

# Wisconsin Medicaid and BadgerCare update

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Wisconsin Medicaid and BadgerCare Information for Providers

To:  
 Counties Certified for Outpatient Mental Health/ Substance Abuse Services in the Home and Community  
 County Departments of Community Programs  
 County Human Service Departments  
 County Mental Health Coordinators  
 County Social Service Departments  
 County Substance Abuse Coordinators  
 County Tribal/ Aging Units  
 Tribal Human Service Facilitators  
 HMOs and Other Managed Care Programs

## Outpatient Mental Health and Substance Abuse Services in the Home or Community for Adults

This *Wisconsin Medicaid and BadgerCare Update* consolidates all of the information for outpatient mental health and substance abuse services in the home or community for adults. Providers should use this *Update* in conjunction with the General Information section of the Mental Health and Substance Abuse Services Handbook and the All-Provider Handbook.

Services Now Expanded to the Home or Community.”

### Medicaid State Share Paid by County/ Tribal Social or Human Services Agency

The county/tribal social or human services agency pays the nonfederal share for this benefit.

### Certification

According to s. 49.45(45), Wis. Stats., Wisconsin Medicaid may pay only county/tribal social or human services agencies to provide outpatient mental health and substance abuse services in the home or community for adults. County/tribal social or human agencies, or the agencies with which they contract to provide outpatient mental health and substance abuse services in the home or community for adults, must be certified under HFS 61.91-61.98 or 75.13, Wis. Admin. Code.

The purpose of this *Wisconsin Medicaid and BadgerCare Update* is to consolidate all of the information for outpatient mental health and substance abuse services in the home or community for adults. This *Update* replaces the following outpatient mental health and substance abuse services in the home or community for adults publications:

- The October 2005 *Update* (2005-63), titled “Rate Changes for Services Receiving Only Federal Funds.”
- The August 2003 *Update* (2003-100), titled “Changes to local codes and paper claims for outpatient mental health and substance abuse services in the home or community as a result of HIPAA.”
- The July 1999 *Update* (99-40), titled “Mental health and substance abuse outpatient services in the home or community.”
- The May 1998 *Update* (98-14), titled “Mental Health and Substance Abuse

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## Wisconsin Medicaid Certification

Refer to Attachments 1 and 2 of this *Update* for certification requirements. County/tribal social or human services agencies may choose to provide this service or choose to contract with any of the following: Medicaid-certified outpatient mental health clinic, Medicaid-certified outpatient substance abuse clinic, Medicaid-certified psychiatrist in private practice, or Medicaid-certified Ph.D. psychologist in private practice.

County/tribal social or human services agencies should complete the Wisconsin Medicaid Mental Health/Substance Abuse Agency Certification Packet. Refer to Attachment 1 for Medicaid certification requirements and provider numbers assigned for agencies providing outpatient mental health services in the home or community for adults.

A county/tribal social or human services agency wishing to provide these services is required to obtain an agency resolution. The resolution must state that the county/tribal social or human services agency agrees to make available the nonfederal share needed to provide Medicaid mental health and substance abuse outpatient services in a home or community setting. Agency resolutions, such as 51.42 or human services board resolutions, meet this requirement.

Providers may initiate Medicaid certification for outpatient mental health services in the home or community for adults by doing one of the following:

- Downloading the Wisconsin Medicaid Mental Health/Substance Abuse Agency Certification Packet from the Medicaid Web site at [dhfs.wisconsin.gov/medicaid/](http://dhfs.wisconsin.gov/medicaid/).
- Calling Provider Services at (800) 947-9627 or (608) 221-9883.

- Writing to the following address:  
Wisconsin Medicaid  
Provider Maintenance  
6406 Bridge Rd  
Madison WI 53784-0006

Refer to the General Information section of the Mental Health and Substance Abuse Services Handbook for more information about provider certification, provider numbers, and provider responsibilities.

### *Recipients Enrolled in Medicaid Managed Care*

Wisconsin Medicaid and BadgerCare recipients enrolled in Medicaid HMOs may receive outpatient mental health and substance abuse services in the home or community for adults on a fee-for-service basis. These services are not included in the HMO's capitation rate. If an HMO enrollee is in need of outpatient mental health and substance abuse services in the home or community, he or she should be referred to the county/tribal social or human services agency which may provide these services on a fee-for-service basis.

Medicaid recipients enrolled in Children Come First or Wraparound Milwaukee must receive outpatient mental health and substance abuse services in the home or community within these managed care programs since this service is included in the programs' capitation rate.

### **Covered Services**

Mental health and substance abuse services provided in home or community settings are the same Medicaid-reimbursable mental health and substance abuse outpatient services as described in HFS 107.13(2) and (3), Wis. Admin. Code, but the services are provided in the home or community. These services include evaluations, psychotherapy, and substance abuse counseling. Services must be provided by Medicaid-certified

**W**isconsin Medicaid and BadgerCare recipients enrolled in Medicaid HMOs may receive outpatient mental health and substance abuse services in the home or community for adults on a fee-for-service basis.

mental health or substance abuse clinics. In addition, psychiatrists or Ph.D. psychologists in private practice may provide services.

Wisconsin Medicaid defines “home or community” as those settings that are therapeutically necessary for the recipient (e.g., a person’s home or senior citizen center). Therapeutic reasons must be documented to show that the setting is necessary, as required in HFS 61.97(8), Wis. Admin. Code.

### *Settings That Are Not Covered Under This Benefit*

Since Wisconsin Medicaid covers services performed in the following settings under the regular Medicaid substance abuse and mental health outpatient benefit, the following places of service are *not* considered “home or community” locations:

- Hospital.
- Hospital outpatient clinic.
- Nursing home.
- Outpatient facility.
- Provider’s office.
- School.

### **Special Circumstances**

The following are requirements for covered services:

- A physician’s prescription is required.
- Wisconsin Medicaid covers staff travel time to deliver covered outpatient mental health and substance abuse services in the home or community for adults. Travel is billed as part of the covered services. Travel time is not allowable when the recipient is not at home since there is no face-to-face contact.

### **Services Provided via Telehealth**

Most outpatient mental health services in the home or community for adults may be provided via telehealth. Refer to the General Information

section of the Mental Health and Substance Abuse Services Handbook for information about Telehealth requirements and claims submission.

### **Documentation Requirements**

Refer to Attachment 3 for documentation requirements for all mental health and substance abuse service providers, including providers of outpatient mental health and substance abuse services in the home or community. For additional information regarding documentation requirements, refer to the General Information section of the Mental Health and Substance Abuse Services Handbook.

Wisconsin Medicaid reimburses the provision of services. Documenting the services provided is part of the provision of services.

### **Prior Authorization**

Prior authorization is not required for outpatient mental health and substance abuse services in the home or community for adults.

### **Copayment**

Wisconsin Medicaid does not require copayment for outpatient mental health and substance abuse services in the home or community for adults.

### **Claims Submission**

#### *Coordination of Benefits*

Except for a few instances, Wisconsin Medicaid is the payer of last resort for any Medicaid-covered service. Therefore, the provider is required to make a reasonable effort to exhaust all existing other health insurance sources before submitting claims to Wisconsin Medicaid or to state-contracted managed care organizations.

Most outpatient mental health services in the home or community for adults may be provided via telehealth.

Refer to the Coordination of Benefits section of the All-Provider Handbook for more information about services that require other health insurance billing, exceptions, claims submission procedures for recipients with other health insurance, and the Other Coverage Discrepancy Report (HCF 1159). This Other Coverage Discrepancy Report is also available on the Medicaid Web site at [dhfs.wisconsin.gov/medicaid/](http://dhfs.wisconsin.gov/medicaid/).

### *Diagnosis Codes*

All diagnoses must be from the *International Classification of Diseases, Ninth Revision, Clinical Modifications (ICD-9-CM)* coding structure. Claims received without an allowable ICD-9-CM code are denied.

Refer to Attachment 4 for a list of allowable diagnosis code ranges for outpatient mental and substance abuse services in the home or community for adults.

### *Procedure Codes and Modifiers*

Healthcare Common Procedure Coding System (HCPCS) or *Current Procedural Terminology (CPT)* codes and modifiers are required on all claims for outpatient mental health and substance abuse services in the home or community for adults. Claims or adjustments received without a HCPCS or CPT code are denied. Refer to Attachment 4 for allowable procedure codes and modifiers.

For procedure codes that do not indicate a time increment, providers are required to choose the appropriate time increment from the rounding guidelines in Attachment 5.

### *Place of Service Codes*

Allowable place of service codes for outpatient mental health and substance abuse services in the home or community are included in Attachment 4.

### *Electronic Claims Submission*

Providers are encouraged to submit claims electronically since electronic claims submission usually reduces claim errors. Claims for outpatient mental health and substance abuse services in the home or community for adults may be submitted using the 837 Health Care Claim: Professional transaction. Electronic claims may be submitted *except* when Wisconsin Medicaid instructs the provider to submit additional documentation with the claim. In these situations, providers are required to submit paper claims.

Refer to the Informational Resources section of the All-Provider Handbook for more information about electronic transactions.

### *Paper Claims Submission*

Paper claims for outpatient mental health and substance abuse services in the home or community for adults must be submitted using the CMS 1500 claim form dated 12/90. Wisconsin Medicaid denies claims for outpatient mental health and substance abuse services in the home or community for adults submitted on any paper claim form other than the CMS 1500.

Wisconsin Medicaid does not provide the CMS 1500 claim form. The form may be obtained from any federal forms supplier.

Refer to Attachment 6 for claim form instructions and Attachments 7 and 8 for sample claims for outpatient mental health and substance abuse services in the home or community for adults.

Providers are encouraged to submit claims electronically since electronic claims submission usually reduces claim errors.

## Reimbursement Information

Wisconsin Medicaid reimburses outpatient mental health and substance abuse services in the home or community for adults when provided by the following professionals:

- Substance abuse counselor without a master's degree.
- Substance abuse counselor with a master's degree.
- Master's-level psychotherapist.
- Psychiatrist.
- Ph.D. psychologist.

### *Reimbursement Limits*

Wisconsin Medicaid reimburses county/tribal social or human services agencies only for the federal share of the Medicaid reimbursement rate for outpatient mental health and substance abuse services in the home or community for adults. County/tribal social or human services agencies are required to provide the nonfederal share of the Medicaid reimbursement rate for outpatient mental health and substance abuse services in the home or community for adults as specified in s. 49.45(45)(b), Wis. Stats.

The federal share may change in October of each year with some exceptions. Providers will be notified of changes in future *Updates*.

Wisconsin Medicaid sends a quarterly report to each county/tribal social or human services agency indicating the federal share amount that the agency has received thus far in a calendar year.

If a county/tribal social or human services agency contracts with other Medicaid-certified providers for these services, the county/tribal social or human services agency pays those providers according to the terms of their contracts with them.

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 [dhfs.wisconsin.gov/medicaid/](http://dhfs.wisconsin.gov/medicaid/).

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# ATTACHMENT 1

## Certification Requirements for Outpatient Mental Health and Substance Abuse Services in the Home or Community for Adults — Agencies

This attachment outlines Wisconsin Medicaid certification requirements for providers of Medicaid outpatient mental health and substance abuse services in the home or community for adults. Prior to obtaining Wisconsin Medicaid certification, providers of mental health and substance abuse services in the home or community are required to be certified by the Department of Health and Family Services (DHFS), Division of Disability and Elder Services (DDES), Bureau of Quality Assurance (BQA). County/tribal social or human services agencies that request billing-only status do not need to be certified by the DDES.

The following table lists provider numbers and definitions for agencies providing the outpatient mental health benefit.

Definitions for Provider Numbers	
Type of Provider Number	Definition
Billing/Performing Provider Number	Issued to providers to allow them to identify themselves on claims as either the biller of services or the performer of services.
Billing-Only Provider Number	Issued to county/tribal social or human services agencies to allow them to serve as the biller of services when contracting with a service performer.

The following terms are used in the table:

- “Agency Providing the Service” — The agency whose staff actually performs the service.
- “Agency Only Allowed to Bill for the Service” — The agency that submits claims to Wisconsin Medicaid for the service. This agency does not perform the service, but it contracts with a provider to perform the service on the billing agency’s behalf. Only a county/tribal social or human services agency can be a billing agency.

Type of Agency	Certification Requirements					Type of Provider Number Assigned
	Division of Disability and Elder Services/Bureau of Quality Assurance	Wisconsin Medicaid	Section of the Certification Packet to Be Completed*	County/Tribal Social or Human Services Agency Required?	Additional Requirements	
Agency Providing the Service (may not bill for the service)	The agency is required to obtain a Wisconsin DHFS certificate to provide outpatient mental health services as authorized under HFS 61.91-61.98 or 75.13, Wis. Admin. Code (which meets Wisconsin Medicaid’s HFS 105, Wis. Admin. Code, requirement).	The agency is required to do the following: <ul style="list-style-type: none"> <li>• Have a DDES, BQA certificate on file.</li> <li>• Complete and submit a Mental Health/Substance Abuse Agency Certification Packet.</li> </ul>	Outpatient Mental Health and/or Substance Abuse Services in the Home or Community	No	No	Outpatient mental health clinic or substance abuse clinic billing/performing provider number

\*This is a section of the Medicaid Mental Health/Substance Abuse Agency Certification Packet.

Type of Agency	Certification Requirements					Type of Provider Number Assigned
	Division of Disability and Elder Services/Bureau of Quality Assurance	Wisconsin Medicaid	Section of the Certification Packet to Be Completed*	County/ Tribal Social or Human Services Agency Required?	Additional Requirements	
Agency Only Allowed to Bill for the Service	Not required	The agency is required to complete and submit a Mental Health/Substance Abuse Agency Certification Packet to be a billing-only provider for outpatient mental health and/or substance abuse services in the home or community. An allowable Medicaid performing provider is required to perform the service.	Outpatient Mental Health and/or Substance Abuse Services in the Home or Community	Yes	The agency is required to have an agency resolution stating that the county or tribe agrees to make available the nonfederal share needed to provide outpatient mental health and substance abuse services in the home or community.	Outpatient mental health clinic or substance abuse clinic billing provider number
Agency Providing <i>and</i> Billing the Service	The agency is required to obtain a Wisconsin DHFS certificate to provide outpatient mental health services as authorized under HFS 61.91-61.98 or 75.13, Wis. Admin. Code.	The agency is required to do the following: <ul style="list-style-type: none"> <li>• Have a DDES, BQA certificate on file.</li> <li>• Complete and submit a Mental Health/Substance Abuse Agency Certification Packet.</li> </ul>	Outpatient Mental Health and/or Substance Abuse Services in the Home or Community	Yes	The agency is required to have an agency resolution stating that the county or tribe agrees to make available the nonfederal share needed to provide outpatient mental health and substance abuse services in the home or community.	Outpatient mental health clinic or substance abuse clinic billing/ performing provider number

\*This is a section of the Medicaid Mental Health/Substance Abuse Agency Certification Packet.



## ATTACHMENT 2

# Certification Requirements for Outpatient Mental Health or Substance Abuse Services in the Home or Community for Adults — Individuals

This attachment outlines Wisconsin Medicaid certification requirements for individuals. The first table identifies the individual provider types that may perform outpatient mental health and/or substance abuse services in the home or community for adults. The second table includes definitions for provider numbers, and the third table lists individual providers, prerequisites, and Medicaid certification requirements.

The list of allowable provider types includes psychiatrists and Ph.D. psychologists who perform in private practice. These providers may submit claims as well as perform the services. Psychiatrists and Ph.D. psychologists may also work within certified programs as defined in this attachment.

<b>Allowable Individual Providers for Outpatient Mental Health and Substance Abuse Services in the Home and Community</b>
Substance Abuse Counselor Without a Master's Degree
Substance Abuse Counselor with a Master's Degree
Master's-Level Psychotherapist
Psychiatrist
Ph.D. Psychologist

<b>Definitions for Provider Numbers</b>	
<b>Type of Provider Number</b>	<b>Definition</b>
Billing/Performing Provider Number	Issued to providers to allow them to identify themselves on claims as either the biller of services or the performer of services.
Nonbilling Performing Provider Number	Issued to providers who practice under the professional supervision of another provider or in collaboration with other providers. This provider number may not be used to independently submit claims to Wisconsin Medicaid.

<b>Individual Providers, Prerequisites, and Medicaid Certification Requirements</b>			
<b>Type of Provider</b>	<b>Prerequisite</b>	<b>Medicaid Certification Requirements</b>	<b>Type of Provider Number Assigned</b>
Substance Abuse Counselor Without a Master's degree	The provider is required to do the following: <ul style="list-style-type: none"> <li>• Work in a certified clinic and meet the requirements listed under HFS 75.13, Wis. Admin. Code (which meets Wisconsin Medicaid's HFS 105, Wis. Admin. Code, requirement).</li> <li>• Have a certificate stating qualifications as a certified (not only registered) substance abuse counselor issued by the Wisconsin Certification Board on Alcohol and Other Drug Abuse counselors.</li> </ul>	The provider is required to complete and submit a Mental Health/Substance Abuse Individual Packet.	Nonbilling performing provider number
Substance Abuse Counselor with a Master's degree	The provider is required to do the following: <ul style="list-style-type: none"> <li>• Work in a certified clinic and meet the requirements listed under HFS 75.13, Wis. Admin. Code (which meets Wisconsin Medicaid's HFS 105, Wis. Admin. Code, requirement).</li> <li>• Have a certificate stating qualifications as a certified (not only registered) substance abuse counselor issued by the Wisconsin Certification Board on Alcohol and Other Drug Abuse counselors and have a clinical social worker's license, a marriage and family therapist's license, or a professional counselor's license from the Department of Regulation and Licensing (DR&amp;L) or a Provider Status Approval Letter issued by the Division of Disability and Elder Services (DDES), Bureau of Quality Assurance (BQA).</li> </ul>	The provider is required to complete and submit a Mental Health/Substance Abuse Individual Packet.	Nonbilling performing provider number
Master's-Level Psychotherapist	The provider is required to do the following: <ul style="list-style-type: none"> <li>• Work in a certified mental health clinic as required under HFS 61.91-61.98, Wis. Admin. Code (which meets Wisconsin Medicaid's HFS 105, Wis. Admin. Code, requirement).</li> <li>• Have a clinical social worker's license, a marriage and family therapist's license, or a professional counselor's license from the DR&amp;L or a Provider Status Approval Letter issued by the DDES, BQA.</li> </ul>	The provider is required to complete and submit a Mental Health and Substance Abuse Individual Packet.	Nonbilling performing provider number
Psychiatrist	The provider is required to do the following: <ul style="list-style-type: none"> <li>• Have a license to practice as a physician, according to ch. 448.05 and 448.07, Wis. Stats (which meets Wisconsin Medicaid's HFS 105, Wis. Admin. Code, requirement).</li> <li>• Have proof that he or she completed psychiatric residency.</li> </ul>	The provider is required to complete and submit a Physician/Osteopath/Physician Assistant Certification Packet.	Billing/performing provider number
Ph.D. Psychologist	The provider is required to have a license to practice as a psychologist, according to ch. 455, Wis. Stats. This must be at the independent practice level. If the effective date of the license is prior to October 1, 1991, the provider is required to have one of the following: <ul style="list-style-type: none"> <li>• A copy of his or her listing in the current National Register of Health Service Providers in Psychology (as required under HFS 105.22[1][b], Wis. Admin. Code).</li> <li>• A copy of documentation that shows he or she is eligible to be listed in the National Register of Health Service Providers in Psychology. The provider is required to include documentation of a doctorate that meets the National Register/Association of State and Provincial Psychology Boards' "Guidelines for Defining a Doctoral Degree in Psychology" with at least two years (minimum of 3,000 hours) of supervised experience in health service. One year (1,500 hours) must be post-internship, which meets the National Register's "Guidelines for Defining an Internship or Organized Health Service Training Program" (as required under HFS 105.22[1][b], Wis. Admin. Code).</li> </ul>	The provider is required to complete and submit a Mental Health and Substance Abuse Individual Packet.	Billing/performing provider number

# ATTACHMENT 3

## Mental Health and Substance Abuse Services Documentation Requirements

Providers are responsible for meeting Medicaid's medical and financial documentation requirements. Refer to HFS 106.02(9)(a), Wis. Admin. Code, for preparation and maintenance documentation requirements and HFS 106.02(9)(c), Wis. Admin. Code, for financial record documentation requirements.

The following are Wisconsin Medicaid's medical record documentation requirements (HFS 106.02[9][b], Wis. Admin. Code) as they apply to all mental health and substance abuse services. In each element, the applicable administrative code language is in parentheses. The provider is required to include the following written documentation in the recipient's medical record as applicable:

1. Date, department or office of the provider (as applicable), and provider name and profession.
2. Presenting problem (chief medical complaint or purpose of the service or services).
3. Assessments (clinical findings, studies ordered, or diagnosis or medical impression).
  - a. Intake note signed by the therapist (clinical findings).
  - b. Information about past treatment, such as where it occurred, for how long, and by whom (clinical findings).
  - c. Mental status exam, including mood and affect, thought processes — principally orientation X3, dangerousness to others and self, and behavioral and motor observations. Other information that may be essential depending on presenting symptoms includes thought processes other than orientation X3, attitude, judgment, memory, speech, thought content, perception, intellectual functioning, and general appearance (clinical findings and/or diagnosis or medical impression).
  - d. Biopsychosocial history, which may include, depending on the situation, educational or vocational history, developmental history, medical history, significant past events, religious history, substance abuse history, past mental health treatment, criminal and legal history, significant past relationships and prominent influences, behavioral history, financial history, and overall life adjustment (clinical findings).
  - e. Psychological, neuropsychological, functional, cognitive, behavioral, and/or developmental testing as indicated (studies ordered).
  - f. Current status, including mental status, current living arrangements and social relationships, support system, current activities of daily living, current and recent substance abuse usage, current personal strengths, current vocational and educational status, and current religious attendance (clinical findings).
4. Treatment plans, including treatment goals, which are expressed in behavioral terms that provide measurable indices of performance, planned intervention, mechanics of intervention (frequency, duration, responsible party[ies]) (disposition, recommendations, and instructions given to the recipient, including any prescriptions and plans of care or treatment provided).
5. Progress notes (therapies or other treatments administered) must provide data relative to accomplishment of the treatment goals in measurable terms. Progress notes also must document significant events that are related to the person's treatment plan and assessments and that contribute to an overall understanding of the person's ongoing level and quality of functioning.

# ATTACHMENT 4

## Procedure Code Information for Outpatient Mental Health and Substance Abuse Services in the Home or Community for Adults

The following tables list the *Current Procedural Terminology* (CPT) codes and HealthCare Common Procedure Coding System (HCPCS) codes and modifiers that providers are required to use when submitting claims for outpatient mental health and substance abuse services in the home or community for adults. Not all providers may be reimbursed for all mental health and substance abuse services in the home or community for adults. To determine which certified providers may be reimbursed for a particular service, consult the charts in this attachment.

Allowable Place of Service Codes for Outpatient Mental Health and Substance Abuse Services in the Home or Community for Adults	
04	Homeless Shelter
12	Home
15	Mobile Unit
34	Hospice
99	Other Place of Service

Professional Level Modifiers		
Modifier	Description	Providers
HN	Bachelors degree level	Substance abuse counselors who have fewer credentials than a master's degree-level psychotherapist.
HO	Masters degree level	Master's-level psychotherapist (Master's-level psychotherapists are Master's-level mental health professionals with 3,000 hours of supervised experience or are listed in an appropriate national registry as stated in HFS 61.96, Wis. Admin. Code. This includes registered nurses with a Master's degree in psychiatric-mental health nursing or community mental health nursing from a graduate school of nursing accredited by the National League for Nursing.)
HP	Doctoral level	Psychologist, Ph.D.
UA	MD, Neurologist, Pediatrician, Psychiatrist	Psychiatrist billing mental health and substance abuse services. Physician billing substance abuse services. Physician assistant billing substance abuse services.
UB	APNP — Psychiatric specialty	Advanced Practice Nurse Prescriber (APNP) — Master's-level registered nurse, only those with an APNP — psychiatric specialty billing pharmacologic management.

Informational Modifier	
Modifier	Description
UC	Outpatient mental health and substance abuse services provided in the home or community.

## Outpatient Mental Health Services Procedure Codes

### Psychiatric Diagnostic or Evaluative Interview Procedures

Procedure Code	Description	Certified Providers Who May Perform Service	Modifiers (Required)	Contracted Rate*	Reimbursement (Federal Share)	ICD-9-CM** Diagnoses Allowed***	Telehealth Services Covered?
90801	Psychiatric diagnostic interview examination (quantity of 1.0 = 1 hour)	Master's degree level	HO, UC	\$90.04	\$51.91	All	Yes
		Doctoral level	HP, UC	\$112.53	\$64.87		
		Psychiatrist	UA, UC	\$150.04	\$86.50		
90802	Interactive psychiatric diagnostic interview examination using play equipment, physical devices, language interpreter, or other mechanisms of communication (quantity of 1.0 = 1 hour)	Master's degree level	HO, UC	\$90.04	\$51.91	All	Yes
		Doctoral level	HP, UC	\$112.53	\$64.87		
		Psychiatrist	UA, UC	\$150.04	\$86.50		

### Psychiatric Therapeutic Procedures: Office or Other Outpatient Facility — *Insight Oriented, Behavior Modifying, and/or Supportive Psychotherapy*

Procedure Code	Description	Certified Providers Who May perform service	Modifiers (Required)	Contracted Rate*	Reimbursement (Federal Share)	ICD-9-CM** Diagnoses Allowed***	Telehealth Services Covered?
90804	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient:	Master's degree level	HO, UC	\$45.02	\$25.95	290-298.9; 300.00-316	Yes
		Doctoral level	HP, UC	\$56.27	\$32.44		
		Psychiatrist	UA, UC	\$75.02	\$43.25		
90805	with medical evaluation and management services	Psychiatrist	UA, UC	\$75.02	\$43.25	290-298.9; 300.00-316	Yes
90806	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient:	Master's degree level	HO, UC	\$90.04	\$51.91	290-298.9; 300.00-316	Yes
		Doctoral level	HP, UC	\$112.53	\$64.87		
		Psychiatrist	UA, UC	\$150.04	\$86.50		
90807	with medical evaluation and management services	Psychiatrist	UA, UC	\$150.04	\$86.50	290-298.9; 300.00-316	Yes
90808	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 75 to 80 minutes face-to-face with the patient:	Master's degree level	HO, UC	\$135.06	\$77.86	290-298.9; 300.00-316	Yes
		Doctoral level	HP, UC	\$168.80	\$97.31		
		Psychiatrist	UA, UC	\$225.06	\$129.75		
90809	with medical evaluation and management services	Psychiatrist	UA, UC	\$225.06	\$129.75	290-298.9; 300.00-316	Yes

\*Contracted rates are effective for dates of service (DOS) on and after October 1, 2003.

\*\*ICD-9-CM = *International Classification of Diseases, Ninth Revision, Clinical Modification*.

\*\*\*The list of ICD-9-CM diagnosis codes for outpatient mental health and substance abuse services in the home or community is inclusive. However, not all Medicaid-covered outpatient mental health and substance abuse services in the home or community are appropriate or allowable.

**Psychiatric Therapeutic Procedures: Office or Other Outpatient Facility — Interactive Psychotherapy**

Procedure Code	Description	Certified Providers Who May Perform Service	Modifiers (Required)	Contracted Rate*	Reimbursement (Federal Share)	ICD-9-CM** Diagnoses Allowed***	Telehealth Services Covered?
90810	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient;	Master's degree level	HO, UC	\$45.02	\$25.95	290-298.9; 300.00-316	Yes
		Doctoral level	HP, UC	\$56.27	\$32.44		
		Psychiatrist	UA, UC	\$75.02	\$43.25		
90811	with medical evaluation and management services	Psychiatrist	UA, UC	\$75.02	\$43.25	290-298.9; 300.00-316	Yes
90812	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient;	Master's degree level	HO, UC	\$90.04	\$51.91	290-298.9; 300.00-316	Yes
		Doctoral level	HP, UC	\$112.53	\$64.87		
		Psychiatrist	UA, UC	\$150.04	\$86.50		
90813	with medical evaluation and management services	Psychiatrist	UA, UC	\$150.04	\$86.50	290-298.9; 300.00-316	Yes
90814	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 75 to 80 minutes face-to-face with the patient;	Master's degree level	HO, UC	\$135.06	\$77.86	290-298.9; 300.00-316	Yes
		Doctoral level	HP, UC	\$168.80	\$97.31		
		Psychiatrist	UA, UC	\$225.06	\$129.75		
90815	with medical evaluation and management services	Psychiatrist	UA, UC	\$225.06	\$129.75	290-298.9; 300.00-316	Yes

\*Contracted rates are effective for DOS on and after October 1, 2003.

\*\*ICD-9-CM = *International Classification of Diseases, Ninth Revision, Clinical Modification*.

\*\*\*The list of ICD-9-CM diagnosis codes for outpatient mental health and substance abuse services in the home or community is inclusive. However, not all Medicaid-covered outpatient mental health and substance abuse services in the home or community are appropriate or allowable.

**Psychiatric Therapeutic Procedures: Other Psychotherapy**

Procedure Code	Description	Certified Providers Who May Perform Service	Modifiers (Required)	Contracted Rate*	Reimbursement (Federal Share)	ICD-9-CM** Diagnoses Allowed***	Telehealth Services Covered?
90845	Psychoanalysis (quantity of 1.0 = 60 minutes)	Master's degree level	HO, UC	\$90.04	\$51.91	290-298.9; 300.00-316	Yes
		Doctoral level	HP, UC	\$112.53	\$64.87		
		Psychiatrist	UA, UC	\$150.04	\$86.50		
90846	Family psychotherapy (without the patient present) (quantity of 1.0 = 60 minutes)	Master's degree level	HO, UC	\$90.04	\$51.91	290-298.9; 300.00-316	Yes
		Doctoral level	HP, UC	\$112.53	\$64.87		
		Psychiatrist	UA, UC	\$150.04	\$86.50		
90847	Family psychotherapy (conjoint psychotherapy) (with patient present) (quantity of 1.0 = 60 minutes)	Master's degree level	HO, UC	\$90.04	\$51.91	290-298.9; 300.00-316	Yes
		Doctoral level	HP, UC	\$112.53	\$64.87		
		Psychiatrist	UA, UC	\$150.04	\$86.50		
90849	Multiple-family group psychotherapy (quantity of 1.0 = 60 minutes)	Master's degree level	HO, UC	\$90.04	\$51.91	290-298.9; 300.00-316	Yes
		Doctoral level	HP, UC	\$112.53	\$64.87		
		Psychiatrist	UA, UC	\$150.04	\$86.50		
90853	Group psychotherapy (other than of a multiple-family group) (quantity of 1.0 = 60 minutes)	Master's degree level	HO, UC	\$22.51	\$12.98	290-298.9; 300.00-316	No
		Doctoral level	HP, UC	\$28.11	\$16.21		
		Psychiatrist	UA, UC	\$37.51	\$21.62		
90857	Interactive group psychotherapy (quantity of 1.0 = 60 minutes)	Master's degree level	HO, UC	\$22.51	\$12.98	290-298.9; 300.00-316	No
		Doctoral level	HP, UC	\$28.11	\$16.21		
		Psychiatrist	UA, UC	\$37.51	\$21.62		

\*Contracted rates are effective for DOS on and after October 1, 2003.

\*\*ICD-9-CM = *International Classification of Diseases, Ninth Revision, Clinical Modification*.

\*\*\*The list of ICD-9-CM diagnosis codes for outpatient mental health and substance abuse services in the home or community is inclusive. However, not all Medicaid-covered outpatient mental health and substance abuse services in the home or community are appropriate or allowable.

**Psychiatric Therapeutic Procedures: Other Psychiatric Services or Procedures**

Procedure Code	Description	Certified providers Who May Perform Service	Modifiers (Required)	Contracted Rate**	Reimbursement (Federal Share)	ICD-9-CM*** Diagnoses Allowed****	Telehealth Services Covered?
90862*	Pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy (quantity of 1.0 = 15 minutes)	Master's level psychiatric nurse	HO, UC	\$22.52	\$12.98	290-298.9; 300.00-316	Yes
		Psychiatric APNP	UB, UC	\$37.51	\$21.62		
		M.D., Psychiatrist	UA, UC	\$37.51	\$21.62		
90875	Individual psychophysiological therapy incorporating biofeedback training by any modality (face-to-face with the patient), with psychotherapy (eg, insight oriented, behavior modifying or supportive psychotherapy); approximately 20-30 minutes	Master's degree level	HO, UC	\$45.02	\$25.95	290-298.9; 300.00-316	Yes
		Doctoral level	HP, UC	\$56.27	\$32.44		
		Psychiatrist	UA, UC	\$75.02	\$43.25		
90876	approximately 45-50 minutes	Master's degree level	HO, UC	\$90.04	\$51.91	290-298.9; 300.00-316	Yes
		Doctoral level	HP, UC	\$112.53	\$64.87		
		Psychiatrist	UA, UC	\$150.04	\$86.50		
90880	Hypnotherapy (quantity of 1.0 = 60 minutes)	Master's degree level	HO, UC	\$90.04	\$51.91	290-298.9; 300.00-316	No
		Doctoral level	HP, UC	\$112.53	\$64.87		
		Psychiatrist	UA, UC	\$150.04	\$86.50		
90887	Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient (quantity of 1.0 = 60 minutes)	Master's degree level	HO, UC	\$90.04	\$51.91	290-298.9; 300.00-316	Yes
		Doctoral level	HP, UC	\$112.53	\$64.87		
		Psychiatrist	UA, UC	\$150.04	\$86.50		
90899	Unlisted psychiatric service or procedure (quantity of 1.0 = 60 minutes)	Master's degree level	HO, UC	\$90.04	\$51.91	290-298.9; 300.00-316	No
		Doctoral level	HP, UC	\$112.53	\$64.87		
		Psychiatrist	UA, UC	\$150.04	\$86.50		

\*90862 — Limited to two units per DOS and four units per month.

\*\*Contracted rates are effective for DOS on and after October 1, 2003.

\*\*\*ICD-9-CM = *International Classification of Diseases, Ninth Revision, Clinical Modification*.

\*\*\*\*The list of ICD-9-CM diagnosis codes for outpatient mental health and substance abuse services in the home or community is inclusive. However, not all Medicaid-covered outpatient mental health and substance abuse services in the home or community are appropriate or allowable.



## Substance Abuse Treatment Procedure Codes

HCPSC Code	Description	Certified Providers Who May Perform Service	Modifiers (Required)	Contracted Rate*	Reimbursement (Federal Share)	ICD-9-CM** Diagnoses Allowed***	Telehealth Services Covered?
H0005	Alcohol and/or drug services; group counseling by a clinician [quantity of 1.0 = 60 minutes]	Bachelor's degree level	HN, UC	\$15.01	\$8.65	303-305.92	No
		Master's degree level	HO, UC	\$22.51	\$12.98		
		Doctoral level	HP, UC	\$28.11	\$16.21		
		Psychiatrist	UA, UC	\$37.51	\$21.62		
H0022	Alcohol and/or drug intervention service (planned facilitation) [quantity of 1.0 = per person in group per 60 minutes]	Bachelor's degree level	HN, UC	\$60.00	\$34.59	303-305.92	Yes
		Master's degree level	HO, UC	\$90.04	\$51.91		
		Doctoral level	HP, UC	\$112.53	\$64.87		
		Psychiatrist	UA, UC	\$150.04	\$86.50		
T1006	Alcohol and/or substance abuse services, family/couple counseling [quantity of 1.0 = 60 minutes]	Bachelor's degree level	HN, UC	\$60.00	\$34.59	303-305.92	Yes
		Master's degree level	HO, UC	\$90.04	\$51.91		
		Doctoral level	HP, UC	\$112.53	\$64.87		
		Psychiatrist	UA, UC	\$150.04	\$86.50		

\*Contracted rates are effective for DOS on and after October 1, 2003.

\*\*ICD-9-CM = *International Classification of Diseases, Ninth Revision, Clinical Modification*.

\*\*\*The list of ICD-9-CM diagnosis codes for outpatient mental health and substance abuse services in the home or community is inclusive. However, not all Medicaid-covered outpatient mental health and substance abuse services in the home or community are appropriate or allowable.

## ATTACHMENT 5

# Rounding Guidelines for Outpatient Mental Health and Substance Abuse Services in the Home or Community for Adults

Providers should use these rounding guidelines only when 1.0 unit of service is equal to one hour. Providers should follow the time specified in the procedure code description for all other codes.

<b>Outpatient Mental Health Services</b>	
<b>Time (Minutes)</b>	<b>Unit(s) Billed</b>
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

# ATTACHMENT 6

## CMS 1500 Claim Form Instructions for Outpatient Mental Health and Substance Abuse Services in the Home or Community for Adults

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

Wisconsin Medicaid recipients receive a Medicaid identification card upon being determined eligible for Wisconsin Medicaid. Always verify a recipient's eligibility before providing nonemergency services by using the Medicaid 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 Informational Provider Resources section of the All-Provider Handbook or the Medicaid Web site for more information about the EVS.

Submit completed paper claims to the following address:

Wisconsin Medicaid  
Claims and Adjustments  
6406 Bridge Rd  
Madison WI 53784-0002

### **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”) insurance only or has no commercial health insurance, leave Element 9 blank.

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

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

## 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

For outpatient mental health and substance abuse services in the home or community for adults, the prescribing physician’s name and Universal Provider Identification Number, eight-digit Medicaid provider number, or license number is required for all services *except* evaluation (90801 and 90802). If a psychiatrist is the referring or prescribing provider *and* the performing provider, the psychiatrist’s name and provider number must be entered in this element.

## **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.

## **Element 22 — Medicaid Resubmission (not required)**

## **Element 23 — Prior Authorization Number (not required)**

## **Element 24A — Date(s) of Service**

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

- When billing for one date of service (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 January 12 through 15, 2005, enter 01/12/05 or 01/12/2005 in the “From” field and enter 13/14/15 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 modifier in the “Modifier” column of Element 24D. Please note that Wisconsin Medicaid has not adopted all national modifiers.

## **Element 24E — Diagnosis Code**

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

## **Element 24F — \$ Charges**

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

**Element 24G — Days or Units**

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

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

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

**Element 24J — COB (not required)****Element 24K — Reserved for Local Use**

When the billing provider (Element 33) is a county-owned clinic (not a “biller only” provider), leave this element blank.

When the billing provider (Element 33) is a “biller only” provider, indicate the performing provider’s individual Medicaid provider number.

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, street, city, state, and zip code. At the bottom of Element 33, enter the billing provider's Medicaid provider number.

This is the county/tribal human or social services agency responsible for the local matching funds.

# ATTACHMENT 7

## Sample CMS 1500 Claim Form for Outpatient Mental Health and Substance Abuse Services in the Home or Community — County Owned Clinics (Not a "Biller Only" Provider)

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>					7a. 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>					4. INSURED'S NAME (Last Name, First Name, Middle Initial)						
5. PATIENT'S ADDRESS (No., Street) <b>609 Willow St</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 Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>			ZIP CODE 		TELEPHONE (INCLUDE AREA CODE) 	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) <b>OI-P</b>					10. IS PATIENT'S CONDITION RELATED TO:					11. INSURED'S POLICY GROUP OR FECA NUMBER	
a. OTHER INSURED'S POLICY OR GROUP NUMBER					a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO					a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>	
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					b. EMPLOYER'S NAME OR SCHOOL NAME	
c. EMPLOYER'S NAME OR SCHOOL NAME					c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO					c. INSURANCE PLAN NAME OR PROGRAM NAME	
d. INSURANCE PLAN NAME OR PROGRAM NAME					10d. RESERVED FOR LOCAL USE					d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i>	
<b>READ BACK OF FORM BEFORE COMPLETING &amp; SIGNING THIS FORM.</b>											
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.					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 _____ DATE _____					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/Prescribing</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					22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)					23. PRIOR AUTHORIZATION NUMBER					24. A DATE(S) OF SERVICE FROM MM DD YY TO MM DD YY	
1. <u>L290.0</u>					3. _____					B Place of Service	
2. _____					4. _____					C Type of Service	
D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER					E DIAGNOSIS CODE					F \$ CHARGES	
1 12 08 05 12 90801 UA UC 1 XX XX 1.0										G DAYS OR UNITS	
2 12 15 05 12 90806 UA UC 1 XX XX 1.0										H EPSDT Family Plan	
3 12 22 05 29 12 90857 HO UC 1 XX XX 2.0										I EMG	
										J COB	
										K RESERVED FOR LOCAL USE	
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	
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. Provider</b> MM/DD/YY					32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)					28. TOTAL CHARGE \$ <b>XXX XX</b>	
SIGNED _____ DATE _____										29. AMOUNT PAID \$ <b>XX XX</b>	
										30. BALANCE DUE \$ <b>XX XX</b>	
										33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # <b>I.M. Billing</b> <b>1 W. Williams</b> <b>Anytown, WI 55555 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 8

## Sample CMS 1500 Claim Form for Outpatient Mental Health and Substance Abuse Services in the Home or Community — "Biller Only" Providers

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 (SSN or ID) <input type="checkbox"/> FECA BLK LUNG (SSN) <input type="checkbox"/> OTHER (ID) <input type="checkbox"/>					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 <b>MM DD YY</b> M <input type="checkbox"/> F <input checked="" type="checkbox"/>																
5. PATIENT'S ADDRESS (No., Street) <b>609 Willow St</b>					6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>																
7. INSURED'S ADDRESS (No., Street) CITY: <b>Anytown</b> STATE: <b>WI</b>					8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>																
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) <b>Ol-P</b>					10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES <input type="checkbox"/> NO <input type="checkbox"/> b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State) _____ c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>																
11. INSURED'S POLICY GROUP OR FECA NUMBER <b>01-P</b>					12. 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>																
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 <b>I.M. Referring/Prescribing</b>					17a. I.D. NUMBER OF REFERRING PHYSICIAN <b>12345678</b>																
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>290.0</b>					22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER																
A		B		C		D		E		F		G		H		I		J		K	
DATE(S) OF SERVICE From MM DD YY To MM DD YY		Place of Service		Type of Service		PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER		DIAGNOSIS CODE		\$ CHARGES		DAYS OR UNITS		EPSDT Family Plan		EMG		COB		RESERVED FOR LOCAL USE	
12 02 05		12				90801 UA UC		1		XX XX		1.0								24681012	
12 15 05		12				90806 UA UC		1		XX XX		1.0								64295318	
12 22 05 29		12				90857 HO UC		1		XX XX		2.0								52623789	
25. FEDERAL TAX I.D. NUMBER		SSN EIN		26. PATIENT'S ACCOUNT NO.				27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES <input type="checkbox"/> NO <input type="checkbox"/>				28. TOTAL CHARGE \$		29. AMOUNT PAID \$		30. BALANCE DUE \$					
				<b>1234JED</b>								<b>XXX XX</b>		<b>XX XX</b>		<b>XX XX</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. Provider</b> MM/DD/YY SIGNED _____ DATE _____					32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)					33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # <b>I.M. Billing</b> <b>1 W. Williams</b> <b>Anytown, WI 55555 87654321</b> PIN# _____ GRP# _____											