

To:
Substance Abuse
Day Treatment
Providers
HMOs and Other
Managed Care
Programs

Changes to local codes, paper claims, and prior authorization for substance abuse day treatment services as a result of HIPAA

This *Wisconsin Medicaid and BadgerCare Update* introduces important changes to local codes, paper claims, and prior authorization (PA) for substance abuse day treatment (formerly referred to as alcohol and other drug abuse [AODA] day treatment) services, effective October 2003, as a result of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). These changes include:

- Adopting nationally recognized codes to replace currently used Wisconsin Medicaid local codes.
- Revising CMS 1500 paper claim instructions.
- Revising Medicaid PA request forms and instructions.

A future *Update* will notify providers of the specific effective dates for the various changes.

Changes as a result of HIPAA

This *Wisconsin Medicaid and BadgerCare Update* introduces important billing and prior authorization (PA) changes for substance abuse day treatment (formerly referred to as alcohol and other drug abuse [AODA] day treatment 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, place of service (POS) codes, and modifiers to replace currently used Wisconsin Medicaid local codes.
- Revising CMS 1500 paper claim instructions.
- Revising PA request forms and instructions.

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

Adoption of national codes

Wisconsin Medicaid will adopt nationally recognized medical codes to replace currently used Wisconsin Medicaid local codes for substance abuse day treatment services.

Allowable procedure codes

Wisconsin Medicaid will adopt a nationally recognized Healthcare Common Procedure Coding System (HCPCS) procedure code to replace currently used Wisconsin Medicaid local procedure codes (W8980-W8982) for substance abuse day treatment services. Refer to Attachment 1 of this *Update* for a procedure code conversion chart. Currently used procedure code W8981 has been eliminated.

Modifiers

Providers will be required to use the nationally recognized HCPCS substance abuse program modifier “HF” for all substance abuse day treatment services.

When an assessment is performed, providers will also be required to use HCPCS modifier “U6,” which is a state-defined national modifier for substance abuse day treatment providers.

Place of service codes

Nationally recognized two-digit POS codes will replace the one-digit Wisconsin Medicaid POS codes. Refer to Attachment 2 for a list of allowable POS codes for substance abuse day treatment services.

Type of service codes

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

Coverage for substance abuse day treatment services

Medicaid coverage, documentation, and PA requirements for substance abuse day treatment services remain unchanged. Refer to the Substance Abuse Day Treatment Handbook and *Updates* for complete Medicaid policies and procedures.

Revision of CMS 1500 paper claim instructions

With the implementation of HIPAA, Medicaid-certified substance abuse day treatment providers will be required to follow the revised instructions for the CMS 1500 paper claim form in this *Update*, even though the actual CMS 1500 claim form is not being revised at this time.

One important change from the current handbook instructions is that claim sort indicator “P” will be required in Element 1, instead of “M.”

Refer to Attachment 3 for the revised instructions. Attachment 4 is a sample of a claim for substance abuse day treatment services that reflects the changes to the billing instructions.

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

Revisions made to the CMS 1500 claim form instructions

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

- The claim sort indicator was changed (Element 1).
- Other insurance indicators were revised (Element 9).
- Medicare disclaimer codes were revised (Element 11).
- Place of service codes were revised (Element 24B).
- Type of service codes are no longer required (Element 24C).
- Up to four modifiers per procedure code may be entered (Element 24D).

Providers will be required to use the nationally recognized HCPCS substance abuse program modifier “HF” for all substance abuse day treatment services.

- 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, substance abuse day treatment providers will be required to use the revised Prior Authorization Request Form (PA/RF), HCF 11018, dated 06/03. Instructions for completion of this revised form are located in Attachment 5. A sample PA/RF is in Attachment 6.

Revisions made to the Prior Authorization Request Form

The following revisions were made to the PA/RF:

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

Prior authorization attachment

The Prior Authorization/Substance Abuse Day Treatment Attachment (PA/SADTA), HCF 11037, dated 06/03, has also been revised. (The PA/SADTA replaces the PA/ADTA. Wisconsin Medicaid changed the name of this attachment to reflect the change in terminology in the industry.) The basic information requested on the form has not changed; only the format of the form has changed. Refer to Attachment 7 for a copy of the completion instructions for the PA/SADTA. Attachment 8 is a copy of the PA/SADTA for providers to photocopy.

Obtaining prior authorization request forms

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

1. Go to www.dhfs.state.wi.us/medicaid/.
2. Choose "Providers" from the options listed in the Wisconsin Medicaid main menu.
3. Select "Provider Forms" under the "Provider Publications and Forms" topic area.

The fillable PDF may be accessed using Adobe Acrobat Reader®* and may be completed electronically. Providers may then include the printed version of the attachment with the PA/RF. To use the fillable PDF, click on the dash-outlined boxes to enter information. Press the "Tab" key to move from one box to the next.

To request paper copies of the PA/SADTA or PA/RF, call Provider Services at (800) 947-9627 or (608) 221-9883. Questions about the forms may also be directed to Provider Services at the telephone numbers previously mentioned.

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

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

The PA/SADTA replaces the PA/ADTA. Wisconsin Medicaid changed the name of this attachment to reflect the change in terminology in the industry.

General HIPAA information

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

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

Information regarding Medicaid HMOs

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

For questions related to Medicaid HMOs or managed care HIPAA-related changes, contact the appropriate managed care organization.

* The Medicaid Web site provides instructions on how to obtain Adobe Acrobat Reader® at no charge from the Adobe® Web site at www.adobe.com/. Adobe Acrobat Reader® does not allow users to save completed fillable PDFs to their computer. Refer to the Adobe® Web site for more information on fillable PDFs.

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

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

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

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

ATTACHMENT 1

Procedure code conversion chart for substance abuse day treatment services

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

Before HIPAA implementation	After HIPAA implementation			
Local procedure code	Replaced by HCPCS* procedure code	Modifier	Additional modifier	Diagnosis code restrictions
W8980 Substance abuse day treatment assessment	H2012 Behavioral health day treatment, per hour	HF Substance abuse program	U6 Assessment	Diagnosis code required, but no restrictions
W8981 Substance abuse day treatment assessment limitation exceeded	Has been eliminated			
W8982 Substance abuse day treatment basic service	H2012 Behavioral health day treatment, per hour	HF Substance abuse program		See the acceptable diagnosis codes listed in Element 21 of Attachment 3 of this <i>Update</i> .

*HCPCS = Healthcare Common Procedure Coding System.

ATTACHMENT 2

Place of service codes for substance abuse day treatment services

The following table lists the nationally recognized place of service (POS) codes that providers will be required to use when submitting claims for substance abuse day treatment services. A future *Wisconsin Medicaid and BadgerCare Update* will notify providers of the specific effective dates for Wisconsin Medicaid's implementation of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Substance abuse day treatment services may be provided in the following POS by substance abuse day treatment programs certified under HFS 75.12, Wis. Admin. Code, only.

POS code	Description
05	Indian Health Service Free-Standing Facility
06	Indian Health Service Provider-Based Facility
07	Tribal 638 Free-Standing Facility
08	Tribal 638 Provider-Based Facility
11	Office
22	Outpatient Hospital
50	Federally Qualified Health Center
71	State or Local Public Health Clinic
72	Rural Health Clinic

ATTACHMENT 3

CMS 1500 claim form instructions for substance abuse day treatment services

(For claims submitted after HIPAA implementation)

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

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

Element 1 — Program Block/Claim Sort Indicator

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

Element 1a — Insured's I.D. Number

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

Element 2 — Patient's Name

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

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

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

Element 4 — Insured's Name (not required)

Element 5 — Patient's Address

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

Element 6 — Patient Relationship to Insured (not required)

Element 7 — Insured's Address (not required)

Element 8 — Patient Status (not required)

Element 9 — Other Insured's Name

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

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

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

Code	Description
OI-P	PAID by commercial health insurance or commercial HMO. In Element 29 of this claim form, indicate the amount paid by commercial health insurance to the provider or to the insured.
OI-D	DENIED by commercial health insurance or commercial HMO following submission of a correct and complete claim, or payment was applied towards the coinsurance and deductible. Do not use this code unless the claim was actually billed to the commercial health insurer.
OI-Y	YES, the recipient has commercial health insurance or commercial HMO coverage, but it was not billed for reasons including, but not limited to: <ul style="list-style-type: none"> ✓ The recipient denied coverage or will not cooperate. ✓ The provider knows the service in question is not covered by the carrier. ✓ The recipient's commercial health insurance failed to respond to initial and follow-up claims. ✓ Benefits are not assignable or cannot get assignment. ✓ Benefits are exhausted.

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

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

Element 11 — Insured’s Policy, Group, or FECA Number

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

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

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

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

Code	Description
M-5	<p>Provider is not Medicare certified. This code may be used when providers are identified in Wisconsin Medicaid files as being Medicare certified, but are billing for dates of service (DOS) before or after their Medicare certification effective dates. Use M-5 in the following instances:</p> <p><i>For Medicare Part A</i> (all three criteria must be met):</p> <ul style="list-style-type: none"> ✓ The provider is identified in Wisconsin Medicaid files as certified for Medicare Part A, but the provider was not certified for the date the service was provided. ✓ The recipient is eligible for Medicare Part A. ✓ The procedure provided is covered by Medicare Part A. <p><i>For Medicare Part B</i> (all three criteria must be met):</p> <ul style="list-style-type: none"> ✓ The provider is identified in Wisconsin Medicaid files as certified for Medicare Part B, but the provider was not certified for the date the service was provided. ✓ The recipient is eligible for Medicare Part B. ✓ The procedure provided is covered by Medicare Part B.
M-7	<p>Medicare disallowed or denied payment. This code applies when Medicare denies the claim for reasons related to policy (not billing errors), or the recipient's lifetime benefit, spell of illness, or yearly allotment of available benefits is exhausted. Use M-7 in the following instances:</p> <p><i>For Medicare Part A</i> (all three criteria must be met):</p> <ul style="list-style-type: none"> ✓ The provider is identified in Wisconsin Medicaid files as certified for Medicare Part A. ✓ The recipient is eligible for Medicare Part A. ✓ The service is covered by Medicare Part A but is denied by Medicare Part A due to frequency limitations, diagnosis restrictions, or the service is not payable due to benefits being exhausted. <p><i>For Medicare Part B</i> (all three criteria must be met):</p> <ul style="list-style-type: none"> ✓ The provider is identified in Wisconsin Medicaid files as certified for Medicare Part B. ✓ The recipient is eligible for Medicare Part B. ✓ The service is covered by Medicare Part B but is denied by Medicare Part B due to frequency limitations, diagnosis restrictions, or the service is not payable due to benefits being exhausted.
M-8	<p>Noncovered Medicare service. This code may be used when Medicare was not billed because the service is not covered in this circumstance. Use M-8 in the following instances:</p> <p><i>For Medicare Part A</i> (all three criteria must be met):</p> <ul style="list-style-type: none"> ✓ The provider is identified in Wisconsin Medicaid files as certified for Medicare Part A. ✓ The recipient is eligible for Medicare Part A. ✓ The service is usually covered by Medicare Part A but not in this circumstance (e.g., recipient's diagnosis). <p><i>For Medicare Part B</i> (all three criteria must be met):</p> <ul style="list-style-type: none"> ✓ The provider is identified in Wisconsin Medicaid files as certified for Medicare Part B. ✓ The recipient is eligible for Medicare Part B. ✓ The service is usually covered by Medicare Part B but not in this circumstance (e.g., recipient's diagnosis).

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

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

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

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

Elements 17 and 17a — Name and I.D. Number of Referring Physician or Other Source

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

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

Element 19 — Reserved for Local Use (not required)

Element 20 — Outside Lab? (not required)

Element 21 — Diagnosis or Nature of Illness or Injury

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

303.90-303.91	304.00-304.01	304.10-304.11	304.20-304.21	304.30-304.31
304.50-304.51	304.70-304.71	304.80-304.81	304.90-304.91	305.00-305.01
305.20-305.21	305.30-305.31	305.40-305.41	305.50-305.51	305.60-305.61
305.70-305.71	305.80-305.81	305.90-305.91		

Element 22 — Medicaid Resubmission (not required)

Element 23 — Prior Authorization Number

Enter the seven-digit prior authorization (PA) number from the approved Prior Authorization Request Form (PA/RF). Services authorized under multiple PA requests must be billed on separate claim forms with their respective PA numbers. Wisconsin Medicaid will only accept one PA number per claim.

Element 24A — Date(s) of Service

Enter the month, day, and year for each service using the following guidelines:

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

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

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

Element 24B — Place of Service

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

Element 24C—Type of Service (not required)**Element 24D — Procedures, Services, or Supplies**

Enter the single most appropriate five-character procedure code. Wisconsin Medicaid denies claims received without an appropriate procedure code.

Modifiers

Enter the appropriate (up to four per procedure code) modifier(s) in the “Modifier” column of Element 24D. Please note that Wisconsin Medicaid has not adopted all national modifiers.

Element 24E — Diagnosis Code

Enter the number (1, 2, 3, or 4) that corresponds to the appropriate ICD-9-CM diagnosis code listed in Element 21.

Element 24F — \$ Charges

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

Element 24G — Days or Units

Enter the appropriate number of units for each line item. All day treatment substance abuse services are one-hour procedure codes. When billing for fractions of an hour, indicate units of service in half-hour increments using the standard rules of rounding. Always use a decimal (e.g., 2.0 units).

Minutes Billed	Quantity
1-6	.1
7-12	.2
13-18	.3
19-24	.4
25-30	.5
31-36	.6
37-42	.7
43-48	.8
49-54	.9
55-60	1.0

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

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

Element 27 — Accept Assignment (not required)

Element 28 — Total Charge

Enter the total charges for this claim.

Element 29 — Amount Paid

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

Element 30 — Balance Due

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

Element 31 — Signature of Physician or Supplier

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

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

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

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

ATTACHMENT 4

Sample CMS 1500 claim form for substance abuse day treatment services

HEALTH INSURANCE CLAIM FORM																																																																																						
<div style="display: flex; justify-content: space-between;"> PICA PICA </div>																																																																																						
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA BLK LUNG (SSN) <input type="checkbox"/> OTHER <input type="checkbox"/>					1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) 1234567890																																																																																	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Recipient, Im A					4. INSURED'S NAME (Last Name, First Name, Middle Initial)																																																																																	
5. PATIENT'S ADDRESS (No., Street) 609 Willow					7. INSURED'S ADDRESS (No., Street)																																																																																	
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ZIP CODE 55555 TELEPHONE (Include Area Code) (XXX) XXX-XXXX					ZIP CODE TELEPHONE (INCLUDE AREA CODE)																																																																																	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) OI-P					11. INSURED'S POLICY GROUP OR FECA NUMBER M-8																																																																																	
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c. EMPLOYER'S NAME OR SCHOOL NAME					c. INSURANCE PLAN NAME OR PROGRAM NAME																																																																																	
d. INSURANCE PLAN NAME OR PROGRAM NAME					d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i>																																																																																	
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																																																																																	
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE I.M. Referring MD					17a. I.D. NUMBER OF REFERRING PHYSICIAN 12345678																																																																																	
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. 303.90					22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.																																																																																	
2. _____					23. PRIOR AUTHORIZATION NUMBER 1234567																																																																																	
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 MODIFIER E DIAGNOSIS CODE F \$ CHARGES G DAYS OR UNITS H EPSDT Family Plan I EMG J COB K RESERVED FOR LOCAL USE																																																																																	
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25. FEDERAL TAX I.D. NUMBER SSN EIN					26. PATIENT'S ACCOUNT NO.																																																																																	
27. ACCEPT ASSIGNMENT? (For gov. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO					28. TOTAL CHARGE \$ XXX XX																																																																																	
29. AMOUNT PAID \$ XX XX					30. BALANCE DUE \$ XX XX																																																																																	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) J.M. Authorized MMDYY SIGNED DATE					32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)																																																																																	
33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # I.M. Billing 1 W. Williams Anytown, WI 55555 87654321 PIN# GRP#																																																																																						

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

PLEASE PRINT OR TYPE

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

ATTACHMENT 5

Prior Authorization Request Form (PA/RF)

Completion Instructions

for substance abuse day treatment services

(For prior authorization requests submitted after HIPAA implementation)

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

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

Under s. 49.45(4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to Medicaid administration such as determining eligibility of the applicant or processing provider claims for reimbursement. The Prior Authorization Request Form (PA/RF) is used by Wisconsin Medicaid and is mandatory when requesting PA. Failure to supply the information requested by the form may result in denial of Medicaid payment for the services.

Providers may submit PA requests, along with the Prior Authorization/Substance Abuse Day Treatment Attachment (PA/SADTA), 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 “136.” The processing type is a three-digit code used to identify the category of service requested. Prior authorization requests will be returned without adjudication if no processing type is indicated.

Element 4 — Billing Provider’s Medicaid Provider Number

Enter the eight-digit Medicaid provider number of the billing provider. The provider number in this element must match the provider name listed in Element 1. The correct suffix for certified substance abuse day treatment program is “21.”

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. Allowable diagnosis code ranges follow. Consult the ICD-9-CM manual for code descriptions:

303.90-303.91	304.00-304.01	304.10-304.11	304.20-304.21	304.30-304.31
304.50-304.51	304.70-304.71	304.80-304.81	304.90-304.91	305.00-305.01
305.20-305.21	305.30-305.31	305.40-305.41	305.50-305.51	305.60-305.61
305.70-305.71	305.80-305.81	305.90-305.91		

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. The maximum backdating allowed is five days from the date of receipt at Wisconsin Medicaid.

Element 15 — Performing Provider Number (not required)**Element 16 — Procedure Code**

Enter the appropriate HealthCare Common Procedure Coding System (HCPCS) code for each service requested.

Element 17 — Modifiers

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

Element 18 — POS

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

Element 19 — Description of Service

Enter a written description corresponding to the appropriate HCPCS code for each service requested.

Element 20 — QR

Enter the appropriate quantity (e.g., hours) requested for the procedure code listed.

Element 21 — Charge

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

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

Element 22 — Total Charges

Enter the anticipated total charge for this request.

Element 23 — Signature — Requesting Provider

The original signature of the provider requesting this service must appear in this element.

Element 24 — Date Signed

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

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

ATTACHMENT 6

Sample Prior Authorization Request Form (PA/RF) for substance abuse day treatment services

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

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

WISCONSIN MEDICAID PRIOR AUTHORIZATION REQUEST FORM (PA/RF)

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

FOR MEDICAID USE — ICN	AT	Prior Authorization Number
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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 136
4. Billing Provider's Medicaid Provider Number 00000021		

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 303.9 - alcohol dependence	11. Start Date — SOI	12. First Date of Treatment — SOI												
13. Diagnosis — Secondary Code and Description 305.2 - cannabis abuse	14. Requested Start Date													
15. Performing Provider Number	16. Procedure Code	17. Modifiers <table style="width: 100%; text-align: center;"> <tr> <td>1</td><td>2</td><td>3</td><td>4</td> </tr> <tr> <td>HF</td><td></td><td></td><td></td> </tr> </table>	1	2	3	4	HF				18. POS 11	19. Description of Service Behavioral health day treatment per hour	20. QR 64	21. Charge XXX.XX
1	2	3	4											
HF														

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.

23. SIGNATURE — Requesting Provider <div style="text-align: center;"><i>I.M. Provider</i></div>	24. Date Signed MM/DD/YY
--	--

FOR MEDICAID USE <input type="checkbox"/> Approved <input type="checkbox"/> Modified — Reason: <input type="checkbox"/> Denied — Reason: <input type="checkbox"/> Returned — Reason:	Procedure(s) Authorized: Quantity Authorized: <div style="text-align: center;"> Grant Date _____ Expiration Date _____ _____ SIGNATURE — Consultant / Analyst </div> <div style="text-align: right;"> _____ Date Signed </div>
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ATTACHMENT 7
Prior Authorization / Substance Abuse Day
Treatment Attachment (PA/SADTA)
Completion Instructions

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

**WISCONSIN MEDICAID
PRIOR AUTHORIZATION / SUBSTANCE ABUSE DAY TREATMENT ATTACHMENT
(PA/SADTA) COMPLETION INSTRUCTIONS**

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

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

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

The use of this form is voluntary and providers may develop their own form as long as it includes all the information on this form and is formatted exactly like this form. If necessary, attach additional pages if more space is needed. Refer to the AODA Day Treatment 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 Day Treatment Attachment (PA/SADTA) 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 (Last, First, Middle Initial)

Enter the recipient's name exactly as it appears on the recipient's Medicaid identification card.

Element 2 — Age — Recipient

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

Element 3 — Recipient Medicaid Identification Number

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

SECTION II — PROVIDER INFORMATION

Element 4 — Name and Credentials — Requesting / Performing Provider

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

Element 5 — Telephone Number — Requesting / Performing Provider

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

Element 6 — Name — Referring / Prescribing Provider

Enter the name of the provider referring/prescribing treatment.

Element 7 — Referring / Prescribing Provider's Medicaid Provider Number

Enter the referring/prescribing provider's eight-digit provider number.

The remaining portions of this attachment are to be used to document the justification for the service requested. **Substance abuse day treatment is not a covered service for recipients who are residents of a nursing home or who are hospital inpatients.**

SECTION III — DOCUMENTATION

Element 8

Describe the length and intensity of treatment requested. Include the anticipated beginning treatment date and estimated substance abuse day treatment discharge date, and attach a copy of treatment design.

Element 9

List the dates of diagnostic evaluations or medical examinations and **specific** diagnostic procedures that were employed.

Element 10

List the codes and descriptions from the most recent *Diagnostic and Statistical Manual of Mental Disorders* (DSM) for the recipient's current primary and secondary diagnosis. Allowable DSM diagnoses are 303.90 (alcohol dependence), 304.00-304.90 (drug dependence), 305.00 (alcohol abuse), or 305.20-305.90 (other drug abuse) (excluding caffeine intoxication).

Element 11

Describe the recipient's current clinical problems and relevant clinical history, including substance abuse history. (Give details of dates of abuse, substance(s) abused, amounts used, date of last use, etc.)

Element 12

Indicate if the recipient has received any substance abuse treatment in the past twelve months.

Element 13

If the recipient received any inpatient substance abuse care, intensive outpatient substance abuse services, or substance abuse day treatment in the past twelve months, give rationale for appropriateness and medical necessity of the current request. Discuss projected outcome of additional treatment requested.

Element 14

Describe the recipient's severity of illness using the indicators in a-f. Refer to the substance abuse day treatment criteria in the AODA Day Treatment Handbook.

Element 15

Discuss the recipient's treatment plan and attach a copy of the plan.

Element 16 — Signature — Recipient or Representative

Signature of the recipient or representative indicates the signer has read the attached request for PA of substance abuse and agrees that it will be sent to Wisconsin Medicaid for review.

Element 17 — Date Signed

Enter the month, day, and year the PA/SADTA was signed by the recipient or the recipient's representative (in MM/DD/YY format).

Element 18 — Relationship (if representative)

Include relationship to recipient (if a representative signs).

Element 19 — Signature — Performing Provider

Enter the signature of the performing provider.

Element 20 — Date Signed

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

Element 21 — Discipline of Performing Provider

Enter the discipline of the performing provider.

Element 22 — Signature — Supervising Physician or Psychologist

Enter the signature of the supervising physician or psychologist.

Element 23 — Date Signed

Enter the month, day, and year the PA/SADTA was signed by the supervising physician or psychologist (in MM/DD/YY format).

Element 24 — Supervising Physician or Psychologist's Medicaid Provider Number

Enter the supervising physician or psychologist's Medicaid provider number.

ATTACHMENT 8
Prior Authorization / Substance Abuse Day
Treatment Attachment (PA/SADTA)
(for photocopying)

(A copy of the "Prior Authorization/Substance Abuse Day Treatment Attachment [PA/SADTA]" [for photocopying] may be found on the following pages.)

(This page was intentionally left blank.)

SECTION III — DOCUMENTATION (Continued)

10. List recipient's **current** primary and secondary diagnosis codes and descriptions from the most recent *Diagnostic and Statistical Manual of Mental Disorders* (DSM).

11. Describe the recipient's **current** clinical problems and relevant clinical history, including substance abuse history. (Give details of dates of abuse, substance(s) abused, amounts used, date of last use, etc.)

12. Has the recipient received any substance abuse treatment in the past twelve months? Yes No
If "Yes," provide information on date of each treatment episode, type of service provided, and **treatment outcomes**.

13. Has the recipient received any inpatient substance abuse care, intensive outpatient substance abuse services, or substance abuse day treatment in the past twelve months? Yes No
If "Yes," give rationale for appropriateness and medical necessity of the current request. Discuss projected outcome of additional treatment requested.

SECTION III — DOCUMENTATION (Continued)

15. Treatment Plan (Continued)

- Briefly describe treatment goals and objectives in specific and measurable terms.

- Describe the expected outcomes of treatment including the plan for continuing care.

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

16. **SIGNATURE** — Recipient or Representative

17. Date Signed

18. Relationship (if representative)

Attach a photocopy of the physician's current prescription for substance abuse day treatment. (Must be dated within one month of receipt at Wisconsin Medicaid.)

19. **SIGNATURE** — Performing Provider

20. Date Signed

21. Discipline of Performing Provider

22. **SIGNATURE** — Supervising Physician or Psychologist

23. Date Signed

24. Supervising Physician or Psychologist's Medicaid Provider Number
