICES **STATE OF WISCONSIN**
Division of Health Care Financing
HCF 11039 (Rev. 06/03)

WISCONSIN MEDICAID
PRIOR AUTHORIZATION / SPELL OF ILLNESS ATTACHMENT (PA/SOIA)

Providers may submit spell of illness (SOI) requests by fax to Wisconsin Medicaid at (608) 221-8616; or, providers may send the completed form with attachments to: Wisconsin Medicaid, Prior Authorization, Suite 88, 6406 Bridge Road, Madison, WI 53784-0088. **Instructions:** Type or print clearly. Before completing this form, read the Prior Authorization/Spell of Illness Attachment (PA/SOIA) Completion Instructions (HCF 11039A).

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 — Therapist	5. Therapist's Medicaid Provider Number
6. Telephone Number — Therapist	7. Name — Prescribing Physician

SECTION III — DOCUMENTATION

8. Requesting SOI for ❑ Physical Therapy (PT) ❑ Occupational Therapy (OT) ❑ Speech and Language Pathology (SLP)

9. Requested Start Date	10. Primary *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) Diagnosis Code or ICD-9-CM Surgical Procedure Code

11. Indicate "yes" or "no" in response to ***each*** of the following statements (Only one of "A" through "F" in addition to "G" must be marked "yes" for SOI approval. Otherwise, the PT, OT, or SLP provider should submit the Prior Authorization Request Form [PA/RF] and the Prior Authorization/Therapy Attachment [PA/TA]).

A. The recipient experienced the onset of a new neuromuscular disease, injury, or condition six weeks ago or less.	❑ Yes	❑ No
B. The recipient experienced the onset of a new musculoskeletal disease, injury, or condition six weeks ago or less.	❑ Yes	❑ No
C. The recipient experienced the onset of a new problem or complication associated with physiologic disease, injury, or condition six weeks ago or less.	❑ Yes	❑ No
D. The recipient experienced the onset of a new psychological disease, injury, or condition six weeks ago or less.	❑ Yes	❑ No
E. The recipient experienced an exacerbation of a pre-existing condition six weeks ago or less.	❑ Yes	❑ No
F. The recipient experienced a regression of his or her condition due to lack of therapy six weeks ago or less.	❑ Yes	❑ No
AND		
G. There is a reasonable expectation that the recipient will return to his or her previous level of function by the end of this SOI or sooner.	❑ Yes	❑ No

I hereby certify that the documentation of the date of onset, exacerbation, or regression of the recipient's disease, injury, or condition is as stated above. The specific start date of the SOI is maintained in the recipient's medical record at my facility and I acknowledge that the SOI ends when the services of a therapist are no longer required or after the maximum allowable treatment days have been used, whichever comes first.

12. **SIGNATURE** — Therapist Providing Evaluation / Treatment	13. Date Signed

Continued

Examples of statements A-F from Element 11:

A. The recipient experienced the onset of a new neuromuscular disease, injury, or condition six weeks ago or less. Examples of this situation include, but are not limited to:

- Diabetic neuropathy.
- Multiple sclerosis.
- Parkinson's disease.
- Stroke-hemiparesis.

B. The recipient experienced the onset of a new musculoskeletal disease, injury, or condition six weeks ago or less. Examples of this situation include, but are not limited to:

- Amputation.
- Complications associated with surgical procedures.
- Fracture.
- Strains and sprains.

C. The recipient experienced the onset of a new problem or complication associated with physiologic disease, injury, or condition six weeks ago or less. Examples of this situation include, but are not limited to:

- Cardio-pulmonary conditions.
- Severe pain.
- Vascular condition.

D. The recipient experienced the onset of a new psychological disease, injury, or condition six weeks ago or less. Examples of this situation include, but are not limited to:

- Affective disorders.
- Organic conditions.
- Thought disorders.

E. The recipient experienced an exacerbation of a pre-existing condition six weeks ago or less. Examples of this situation include, but are not limited to:

- Multiple sclerosis.
- Parkinson's disease.
- Rheumatoid arthritis.
- Schizophrenia.

F. The recipient experienced a regression of his or her condition due to lack of therapy six weeks ago or less. Examples of this situation include, but are not limited to:

- Decrease of functional ability.
- Decrease of mobility.
- Decrease of motion.
- Decrease of strength.