

Wisconsin Medicaid and BadgerCare update

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Wisconsin Medicaid and BadgerCare Information for Providers

To:
 AODA Counselors
 County Substance Abuse Coordinators
 Mental Health/ Substance Abuse Clinics
 Outpatient Hospital Providers
 Physician Clinics
 Physicians
 Psychologists
 HMOs and Other Managed Care Programs

Outpatient Substance Abuse Treatment Services

This *Wisconsin Medicaid and BadgerCare Update* consolidates all of the information for outpatient substance abuse treatment services. 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.

This *Wisconsin Medicaid and BadgerCare Update* consolidates all of the information for outpatient substance abuse treatment services. This *Update* replaces the following outpatient substance abuse treatment services publications:

- The April 2004 *Update* (2004-34), titled “Medical Record Documentation Requirements for Mental Health and Substance Abuse Services.”
- The July 2003 *Update* (2003-60), titled “Changes to local codes, paper claims, and prior authorization for outpatient mental health and substance abuse services as a result of HIPAA.”
- Outpatient substance abuse services information in the Wisconsin Medical Assistance Program Provider Handbook, Part H, Divisions I and II.

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.

New Information

Revised allowable *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis code ranges are listed in Attachment 8 of this *Update*.

Certification

To be reimbursed for providing outpatient substance abuse treatment services to Medicaid recipients, a provider is first required to be certified by the Office of the Secretary of the Department of Health and Family Services (DHFS), Office of Quality Assurance (OQA) for outpatient substance abuse treatment under

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HFS 75.13, Wis. Admin. Code. For information regarding this certification, providers may contact the DHFS, OQA by telephone at (608) 243-2025 or by mail at the following address:

Office of the Secretary of the
Department of Health and Family Services
Office of Quality Assurance
Program Certification Unit
2917 International Ln Ste 300
Madison WI 53704

A provider meeting DHFS, OQA certification should do the following to obtain Medicaid certification.

Agencies should complete the Wisconsin Medicaid Mental Health/Substance Abuse Agency Certification Packet. Refer to Attachment 1 for Medicaid certification requirements and the types of provider numbers assigned to agencies providing outpatient substance abuse treatment services.

Individuals should complete the Wisconsin Medicaid Mental Health/Substance Abuse Individual Packet. Refer to Attachment 2 for Medicaid certification requirements and the types of provider numbers assigned to individuals providing outpatient substance abuse treatment services. Individual outpatient substance abuse treatment providers must obtain and maintain individual Medicaid certification.

Providers may initiate Medicaid outpatient substance abuse treatment provider certification by doing one of the following:

- Downloading mental health and substance abuse certification materials from the Medicaid Web site at 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.

Covered Services

Outpatient substance abuse treatment services are provided to ameliorate negative symptoms from substance abuse and to restore effective functioning in persons with substance abuse dependency or addiction when they are medically necessary. The services include individual substance abuse counseling (such as assessment, family counseling, group counseling, and counseling of persons affected by problems related to the abuse of alcohol or drugs).

Before being enrolled in a substance abuse treatment program, the recipient must receive a complete medical evaluation by a physician, including diagnosis, summary of present medical findings, medical history, and explicit recommendations for participation in the substance abuse treatment program. A medical evaluation performed for this purpose within 60 days prior to enrollment will be valid for re-enrollment.

Special Circumstances

The following are requirements for covered services:

- A physician's signed and dated prescription/order is required for

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Medicaid coverage of all outpatient substance abuse treatment services.

- The provider is required to engage in face-to-face contact with the recipient for at least 5/6 of the time.

Policies regarding concurrent coverage of services are as follows:

- Wisconsin Medicaid covers a continuum of non-inpatient hospital substance abuse services, including day treatment and intensive and non-intensive outpatient and aftercare services, but not concurrently.
- Wisconsin Medicaid covers outpatient substance abuse services concurrently with outpatient mental health or adult mental health day treatment services as long as services are medically necessary and appropriate. Refer to the “Prior Authorization” section of this *Update* for additional information on concurrent services.

Services Provided via Telehealth

Providers certified under HFS 75.13, Wis. Admin. Code, may provide most outpatient substance abuse treatment services via Telehealth. Telehealth services provided by psychiatrists and Ph.D. psychologists in private practice are also reimbursed.

In addition, effective for dates of service (DOS) on and after July 1, 2006, Wisconsin Medicaid reimburses the originating site a facility fee. These recent changes to Telehealth policy came after the General Information section of the Mental Health and Substance Abuse Services Handbook was published. The general section of the handbook contains information about Telehealth requirements and claims submission. Refer to the June 2006 *Update* (2006-58), titled “Wisconsin Medicaid Reimburses Selected Services Provided

Through Telemedicine,” for updated Telehealth policy information.

Noncovered Services

The following outpatient substance abuse treatment services are not covered by Wisconsin Medicaid:

- Collateral interviews and consultations, except as provided in HFS 107.06(4)(c), Wis. Admin. Code.
- Court appearances, except when necessary to defend against commitment.
- Medical detoxification provided in a non-hospital setting, as described in HFS 75.07, 75.08, and 75.09, Wis. Admin. Code.

Documentation Requirements

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

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

Prior Authorization

Services Requiring Prior Authorization

Prior authorization (PA) is required for outpatient substance abuse treatment services beyond 15 hours or \$500 of combined outpatient mental health and substance abuse services only, whichever limit is reached first, in a calendar year. Services are counted without regard to the agency or individual provider performing the service. The 15-hour/\$500 accumulation requirement is separate from any

Prior authorization (PA) is required for outpatient substance abuse treatment services beyond 15 hours or \$500 of combined outpatient mental health and substance abuse services only, whichever limit is reached first, in a calendar year.

other PA threshold as stated in HFS 104.01(12)(a)1j, Wis. Admin. Code.

Prior authorization is required beyond \$500 in a calendar year for outpatient substance abuse services provided in an outpatient hospital.

Concurrent Outpatient Mental Health Services

Prior authorization is normally granted only to one provider at a given time; however, concurrent PAs may be approved for separate providers for mental health and substance abuse services. Concurrent PA requests must meet the following requirements:

- The PA requests must clearly indicate that each provider is aware of the services being provided by the other and describes how these services are being coordinated.
- Justification must be given for having services provided by separate providers.
- The overall intensity of service must be within the range ordinarily approved for outpatient mental health and substance abuse services. For example, outpatient substance abuse treatment is generally not approved concurrently with one or two hours of family psychotherapy per week, but one two-hour substance abuse group therapy session plus one one-hour individual psychotherapy session may be approved.

Concurrent Adult Mental Health Day Treatment Services

Outpatient substance abuse counseling may be provided concurrently with mental health day treatment services that are considered medically necessary and appropriate when the provider demonstrates that all three of the following conditions are met:

- Both services are diagnostically appropriate for the recipient.
- The providers are communicating with each other about the recipient's needs, the

treatment is coordinated, and the outpatient substance abuse services augment the mental health day treatment services.

- One of the following statements is true:
 - ✓ There is a pre-existing relationship between the recipient and the outpatient substance abuse service provider.
 - ✓ The recipient has appropriate mental health day treatment needs, and the recipient has a need for specialized intervention that the day treatment staff is not trained to provide.

In general, a recipient who is able to benefit from outpatient substance abuse services will not require as high a level of mental health day treatment services and the requested hours of service may be modified to reflect this.

Reimbursement for Prior Authorized Services

Prior authorization is required for certain services before they are provided. Wisconsin Medicaid does not reimburse providers for services provided either before the grant date or after the expiration date indicated on the approved PA request. If the provider delivers a service either before the grant date or after the expiration date of an approved PA request or provides a service that requires PA without obtaining PA, the provider is responsible for the cost of the service. In these situations, providers may *not* collect payment from the recipient.

Prior authorization does not guarantee reimbursement. To receive Medicaid reimbursement, *all* Medicaid requirements must be met. For more information about general PA requirements, obtaining PA forms and attachments, and submitting PA requests, refer

In general, a recipient who is able to benefit from outpatient substance abuse services will not require as high a level of mental health day treatment services and the requested hours of service may be modified to reflect this.

to the Prior Authorization section of the All-Provider Handbook.

Prior Authorization Request Forms and Attachments

To request PA for outpatient substance abuse treatment services, providers are required to complete and submit the following forms and documentation to Wisconsin Medicaid:

- *Prior Authorization Request Form (PA/RF)*, HCF 11018 (Rev. 10/03). Refer to Attachments 4 and 5 for PA/RF completion instructions and a sample form for outpatient substance abuse treatment services.
- *Prior Authorization/Substance Abuse Attachment (PA/SAA)*, HCF 11032 (Rev. 06/03). The completion instructions and PA/SAA for outpatient substance abuse treatment services are located in Attachments 6 and 7 for photocopying and may also be downloaded and printed from the Medicaid Web site.
- Signed physician's prescription/order dated not more than one year prior to the requested first DOS.

Providers may also be required to attach copies of assessments, treatment summaries, treatment plans, or other documentation as directed by the PA/SAA. Providers are responsible for ensuring that information attached to the form adequately responds to what is requested, clearly indicating the intended purpose of the attached documentation.

Refer to the General Information section of the Mental Health and Substance Abuse Services Handbook for backdating procedures.

Grant and Expiration Dates

Refer to the Prior Authorization section of the All-Provider Handbook for information on other circumstances affecting PA, such as determination of grant dates and service interruptions.

Claims Submission

Coordination of Benefits

Except in 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 (MCOs).

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 (Rev. 08/05).

Diagnosis Codes (Submitted on the CMS 1500 and UB-92 Claim Forms)

All diagnoses must come from the ICD-9-CM coding structure and must be an allowable diagnosis code for the DOS. Claims received without an allowable ICD-9-CM code are denied.

Refer to Attachment 8 for a list of allowable diagnosis code ranges for outpatient substance abuse treatment services.

Procedure Codes (Submitted on the CMS 1500 Claim Form)

Healthcare Common Procedure Coding System (HCPCS) codes are required on all outpatient substance abuse treatment claims submitted on

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the CMS 1500 claim form. Claims or adjustments received without a HCPCS code are denied. Refer to Attachment 8 for allowable procedure codes and modifiers. Refer to Attachment 9 for maximum allowable fees and copayment rates.

For procedure codes that do not indicate a time increment, providers are required to use the rounding guidelines in Attachment 10.

Revenue Codes (Submitted on the UB-92 Claim Form)

Refer to Attachment 8 or the UB-92 Uniform Billing Manual for a list of allowable revenue codes for outpatient substance abuse treatment services provided by outpatient substance abuse clinics. However, outpatient substance abuse services provided by a psychologist to a hospital inpatient recipient must be billed on the CMS 1500 claim form. This does not include group therapy and medication management which are not separately billable for inpatient recipients.

Place of Service Codes (Submitted on the CMS 1500 Claim Form)

Allowable place of service codes for outpatient substance abuse treatment services are included in Attachment 8.

Outpatient substance abuse treatment services are performed only in the office of the provider or in a hospital, hospital outpatient clinic, outpatient facility, nursing home, or school. This benefit does not include services provided in home or community settings. For outpatient services covered in the home or community, please refer to Medicaid publications about outpatient mental health and substance abuse services in the home and community.

Electronic Claims Submission

Providers are encouraged to submit claims electronically since electronic claims submission usually reduces claim errors. Claims for outpatient substance abuse treatment services may be submitted using the 837 Health Care Claim: Professional transaction or the 837 Health Care Claim: Institutional 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

With the exception of outpatient substance abuse treatment services billed as hospital outpatient services using revenue codes, paper claims for substance abuse services must be submitted using the CMS 1500 claim form. Refer to Attachment 11 for CMS 1500 claim form instructions. Attachments 12 and 13 are samples of claims for outpatient substance abuse treatment services.

Paper claims for outpatient substance abuse treatment services billed as hospital outpatient services using appropriate revenue codes must be submitted using the UB-92 claim form. Refer to Attachment 14 for UB-92 claim form instructions. Attachment 15 is a sample of a claim for outpatient substance abuse treatment services.

Wisconsin Medicaid does not provide the CMS 1500 or the UB-92 claim forms. These forms may be obtained from any federal forms supplier.

With the exception of outpatient substance abuse treatment services billed as hospital outpatient services using revenue codes, paper claims for substance abuse services must be submitted using the CMS 1500 claim form.

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/.

PHC 1250

Reimbursement

Wisconsin Medicaid reimburses for services provided by the following professionals in an outpatient substance abuse treatment clinic:

- Substance abuse counselor without a Master's degree (certified, not only registered).
- Substance abuse counselor with a Master's degree (certified, not only registered).
- Ph.D. Psychologist.
- Physician.
- Ancillary provider.

Wisconsin Medicaid reimburses outpatient substance abuse treatment providers the lesser of the billed amount and the maximum allowable fee for a service.

Ancillary Providers

Wisconsin Medicaid reimburses for coordination of care services and delegated medical acts (e.g., giving injections or checking medications) provided by ancillary providers (e.g., registered nurses) if all of the following are true:

- The services are provided under the *direct, immediate, on-site* supervision of a physician.
- The services are pursuant to the physician's plan of care.
- The supervising physician has not provided Medicaid-reimbursable services during the same office or outpatient evaluation and management visit.

"On-site" means that the supervising physician is in the same building in which services are being provided and is immediately available for consultation or, in the case of emergencies, for direct intervention. The physician is not required to be in the same room as the ancillary provider, unless dictated by medical necessity and good medical practice.

Claims for services provided by ancillary providers must be submitted under the

supervising physician's Medicaid provider number using the lowest appropriate level office or outpatient visit procedure code or other appropriate *Current Procedural Terminology* code for the service performed. These services are not to be billed in addition to, or combined with, the service if the physician sees the patient during the same visit.

Recipient Copayment Information

Providers are prohibited from collecting copayment from nursing home residents and individuals under age 18 who are receiving outpatient substance abuse treatment services. All other recipients receiving outpatient substance abuse treatment services are charged copayment.

Refer to the Recipient Eligibility section of the All-Provider Handbook for general copayment policies, exemptions, and limitations.

The maximum allowable fee amount determines the copayment amount that providers may request from a recipient for most outpatient substance abuse treatment services. Outpatient psychotherapy and outpatient substance abuse treatment services greater than 15 hours or \$500 of accumulated services per recipient, per calendar year, are exempt from copayment. The maximum allowable fee schedule lists all the procedure codes allowed by Wisconsin Medicaid for a provider type and Wisconsin Medicaid's maximum allowable fee for each procedure code.

Information Regarding Medicaid HMOs

This *Update* contains Medicaid fee-for-service policy and applies to providers of services to recipients on fee-for-service Medicaid only. For Medicaid HMO or managed care policy, contact the appropriate MCO. Wisconsin Medicaid HMOs are required to provide at least the same benefits as those provided under fee-for-service arrangements.

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ATTACHMENT 1

Certification Requirements for Outpatient Substance Abuse Services Provided by Agencies

This attachment outlines Wisconsin Medicaid certification requirements for Medicaid outpatient substance abuse service providers. Prior to obtaining Wisconsin Medicaid certification, outpatient substance abuse service providers are required to be certified by the Office of the Secretary of the Department of Health and Family Services (DHFS), Office of Quality Assurance (OQA). County/tribal social or human services agencies that request billing-only status do not need to be certified by the DHFS.

The following table lists required provider number types and definitions for agencies providing outpatient substance abuse services.

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 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
	Office of the Secretary of the Department of Health and Family Services/Office of Quality Assurance	Wisconsin Medicaid	Section of Certification Packet to Be Completed*	County/Tribal Social or Human Services Agency?	
Agency Providing the Service	The agency is required to obtain a Wisconsin DHFS certificate to provide outpatient substance abuse services as authorized under HFS 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"> • Have a DHFS, OQA certificate on file. • Complete and submit a Mental Health and Substance Abuse Agency Certification Packet. An allowable Medicaid performing provider is required to perform the service. 	Outpatient Substance Abuse Services	No	Outpatient substance abuse clinic billing/performing provider number
		Hospitals are required to complete one of the following: <ul style="list-style-type: none"> • The Hospital Certification Packet if billing as an outpatient hospital (using revenue codes on the UB-92 claim form). Outpatient hospitals utilizing substance abuse counselors are required to be certified as a DHFS, OQA-certified mental health clinic under HFS 75, Wis. Admin. Code. The clinic must be located at the hospital site in order to bill as an outpatient hospital. • The Mental Health and Substance Abuse Agency Certification Packet if billing as a certified outpatient substance abuse clinic (using procedure codes on the CMS 1500 claim form). 	Outpatient Substance Abuse Services	No	Hospitals will receive one of the following: <ul style="list-style-type: none"> • Outpatient substance abuse clinic billing/performing provider number. • Outpatient hospital number.
Agency Only Allowed to Bill for the Service	Not required	The agency is required to complete and submit a Mental Health and Substance Abuse Agency Certification Packet to be a billing-only provider for outpatient substance abuse services. An allowable Medicaid performing provider is required to perform the service.	Outpatient Substance Abuse Services	Yes	Outpatient substance abuse clinic billing provider number

*These are sections of the Medicaid Mental Health/Substance Abuse Agency Certification Packet.

ATTACHMENT 2

Certification Requirements for Outpatient Substance Abuse Services Provided by Individuals

This attachment outlines Wisconsin Medicaid certification requirements for individuals. The first table identifies the individual provider types who may perform outpatient substance abuse services. The second table includes definitions for provider numbers, and the third table lists individual providers, prerequisites, and Medicaid certification requirements.

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

Services provided by substance abuse counselors must be billed under the billing provider number of the agency at which they work; their provider numbers indicate they are performing providers.

Allowable Individual Providers for Outpatient Substance Abuse Services
Substance Abuse Counselor Without a Master's Degree
Substance Abuse Counselor with a Master's Degree
Ph.D. Psychologist
Physician

Definitions for Provider Numbers	
Type of Provider Number	Definition
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.
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.
Group/Clinic Billing Number	Issued only to physicians and Ph.D. psychologists in private practice as an accounting convenience for a clinic in which more than one individual provider performs the service(s). A provider using a group/clinic billing number receives one reimbursement, one Remittance and Status Report, and the 835 Health Care Claim/Payment Advice transaction for covered services performed by individual providers within a group/clinic.

Individual Providers, Prerequisites, and Medicaid Certification Requirements			
Type of Provider	Prerequisite	Medicaid Certification Requirements	Type of Provider Number Assigned
Substance Abuse Counselor Without Master's Degree	<p>The provider is required to do the following:</p> <ul style="list-style-type: none"> • 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). • Have a certificate stating qualifications as a <i>certified</i> (not only registered) substance abuse counselor issued by the Wisconsin Certification Board on Alcohol and Other Drug Abuse counselors. 	The provider is required to complete and submit a Mental Health/Substance Abuse Individual Certification Packet.	Nonbilling performing provider number
Substance Abuse Counselor with Master's Degree	<p>The provider is required to do the following:</p> <ul style="list-style-type: none"> • 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). • Have a certificate stating qualifications as a <i>certified</i> (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 <i>or</i> a Provider Status Approval Letter issued by the Division of Disability and Elder Services, Bureau of Quality Assurance. 	The provider is required to complete and submit a Mental Health/Substance Abuse Individual Certification Packet.	Nonbilling performing provider number
Ph.D. Psychologist	<p>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:</p> <ul style="list-style-type: none"> • 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). • 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). 	The provider is required to complete and submit a Mental Health/Substance Abuse Individual Certification Packet.	Billing/performing provider number
Physician	The provider is required to have a license to practice as a physician, according to ch. 448.05, Wis. Stats., as required under HFS 105, Wis. Admin. Code.	The provider is required to complete and submit a Physician/Osteopath/Physician Assistant Certification 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

Prior Authorization Request Form (PA/RF) Completion Instructions for Outpatient Substance Abuse Services

Wisconsin Medicaid requires certain 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 will 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), HCF 11018, 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 Attachment (PA/SAA), HCF 11032, by fax to Wisconsin Medicaid at (608) 221-8616 or mail 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 — 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.* Nonbilling performing providers (Master's degree psychotherapists) are required to indicate the clinic name and number as the billing provider.

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. Nonbilling performing providers (substance abuse counselor [certified, not only registered]) are required to indicate the clinic telephone number.

Element 3 — Processing Type

The processing type is a three-digit code used to identify a category of service requested. Enter processing type "128" (substance abuse services [other than day treatment]).

Element 4 — Billing Provider’s Medicaid Provider Number

Enter the eight-digit Medicaid provider number of the billing provider. The provider number in this element must correspond with the provider name listed in Element 1. Nonbilling performing providers are required to indicate the eight-digit Medicaid provider number of the clinic.

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 Medicaid 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 Revision, Clinical Modification* (ICD-9-CM) diagnosis code and description most relevant to the service requested.

Element 11 — Start Date — SOI (not required)

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

Element 13 — Diagnosis — Secondary Code and Description

Enter the appropriate secondary ICD-9-CM diagnosis code and description additionally descriptive of the recipient’s clinical condition.

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 desired, follow the procedure for requesting as described in the All-Provider Handbook.

Element 15 — Performing Provider Number

For substance abuse clinics not located in an outpatient hospital, enter the eight-digit Medicaid performing provider number of the provider who will be providing the service.

Element 16 — Procedure Code

Enter the appropriate *Current Procedural Terminology* code or Healthcare Common Procedure Coding System code for each service requested.

Element 17 — Modifiers

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

Element 18 — POS

Enter the appropriate place of service (POS) code designating where the requested service would be provided. Refer to Attachment 8 of this *Wisconsin Medicaid and BadgerCare Update* for a list of allowable POS codes.

Element 19 — Description of Service

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

Element 20 — QR

Enter the appropriate quantity (e.g., number of services, days' supply) requested for the procedure code listed. Refer to Attachment 10 for rounding guidelines.

Element 21 — Charge

Enter the usual and customary charge for each service requested. If the quantity is greater than "1.0," 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 service requested. Providers are reimbursed for authorized services according to the provider *Terms of 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 5

Sample Prior Authorization Request Form (PA/RF) for Outpatient Substance Abuse Services

DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Health Care Financing
HCF 11018 (Rev. 10/03)

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

WISCONSIN MEDICAID PRIOR AUTHORIZATION REQUEST FORM (PA/RF)

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

FOR MEDICAID USE — ICN	AT	Prior Authorization Number 1234567
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SECTION I — PROVIDER INFORMATION

1. Name and Address — Billing Provider (Street, City, State, Zip Code) I.M. Provider 1 W. Williams Anytown WI 55555	2. Telephone Number — Billing Provider (XXX) XXX-XXXX	3. Processing Type 128
4. Billing Provider's Medicaid Provider Number 87654321		

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) 1234 Street St. 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 303.91 Chronic alcoholism					11. Start Date — SOI		12. First Date of Treatment — SOI		
13. Diagnosis — Secondary Code and Description					14. Requested Start Date MM/DD/YY				
15. Performing Provider Number	16. Procedure Code	17. Modifiers				18. POS	19. Description of Service	20. QR	21. Charge
		1	2	3	4				
98765432	H0022	HO				11	Ind planned facilitation	2	XXX.XX
98765432	H0005	HO				11	Group substance abuse counseling	26	XXX.XX
98765432	T1006	HO				11	Family substance abuse counseling	2	XXX.XX

An approved authorization does not guarantee payment. Reimbursement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after the authorization expiration date. Reimbursement will be in accordance with Wisconsin Medicaid payment methodology and policy. If the recipient is enrolled in a Medicaid HMO at the time a prior authorized service is provided, Medicaid reimbursement will be allowed only if the service is not covered by the HMO.

23. SIGNATURE — Requesting Provider <i>I.M. Provider</i>	24. Date Signed MM/DD/YY
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FOR MEDICAID USE

Procedure(s) Authorized: _____
Quantity Authorized: _____

Approved

_____ Grant Date _____ Expiration Date

Modified — Reason:

Denied — Reason:

Returned — Reason:

_____ SIGNATURE — Consultant / Analyst _____ Date Signed

ATTACHMENT 6
Prior Authorization/Substance Abuse Attachment (PA/SAA)
Completion Instructions

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

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

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

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

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

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

Attach the completed Prior Authorization/Substance Abuse Attachment (PA/SAA), HCF 11032, to the Prior Authorization Request Form (PA/RF), HCF 11018, and physician prescription (if necessary) and send it to Wisconsin Medicaid. Providers may submit PA requests by fax to Wisconsin Medicaid at (608) 221-8616. Providers who wish to submit PA requests by mail may do so by submitting them to the following address:

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

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

SECTION I — RECIPIENT INFORMATION

Element 1 — Name — Recipient

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

Element 2 — Age — Recipient

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

Element 3 — Recipient Medicaid Identification Number

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

SECTION II — PROVIDER INFORMATION

Element 4 — Name and Credentials — Performing Provider

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

Element 5 — Performing Provider's Medicaid Provider Number

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

Element 6 — Telephone Number — Performing Provider

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

Element 7 — Name — Referring / Prescribing Provider

Enter the name of the provider referring/prescribing treatment.

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

Enter the referring/prescribing provider's eight-digit Medicaid provider number, if available.

SECTION III — TYPE OF TREATMENT REQUESTED

Element 9

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

SECTION IV — DOCUMENTATION

Element 10

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

Element 11

Enter the date of the most recent medical evaluation, which includes diagnosis, summary of present medical findings, and medical history.

Element 12

Specify any diagnostic procedures employed.

Element 13

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

Element 14

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

Element 15

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

Element 16

Provide a detailed description of treatment objectives and goals.

Element 17

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

SECTION V — SIGNATURES

Element 18 — Signature — Recipient or Representative (optional)

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

Element 19 — Date Signed

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

Element 20 — Relationship (if representative)

When a representative signs on behalf of the recipient, include his or her relationship to the recipient.

Element 21 — Signature — Performing Provider

Wisconsin Medicaid requires the performing provider’s signature to process the PA request. Read the PA statement before dating and signing the attachment.

Element 22 — Date Signed

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

Element 23 — Discipline of Performing Provider

Enter the discipline of the performing provider.

Element 24 — Performing Provider’s Medicaid Provider Number

Enter the performing provider’s Medicaid provider number.

Element 25 — Signature — Supervising Provider

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

Element 26 — Date Signed

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

Other Information

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

ATTACHMENT 7
Prior Authorization/Substance Abuse Attachment (PA/SAA)
(for photocopying)

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

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

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

SECTION I — RECIPIENT INFORMATION

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

2. Age — Recipient

3. Recipient Medicaid Identification Number

SECTION II — PROVIDER INFORMATION

4. Name and Credentials — Performing Provider

5. Performing Provider's Medicaid Provider Number

6. Telephone Number — Performing Provider

7. Name — Referring / Prescribing Provider

8. Referring / Prescribing Provider's Medicaid Provider Number

SECTION III — TYPE OF TREATMENT REQUESTED

9.

Primary Intensive Outpatient Treatment

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

Aftercare / Follow-Up Service

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

Continued

SECTION III — TYPE OF TREATMENT REQUESTED (Continued)

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

SECTION IV — DOCUMENTATION

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

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

12. Specify diagnostic procedures employed.

SECTION IV — DOCUMENTATION (Continued)

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

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

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

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

Continued

SECTION IV — DOCUMENTATION (Continued)

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

SECTION V — SIGNATURES

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

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

19. Date Signed

20. Relationship (if representative)

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

21. **SIGNATURE** — Performing Provider

22. Date Signed

23. Discipline of Performing Provider

24. Performing Provider's Medicaid Provider Number

25. **SIGNATURE** — Supervising Provider

26. Date Signed

ATTACHMENT 8

Outpatient Substance Abuse Services Procedure Codes and Revenue Codes

The following table lists the Healthcare Common Procedure Coding System (HCPCS) code and modifier or revenue code that providers are required to use when requesting prior authorization (PA) and submitting claims for outpatient substance abuse services. Not all providers may be reimbursed for all substance abuse services. Consult the tables in this attachment to determine which certified providers may be reimbursed for a particular service.

Place of Service Codes	
(Submitted Only on the CMS 1500 Claim Form)	
03	School
11	Office
21*	Inpatient Hospital
22	Outpatient Hospital
23	Emergency Room — Hospital
31	Skilled Nursing Facility
32	Nursing Facility
51*	Inpatient Psychiatric Facility
54	Intermediate Care Facility/Mentally Retarded
61*	Comprehensive Inpatient Rehabilitation Facility

*The place of service (POS) codes, "21", "51", and "61" are not allowable for Master's degree-level providers and substance abuse counselors. Payment is included in the hospital's Medicaid diagnosis-related group reimbursement.

Professional Level Modifiers		
(Submitted Only on the CMS 1500 Claim Form)		
Modifier	Description	Providers
HN	Bachelors degree level	Substance abuse counselors who have less credentials than a Master's degree-level psychotherapist
HO	Masters degree level	Substance abuse counselors who are also Master's degree-level psychotherapists (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, Psychiatrist	Physician billing substance abuse services Physician assistant billing substance abuse services

Substance Abuse Treatment Procedure Codes

(Submitted Only on the CMS 1500 Claim Form)

Substance Abuse Therapeutic Procedures

HCPCS Code	Description	Certified Providers Who May Perform Service	Modifier (Required)	Limitations	ICD-9-CM** Diagnoses Allowed***	Allowable Place of Service	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	Accumulates toward the 15-hour/\$500 per calendar year threshold beyond which PA is required.	303.00-305.93; 308.9; 309.24; 309.28; 309.9; 312.31	03, 11, 22, 23, 31, 32, 54	No
		Master's degree level	HO				
		Doctoral level	HP				
		MD	UA				
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	Accumulates toward the 15-hour/\$500 per calendar year threshold beyond which PA is required (except for inpatient hospitals).	303.00-305.93; 308.9; 309.24; 309.28; 309.9; 312.31	03, 11, 21*, 22, 23, 31, 32, 51*, 54, 61*	Yes (use "GT" modifier)
		Master's degree level	HO				
		Doctoral level	HP				
		MD	UA				
H0047	Alcohol and/or other drug abuse services, not otherwise specified [Wisconsin Medicaid: Limitation — Exceeded]	Master's degree level	HO	Accumulates toward the 15-hour/\$500 per calendar year threshold beyond which PA is required (except for inpatient hospitals).	303.00-305.93; 308.9; 309.24; 309.28; 309.9; 312.31	03, 11, 21*, 22, 23, 31, 32, 51*, 54, 61*	Yes (use "GT" modifier)
		Doctoral level	HP				
		MD	UA				
T1006	Alcohol and/or substance abuse services, family/couple counseling [quantity of 1.0 = 60 minutes]	Bachelor's degree level	HN	Accumulates toward the 15-hour/\$500 per calendar year threshold beyond which PA is required.	303.00-305.93; 308.9; 309.24; 309.28; 309.9; 312.31	03, 11, 21*, 22, 23, 31, 32, 51*, 54, 61*	Yes (use "GT" modifier)
		Master's degree level	HO				
		Doctoral level	HP				
		MD	UA				

* The POS codes, "21", "51", and "61" are not allowable for Master's degree-level providers and substance abuse counselors. Payment is included in the hospital's Medicaid diagnosis-related group reimbursement.

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

*** The list of ICD-9-CM diagnosis codes for outpatient substance abuse treatment services is inclusive. However, not all Medicaid-covered outpatient substance abuse services are appropriate or allowable.

Substance Abuse Treatment Revenue Codes*

(Submitted Only on the UB-92 Claim Form)

Revenue Code	Description	Certified Providers Who May Perform Service	Modifier	Limitations	ICD-9-CM** Diagnoses Allowed***	Telehealth Services Covered?
0944	Drug rehabilitation	Bachelor's degree level	HN	Accumulates toward the \$500 per calendar year threshold beyond which PA is required.	304.00-304.93; 305.10-305.93; 308.9; 309.24; 309.28; 309.9; 312.31	For individual services only.
		Master's degree level	HO			
		Doctoral level	HP			
0945	Alcohol rehabilitation	Bachelor's degree level	HN	Accumulates toward the \$500 per calendar year threshold beyond which PA is required.	303.00-303.93; 305.00; 308.9; 309.24; 309.28; 309.9; 312.31	For individual services only.
		Master's degree level	HO			
		Doctoral level	HP			

* Outpatient substance abuse services, other than group therapy and medication management, provided by a psychologist to a hospital inpatient recipient must be billed on the CMS 1500 claim form.

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

*** The list of ICD-9-CM diagnosis codes for outpatient substance abuse treatment services is inclusive. However, not all Medicaid-covered outpatient substance abuse services are appropriate or allowable.

ATTACHMENT 9

Outpatient Substance Abuse Services Maximum Allowable Fees and Copayment Rates

The following table includes maximum allowable fees and copayment rates for allowable Healthcare Common Procedure Coding System (HCPCS) codes. Maximum allowable fees listed in this attachment may be subject to change. Wisconsin Medicaid will notify providers if the fees change from those printed in this *Wisconsin Medicaid and BadgerCare Update*.

Professional Level Modifiers		
Modifier	Description	Providers
HN	Bachelors degree level	Substance abuse counselors who have less credentials than a Master's degree-level psychotherapist
HO	Masters degree level	Substance abuse counselors who are also Master's degree-level psychotherapists (Master's-level psychotherapists are Master's-level substance abuse 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	Physician billing substance abuse services Physician assistant billing substance abuse services

Substance Abuse Treatment Procedure Codes

Substance Abuse Therapeutic Procedures					
Procedure Code	Description	Certified Providers Who May Perform Service	Modifier (Required)	Maximum Allowable Fee Effective July 1, 2002	Copayment
H0005	Alcohol and/or drug services; group counseling by a clinician [quantity of 1.0 = 60 minutes]	Bachelor's degree level	HN	\$8.45	\$0.50
		Master's degree level	HO	\$11.26	\$1.00
		Doctoral level	HP	\$13.82	\$1.00
		MD	UA	\$20.23	\$1.00
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	\$31.96	\$2.00
		Master's degree level	HO	\$55.00	\$3.00
		Doctoral level	HP	\$65.00	\$3.00
		MD	UA	\$80.13	\$3.00
H0047	Alcohol and/or other drug abuse services, not otherwise specified [Wisconsin Medicaid: Limitation — Exceeded]	Master's degree level	HO	\$55.00	\$3.00
		Doctoral level	HP	\$65.00	\$3.00
		MD	UA	\$80.13	\$3.00
T1006	Alcohol and/or substance abuse services, family/couple counseling [quantity of 1.0 = 60 minutes]	Bachelor's degree level	HN	\$31.96	\$2.00
		Master's degree level	HO	\$55.00	\$3.00
		Doctoral level	HP	\$65.00	\$3.00
		MD	UA	\$80.13	\$3.00

Outpatient Substance Abuse Services Revenue Codes

Revenue Code	Description	Certified Providers Who May Perform Service	Modifier	Rate	Copayment
0944	Drug rehabilitation	Bachelor's degree level	HN	The hospital's specific rate per visit.	\$3.00 per visit, per day
		Master's degree level	HO		
		Doctoral level	HP		
0945	Alcohol rehabilitation	Bachelor's degree level	HN	The hospital's specific rate per visit.	\$3.00 per visit, per day
		Master's degree level	HO		
		Doctoral level	HP		

ATTACHMENT 10

Rounding Guidelines for Outpatient Substance Abuse Services

The following table illustrates the rules of rounding and gives the appropriate billing unit for all services. 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.

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

ATTACHMENT 11

CMS 1500 Claim Form Instructions for Outpatient Substance Abuse Services

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 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 Resources section of the All-Provider Handbook or the Medicaid Web site at dhfs.wisconsin.gov/medicaid/ 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

County-Owned Outpatient Substance Abuse Services Clinics

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

Psychiatrists and Ph.D. Psychologists in Private Practice and Privately Owned Outpatient Substance Abuse Services Clinics (by Substance Abuse Counselors, Master's-Level Providers, Physicians, and Ph.D. Psychologists)

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 toward 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.

Outpatient substance abuse service providers are *not* required to be Medicare enrolled to provide Medicare-covered services for dual eligibles. Dual eligibles are those recipients covered under both Medicare and 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 (all three criteria must be met):</i></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 (all three criteria must be met):</i></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 (all three criteria must be met):</i></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 (all three criteria must be met):</i></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 (all three criteria must be met):</i></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 (all three criteria must be met):</i></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 (not required)

All outpatient substance abuse services require a physician's prescription/order. The prescribing physician's name and Universal Provider Identification Number, eight-digit Medicaid provider number, or license number is required for all services. 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. Refer to Attachment 8 of this *Wisconsin Medicaid and BadgerCare Update* for allowable diagnosis codes.

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), HCF 11018. 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 on January 12 through 15, 2007, enter 01/12/07 or 01/12/2007 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 the following are true:

- 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. Refer to Attachment 8 for allowable POS codes for outpatient substance abuse services.

Note: Services provided to a hospital inpatient recipient by Master's-level psychotherapists or substance abuse counselors are not separately reimbursable as substance abuse professional services. Group therapy and medication management services are not separately reimbursable by any provider as professional substance abuse services when provided to a hospital inpatient recipient.

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.

Note: Wisconsin Medicaid has not adopted all 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). Refer to Attachment 10 for rounding guidelines.

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

Element 24I — EMG (not required)

Element 24J — COB (not required)

Element 24K — Reserved for Local Use

Enter the eight-digit Medicaid provider number of the performing provider for each procedure. When submitting claims for ancillary services under a supervising physician, enter the eight-digit Medicaid provider number of the supervising physician.

When the billing provider 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.

County-Owned Outpatient Substance Abuse Clinics

Though county-owned outpatient substance abuse services clinics are *not* required to indicate a performing provider number in this element, Wisconsin Medicaid encourages them to do so if the provider is individually Medicaid certified. Providers in county-owned clinics are not required to be individually Medicaid certified, but counties are encouraged to have staff be individually certified.

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)

If the services were provided to a recipient in a nursing facility (POS code "31," "32," or "54"), indicate the nursing home's Medicaid provider number.

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 eight-digit Medicaid provider number.

ATTACHMENT 13

Sample CMS 1500 Claim Form for Billing-Only Agencies

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) 1234567890																
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Recipient, Im A.					3. PATIENT'S BIRTH DATE MM DD YY M <input type="checkbox"/> F <input checked="" type="checkbox"/>																
5. PATIENT'S ADDRESS (No., Street) 609 Willow St					6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>																
CITY Anytown			STATE WI		7. INSURED'S ADDRESS (No., Street)			8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>													
ZIP CODE 55555		TELEPHONE (Include Area Code) (XXX) XXX-XXXX			9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) OI-P		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO														
9a. OTHER INSURED'S POLICY OR GROUP NUMBER					11. INSURED'S POLICY GROUP OR FECA NUMBER M-7																
9b. OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>					10a. EMPLOYER'S NAME OR SCHOOL NAME																
9c. EMPLOYER'S NAME OR SCHOOL NAME					10b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input type="checkbox"/> NO																
9d. INSURANCE PLAN NAME OR PROGRAM NAME					10c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO																
10d. RESERVED FOR LOCAL USE					11. INSURANCE PLAN NAME OR PROGRAM NAME																
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/Prescribing					17a. I.D. NUMBER OF REFERRING PHYSICIAN 12345678																
19. RESERVED FOR LOCAL USE					16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY																
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. 303.90					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																
2. _____					20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO																
3. _____					22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.																
4. _____					23. PRIOR AUTHORIZATION NUMBER																
A		B		C		D		E		F		G		H		I		J		K	
DATE(S) OF SERVICE From		To		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	
1	14	07	21	28	11			H0022		1	XXX	XX	3.0								65432109
2	14	07			11			H0005		1	XXX	XX	3.0								65432109
3																					
4																					
5																					
6																					
25. FEDERAL TAX I.D. NUMBER SSN EIN					26. PATIENT'S ACCOUNT NO. 1234JED					27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <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.) I.M. Provider MM/DD/YY					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 76543210											
SIGNED _____ DATE _____										PIN# _____ GRP# _____											

ATTACHMENT 14

UB-92 (CMS 1450) Claim Form Instructions for Outpatient Substance Abuse Services

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

These instructions are for the completion of the UB-92 (CMS 1450) claim for Wisconsin Medicaid. For complete billing instructions, refer to the National UB-92 Uniform Billing Manual prepared by the National Uniform Billing Committee (NUBC). The National UB-92 Uniform Billing Manual contains important coding information not available in these instructions. Providers may purchase the National UB-92 Uniform Billing Manual by calling (312) 422-3390 or writing to the following address:

American Hospital Association
National Uniform Billing Committee
29th Fl
1 N Franklin
Chicago IL 60606

For more information, go to the NUBC Web site at www.nubc.org/.

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 Resources section of the All-Provider Handbook or the Medicaid Web site at dhfs.wisconsin.gov/medicaid/ 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

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

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

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

Enter the Pre-Admission Review control number as required.

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

Form Locator 4 — Type of Bill

Enter the three-digit type of bill number. The first digit identifies the type of facility. The second digit classifies the type of care. The third digit (“X”) indicates the billing frequency, and providers should enter one of the following for “X”:

- 1 = Admit through discharge claim.
- 2 = Interim — first claim.
- 3 = Interim — continuing claim.
- 4 = Interim — final claim.

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

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

Enter both dates in MM/DD/YY format (e.g., January 2, 2007, would be 010207).

Form Locator 7 — Cov D.

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

Form Locator 8 — N-C D. (not required)

Form Locator 9 — C-I D. (not required)

Form Locator 10 — L-R D. (not required)

Form Locator 11 — Unlabeled Field (not required)

Form Locator 12 — Patient Name

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

Form Locator 13 — Patient Address (not required)

Form Locator 14 — Birthdate (not required)

Form Locator 15 — Sex (not required)

Form Locator 16 — MS (not required)

Form Locator 17 — Admission Date (not required)

Form Locator 18 — Admission Hr (not required)

Form Locator 19 — Admission Type (not required)

Form Locator 20 — Admission Src (not required)

Form Locator 21 — D Hr (not required)

Form Locator 22 — Stat (not required)

Form Locator 23 — Medical Record No.

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

Form Locators 24-30 — Condition Codes (required, if applicable)

If appropriate, enter a code to identify conditions relating to this claim.

Form Locator 31 — Unlabeled Field (not required)**Form Locators 32-35 a-b — Occurrence Code and Date (required, if applicable)**

If appropriate, enter the code and associated date defining a significant event relating to this claim that may affect payer processing. Enter dates in MM/DD/YY format (e.g., January 1, 2007, would be 010107).

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

Wisconsin Medicaid uses the following value codes:

Code	Description
81	<i>Medicare Part B Charges When Part A Exhausted.</i> Enter the full amount of Medicare Part B charges when billing for services after Medicare Part A has been exhausted.
83	<i>Medicare Part A Charges When Part A Exhausted.</i> Enter the sum of the Medicare paid amount, the coinsurance amount, and the deductible when billing for services after Medicare Part A has been exhausted.

Form Locator 42 — Rev. Cd.

Enter the national four-digit revenue code that identifies a specific accommodation, ancillary service, or billing calculation. Enter revenue code “0001” on the line with the sum of all the charges. Refer to Attachments 8 and 9 of this *Wisconsin Medicaid and BadgerCare Update* for information about revenue codes.

Form Locator 43 — Description (not required)**Form Locator 44 — HCPCS/Rates (required, if applicable)****Form Locator 45 — Serv. Date**

Enter the date of service (DOS) in MM/DD/YY format in Form Locator 45 or Form Locator 43. Multiple DOS must be indicated in Form Locator 43.

Form Locator 46 — Serv. Units

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

Form Locator 47 — Total Charges

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

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

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

Form Locator 51 A-C — Provider No.

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

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

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

Form Locator 55 A-C & P — Est Amount Due (required, if applicable)

Enter the dollar amount of any patient liability.

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

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

Form Locator 61 A-C — Group Name (not required)**Form Locator 62 A-C — Insurance Group No. (not required)****Form Locator 63 A-C — Treatment Authorization Codes (not required)****Form Locator 64 A-C — ESC (not required)**

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

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

Form Locator 67 — Prin. Diag Cd.

Enter the complete *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) code (up to five digits) describing the principal diagnosis (e.g., the condition established after study to be chiefly responsible for causing the admission or other health care episode). Any condition that is not manifested upon admission or that develops subsequently should not be selected as the principal diagnosis. Refer to Attachment 8 for allowable diagnosis codes.

Form Locators 68-75 — Other Diag. Codes

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

Form Locator 76 — Adm. Diag. Cd. (not required)

Form Locator 77 — E-Code (not required)

Form Locator 78 — Race/Ethnicity (not required)

Form Locator 79 — P.C. (not required)

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

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

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

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

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

Form Locator 82 a-b — Attending Phys. ID

Enter the Universal Provider Identification Number or license number and name of the attending physician.

Form Locator 83 a-b — Other Phys. ID (not required)

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

Commercial health insurance billing information

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

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

When the recipient has Wausau Health Protection Plan (“HPP”), BlueCross & BlueShield (“BLU”), Wisconsin Physicians Service (“WPS”), Medicare Supplement (“SUP”), TriCare (“CHA”), Vision only (“VIS”), a health maintenance organization (“HMO”), or some other (“OTH”) commercial insurance, *and* the service requires commercial health insurance billing according to the Coordination of Benefits section of the All-Provider Handbook, then one of the following three OI explanation codes *must* be indicated in Form Locator 84. The description is not required, nor is the policyholder, plan name, group number, etc.

Code	Description
OI-P	PAID in part or in full by commercial health insurance or commercial HMO. In Form Locator 54 of this claim form, indicate the amount paid by commercial health insurance to the provider or to the insured.
OI-D	DENIED by commercial health insurance or commercial HMO following submission of a correct and complete claim, or payment was applied towards the coinsurance and deductible. Do not use this code unless the claim was actually billed to the commercial health insurer.
OI-Y	YES, the recipient has commercial health insurance or commercial HMO coverage, but it was not billed for reasons including, but not limited to: <ul style="list-style-type: none">✓ 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 submit claims to Wisconsin Medicaid for services that are included in the capitation payment.

Medicare Information

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

Do not indicate a Medicare disclaimer code when one or more of the following statements is true:

- Medicare never covers the procedure in any circumstance.
- Wisconsin Medicaid indicates the recipient does *not* have any Medicare coverage 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 the provider is not Medicare certified.
- Medicare has allowed the charges. In this case, attach the Explanation of Medicare Benefits or Medicare Remittance Advice, but do not indicate on the claim form the amount Medicare paid.

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

Form Locator 85 — Provider Representative

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

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

Form Locator 86 — Date

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

ATTACHMENT 15

Sample UB-92 Claim Form for Outpatient Substance Abuse Services

APPROVED OMB NO. 0938-0279

IM BILLING HOSPITAL 321 HOSPITAL RD ANYTOWN, WI 55555 (555) 321-1234				2				3 PATIENT CONTROL NO.				4 TYPE OF BILL 131							
5 FED. TAX NO.				6 STATEMENT COVERS PERIOD FROM 020407 THROUGH 020907				7 COV D 1		8 N-C-D		9 C-I-D		10 L-R-D		11			
12 PATIENT NAME RECIPIENT, IMA H.						13 PATIENT ADDRESS													
14 BIRTHDATE		15 SEX		16 MS		17 DATE		ADMISSION 18 HR 3 19 TYPE 1 20 SRC 1		21 D HRI		22 STAT		23 MEDICAL RECORD NO.		24		CONDITION CODES 25 26 27 28 29 30 31	
32 OCCURRENCE DATE		33		34 OCCURRENCE DATE		35		36 OCCURRENCE SPAN FROM THROUGH		37 A B C									
38																			
39 CODE		VALUE CODES AMOUNT		40		41 CODE		VALUE CODES AMOUNT											
42 REV. CD.		43 DESCRIPTION		44 HCPCS / RATES		45 SERV. DATE		46 SERV. UNITS		47 TOTAL CHARGES		48 NON-COVERED CHARGES		49					
1 0945						020507		1.0		XXX XX									
2																			
3																			
4																			
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14																			
15																			
16 0001		Total Charges																	
17																			
18																			
19																			
20																			
21																			
22																			
23																			
50 PAYER		51 PROVIDER NO.		52 REL INFO		53 ASG BEN		54 PRIOR PAYMENTS		55 EST AMOUNT DUE		56							
A 45009 BLUE CROSS		BC111						XXXX XX											
B T19 MEDICAID		87654321																	
C PATIENT LIABILITY AMOUNT										XX XX									
57																			
58 INSURED'S NAME		59 P.REL		60 CERT. - SSN - HIC - ID NO.		61 GROUP NAME		62 INSURANCE GROUP NO.											
A				1234567890															
B																			
C																			
63 TREATMENT AUTHORIZATION CODES		64 ESC		65 EMPLOYER NAME		66 EMPLOYER LOCATION													
A																			
B																			
C																			
67 PRIN DIAG CD		68 CODE		69 CODE		OTHER DIAG. CODES 70 CODE 71 CODE 72 CODE		73 CODE		74 CODE		75 ADM. DIAG. CD		76 E-CODE		77		78	
303.90																			
79 P.C		80 PRINCIPAL PROCEDURE CODE DATE		81 OTHER PROCEDURE CODE DATE						82 ATTENDING PHYS. ID									
										83 OTHER PHYS. ID		N24680 I.M. Referring, M.D.							
										OTHER PHYS. ID									
84 REMARKS																			
a OI-P																			
b																			
c																			
d																			
										85 PROVIDER REPRESENTATIVE X Ima H. Provider		86 DATE 030107							

UB-92 HCFA-1450

OCR/Original

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