

To:  
Inpatient Hospital  
Providers  
Institutes for  
Mental Disease  
Providers  
Outpatient Hospital  
Providers  
HMOs and Other  
Managed Care  
Programs

## Changes to local codes, paper claims, and prior authorization for hospital 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 hospital 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 UB-92 (CMS 1450) 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 hospital 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 procedure codes and place of service (POS) codes to replace currently used Wisconsin Medicaid local codes.
- Revising UB-92 (CMS 1450) 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 procedure and revenue codes for hospital services.

#### *Allowable revenue codes*

Wisconsin Medicaid will adopt nationally recognized four-digit revenue codes to replace currently used three-digit local codes for hospital services. Providers will be required to

add a preceding “0” to the current three-digit revenue codes.

*Note:* For outpatient claims, enter the single most appropriate procedure code for every revenue code (including outpatient laboratory services identified by codes 030X, 031X, 0923, and 0925) on every outpatient claim except revenue code “0001.”

In addition, Wisconsin Medicaid will adopt nationally recognized revenue codes to replace currently used Wisconsin Medicaid local procedure codes (W9111-W9115) for hospital services. Refer to Attachment 1 of this *Update* for a procedure code to revenue code conversion chart.

For a complete list of revenue codes, refer to the National UB-92 Uniform Billing Manual. Providers will be required to use the appropriate revenue code that describes the service performed. Providers should continue to refer to their service-specific *Updates* and handbooks for other nationally recognized procedure codes Wisconsin Medicaid covers.

#### *Type of service codes*

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

#### *Place of service codes*

Nationally recognized two-digit POS codes will replace the one-digit Wisconsin Medicaid POS codes on PA requests. Refer to Attachment 2 for a list of allowable POS codes for hospital services.

#### *Coverage for hospital services*

Medicaid coverage and documentation requirements for hospitals will remain unchanged. Refer to the Hospital Handbook and *Updates* for complete Medicaid policies and procedures.

## **Revision of UB-92 paper claim instructions**

With the implementation of HIPAA, Medicaid-certified hospitals will be required to follow the revised instructions for the UB-92 paper claim form in this *Update*, even though the actual UB-92 claim form is not being revised at this time. Refer to Attachment 3 for the revised instructions. Attachments 4 and 5 are claim samples for hospital 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 UB-92 claim form instructions*

Revisions to the UB-92 paper claim form instructions include the following:

- Type of bill revised. Critical access hospitals should bill inpatient and outpatient hospital claims with bill type 851 (Form Locator 4).
- Spenddown amount (value code “22”) should no longer be entered in Form Locators 39-41 a-d. Wisconsin Medicaid will automatically reduce the provider’s reimbursement by the recipient’s spenddown amount.
- Revenue codes revised (Form Locator 42).
- HCPCS/Rates instructions revised for outpatient claims (Form Locator 44).
- Service date no longer required (Form Locator 45).
- Insured’s name no longer required (Form Locators 58 A-C).
- Other diagnosis codes clarified (Form Locators 68-75).
- Medicare and other insurance disclaimer codes revised, including the elimination of “M-6” (Form Locator 84).

**F**or outpatient claims, enter the single most appropriate procedure code for every revenue code (including outpatient laboratory services identified by codes 030X, 031X, 0923, and 0925) on every outpatient claim except revenue code “0001.”

## **Revision of prior authorization request forms and instructions**

With the implementation of HIPAA, hospital 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 6. A sample inpatient hospital PA/RF is in Attachment 7; a sample outpatient hospital PA/RF is in Attachment 8.

### *Revisions made to the Prior Authorization Request Form*

The following revisions were made to the PA/RF:

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

### *Prior authorization attachments*

The Prior Authorization/Substance Abuse Attachment (PA/SAA), HCF 11032, dated 06/03, formerly the Prior Authorization Alcohol and Other Drug Abuse Attachment (PA/AA), and the Prior Authorization/ Psychotherapy Attachment (PA/PSYA), HCF 11031, dated 06/03, have also been revised. The basic information requested on the forms have not changed; only the format of the forms have changed. Refer to Attachment 9 for a copy of the completion instructions for the PA/SAA and Attachment 11 for the PA/PSYA Completion Instructions. Attachments 10 and 12, respectively, are copies of the PA/SAA and PA/PSYA for providers to photocopy.

**W**ith the implementation of HIPAA, hospital providers will be required to use the revised Prior Authorization Request Form (PA/RF), HCF 11018, dated 06/03.

## *Obtaining prior authorization request forms*

The PA/SAA and PA/PSYA 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/SAA, PA/PSYA, and other Medicaid forms, follow these instructions:

1. Go to [www.dhfs.state.wi.us/medicaid/](http://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/SAA, PA/PSYA, or PA/RF, call Provider Services at (800) 947-9627 or (608) 221-9883. Questions about the forms may also be directed to Provider Services at the telephone numbers previously mentioned.

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

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

## General HIPAA information

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

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

## Information regarding Medicaid HMOs

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

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

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

Wisconsin Medicaid and BadgerCare are administered by the Division of Health Care Financing, Wisconsin Department of Health and Family Services, P.O. Box 309, Madison, WI 53701-0309.

For questions, call Provider Services at (800) 947-9627 or (608) 221-9883 or visit our Web site at [www.dhfs.state.wi.us/medicaid/](http://www.dhfs.state.wi.us/medicaid/).

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\* The Medicaid Web site provides instructions on how to obtain Adobe Acrobat Reader® at no charge from the Adobe® Web site at [www.adobe.com/](http://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

## Hospital services procedure code conversion chart

The following table lists the nationally recognized revenue codes (converted from local procedure codes) that providers will be required to use when submitting claims for hospital services. A future *Wisconsin Medicaid and BadgerCare Update* will notify providers of the specific effective dates for Wisconsin Medicaid's implementation of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Before HIPAA implementation		After HIPAA implementation	
Local procedure code	Local procedure code description	Nationally recognized revenue code	National revenue code description
W9111	Acquisition and storage charges for lung used in transplant	081X*	Acquisition of body components**
W9112	Acquisition and storage charges for liver used in transplant		
W9113	Acquisition and storage charges for pancreas used in transplant		
W9114	Acquisition and storage charges for kidney used in transplant		
W9115	Acquisition and storage charges for bone used in transplant		
* Refer to the National UB-92 Uniform Billing Manual and select the appropriate revenue code subcategory.			
** To reference the specific organ used in the transplantation procedure, enter the appropriate <i>International Classification of Diseases, Ninth Revision, Clinical Modification</i> surgical procedure code.			

## ATTACHMENT 2

### Allowable place of service codes for hospital services

The following table lists the nationally recognized place of service (POS) codes that providers will be required to use when submitting prior authorization requests for inpatient and outpatient hospital 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).

Inpatient hospital POS code	Description
21	Inpatient Hospital
51	Inpatient Psychiatric Facility
61	Comprehensive Inpatient Rehabilitation Facility

Outpatient hospital POS code	Description
22	Outpatient Hospital

# ATTACHMENT 3

## UB-92 (CMS 1450) claim form instructions for hospital services

(For claims submitted after HIPAA implementation)

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

These instructions are for the completion of the UB-92 (CMS 1450) claim for Wisconsin Medicaid. For complete billing instructions, refer to the National UB-92 Uniform Billing Manual prepared by the National Unified Billing Committee (NUBC). The National UB-92 Uniform Billing Manual contains important coding information not available in these instructions. Providers may purchase the National UB-92 Uniform Billing Manual by writing or calling:

American Hospital Association  
National Uniform Billing Committee  
29th Fl  
1 N Franklin  
Chicago IL 60606  
(312) 422-3390

For more information, go to the NUBC Web site at [www.nubc.org/](http://www.nubc.org/).

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

### **Form Locator 1 — Provider Name, Address, and Telephone Number**

Enter the name of the provider submitting the claim and the complete mailing address. The minimum requirement is the provider's name, city, state, and Zip code. The name in Form Locator 1 should correspond with the provider number in Form Locator 51.

### **Form Locator 2 — ERO Assigned Number (required, if applicable)**

Enter the Pre-Admission Review control number as required.

### **Form Locator 3 — Patient Control No. (not required)**

### **Form Locator 4 — Type of Bill**

Enter the three-digit type of bill number. Some of the bill numbers for hospital include the following:

111 = Hospital, Inpatient, Admit Through Discharge Claim

131 = Hospital, Outpatient, Admit Through Discharge Claim

851 = Special Facility, Critical Access Hospital (Inpatient and Outpatient Hospitals), Admit Through Discharge Claim

### **Form Locator 5 — Fed. Tax No. (not required)**

**Form Locator 6 — Statement Covers Period (From - Through)**

Enter both dates in MM/DD/YY format (e.g., January 2, 2004, would be 010204).

**Form Locator 7 — Cov D.**

Enter the total number of days covered by the primary payer, as qualified by the payer organization.

*For inpatient claims:*

For inpatient claims, do not count the day of discharge.

*For outpatient claims:*

For outpatient claims, covered days must represent the actual number of visits (days of service) in the “from - through” period.

**Form Locator 8 — N-C D. (required for inpatient claims)**

Enter the total noncovered days by the primary payer. The sum of covered days and noncovered days must equal the number of days in the “from - through” period.

**Form Locator 9 — C-I D. (not required)****Form Locator 10 — L-R D. (not required)****Form Locator 11 — Unlabeled Field (not required)****Form Locator 12 — Patient 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.

**Form Locator 13 — Patient Address (not required)****Form Locator 14 — Birthdate (not required)****Form Locator 15 — Sex (not required)****Form Locator 16 — MS (not required)****Form Locator 17 — Admission Date (required for inpatient claims)**

Enter the admission date in MM/DD/YY format (e.g., January 2, 2004, would be 010204).

**Form Locator 18 — Admission Hr (not required)****Form Locator 19 — Admission Type (required for inpatient claims)**

Enter the appropriate admission type for inpatient hospital services. Admission type is not required for outpatient hospital services.

**Form Locator 20 — Admission Src**

Enter the code indicating the source of this admission.

**Form Locator 21 — D Hr (not required)****Form Locator 22 — Stat (required for inpatient claims)**

Enter the code indicating patient status as of the “Statement Covers Period” through date from Form Locator 6.

**Form Locator 23 — Medical Record No. (required for inpatient claims)**

Enter the number assigned to the patient’s medical/health record by the provider. This number will appear on the Remittance and Status Report and/or the 835 Health Care Claim Payment/Advice transaction.

**Form Locators 24-30 — Condition Codes (required, if applicable)****Form Locator 31 — Unlabeled Field (not required)****Form Locators 32-35 a-b — Occurrence Code and Date (required, if applicable)****Form Locator 36 a-b — Occurrence Span Code (From - Through) (not required)****Form Locator 37 A-C — Internal Control Number/Document Control Number (not required)****Form Locator 38 — Responsible Party Name and Address (not required)****Form Locators 39-41 a-d — Value Code and Amount (required, if applicable)**

Wisconsin Medicaid uses the following value codes:

- 81 — *Medicare Part B Charges When Part A Exhausted.* Enter the full amount of Medicare Part B charges when billing for services after Medicare Part A has been exhausted.
- 83 — *Medicare Part A Charges When Part A Exhausted.* Enter the sum of the Medicare paid amount, the coinsurance amount, and the deductible when billing for services after Medicare Part A has exhausted.

Refer to the Hospital Services Handbook for information regarding inpatient dual-entitlee billing instructions for partial or no Part A benefits.

**Form Locator 42 — Rev. Cd.**

Enter the national four-digit revenue code which identifies a specific accommodation, ancillary service, or billing calculation. Enter revenue code “0001” on the line with the sum of all the charges.

**Form Locator 43 — Description (not required)****Form Locator 44 — HCPCS/Rates (required, if applicable)**

For outpatient claims, enter the single most appropriate procedure code for *every* revenue code (including outpatient laboratory services identified by codes 030X, 031X, 0923, and 0925) on every outpatient claim except revenue code “0001.”

**Form Locator 45 — Serv. Date (not required)****Form Locator 46 — Serv. Units**

Enter the number of covered accommodations days, ancillary units of service, or visits, where appropriate.

**Form Locator 47 — Total Charges**

Enter the usual and customary charges pertaining to the related revenue code for the current billing period as entered in Form Locator 6, “statement covers period.” Enter revenue code “0001” to report the sum of all charges in Form Locator 47.

**Form Locator 48 — Non-covered Charges (not required)****Form Locator 49 — Unlabeled Field (not required)****Form Locator 50 A-C — Payer**

Enter all health insurance payers here. For example, enter “T19” for Wisconsin Medicaid and/or the name of commercial health insurance.

**Form Locator 51 A-C — Provider No.**

Enter the number assigned to the provider by the payer indicated in Form Locator 50 A-C. For Wisconsin Medicaid, enter the eight-digit provider number. The provider number in Form Locator 51 should correspond with the name in Form Locator 1.

**Form Locator 52 A-C — Rel Info (not required)****Form Locator 53 A-C — Asg Ben (not required)****Form Locator 54 A-C & P — Prior Payments (required, if applicable)**

Enter the actual amount paid by commercial health insurance. (If the dollar amount indicated in Form Locator 54 is greater than zero, “OI-P” must be indicated in Form Locator 84.) If the commercial health insurance denied the claim, enter “000.” Do **not** enter Medicare-paid amounts in this field.

**Form Locator 55 A-C & P — Est Amount Due (not required)****Form Locator 56 — Unlabeled Field (not required)****Form Locator 57 — Unlabeled Field (not required)****Form Locator 58 A-C — Insured’s Name (not required)****Form Locator 59 A-C — P. Rel (not required)****Form Locator 60 A-C — Cert. - SSN - HIC. - ID No.**

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

**Form Locator 61 A-C — Group Name (not required)**

**Form Locator 62 A-C — Insurance Group No. (not required)**

**Form Locator 63 A-C — Treatment Authorization Codes (required, if applicable)**

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.

**Form Locator 64 A-C — ESC (not required)**

**Form Locator 65 A-C — Employer Name (not required)**

**Form Locator 66 A-C — Employer Location (not required)**

**Form Locator 67 — Prin. Diag Cd.**

Enter the complete *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) code describing the principal diagnosis (e.g., the condition established after study to be chiefly responsible for causing the admission or other health care episode). Any condition which is not manifested upon admission or that develops subsequently should not be selected as the principal diagnosis.

*For inpatient claims:*

The principal diagnosis selected must be the reason for admission. It should relate to one or more conditions or symptoms identified in the admission notes and/or admission work-up. Manifestation codes are not to be recorded as the principal diagnosis; code the underlying disease first. The principal diagnosis code may not include “E” codes. “V” codes may be used as the principal diagnosis.

*For outpatient claims:*

The principal diagnosis identifies the condition chiefly responsible for the patient’s visit or treatment. The principal diagnosis code may not include “E” codes. “V” codes may be used as the principal diagnosis.

**Form Locators 68-75 — Other Diag. Codes**

Enter the ICD-9-CM diagnosis codes corresponding to additional conditions that coexist at the time of admission, or develop subsequently, and which have an effect on the treatment received or the length of stay. Diagnoses which relate to an earlier episode and which have no bearing on this episode are to be excluded. Providers should prioritize diagnosis codes as relevant to this claim.

**Form Locator 76 — Adm. Diag. Cd. (required for inpatient claims)**

Enter the ICD-9-CM diagnosis code provided at the time of admission as stated by the physician.

**Form Locator 77 — E-Code (not required)**

**Form Locator 78 — Race/Ethnicity (not required)**

**Form Locator 79 — P.C. (not required)**

### Form Locator 80 — Principal Procedure Code and Date (required, if applicable)

Enter the procedure code that identifies the principal procedure performed during the period covered by this claim and the date on which the principal procedure described on the claim was performed.

*Note:* Most often the principal procedure will be that procedure which is most closely related to the principal discharge diagnosis.

### Form Locator 81 — Other Procedure Code and Date (required, if applicable)

If more than six procedures are performed, report those that are most important for the episode using the same guidelines in Form Locator 80 for determining the principal procedure.

### Form Locator 82 a-b — Attending Phys. ID

Enter the Unique Physician Identification Number (UPIN) or license number and name.

### Form Locator 83 a-b — Other Phys. ID

Enter the UPIN or license number and name.

### Form Locator 84 a-d — Remarks (enter information when applicable)

#### *Commercial health insurance billing information*

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

When the recipient has dental (“DEN”), Medicare Cost (“MCC”), Medicare + Choice (“MPC”) insurance only, or has no commercial health insurance, do not indicate an other insurance (OI) explanation code in Form Locator 84.

When 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 insurance, **and** the service requires commercial health insurance billing according to the Coordination of Benefits section of the All-Provider Handbook, then one of the following three OI explanation codes **must** be indicated in Form Locator 84. The description is not required, nor is the policyholder, plan name, group number, etc.

Code	Description
OI-P	PAID in part or in full by commercial health insurance or commercial HMO. In Form Locator 54 of this claim form, indicate the amount paid by commercial health insurance to the provider or to the insured.
OI-D	DENIED by commercial health insurance or commercial HMO following submission of a correct and complete claim, or payment was applied towards the coinsurance and deductible. Do not use this code unless the claim was actually billed to the commercial health insurer.
OI-Y	YES, the recipient has commercial health insurance or commercial HMO coverage, but it was not billed for reasons including, but not limited to: <ul style="list-style-type: none"><li>✓ The recipient denied coverage or will not cooperate.</li><li>✓ The provider knows the service in question is not covered by the carrier.</li><li>✓ The recipient’s commercial health insurance failed to respond to initial and follow-up claims.</li><li>✓ Benefits are not assignable or cannot get assignment.</li><li>✓ Benefits are exhausted.</li></ul>

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

*Medicare information*

Use Form Locator 84 for Medicare information. Submit claims to Medicare before billing Wisconsin Medicaid.

Do not indicate a Medicare disclaimer code 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 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 the provider is not Medicare certified.

*Note:* Home health agencies, medical equipment vendors, pharmacies, and physician services providers must be Medicare certified to perform Medicare-covered services for dual entitlees.

- Medicare has allowed the charges. In this case, attach the Explanation of Medicare Benefits or Medicare Remittance Advice, but do not indicate on the claim form the amount Medicare paid.

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

Code	Description
<b>M-5</b>	<p><b>Provider is not Medicare certified.</b> This code may be used when providers are identified in Wisconsin Medicaid files as being Medicare certified, but are billing for dates of service before or after their Medicare certification effective dates. Use M-5 in the following instances:</p> <p><i>For Medicare Part A (all three criteria must be met):</i></p> <ul style="list-style-type: none"> <li>✓ 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.</li> <li>✓ The recipient is eligible for Medicare Part A.</li> <li>✓ The procedure provided is covered by Medicare Part A.</li> </ul> <p><i>For Medicare Part B (all three criteria must be met):</i></p> <ul style="list-style-type: none"> <li>✓ 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.</li> <li>✓ The recipient is eligible for Medicare Part B.</li> <li>✓ The procedure provided is covered by Medicare Part B.</li> </ul>

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

### Form Locator 85 — Provider Representative

The provider or the authorized representative must sign in Form Locator 85.

*Note:* The signature may be a computer-printed or typed name, or a signature stamp.

### Form Locator 86 — Date

Enter the month, day, and year on which the claim is submitted to the payer. The date must be entered in MM/DD/YY or MM/DD/YYYY format.

# ATTACHMENT 4

## Sample UB-92 claim form for inpatient hospitals

APPROVED OMB NO. 0938-0279

IM BILLING HOSPITAL 321 HOSPITAL RD ANYTOWN, WI 55555 (555) 321-1234				2				3 PATIENT CONTROL NO.				4 TYPE OF BILL 111																							
5 FED. TAX NO.		6 STATEMENT COVERS PERIOD FROM		7 COV.D		8 N-C-D		9 C-I-D		10 L-R-D		11																							
		020404		020904		5		1																											
12 PATIENT NAME RECIPIENT, IMA H.						13 PATIENT ADDRESS																													
14 BIRTHDATE		15 SEX		16 MS		17 DATE		ADMISSION 18 HR		19 TYPE		20 SRC		21 D-HR		22 STAT		23 MEDICAL RECORD NO.		24		25		26		27		28		29		30		31	
						101703		1		1		01		03		7654321																			
32 CODE		OCCURRENCE DATE		34 CODE		OCCURRENCE DATE		36 CODE		OCCURRENCE SPAN FROM		THROUGH		37																					
38																																			
42 REV. CD.		43 DESCRIPTION				44 HCPCS / RATES				45 SERV. DATE		46 SERV. UNITS		47 TOTAL CHARGES		48 NON-COVERED CHARGES		49																	
1		0120				302.52						5		1512 60																					
2		0250										19		243 95																					
3		0271										19		65 32																					
4		0272										8		179 44																					
5		0300										6		513 80																					
6		0305										1		62 00																					
7		0324										1		124 75																					
8		0350										1		470 72																					
9		0420										5		341 85																					
10		0424										1		142 87																					
11		0450										3		637 13																					
12		0730										1		132 00																					
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19																																			
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21																																			
22		0001 TOTAL CHARGES												4426 43																					
23																																			
50 PAYER				51 PROVIDER NO.				52 REL INFO		53 ASG BEN		54 PRIOR PAYMENTS		55 EST AMOUNT DUE		56																			
A T19 MEDICAID				B 87654321																															
C																																			
57				<b>DUE FROM PATIENT</b>																															
58 INSURED'S NAME				59 P.REL				60 CERT. - SSN - HIC. - ID NO.				61 GROUP NAME		62 INSURANCE GROUP NO.																					
A								B 1234567890																											
B																																			
C																																			
63 TREATMENT AUTHORIZATION CODES				64 ESC				65 EMPLOYER NAME				66 EMPLOYER LOCATION																							
A 1234567																																			
B																																			
C																																			
67 PRIN DIAG CD		68 CODE		69 CODE		70 CODE		OTHER DIAG. CODES		72 CODE		74 CODE		75 ADM. DIAG. CD		77 E-CODE		78																	
9661		78039		43889		72989		7813		43820		43811		9661																					
79 P.C		80 PRINCIPAL PROCEDURE CODE		81 OTHER PROCEDURE CODE		82 ATTENDING PHYS. ID		83 OTHER PHYS. ID		84 REMARKS		85 PROVIDER REPRESENTATIVE		86 DATE																					
						N24680 PHYSIESON		N12345				X I.M. Provider		021904																					

UB-92 HCFA-1450

OCR/Original

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

# ATTACHMENT 5

## Sample UB-92 claim form for outpatient hospitals

APPROVED OMB NO. 0938-0279

1M BILLING HOSPITAL 321 HOSPITAL RD ANYTOWN, WI 55555 (555) 321-1234				2				3 PATIENT CONTROL NO.				4 TYPE OF BILL 131																											
5 FED. TAX NO.				6 STATEMENT COVERS PERIOD FROM 020404		6 STATEMENT COVERS PERIOD THROUGH 020404		7 COV D 1		8 N-C-D		9 C-I-D		10 L-R-D		11																							
12 PATIENT NAME RECIPIENT, IMA H.								13 PATIENT ADDRESS																															
14 BIRTHDATE		15 SEX		16 MS		17 DATE		18 HR		19 TYPE		20 SRC		21 D HR		22 STAT		23 MEDICAL RECORD NO.		24		25		26		27		28		29		30		31					
32 OCCURRENCE DATE		33 OCCURRENCE DATE		34 OCCURRENCE DATE		35 OCCURRENCE DATE		36 OCCURRENCE SPAN FROM		36 OCCURRENCE SPAN THROUGH		37 A		37 B		37 C		37 D		37 E		37 F		37 G		37 H		37 I		37 J		37 K		37 L					
39 CODE		39 CODE		39 CODE		39 CODE		39 CODE		39 CODE		39 CODE		39 CODE		39 CODE		39 CODE		39 CODE		39 CODE		39 CODE		39 CODE		39 CODE		39 CODE		39 CODE		39 CODE					
42 REV. CD.		43 DESCRIPTION		44 HOPCS / RATES		45 SERV. DATE		46 SERV. UNITS		47 TOTAL CHARGES		48 NON-COVERED CHARGES		49		49		49		49		49		49		49		49		49		49							
1	0300			81000				1		23 00																													
2	0306			89050				1		46 00																													
3	0450			99201				1		39 00																													
22	0001	TOTAL CHARGES								108 00																													
50 PAYER A 45009 BLUE CROSS B T19 MEDICAID C				51 PROVIDER NO. BC111 87654321				52 REL INFO		53 ASG BEN		54 PRIOR PAYMENTS 25 00		55 EST AMOUNT DUE 83 00		56		57 <b>DUE FROM PATIENT</b>		58 INSURED'S NAME		59 P. REL		60 CERT. - SSN - HIC - ID NO. 1234567890		61 GROUP NAME		62 INSURANCE GROUP NO.		63 TREATMENT AUTHORIZATION CODES		64 ESC		65 EMPLOYER NAME		66 EMPLOYER LOCATION			
67 PRIN DIAG CD V288		68 CODE		69 CODE		70 CODE		71 CODE		72 CODE		73 CODE		74 CODE		75 CODE		76 ADM. DIAG. CD		77 E-CODE		78		79 P.C.		80		81		82 ATTENDING PHYS. ID		83 OTHER PHYS. ID A12345 I.M. Referring, M.D.		84 REMARKS OI-P		85 PROVIDER REPRESENTATIVE X I.M. Provider		86 DATE 021904	

UB-92 HCFA-1450

OCR/Original

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

# ATTACHMENT 6

## Prior Authorization Request Form (PA/RF)

### Completion Instructions for hospital 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 with either the Prior Authorization/Substance Abuse Attachment (PA/SAA) or the Prior Authorization/Psychotherapy Attachment (PA/PSYA)\* by fax to Wisconsin Medicaid at (608) 221-8616; or, providers 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 a category of service requested. Prior authorization requests will be returned without adjudication if no processing type is indicated.

---

\* The PA/AA and PA/PSYA are only used for outpatient hospital services.

### *Inpatient Hospital*

- 117 — Physician Services (includes Family Planning Clinics, Rural Health Clinics, and Federally Qualified Health Centers)
- 133 — Transplant Services
- 134 — Acquired Immune Deficiency Syndrome (AIDS) Services (hospital and nursing home)
- 135 — Ventilator Service
- 999 — Other (use only if the requested category or service is not listed above)

### *Outpatient Hospital*

- 127 — Psychotherapy (UB-92 billing providers only)
- 128 — Substance Abuse Services (other than Day Treatment)
- 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 correspond with the provider name listed in Element 1.

### **SECTION II — RECIPIENT INFORMATION**

#### **Element 5 — Recipient Medicaid ID Number**

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

#### **Element 6 — Date of Birth — Recipient**

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

#### **Element 7 — Address — Recipient**

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

#### **Element 8 — Name — Recipient**

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

#### **Element 9 — Sex — Recipient**

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

### **SECTION III — DIAGNOSIS / TREATMENT INFORMATION**

#### **Element 10 — Diagnosis — Primary Code and Description**

Enter the appropriate *International Classification of Diseases, Ninth Edition, Clinical Modification* (ICD-9-CM) diagnosis code and description most relevant to the service/procedure requested.

#### **Element 11 — Start Date — SOI (not required)**

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

#### **Element 13 — Diagnosis — Secondary Code and Description**

Enter the appropriate secondary ICD-9-CM diagnosis code and description relevant to the service/procedure requested, if applicable.

#### **Element 14 — Requested Start Date (not required)**

## Element 15 — Performing Provider Number (not required)

## Element 16 — Procedure Code

Enter the appropriate *Current Procedural Terminology* procedure code, National Uniform Billing Committee revenue code, Healthcare Common Procedure Coding System procedure code, or ICD-9-CM surgical code for each service/procedure/item requested.

## Element 17 — Modifiers

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

## Element 18 — POS

Enter the appropriate place of service code designating where the requested service/procedure/item would be provided/performed/dispensed.

## Element 19 — Description of Service

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

## Element 20 — QR

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

### *Inpatient Hospital*

Brain injury care services	Number of days
Hospital transplant	Per hospital stay
Hospital and nursing home AIDS services	Number of days
Hospital and nursing home ventilator services	Number of days

### *Outpatient Hospital*

Psychotherapy	Number of sessions
Substance abuse	Number of sessions

## Element 21 — Charge

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

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

## Element 22 — Total Charges

Enter the anticipated total charge for this request.

## Element 23 — Signature — Requesting Provider

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

## Element 24 — Date Signed

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

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





# ATTACHMENT 9

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

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

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

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

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

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

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

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

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

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

**SECTION I — RECIPIENT INFORMATION**

**Element 1 — Name — Recipient**

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

**Element 2 — Age — Recipient**

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

**Element 3 — Recipient Medicaid Identification Number**

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

**SECTION II — PROVIDER INFORMATION**

**Element 4 — Name and Credentials — Performing Provider**

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

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

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

**Element 6 — Telephone Number — Performing Provider**

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

**Element 7 — Name — Referring / Prescribing Provider**

Enter the name of the provider referring/prescribing treatment.

**Element 8 — Referring / Prescribing Provider's Medicaid Provider Number**

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

**SECTION III — TYPE OF TREATMENT REQUESTED**

**Element 9**

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

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

**SECTION IV — DOCUMENTATION**

**Element 10**

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

**Element 11**

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

**Element 12**

Specify diagnostic procedures employed.

**Element 13**

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

**Element 14**

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

**Element 15**

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

**Element 16**

Provide a detailed description of treatment objectives and goals.

**Element 17**

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

**SECTION V — SIGNATURES**

**Element 18 — Signature — Recipient or Representative (optional)**

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

**Element 19 — Date Signed**

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

**Element 20 — Relationship (if representative)**

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

**Element 21 — Signature — Performing Provider**

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

**Element 22 — Date Signed**

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

**Element 23 — Discipline of Performing Provider**

Enter the discipline of the performing provider.

**Element 24 — Performing Provider's Medicaid Provider Number**

Enter the performing provider's Medicaid provider number.

**Element 25 — Signature — Supervising Provider**

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

**Element 26 — Date Signed**

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

*Other Information*

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

ATTACHMENT 10  
Prior Authorization / Substance Abuse Attachment  
(PA/SAA) (for photocopying)

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

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

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

**SECTION I — RECIPIENT INFORMATION**

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

3. Recipient Medicaid Identification Number

**SECTION II — PROVIDER INFORMATION**

4. Name and Credentials — Performing Provider

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

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

**SECTION III — TYPE OF TREATMENT REQUESTED**

9.

Primary Intensive Outpatient Treatment

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

Aftercare / Follow-Up Service

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

*Continued*

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**SECTION III — TYPE OF TREATMENT REQUESTED (Continued)**

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

---

**SECTION IV — DOCUMENTATION**

---

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

---

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

---

12. Specify diagnostic procedures employed.

---

*Continued*

---

**SECTION IV — DOCUMENTATION (Continued)**

---

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

---

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

---

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

---

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

---

*Continued*

---

**SECTION IV — DOCUMENTATION (Continued)**

---

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

---

**SECTION V — SIGNATURES**

---

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

---

18. **SIGNATURE** — Recipient or Representative (optional)

19. Date Signed

---

20. Relationship (if representative)

---

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

---

21. **SIGNATURE** — Performing Provider

22. Date Signed

---

23. Discipline of Performing Provider

24. Performing Provider's Medicaid Provider Number

---

25. **SIGNATURE** — Supervising Provider

26. Date Signed

---

# ATTACHMENT 11

## Prior Authorization / Psychotherapy Attachment (PA/PSYA) Completion Instructions

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

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

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

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

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

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

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

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

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

**GENERAL INSTRUCTIONS**

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

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

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

**SECTION I — RECIPIENT INFORMATION**

**Element 1 — Name — Recipient**

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

**Element 2 — Age — Recipient**

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

**Element 3 — Recipient Medicaid Identification Number**

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

## SECTION II — PROVIDER INFORMATION

### Element 4 — Name — Performing Provider

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

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

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

### Element 6 — Telephone Number — Performing Provider

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

### Element 7 — Discipline — Performing Provider

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

### Element 8 — Name — Prescribing Provider

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

### Element 9 — Prescribing Provider's Medicaid Provider Number

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

## SECTION III — DOCUMENTATION

### Element 10 — Diagnosis

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

### Element 11 — Date Treatment Began

Enter the date of the first treatment by this provider.

### Element 12 — Diagnosed by

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

### Element 13 — Consultation

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

### Element 14 — Results of Consultation

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

### Element 15 — Presenting Symptoms

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

### Elements 16-17 — Intellectual Functioning

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

### Element 18 — Historical Data

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

### Element 19 — Present GAF (DSM)

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

### Element 20 — Present Mental Status / Symptomatology

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

### Element 21 — Updated / Historical Data

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

### Element 22 — Treatment Modalities

Indicate the treatment modalities to be used.

**Element 23 — Number of Minutes Per Session**

Indicate the length of session for each modality.

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

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

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

**Element 26 — Psychoactive Medication**

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

**Element 27 — Rationale for Further Treatment**

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

**Element 28 — Goals / Objectives of Treatment**

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

**Element 29 — Steps to Termination**

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

**Element 30 — Family Members**

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

**Element 31 — Signature — Performing Provider**

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

**Element 32 — Date Signed**

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

**Element 33 — Signature — Recipient (optional)**

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

**Element 34 — Date Signed**

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

**Element 35 — Signature — Supervising Provider**

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

**Element 36 — Date Signed**

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

*Other Required Information*

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

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

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

ATTACHMENT 12  
Prior Authorization / Psychotherapy Attachment  
(PA/PSYA) (for photocopying)

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

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

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

**SECTION I — RECIPIENT INFORMATION**

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

**SECTION II — PROVIDER INFORMATION**

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

**SECTION III — DOCUMENTATION**

10. Diagnosis

Axis I a) \_\_\_\_\_  
b) \_\_\_\_\_

Axis II \_\_\_\_\_

Axis III \_\_\_\_\_

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

Axis V (past year) (optional) \_\_\_\_\_

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

*Continued*

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**SECTION III — DOCUMENTATION (Continued)**

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15. Presenting Symptoms

Severity:     Mild             Moderate             Severe

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

Yes     No

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

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18. Historical Data

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

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19. Present GAF (DSM)

Is the recipient progressing in treatment?     Yes     No

If no, explain.

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*Continued*

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**SECTION III — DOCUMENTATION (Continued)**

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

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

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22. Treatment Modalities

Psychodynamic       Behavior Modification       Biofeedback       Play Therapy

Other (specify) \_\_\_\_\_

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23. Number of Minutes Per Session

Individual \_\_\_\_\_      Group \_\_\_\_\_      Family \_\_\_\_\_

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24. Frequency of Requested Sessions

Monthly       Twice / month       Once / week

Other (specify) \_\_\_\_\_

---

25. Total Number of Sessions Requested

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26. Psychoactive Medication?       Yes       No

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

If yes, names and dosage(s) \_\_\_\_\_

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27. Rationale for Further Treatment

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**SECTION III — DOCUMENTATION (Continued)**

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28. Goals / Objectives of Treatment

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

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

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31. **SIGNATURE** — Performing Provider

32. Date Signed

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

34. Date Signed

---

35. **SIGNATURE** — Supervising Provider

36. Date Signed

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