

To:  
Intensive In-Home  
Treatment  
Providers  
HMOs and Other  
Managed Care  
Programs

## Changes to local codes, paper claims, and prior authorization for intensive in-home treatment, a HealthCheck “Other Service,” as a result of HIPAA

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

- Adopting 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 intensive in-home treatment, a HealthCheck “Other Service.” These changes will be implemented in October 2003 as a result of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). A future *Update* will

notify providers of the specific effective dates for the various changes. These changes are not policy or coverage related (e.g., PA requirements, documentation requirements), but include:

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

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

### Adoption of nationally recognized codes

Wisconsin Medicaid will adopt nationally recognized medical codes to replace currently used Wisconsin Medicaid local codes for intensive in-home treatment services.

### *Allowable procedure codes*

Wisconsin Medicaid will adopt nationally recognized codes to replace currently used Wisconsin Medicaid local procedure codes (W7027-W7030) for intensive in-home treatment services. Refer to Attachment 1 of this *Update* for a procedure code conversion chart. Providers will be required to use the appropriate *Current Procedural Terminology* (CPT)/HealthCare Common Procedure Coding System (HCPCS) procedure 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.

### *Modifiers*

Providers will be required to use nationally recognized CPT/HCPCS modifiers in Element 24D of the CMS 1500 claim form and Element 17 of the Prior Authorization Request Form (PA/RF).

Each procedure code will need to be billed with child/adolescent program modifier “HA” plus the modifier indicating the professional level of the performing provider. The professional level modifier is needed for reimbursement purposes; modifier “HO,” for example, would indicate that a Master’s degree level psychotherapist performed the service. Refer to Attachment 1 for a procedure code conversion chart that shows the appropriate modifiers.

### *Type of service codes*

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

### *Time units and rounding guidelines*

Providers should note that the time unit for procedure code H0004 — behavioral health

counseling and therapy — will be 15 minutes. The maximum allowable fee has been adjusted for this new time unit. The time unit for all other intensive in-home treatment procedure codes is one hour. Refer to Attachment 3 for rounding guidelines for intensive in-home treatment services.

### *Place of service codes*

Nationally recognized two-digit POS codes will replace the one-digit POS codes used currently by Wisconsin Medicaid. Refer to Attachment 2 for a list of allowable POS codes for intensive in-home treatment services. For travel, always use the POS code “99” — other place of service.

### *Coverage for intensive in-home treatment services*

Medicaid coverage and documentation requirements for intensive in-home treatment remain unchanged. Refer to the Mental Health and Substance Abuse Handbook, in conjunction with the October 1992 Medical Assistance Provider Bulletin (MAPB-092-001-Z), titled “WMAP reimbursement for intensive in-home treatment and mental health day treatment for severely emotionally disturbed children and adults,” and the All-Provider Handbook for complete Medicaid policies and procedures.

### **Revision of CMS 1500 paper claim instructions**

With the implementation of HIPAA, Medicaid-certified providers of intensive in-home treatment are 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 4 for the revised instructions. Attachment 5 is a sample of a claim for intensive in-home treatment services that reflects the changes to the billing instructions.

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

With the implementation of HIPAA, intensive in-home treatment providers will be required to use the revised PA/RF, HCF 11018, dated 06/03.

*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 CMS 1500 paper claim form instructions include the following:

- 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 can now be entered (Element 24D).
- HealthCheck indicator "H" is no longer required (Element 24H).
- Spenddown amount should no longer be entered (Element 24K). Wisconsin Medicaid will automatically reduce the provider's reimbursement by the recipient's spenddown amount.

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

With the implementation of HIPAA, intensive in-home treatment providers will be required to use the revised PA/RF, HCF 11018, dated 06/03. Instructions for completion of this revised form are located in Attachment 6. A sample PA/RF is in Attachment 7.

### *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/Intensive In-Home Treatment Attachment (PA/ITA) has also been revised. The basic information requested on the form has not changed; only the format of the form has changed. Refer to Attachment 8 for a copy of the completion instructions for the PA/ITA. Attachment 9 is a copy of the PA/ITA for providers to photocopy.

### *Obtaining Prior Authorization Request Forms*

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

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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.

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/).

# ATTACHMENT 1

## Procedure code conversion chart for intensive in-home treatment services

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

Before HIPAA implementation	After HIPAA implementation		
Local procedure code	Replaced by HCPCS*/CPT** procedure codes	Program modifier	Professional level modifier
<b>W7027</b> Intensive in-home psychotherapy; certified psychotherapist	<b>H0004</b> Behavioral health counseling and therapy, per 15 minutes	<b>HA</b> Child/adolescent program	<b>HO</b> Masters degree level
			<b>HP</b> Doctoral level
			<b>UA</b> M.D.
	<b>H0022</b> Alcohol and/or drug intervention service (planned facilitation) — 60 minutes	<b>HA</b> Child/adolescent program	<b>HO</b> Masters degree level
			<b>HP</b> Doctoral level
			<b>UA</b> M.D.
	<b>T1006</b> Alcohol and/or substance abuse services, family/couple counseling — 60 minutes (This code should be used only when the primary diagnosis is alcohol or drug abuse related)	<b>HA</b> Child/adolescent program	<b>HO</b> Masters degree level
			<b>HP</b> Doctoral level
			<b>UA</b> M.D.
<b>W7028</b> Intensive in-home psychotherapy; second team member	<b>H0004</b> Behavioral health counseling and therapy, per 15 minutes	<b>HA</b> Child/adolescent program	<b>HM</b> Less than bachelor degree level
			<b>HN</b> Bachelors degree level
	<b>H0022</b> Alcohol and/or drug intervention service (planned facilitation) — 60 minutes	<b>HA</b> Child/adolescent program	<b>HM</b> Less than bachelor degree level
			<b>HN</b> Bachelors degree level
	<b>T1006</b> Alcohol and/or substance abuse services, family/couple counseling — 60 minutes (This code should be used only when the primary diagnosis is alcohol or drug abuse related)	<b>HA</b> Child/adolescent program	<b>HM</b> Less than bachelor degree level
			<b>HN</b> Bachelors degree level

\*HCPCS = Healthcare Common Procedure Coding System

\*\*CPT = Current Procedural Terminology

Before HIPAA implementation	After HIPAA implementation		
Local procedure code	Replaced by HCPCS*/CPT** procedure codes	Program modifier	Professional level modifier
<b>W7029</b> Travel to intensive in-home psychotherapy; certified psychotherapist	<b>99082</b> Unusual travel (e.g., transportation and escort of patient) — 60 minutes	<b>HA</b> Child/adolescent program	<b>HO</b> Masters degree level
			<b>HP</b> Doctoral level
			<b>UA</b> M.D.
<b>W7030</b> Travel to intensive in-home psychotherapy; second team member	<b>99082</b> Unusual travel (e.g., transportation and escort of patient) — 60 minutes	<b>HA</b> Child/adolescent program	<b>HM</b> Less than bachelor degree level
			<b>HN</b> Bachelors degree level

\*HCPCS = Healthcare Common Procedure Coding System

\*\*CPT = *Current Procedural Terminology*

## ATTACHMENT 2

### Place of service codes for intensive in-home treatment services

The tables below list the place of service (POS) codes that providers will be required to use when submitting claims after implementation of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). A future *Wisconsin Medicaid and BadgerCare Update* will notify providers of the specific effective dates for Wisconsin Medicaid's implementation of HIPAA.

Providers may use the following POS codes with procedure codes H0004, H0022, T1006, and 99082:

Code	Description
04	Homeless Shelter
12	Home
99*	Other Place of Service

\*When submitting claims with procedure code 99082, always use POS code "99."

# ATTACHMENT 3

## Rounding guidelines for intensive in-home treatment services

Time units are calculated based on rounding minutes of service. The following charts illustrate the rules of rounding and give the appropriate billing unit.

Use the following rounding guidelines for procedure code H0004:

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

Use the following rounding guidelines for procedure codes H0022, T1006, and 99082:

Time (Minutes)	Unit(s) billed
1-6	.1
7-12	.2
13-18	.3
19-24	.4
25-30	.5
31-36	.6
37-42	.7
43-48	.8
49-54	.9
55-60	1.0
Etc.	Etc.

# ATTACHMENT 4

## CMS 1500 claim form instructions for intensive in-home treatment services

(For claims submitted after HIPAA implementation)

Use the following claim form completion instructions, **not** the claim form's printed descriptions, to avoid denial or inaccurate Medicaid claim payment. Complete all required elements as appropriate. Do not include attachments unless instructed to do so.

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

### **Element 1 — Program Block/Claim Sort Indicator**

*County-owned outpatient mental health and substance abuse services clinics*

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

*Psychiatrists and Ph.D. psychologists in private practice and privately owned outpatient mental health and substance abuse services clinics*

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

### **Element 1a — Insured's I.D. Number**

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

### **Element 2 — Patient's Name**

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

### **Element 3 — Patient's Birth Date, Patient's Sex**

Enter the recipient's birth date in MM/DD/YY format (e.g., February 3, 1955, would be 02/03/55) or in MM/DD/YYYY format (e.g., February 3, 1955, would be 02/03/1955). Specify whether the recipient is male or female by placing an "X" in the appropriate box.

### **Element 4 — Insured's Name (not required)**

### **Element 5 — Patient's Address**

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

### **Element 6 — Patient Relationship to Insured (not required)**

### **Element 7 — Insured's Address (not required)**

### **Element 8 — Patient Status (not required)**

## Element 9 – Other Insured’s Name

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

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

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

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

## Element 10 – Is Patient’s Condition Related to (not required)

### Element 11 – Insured’s Policy, Group, or FECA Number

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

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

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

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

Code	Description
M-5	<p><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 (DOS) before or after their Medicare certification effective dates. Use M-5 in the following instances:</p> <p><i>For Medicare Part A (all three criteria must be met):</i></p> <ul style="list-style-type: none"> <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>
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>

Elements 12 and 13 — Authorized Person's Signature (not required)

Element 14 — Date of Current Illness, Injury, or Pregnancy (not required)

Element 15 — If Patient Has Had Same or Similar Illness (not required)

Element 16 — Dates Patient Unable to Work in Current Occupation (not required)

## Elements 17 and 17a — Name and I.D. Number of Referring Physician or Other Source (not required)

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

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

## Element 19 — Reserved for Local Use (not required)

## Element 20 — Outside Lab? (not required)

## Element 21 — Diagnosis or Nature of Illness or Injury

Enter the *Diagnostic and Statistical Manual of Mental Disorders, Third Edition, Revised* 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.

Allowable diagnosis codes for in-home treatment services are:

292.00-292.90	294.80	295.1x	295.2x	295.3x	295.6x	295.70	295.9x	296.2x-296.70	299.00	299.80	300.11	
300.12-300.15	300.40	300.60	300.70	300.81	301.00	301.13	301.20-301.50	301.60-301.90	302.20-302.40			
302.50	302.60	302.70-302.79	302.81-302.84	302.85	302.89	302.90	303.90	304.00-304.90	305.00			
305.20-305.90	306.51	307.10	307.20-307.23	307.50	307.51	307.52	307.53	307.80	309.00	309.21		
309.23-309.90	311.00	312.00	312.20	312.33	312.34	312.90	313.00	313.21	313.81	313.89	314.01	316.00

## 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 or MM/DD/YYYY format in the “From” field.
- When billing for two, three, or four DOS on the same detail line, enter the first DOS in MM/DD/YY or MM/DD/YYYY format in the “From” field and enter subsequent DOS in the “To” field by listing **only** the date(s) of the month. For example, for DOS December 1, 8, 15, and 22, 2003, indicate 12/01/03 or 12/01/2003 in the “From” field and indicate 08/15/22 in the “To” field.

It is allowable to enter up to four DOS per line if:

- All DOS are in the same calendar month.
- All services are billed using the same procedure code and modifier, if applicable.
- All services have the same place of service (POS) code.
- All services were performed by the same provider.
- The same diagnosis is applicable for each service.
- The charge for all services is identical. (Enter the total charge **per detail line** in Element 24F.)
- The number of services performed on each DOS is identical.
- All services have the same family planning indicator, if applicable.
- All services have the same emergency indicator, if applicable.

## Element 24B — Place of Service

Enter the appropriate two-digit POS code for each service.

### **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 (two per procedure code) modifiers 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 diagnosis code listed in Element 21.

### **Element 24F — \$ Charges**

Enter the total charge for each line item. Providers are required to bill Wisconsin Medicaid their usual and customary charge. The usual and customary charge is the provider’s charge for providing the same service to persons not entitled to Medicaid benefits.

### **Element 24G — Days or Units**

Enter the appropriate number of units for each line item. Always use a decimal (e.g., 2.0 units).

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

### **Element 24I — EMG**

Enter an “E” for **each** procedure performed as an emergency. If the procedure is not an emergency, leave this element blank.

### **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. Use the performing provider number of the certified in-home psychotherapy provider for both the certified in-home psychotherapy provider and the second team member. Any other information entered in this element may cause claim denial.

### **Element 25 — Federal Tax I.D. Number (not required)**

### **Element 26 — Patient’s Account No. (not required)**

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

### **Element 27 — Accept Assignment (not required)**

### **Element 28 — Total Charge**

Enter the total charges for this claim.

### **Element 29 — Amount Paid**

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

### **Element 30 — Balance Due**

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

### **Element 31 — Signature of Physician or Supplier**

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

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

### **Element 32 — Name and Address of Facility Where Services Were Rendered (not required)**

### **Element 33 — Physician's, Supplier's Billing Name, Address, ZIP Code, and Phone #**

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

# ATTACHMENT 5

## Sample CMS 1500 claim form for intensive in-home treatment services for private mental health clinic

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION

HEALTH INSURANCE CLAIM FORM																																																																																																											
1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/> <small>(Medicare #) (Medicaid #) (Sponsor's SSN) (VA File #) (SSN or ID) (SSN) (ID)</small>					1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) <b>1234567890</b>																																																																																																						
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <b>Recipient, Im A</b>					3. PATIENT'S BIRTH DATE MM DD YY <b>MM DD YY</b> SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F																																																																																																						
5. PATIENT'S ADDRESS (No., Street) <b>609 Willow</b>					6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>																																																																																																						
CITY <b>Anytown</b>			STATE <b>WI</b>		8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>			CITY 		STATE 																																																																																																	
ZIP CODE <b>55555</b>			TELEPHONE (Include Area Code) <b>(xxx)xxx-xxxx</b>		Employed <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Student <input type="checkbox"/>			ZIP CODE 		TELEPHONE (INCLUDE AREA CODE) 																																																																																																	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)					10. IS PATIENT'S CONDITION RELATED TO:																																																																																																						
a. OTHER INSURED'S POLICY OR GROUP NUMBER					a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO																																																																																																						
b. OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>					b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input type="checkbox"/> NO																																																																																																						
c. EMPLOYER'S NAME OR SCHOOL NAME					c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO																																																																																																						
d. INSURANCE PLAN NAME OR PROGRAM NAME					10d. RESERVED FOR LOCAL USE																																																																																																						
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.																																																																																																											
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.  SIGNED _____ DATE _____						13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.  SIGNED _____																																																																																																					
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY				15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY				16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY																																																																																																			
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE <b>I.M. Referring MD</b>				17a. I.D. NUMBER OF REFERRING PHYSICIAN <b>12345678</b>				18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																																																																																																			
19. RESERVED FOR LOCAL USE						20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO																																																																																																					
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. <b>313.81</b>						22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.																																																																																																					
2. _____						23. PRIOR AUTHORIZATION NUMBER <b>1234567</b>																																																																																																					
3. _____						24. A DATE(S) OF SERVICE From To B Place of Service C Type of Service D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS I MODIFIER E DIAGNOSIS CODE F \$ CHARGES G DAYS OR UNITS H EFSDT Family Plan I EMG J COB K RESERVED FOR LOCAL USE																																																																																																					
4. _____						<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 10%;">1</td> <td style="width: 10%;">10</td> <td style="width: 10%;">16</td> <td style="width: 10%;">03</td> <td style="width: 10%;">12</td> <td style="width: 10%;"></td> <td style="width: 10%;">H0004</td> <td style="width: 10%;">HA</td> <td style="width: 10%;">HO</td> <td style="width: 10%;">1</td> <td style="width: 10%;">XX</td> <td style="width: 10%;">XX</td> <td style="width: 10%;">4.7</td> <td style="width: 10%;"></td> <td style="width: 10%;"></td> <td style="width: 10%;">11223344</td> </tr> <tr> <td>2</td> <td>10</td> <td>16</td> <td>03</td> <td>12</td> <td></td> <td>H0004</td> <td>HA</td> <td>HM</td> <td>1</td> <td>XX</td> <td>XX</td> <td>4</td> <td></td> <td></td> <td>11223344</td> </tr> <tr> <td>3</td> <td></td> </tr> <tr> <td>4</td> <td></td> </tr> <tr> <td>5</td> <td></td> </tr> <tr> <td>6</td> <td></td> </tr> </table>						1	10	16	03	12		H0004	HA	HO	1	XX	XX	4.7			11223344	2	10	16	03	12		H0004	HA	HM	1	XX	XX	4			11223344	3																4																5																6															
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25. FEDERAL TAX I.D. NUMBER SSN EIN				26. PATIENT'S ACCOUNT NO. <b>1234JED</b>				27. ACCEPT ASSIGNMENT? (For gov. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ <b>XXXX</b>		29. AMOUNT PAID \$		30. BALANCE DUE \$ <b>XXXX</b>																																																																																													
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.)  <b>I.M. Authorized</b> MMDYYY SIGNED DATE						32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)  <b>In-Home Treatment Provider</b> <b>1 W. Williams</b> <b>Anytown, WI 55555</b>																																																																																																					
						33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # <b>1 W. Williams</b> <b>Anytown, WI 55555</b> <b>87654321</b> PIN# GRP#																																																																																																					

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

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

# ATTACHMENT 6

## Prior Authorization Request Form (PA/RF) Completion Instructions for intensive in-home treatment services

(For claims 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/Intensive In-Home Treatment Attachment (PA/ITA), by fax to Wisconsin Medicaid at (608) 221-8616; or, providers may submit PA requests with attachments to:

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

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

### SECTION I — PROVIDER INFORMATION

#### Element 1 — Name and Address — Billing Provider

Enter the name and complete address (street, city, state, and Zip code) of the billing provider. The name listed in this element must correspond with the Medicaid provider number listed in Element 4. *No other information should be entered in this element, since it also serves as a return mailing label.*

#### Element 2 — Telephone Number — Billing Provider

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

#### Element 3 — Processing Type

Enter processing type “129” — Child/Adolescent Mental Health Day Treatment and In-Home Treatment Services (not AODA Day Treatment).

#### **Element 4 — Billing Provider's Medicaid Provider Number**

Enter the eight-digit Medicaid provider number of the billing provider. The provider number in this element must 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 ICD-9-CM diagnosis code and description most relevant to the service/procedure requested.

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

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

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

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

#### **Element 14 — Requested Start Date**

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

#### **Element 15 — Performing Provider Number**

Enter the eight-digit Medicaid provider number of the provider who will be providing the service, *only* if this number is different from the billing provider number listed in Element 4.

#### **Element 16 — Procedure Code**

Enter the appropriate procedure code for each service requested.

**Element 17 — Modifiers**

Enter the two modifiers that correspond to the procedure code listed.

**Element 18 — POS**

Enter the appropriate place of service (POS) code designating where the requested service/procedure/item would be provided/performed/dispensed. See Attachment 2 of this *Wisconsin Medicaid and BadgerCare Update* for a list of allowable POS codes for Intensive In-Home Treatment Services.

**Element 19 — Description of Service**

Enter a written description corresponding to the appropriate procedure code for services.

**Element 20 — QR**

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

**Element 21 — Charge**

Enter the usual and customary charge for each service/procedure/item requested. If the quantity is greater than “1,” multiply the quantity by the charge for each service/procedure/item requested. Enter that total amount in this element.

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

**Element 22 — Total Charge**

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 7

## Sample Prior Authorization Request Form (PA/RF) for intensive in-home treatment services

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

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

### WISCONSIN MEDICAID PRIOR AUTHORIZATION REQUEST FORM (PA/RF)

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

<b>FOR MEDICAID USE — ICN</b>	AT	Prior Authorization Number
-------------------------------	----	----------------------------

SECTION I — PROVIDER INFORMATION		
1. Name and Address — Billing Provider (Street, City, State, Zip Code)  I.M. Provider 1 W. Wilson Anytown, WI 55555	2. Telephone Number — Billing Provider  (XXX) XXX-XXXX	3. Processing Type  129
4. Billing Provider's Medicaid Provider Number  56781234		

SECTION II — RECIPIENT INFORMATION		
5. Recipient Medicaid ID Number  1234567890	6. Date of Birth — Recipient (MM/DD/YY) MM/DD/YY	7. Address — Recipient (Street, City, State, Zip Code)  609 Willow Anytown, WI 55555
8. Name — Recipient (Last, First, Middle Initial) Recipient, Im A		9. Sex — Recipient <input checked="" type="checkbox"/> M <input type="checkbox"/> F

SECTION III — DIAGNOSIS / TREATMENT INFORMATION									
10. Diagnosis — Primary Code and Description 313.81 - oppositional disorder					11. Start Date — SOI		12. First Date of Treatment — SOI		
13. Diagnosis — Secondary Code and Description N/A					14. Requested Start Date MM/DD/YY				
15. Performing Provider Number	16. Procedure Code	17. Modifiers				18. POS	19. Description of Service	20. QR	21. Charge
12345678	H0004	HA	HO			12	Behavioral health counseling and therapy, per 15 minutes	104	XXX.XX
23456789	H0004	HA	HN			99	Behavioral health counseling and therapy, per 15 minutes	35	XXX.XX
12345678	99082	HA	HO			99	travel	13	
23456789	99082	HA	HN			99	travel	26	

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.

	<b>22. Total Charges</b> X,XXX.XX
--	-----------------------------------

23. SIGNATURE — Requesting Provider 	24. Date Signed MM/DD/YY
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<b>FOR MEDICAID USE</b>	Procedure(s) Authorized:	Quantity Authorized:						
<input type="checkbox"/> Approved <table style="width: 100%; border: none; margin-top: 5px;"> <tr> <td style="width: 33%; border-bottom: 1px solid black;"></td> <td style="width: 33%; border-bottom: 1px solid black;"></td> <td style="width: 33%; border-bottom: 1px solid black;"></td> </tr> <tr> <td style="text-align: center; font-size: small;">Grant Date</td> <td style="text-align: center; font-size: small;">Expiration Date</td> <td></td> </tr> </table>						Grant Date	Expiration Date	
Grant Date	Expiration Date							
<input type="checkbox"/> Modified — Reason:								
<input type="checkbox"/> Denied — Reason:								
<input type="checkbox"/> Returned — Reason:								
_____ SIGNATURE — Consultant / Analyst		_____ Date Signed						

ATTACHMENT 8  
Prior Authorization / Intensive In-Home Treatment  
Attachment (PA/ITA)  
Completion Instructions

(A copy of the "Prior Authorization/Intensive In-Home Treatment Attachment [PA/ITA] Completion Instructions may be found on the following pages.)

**WISCONSIN MEDICAID  
PRIOR AUTHORIZATION / INTENSIVE IN-HOME TREATMENT ATTACHMENT (PA/ITA)  
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 or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of prior authorization (PA) or Medicaid payment for the services.

The use of this form is voluntary; 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. Providers should refer to service-specific provider bulletins for service restrictions and additional documentation requirements. Provide enough information for Wisconsin Medicaid medical consultants to make a reasonable judgement about the case.

Attach the completed Prior Authorization/Intensive In-Home Treatment Attachment (PA/ITA) to the Prior Authorization Request Form (PA/RF), physician prescription, and HealthCheck screen documentation dated within 365 days prior to the grant date being requested and send it to Wisconsin Medicaid. Providers may submit PA requests by fax to Wisconsin Medicaid at (608) 221-8616. Providers who wish to submit PA requests by mail may do so by submitting them to the following address:

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

**GENERAL INSTRUCTIONS**

The information contained on this PA/ITA will be used to make a decision about the amount of intensive in-home treatment which will be approved for Medicaid reimbursement. Complete each section as thoroughly as possible. Where noted in these instructions, the provider may attach material which he or she may have in his or her records.

In-home services are generally deemed appropriate for children who meet the criteria of being severely emotionally disturbed (SED) (see Element 16). The provider must also justify the appropriateness of providing the services in the home rather than in the clinic setting. The unique needs of an SED child and his or her family necessitate a team approach. For purposes of Medicaid reimbursement, this team must be led by a Medicaid-certified psychotherapy provider.

All requests for in-home psychotherapy must include documentation of a HealthCheck screen performed by a valid HealthCheck screener and a physician order for in-home psychotherapy, both dated within 365 days prior to the grant date being requested. Prior authorization will not be granted without this documentation. The initial PA may be backdated up to 10 working days prior to the first receipt of the request at Wisconsin Medicaid, but no earlier than the date of the HealthCheck and the physician order. HealthChecks and physician orders expire after one year, so they must be renewed at least annually.

**Initial Prior Authorization Request**

Complete the PA/RF and the entire PA/ITA. The initial authorization will be for a period of no longer than 13 weeks.

**First Reauthorization**

- Complete the PA/RF and Sections I-III of the PA/ITA.
- Attach a copy of the HealthCheck verification and physician order dated within 365 days prior to the grant date being requested that were included with the initial authorization. (As long as the HealthCheck verification and physician order submitted in the initial request are timely, they may be used for subsequent requests.)
- Attach a brief summary of the treatment to date, including progress on treatment goals, and affirm that the family is

appropriately involved in the treatment process. The treatment summary information should correspond specifically to the short-term and long-term goals of the previous treatment plan and reference the same measures of improvement. If changes were made to the treatment plan, send a copy of the amended or updated plan.

- Authorization may be granted for up to 13 weeks.

### **Subsequent Reauthorizations**

- Complete the PA/RF and Sections I-III of the PA/ITA.
- Attach a copy of the HealthCheck verification and the physician order dated within 365 days prior to the grant date being requested that were included with the initial authorization. (As long as the HealthCheck verification and the physician order submitted in the initial request are timely, they may be used for subsequent requests.)
- Attach a brief summary of the treatment to date, including progress on treatment goals, and affirm that the family is appropriately involved in the treatment process. The treatment summary information should correspond specifically to the short-term and long-term goals of the previous treatment plan and reference the same measures of improvement. If changes were made to the treatment plan, send a copy of the amended or updated plan.
- Summarize the treatment since the previous authorization. The treatment summary information should correspond specifically to the short-term and long-term goals of the previous treatment plan and reference the same measures of improvement. The need for continued in-home treatment must be clearly documented. Where no change is noted in the treatment summary, justify the continued use of the in-home treatment or note how changes in the treatment plan address the lack of progress.
- Specifically address aftercare planning. Discuss plans for terminating in-home treatment and the services which the recipient/family will require.
- Authorization will be for a period of no longer than 13 weeks.

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

### **Additional Considerations for In-Home Treatment for Substance Abuse**

When substance abuse treatment issues are identified as part of the in-home treatment plan, an appropriately qualified alcohol and other drug abuse (AODA) counselor must be identified as part of the treatment team. In-home treatment by a team headed by an AODA counselor (without a certified psychotherapist participating) will generally not be approved. In these instances the provider must document the absence of significant psychopathology and the primary goal of intervention must be motivational with a goal of getting the recipient and/or family involved in traditional outpatient services.

### **Multiple Services**

When a recipient will require PA for other services concurrent to the in-home treatment (e.g., mental health or substance abuse day treatment), a separate PA/RF must be submitted for those services and the appropriate PA attachment and all required materials must be submitted for that other service. Indicate on this PA request that services will be coordinated with the other service provider (if the service will be provided by a different agency). These other services must be identified on the multi-agency treatment plan.

## **SECTION I — RECIPIENT INFORMATION**

### **Element 1 — Name — Recipient**

Enter the recipient's last name, followed by his or her first name and middle initial, exactly as it appears on the recipient's Medicaid identification card.

### **Element 2 — Age — Recipient**

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

### **Element 3 — Recipient Medicaid Identification Number**

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

## **SECTION II — PROVIDER INFORMATION**

### **Element 4 — Name — Medicaid-Certified Clinic**

Enter the name of the Medicaid-certified psychotherapy clinic which will be billing for the services.

### **Element 5 — Certified Clinic's Medicaid Provider Number**

Enter the eight-digit Medicaid provider number of the clinic which will be billing for in-home treatment.

**Element 6 — Name — Medicaid-Certified Performing Psychotherapist**

Enter the name of the Medicaid-certified psychotherapist who will be the lead member of the team providing services. Master's level psychotherapists must obtain a Medicaid performing provider number in order to bill for these services even if this is not ordinarily required for the type of facility by which they are employed.

**Element 7 — Performing Psychotherapist's Medicaid Provider Number**

Enter the eight-digit Medicaid provider number of the certified psychotherapist identified in Element 6.

**Element 8 — Telephone Number — Psychotherapist**

Enter the telephone number, including area code, of the certified psychotherapist identified in Element 6.

**Element 9 — Discipline — Psychotherapist**

Enter the discipline of the certified psychotherapist identified in Element 6 (e.g., MSW, Ph.D.).

**SECTION III**

**Element 10**

Enter the requested start date and end date for this authorization request. The initial authorization may be backdated up to 10 working days prior to the receipt of the request at Wisconsin Medicaid if the provider documents the clinical need for beginning services immediately. Note guidelines for length of authorizations under the "General Instructions" section.

**Element 11**

Enter the total expected number of hours the family will receive direct treatment services over this PA grant period (e.g., the current 13-week period). When two therapists are present at the same time, this is still counted as one hour of treatment received by the family. Also indicate the anticipated pattern of treatment for each team member (e.g., two-hour session once a week for 13 weeks by the certified psychotherapist, two-hour session once a week by the second team member with certified therapist plus one-hour session twice a week for 13 weeks for the second team member independently. More than 104 hours of direct treatment to the family during a 13-week period will not be authorized.

**Element 12**

Indicate the number of hours the certified psychotherapist will provide direct treatment services to the family and the number of hours that the second team member will provide direct treatment to the family. If more than two providers will be involved in providing services, document that all individuals meet the criteria in these guidelines. Total hours of treatment must not exceed the limitation noted in Element 11. Reimbursement is not allowed for more than two providers for the same treatment session. Since two providers may be providing services at the same time on occasion, the total hours in this section may exceed the number of hours of treatment the family will receive as noted in Element 11. If the primary psychotherapist is involved in treatment more than 50% of the time (e.g., if the primary therapist's direct treatment hours exceed those of the second team member's), special justification should be noted on the request.

Indicate the name and qualifications of the second team member. Attach a résumé, if available. The minimal qualifications must be:

- An individual who possesses at least a bachelor's degree in a behavioral science, a registered nurse (RN), an occupational therapist, a Medicaid-certified AODA counselor, or a professional with equivalent training. The second team member must have at least 1,000 hours of supervised clinical experience working in a program whose primary clientele are emotionally disturbed youth.
- Other individuals who have had at least 2,000 hours of supervised clinical experience working in a program whose primary clientele are emotionally disturbed youth.
- The second team member will be reimbursed at a lower rate, even if that person is a certified Medicaid psychotherapist. The second team member works under the supervision of the certified psychotherapy provider.

If the second team member is a Medicaid-certified psychotherapy provider, only his or her Medicaid provider number need be entered to document his or her qualifications.

**Element 13**

Indicate the travel time required to provide the service. Travel time should consist of the time to travel from the provider's office to the recipient's home or from the previous appointment to the recipient's home. Travel time exceeding one hour one-way will generally not be authorized.

## SECTION IV

### Element 14

Present a summary of the mental health assessment and differential diagnosis. Diagnoses on all five axes of the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) are required. The assessment should address the level of reality testing, thought processes, drive control, relational capacity, and defense functioning. The assessment summary should provide documentation supporting the diagnosis. A psychiatrist or psychologist\* must review and sign the summary and diagnosis indicating his or her agreement with the results. In those cases, where the only, or primary, diagnosis is a conduct disorder, the request must provide sufficient justification for the appropriateness of in-home treatment. In those cases where the only, or primary, diagnosis is a psychoactive substance abuse disorder, requests will generally not be approved unless there is sufficient justification for the appropriateness of an in-home intervention (see "Additional Considerations for In-Home Treatment of Substance Abuse" in the General Instructions). Providers may attach copies of an existing assessment if it is no longer than two pages.

### Element 15

Present a summary of the recipient's illness/treatment/medication history. In those cases where the recipient has spent significant amounts of time out of the home, or is out of the home at the time of the request, the treatment plan must specifically address the transition, reintegration, and attachment issues. For individuals with significant substance abuse problems, the multi-agency treatment plan must address how these will be addressed. For individuals 16 years and over who have spent significant amounts of time out of the home, the request must discuss why intensive in-home treatment is preferred over preparing the recipient for independent living. *Providers may attach copies of illness/treatment/medication histories that are contained in their records if they do not exceed two pages.*

### Element 16

Complete the checklist for determining that an individual meets the criteria for severe emotional disturbance. The following information defines the allowable conditions for b. and c. of the checklist.

For b., the individual must have one of the following diagnoses from the most recent version of the DSM.

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

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

Adult diagnostic categories appropriate for children and adolescents are:

- Substance-related disorders (303.90; 304.00-304.90; 305.00; 305.20-305.70; 305.90, except caffeine intoxication).
- Schizophrenia and other psychotic disorders (293.81; 293.82; 295.10-295.40; 295.60-295.70; 295.90; 297.1; 297.3; 298.9).
- Mood disorders (293.83; 296.00-296.90; 300.4; 301.13; 311).
- Anxiety disorders (300.00-300.02; 300.21-300.23; 300.29; 300.3; 308.3; 309.81).
- Somatoform disorders (300.11; 300.81).
- Dissociative disorders (300.12-300.15; 300.6).
- Sexual and gender identity disorders (302.2-302.4; 302.6; 302.89; 302.9).
- Eating disorders (307.1; 307.51).
- Impulse-control disorders (312.30; 312.33; 312.34).
- Adjustment disorders (309.0; 309.24; 309.28; 309.3; 309.4; 309.9).
- Personality disorders coded on Axis II (301.0; 301.20-301.9).

For c., the symptoms and functional impairments are defined as follows.

\*In all instances, psychologist means one who meets the criteria for Medicaid certification at the Ph.D. psychologist level: Licensed in Wisconsin and listed or eligible to be listed in the national register of health care providers in psychology.

### *Symptoms*

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

### *Functional Impairments (compared to expected developmental level):*

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

### *Eligibility criteria may be waived under the following circumstances:*

- This individual would otherwise meet the definition of SED, but has not yet received services from more than one system and in the judgment of the medical consultant, would be likely to do so where the intensity of treatment requested was not provided. Attach explanation.
- This individual would otherwise meet the definition of SED, but functional impairment has not persisted for six months, and in the judgment of the medical consultant, the nature of the acute episode is such an impairment in functioning that it is likely to be evident without the intensity of the treatment requested. Attach explanation.

### **Element 17**

Present an assessment of the family's strengths and weaknesses. Present evidence that the family is willing to be involved in treatment and is capable of benefiting from treatment. Where the presence of significant psychological dysfunctioning or substance abuse problems is indicated among family members, indicate on the multi-agency treatment plan how these problems will be addressed.

Reimbursement for treatment services primarily directed at recipients over the age of 20 are not available through HealthCheck "Other Services," except as noted in Element 11. Indicate which family members will be involved in treatment. If an assessment of the family's willingness and ability to be involved in treatment is an initial treatment goal, indicate this with at least minimal justification for believing this to be the case. If a family assessment is contained in the psychiatric evaluation or illness/treatment history, indicate this.

### **Element 18**

The provider must specifically identify the rationale for providing services in the home for this child/family. A significant history of failed outpatient treatment along with documentation which identifies a significant risk of out-of-home placement will support such a request. Strong justification is needed if outpatient clinic services have not been previously attempted. The provider should identify specific barriers to the family receiving treatment in a clinic setting or specific advantages for this family receiving services in the home (not simply general advantages of in-home treatment). The provider should present this justification in their own words and not assume that the consultant can infer this from other information submitted with this request.

### Element 19

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

## SECTION V

### Element 20

The following materials must be attached and labeled.

- a. The (PA/RF) may be obtained from Wisconsin Medicaid. Use processing type 129 in Element 1. The words "HealthCheck Other Services" should be written *in red* across the top of the form. Providers should use the appropriate procedure codes, modifiers, and descriptions in Elements 14 and 18.

The quantity requested in Element 19 should represent total hours for the grant period requested and Element 20 should represent charges for all hours indicated in Element 19.

- b. The request must include documentation that the recipient had a comprehensive HealthCheck screening within 365 days prior to the grant date being requested. This documentation must be one of the following:
  - A copy of the HealthCheck verification card showing a comprehensive screen in the past year.
  - A copy of the HealthCheck provider's billing form showing a claim for a comprehensive HealthCheck screening.
  - A copy of the HealthCheck provider's Remittance and Status Report showing a claim for a comprehensive HealthCheck screening.
  - A HealthCheck referral from the HealthCheck provider.
  - A letter on the HealthCheck provider's letterhead indicating the date on which they performed a comprehensive HealthCheck screening on the recipient.
  - A physician's prescription for the service with a note on the prescription that this is subsequent to a comprehensive HealthCheck screening performed at his or her practice and the date of the screen.
- c. The multi-agency treatment plan must be developed by representatives from all systems identified on the SED eligibility checklist. The plan must address the role of each system in the overall treatment and the major goals for each agency involved. The plan should be signed by all participants, but to facilitate submission, the provider may document who was involved. Where some agency was not involved in the planning, the provider must document the reason and what attempts were made to include them. The plan should indicate why services in the home are necessary and desirable. *The individual who is coordinating the multi-agency planning should be clearly identified.* A psychiatrist or psychologist must sign either the multi-agency plan or in-home treatment plan. A physician should sign the multi-agency plan if the recipient is taking medication. A model plan may be obtained from the forms page of the Wisconsin Medicaid Web site. To access the model plan, 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.

If a plan other than the model is used, all information on the model must be included.

- d. The in-home treatment team must complete a treatment plan covering their services. A psychiatrist or psychologist must sign either the in-home treat plan or the multi-agency treatment plan. Providers may obtain a copy of a model plan from the SED Coordinator or use one of their own which provides equivalent information. The plan must contain measurable goals, specific methods, and an expected time frame for achievement of the goals. The methods must allow for a clear determination that the services provided meet criteria for Medicaid-covered services. Services which are primarily social or recreational in nature are not reimbursable. The plan should clearly identify which team members are providing the Medicaid-covered services being requested.

Services provided to the recipient's parents, foster parents, siblings, or other individuals significantly involved with the recipient are deemed appropriate as part of the in-home treatment plan when these services are required to directly affect the recipient's functioning at home or in the community. Such services include family therapy necessary to deal with issues of family dysfunctioning, behavior training with responsible adults to identify problem behaviors and develop appropriate responses, supervision of the child and family members in the home setting to evaluate the effect of behavioral intervention approaches and provide feedback to the family on implementing these interventions, and minimal supportive interventions with the family members which are necessary to ensure their ability to continue their participation

in the in-home treatment process. Interventions with family members or significant others which are primarily for the benefit of these others are not reimbursable under these guidelines, except where these other individuals meet the criteria for intensive in-home treatment (e.g., they are 20 years of age or under) and authorization has been received for these other services under these guidelines. For instance, intervention directed solely at a parent's alcohol abuse is considered substance abuse treatment, is covered by the policy for substance abuse treatment service, and is not reimbursable in the home. However, when the intervention is with the whole family and is focusing on the way in which the parent's alcohol abuse is affecting the child and/or contributing to the problem behaviors, this may be authorized under these guidelines.

Initial treatment goals may include assessment of the recipient and family in the home and these goals may be procedural (e.g., complete assessment, have all members of family attend 75% of meetings, complete substance abuse assessment). Where an assessment is part of the initial intervention, be concrete as to the components of the assessment (e.g., psychiatrist will complete psychiatric evaluation, AODA counselor will complete substance abuse assessment). Where appropriate, identify any standardized assessment tools that will be utilized.

- e. Providers must complete and attach the results of either the Achenbach Child Behavior Checklist or the Child and Adolescent Functional Assessment Scale (CAFAS). Information about these screening instruments is available on the Internet under "Achenbach Behavior Checklist" and "Child and Adolescent Functional Assessment Scale."
- f. A substance abuse assessment must be included if substance abuse-related programming is part of the recipient's treatment program. The assessment may be summarized in Element 14 as part of the psychiatric assessment or illness history.
- g. Attach a physician's prescription for in-home treatment services.

The PA/ITA must be signed and dated by the certified psychotherapy provider who is leading the in-home treatment team. It must also be signed and dated by the supervising therapist if the certified psychotherapy provider is not a Ph.D. psychologist or psychiatrist. In signing, these individuals accept responsibility for supervising the other individuals who are part of the in-home treatment team. In signing, they provide assurance that an individual who meets the criteria for a Medicaid-certified psychotherapy provider will be available to the other team members when they are in the home alone with the child/family.

**Element 21 — Signature — Certified Therapist**

Enter the signature of the certified therapist.

**Element 22 — Date Signed**

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

**Element 23 — Signature — Supervising Therapist**

Enter the signature of the supervising therapist.

**Element 24 — Date Signed**

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

ATTACHMENT 9  
Prior Authorization / Intensive In-Home Treatment  
Attachment (PA/ITA)  
(for photocopying)

(A copy of the "Prior Authorization/Intensive In-Home Treatment Attachment [PA/ITA]" [for photocopying] is located on the following pages.)

**WISCONSIN MEDICAID**  
**PRIOR AUTHORIZATION / INTENSIVE IN-HOME TREATMENT ATTACHMENT (PA/ITA)**

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/Intensive In-Home Treatment Attachment (PA/ITA) Completion Instructions (HCF 11036A).

**CHECK ONE:**     **Initial PA Request**         **First Reauthorization**         **Subsequent Reauthorization**

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**SECTION I — RECIPIENT INFORMATION**

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

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**SECTION II — PROVIDER INFORMATION**

4. Name — Medicaid-Certified Clinic	5. Certified Clinic's Medicaid Provider Number
6. Name — Medicaid-Certified Performing Psychotherapist	7. Performing Psychotherapist's Medicaid Provider Number
8. Telephone Number — Psychotherapist	9. Discipline — Psychotherapist

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**SECTION III**

10. Requested start date and end date for this authorization period. See instructions for maximum allowable authorization guidelines. If start date is prior to when request will be received at Wisconsin Medicaid, please indicate clinical rationale.

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11. Number of hours of treatment to be provided to family over this PA grant period. Please note anticipated pattern of treatment by provider (e.g., two-hour session once a week by certified therapist, two-hour session once a week by family aide with certified therapist plus one-hour session twice a week by family aide independently).

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**SECTION III — Continued**

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12. Indicate for the period covered by this request:

- The number of hours the certified psychotherapist will provide treatment \_\_\_\_\_
- The number of hours the second team member will provide treatment \_\_\_\_\_
- The name and credentials of the second team member. Include degree and number of hours of supervised clinical work with severe emotional disturbance (SED) children (attach résumé, if available):

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13. Indicate the travel time for the period covered by this request:

**Certified psychotherapist**

Anticipated number of visits \_\_\_\_\_  
Travel time per visit x \_\_\_\_\_  
= \_\_\_\_\_

**Other therapist**

Anticipated number of visits \_\_\_\_\_  
Travel time per visit x \_\_\_\_\_  
= \_\_\_\_\_

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**SECTION IV**

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

14. Present a summary of the recipient's psychiatric assessment and differential diagnosis. Diagnoses on all five axes of *Diagnostic and Statistical Manual of Mental Disorders, Third Edition, Revised* are required. The summary must also present adequate information to support the diagnosis. A psychiatrist or a Ph.D. psychologist\* must review and sign the summary and diagnoses.

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

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**SECTION IV — Continued**

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15. Present a summary of the recipient's illness / treatment / medication history and other significant background information. Define the potential for change. Note if the child is currently in out-of-home placement and, if so, the timeline for reintegration.

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**SECTION IV — Continued**

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16. Complete the checklist for determination that an individual meets the criteria for SED.

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

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

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

\_\_\_\_\_

c. **The individual has the following symptoms and functional impairments**

The individual must have 1 or 2.

1. Symptoms (must have one)

- Psychotic symptoms.
- Suicidality.
- Violence.

2. Functional impairments (must have two)

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

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

- Mental Health.
- Social Services.
- Child Protective Services.
- Juvenile Justice.
- Special Education.

**Eligibility criteria may be waived under certain circumstances**

- This individual would otherwise meet the definition of SED, but has not yet received services from more than one system and in the judgment of the medical consultant, would be likely to do so if the intensity of treatment requested was not provided. Attach explanation.
- This individual would otherwise meet the definition of SED, but functional impairment has not persisted for six months, but in the judgment of the medical consultant, the nature of the acute episode is such an impairment in functioning that it is likely to be evident without the intensity of the treatment requested. Attach explanation.

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17. Present an assessment of the family's strengths and weaknesses.

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**SECTION IV — Continued**

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18. Indicate the rationale for in-home treatment. Elaborate on this choice where prior outpatient treatment is absent or limited.

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19. Indicate the expected date for termination of in-home treatment. Describe anticipated service needs following completion of in-home treatment and transition plans.

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**SECTION V**

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20. Please attach and label all the following:

- a. The Prior Authorization/Request Form (PA/RF).
- b. A physician's prescription for in-home treatment service.
- c. Documentation that the recipient had a comprehensive HealthCheck screening within the past year. A copy of this documentation must be attached to all requests for reauthorizations (a copy of the original documentation may be used). **The initial request for these services must be received by Wisconsin Medicaid within one year of when the HealthCheck screening was dated.**
- d. A multi-agency treatment plan.
- e. An in-home psychotherapy treatment plan.
- f. Results of either the Achenbach Child Behavior Checklist or the Child Adolescent Functional Assessment Scale (CAFAS).
- g. A substance abuse assessment may be included. A substance abuse assessment **must** be included if substance abuse-related programming is part of the recipient's treatment program.

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I attest to the accuracy of the information on this PA request. I understand that I am responsible for the supervision of the other team member(s) identified on this attachment. I, or someone with comparable qualifications, will be available to the other team member(s) at all times when they are in the home alone working with the child/family.

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21. **SIGNATURE** — Certified Therapist

22. Date Signed

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23. **SIGNATURE** — Supervising Therapist

24. Date Signed

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