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and BadgerCare

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Wisconsin Medicaid and BadgerCare Information for Providers

To:

Outpatient Mental Health Clinics

Psychotherapists

HMOs and Other Managed Care Programs

HealthCheck "Other Services" In-Home Mental Health and Substance Abuse Treatment Services for Children

This *Wisconsin Medicaid and BadgerCare Update* consolidates all of the information for in-home mental health and substance abuse treatment services for children. 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.

Introduction

The purpose of this *Wisconsin Medicaid and BadgerCare Update* is to consolidate all of the information for in-home mental health and substance abuse treatment services for children. These services were formerly identified as intensive in-home treatment services. This *Update* replaces the following in-home mental health and substance abuse treatment for children publications:

- The February 2004 *Update* (2004-10), titled "Revisions to Prior Authorization Request Form (PA/RF) instructions for intensive in-home treatment providers."
- The July 2003 *Update* (2003-74), titled "Changes to local codes, paper claims, and prior authorization for intensive in-home treatment, a HealthCheck 'Other Service,' as a result of HIPAA."
- The February 1995 *Update* (95-6), titled "In-Home Treatment Under HealthCheck 'Other Services' Prior Authorization: Changes to Requirements, PA/ITA Attachment, and Instructions."
- The October 1992 Medical Assistance Provider Bulletin (MAPB-092-001-Z), titled "WMAP Reimbursement for Intensive In-Home Treatment and Mental Health Day Treatment for Severely Emotionally Disturbed Children and Adolescents."

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.

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HealthCheck "Other Services"

Wisconsin Medicaid may cover services that are not described in the Medicaid state plan under HealthCheck "Other Services." Services that are included in the Medicaid state plan are not covered as HealthCheck "Other Services." Refer to the General Information section of the Mental Health and Substance Abuse Services Handbook for further information on HealthCheck "Other Services."

In-home mental health and substance abuse treatment services for children are a HealthCheck "Other Service." HealthCheck "Other Services" are available to persons under age 21 and must be prior authorized. In-home mental health and substance abuse treatment services for children may be reimbursed by Wisconsin Medicaid when they are determined to be medically necessary to treat mental health and/or substance abuse needs identified during a HealthCheck screen. They are described in more detail in this *Update*.

Certification

To be reimbursed for providing in-home mental health and 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 mental health and substance abuse treatment under HFS 61.91-61.98 or 75.13, Wis. Admin. Code. For information regarding this certification providers can call the DHFS, OQA at (608) 243-2025 or write to 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

Medicaid-certified outpatient mental health clinics or outpatient substance abuse clinics wishing to provide in-home mental health and substance abuse services do not require any additional certification.

Hospitals providing outpatient mental health services that are being billed under their hospital number must become separately certified by Wisconsin Medicaid as outpatient psychotherapy clinics to provide in-home mental health and substance abuse treatment services for children and must follow the certification requirements for outpatient psychotherapy clinics.

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 of this *Update* for Medicaid certification requirements and provider numbers assigned for agencies providing in-home mental health and substance abuse treatment services for children.

In-home mental health and substance abuse treatment services for children must be provided by an outpatient mental health clinic certified under HFS 61.91-61.98, Wis. Admin. Code, or an outpatient substance abuse clinic certified under HFS 75.13, Wis. Admin. Code, and be certified by Wisconsin Medicaid under HFS 105.22 or 105.23, Wis. Admin. Code.

Individuals should complete the Wisconsin Medicaid Mental Health/Substance Abuse Individual Packet. Refer to Attachment 2 for Medicaid certification requirements and provider numbers assigned for individuals

Medicaid-certified outpatient mental health clinics or outpatient substance abuse clinics wishing to provide in-home mental health and substance abuse services do not require any additional certification.

All in-home mental health and substance abuse treatment services for children must have at least one Medicaid-certified provider.

providing in-home mental health and substance abuse treatment services for children.

All in-home mental health and substance abuse treatment services for children must have at least one Medicaid-certified provider. The certified psychotherapy provider or substance abuse counselor is required to obtain his or her own performing provider number so that the clinic can be reimbursed as the billing provider for in-home mental health and substance abuse treatment services for children.

When there is a team, the second team member must meet one of the following qualifications:

- Possess at least a Bachelor's degree in a behavioral science or be a registered nurse, an occupational therapist, a Medicaid-certified psychotherapist, a substance abuse counselor, or a professional with equivalent training. In addition, the second team member must have at least 1,000 hours of supervised clinical experience* working in a program whose primary clientele are emotionally disturbed youth.
- Have at least 2,000 hours of supervised clinical experience working in a program whose primary clientele are emotionally disturbed youth.

The second team member does not need separate Medicaid certification but must work under the supervision of the certified psychotherapy provider. The certified psychotherapy provider's performing provider number is used to submit claims for services performed by the second team member.

The second team member may also be a Medicaid-certified psychotherapy provider. However, for billing purposes, this person is identified as the second team member and is reimbursed at a lower rate.

Providers may initiate Medicaid certification for in-home mental health and substance abuse service treatment by doing one of the following:

- Downloading mental health/substance abuse agency 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

In-home mental health and substance abuse treatment services for children are covered when medically necessary and designed to address an individual child's treatment needs. The services can be a combination of individual and family treatment modalities. Treatment needs are determined by an in-depth assessment of the child/adolescent, and an individualized treatment plan with measurable goals and objectives are developed for the in-home services. The child and family are integral to assessment and development of the treatment plan, contributing to the plan's goals and desires. Methods of intervention must meet professional standards of practice.

If a more in-depth assessment of the family's willingness and ability to be involved in treatment is an initial treatment goal, these

services can be covered as in-home mental health/substance abuse treatment services. The provider needs to clearly document the need for further assessment.

Since most children receiving in-home mental health and substance abuse treatment services often receive services from more than one agency, interagency collaboration and coordination of the services is required and documentation of service coordination should be included in the multi-agency plan. This can either be combined with the in-home treatment plan or left as two separate documents. The multi-agency plan describes the other agencies' involvement with the child and family and how the services of the other agencies are coordinated with the in-home team. The other agencies included in the multi-agency plan are those with which the child and family are involved, as described in the determination of severe emotional disturbance included in the Prior Authorization/In-Home Treatment Attachment (PA/ITA), HCF 11036 (01/07).

If the child/adolescent is on psychotropic medication(s), the multi-agency treatment plan must include the prescribing physician's name, the medication(s) and dosages being prescribed, target symptoms, and the frequency of medication monitoring by the physician.

Treatment Approaches

Wisconsin Medicaid may cover various treatment approaches. Two approaches, team and individual, are described as follows, although they are not intended to be the only treatment approaches covered by Wisconsin Medicaid.

Team Approach — The team approach is used when two staff members are involved in the treatment. The team is led by a certified psychotherapist or substance abuse counselor who assesses the needs of the child and family and directs the care provided by the second team member. The second team member usually provides more hours of direct care than the certified psychotherapist or substance abuse counselor, who also provides in-home services, assesses the effectiveness of the treatment plan, and makes changes to the plan as needed. Wisconsin Medicaid typically reimburses up to eight hours per week of direct treatment services to the child and/or family.

The team approach may also be used to provide more intensive services for shorter periods of time. For example, an in-home team may be needed immediately following an episode of domestic violence and may be working in the home with the child and family intensively (e.g., 40 hours per week for two weeks). Providers who request PA for services in excess of the typical eight hours of direct time per week should explain the additional hours of the in-home team. Only direct, medically necessary services will be authorized and reimbursed.

Individual Approach — The individual approach is used when there is one staff member providing the in-home services.

The individual staff member must be a Medicaid-certified psychotherapist or substance abuse counselor. A person qualified only as a second team member cannot provide in-home mental health and substance abuse treatment services for children without the direction of a certified psychotherapist or substance abuse counselor. The individual approach may be most appropriate when the child and family therapy/counseling needs are of a less severe nature or for a specific need that does not require the services of a team (e.g., when the child is in need of specialized services, such as services to help victims of incest, when the

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service is being provided because the child is physically and emotionally unable to receive services outside the home, or when it is therapeutically necessary). Individual services would typically be approved at a lower intensity than those of a team.

The individual approach could also be used when the only provider is a Medicaid-certified psychotherapist or substance abuse counselor, when the only diagnosis is one of substance abuse, dependence, or addiction.

All methods of intervention must meet professional standards of practice.

All methods of intervention must meet professional standards of practice.

Requirements

In-home mental health and substance abuse treatment services for children are covered when criteria for medical necessity of the services are met, and when the following requirements are present:

- A physician's prescription/order signed and dated not more than one year prior to the requested first date of service (DOS).
- Verification that a HealthCheck screen has been performed by a valid HealthCheck screener dated not more than one year prior to the requested first DOS.
- A written diagnostic assessment is performed or approved by a psychiatrist or clinical psychologist, which is strength-based and includes the child's strengths and symptoms, including a five-axis diagnosis of mental illness and/or substance abuse.
- The individual meets at least one of the following criteria under s. 49.45(25)(a), Wis. Stats., for a determination of "severely emotionally disturbed" (SED):
  - ✓ Under age 21; emotional and behavioral problems are severe in degree; are expected to persist for at least one year; substantially interfere with the individual's functioning in his or her family, school, or community and with his or her ability to cope with the ordinary demands of life; and cause the individual to need services from two or more agencies or organizations that provide social services or services or treatment for mental health, juvenile justice, child welfare, special education or health.
  - ✓ Substantially meets the criteria for SED except the severity of the emotional and behavioral problems have not yet substantially interfered with the individual's functioning but would likely do so without in-home mental health and substance abuse treatment services.
  - ✓ Substantially meets the criteria for SED except the individual has not yet received services from more than one system and in the judgment of the medical consultant, would be likely to do so if the intensity of treatment requested was not provided.
- A coordinated, written treatment plan that describes both the in-home treatment activities and any multi-agency involvement, or separate multi-agency and in-home treatment plans. The treatment plans must describe measurable goals for the interventions listed and coordination with the other agencies involved and must be signed by the primary caregiver and the in-home services certified therapist. Either the in-home or multi-agency treatment plan need to be signed by a psychiatrist or psychologist, not both. If the in-home or multi-agency treatment plans are combined, a signature by a psychiatrist or psychologist is required.
- Completed Achenbach Child Behavior Checklist or the Child and Adolescent Functional Assessment Scale.

Services Provided Must Be Directly Related to the Child/Adolescent's Mental Illness or Substance Abuse

Services provided must be directly related to the identified child/adolescent's mental illness or substance abuse. Services delivered to other family members, either as a group or individually, must relate directly to the child/adolescent's mental illness or substance abuse. Services for the parent or guardian, for example, that relate to parenting skills, are appropriate when the documentation suggests that the child's behavioral problems may be a direct result of inadequate or inappropriate parenting skills. If the mental health and/or substance abuse needs of the parent or guardian are such that treatment for the child and family is or could be deemed ineffective, the in-home treatment services may be discontinued until or unless the family member obtains treatment.

In-home mental health and substance abuse treatment is usually provided when less intensive or other treatment has failed. Previous mental health/substance abuse treatment and outcomes need to be described. If no other treatment has been provided, the provider needs to explain why he or she believes in-home treatment services are preferable to outpatient services.

When little or no progress is achieved, as documented on treatment plan updates, the treatment team needs to explain why further treatment is needed and how the treatment plan will address the apparent lack of progress. If progress is reported, the treatment plan needs to give rationale for continued treatment.

Most in-home mental health and substance abuse treatment services for children will be provided in the home and its surroundings, as the home is the usual natural environment for the child. However, if circumstances require services to be provided elsewhere, the provider is required to document this clearly in the narrative of the PA request, and the treatment plan must include details of the treatment in an alternate setting. Examples may include, but are not limited to, the following:

- If the child is in an out-of-family home placement and reunification is planned within the next six months, the services are being requested in the family home including transportation of the child to and from the family home.
- If the home setting is unsafe for the provision of services and the child and family are willing to participate in a different setting, this should be explained in the narrative of the PA request and an alternate setting should be identified.
- If the child's parent/caregiver is confined to a corrections facility or hospital but will soon be rejoining the family, this should be explained in the narrative of the PA request, and the services can be provided in the absent parent/caregiver's living quarters.

Most in-home mental health and substance abuse treatment services for children will be provided in the home and its surroundings, as the home is the usual natural environment for the child.

Non-home settings cannot include any places of service allowed under the outpatient psychotherapy services benefit (i.e., office of the provider, hospital outpatient clinic, outpatient facility, nursing home, school, or hospital).

When substance abuse treatment issues, in addition to a mental illness, are identified in the in-depth differential diagnostic assessment and are addressed in the in-home treatment plan, a Medicaid-certified substance abuse counselor must be identified as part of the treatment team.

When an in-depth differential diagnostic assessment reveals the presence of a substance abuse diagnosis only (mental illness

has been ruled out), and is the focus of in-home treatment, a Medicaid-certified substance abuse counselor may be approved as the only in-home provider.

When a recipient is receiving other services concurrent with the in-home treatment (e.g., mental health or substance abuse day treatment), the multi-agency treatment plan must indicate that these services are not duplicative of in-home services and how and by whom they are coordinated.

Limitations

In-home mental health and substance abuse treatment services for children are typically approved for up to one year.

Wisconsin Medicaid typically approves up to eight hours per week of direct in-home treatment services to the child and/or family (some of these treatment hours may involve more than one therapist). Fewer hours may be approved, based on the clinical situation.

Reimbursement for in-home treatment services primarily directed at recipients over the age of 20 are not available through HealthCheck "Other Services."

In-home mental health and substance abuse treatment services for children are typically approved for up to one year. In rare instances, services beyond one year may be approved if they are determined to be medically necessary, meet all requirements, and the documentation shows why transition to outpatient services, if needed, would not meet the needs of the child and/or family. Each situation is reviewed independently.

Travel Time

Travel time is separately reimbursed. Travel time should consist of the time to travel from the provider's office to the recipient's home or from the previous appointment to the recipient's home, whichever is less. Travel time exceeding one hour one way will generally not be authorized. Providers need to explain the need for travel time in excess of two hours round trip or one hour one-way on the PA form.

Services Provided via Telehealth

Providers certified under HFS 61.91-61.98 or 75.13, Wis. Admin. Code, may provide most outpatient mental health and 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 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 services are not considered medically necessary and are not covered by Wisconsin Medicaid:

- Social or recreational services that are not related to the therapeutic process. This should not be construed as implying that appropriate clinical interventions that employ social or recreational activities to augment the therapeutic process are not reimbursed. For example, a group may use a recreational activity to provide a focus for a discussion of styles of relating or communication skills.
- Services directed at the parent or guardian's primary mental health or substance abuse problems. These

treatment services may be reimbursed under other Wisconsin Medicaid mental health and substance abuse benefits and are subject to the policy associated with these other benefits.

Documentation Requirements

Refer to Attachment 3 for documentation requirements for all mental health and substance abuse service providers, including in-home mental health and 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.

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

Prior Authorization

All in-home mental health and substance abuse treatment services for children require PA before initiation of services. To request PA for in-home mental health and substance abuse treatment services for children, providers will need to submit the following completed forms and required documentation to Wisconsin Medicaid:

- *Prior Authorization Request Form* (PA/RF), HCF 11018, (Rev. 10/03). The completion instructions and a sample PA/RF for in-home mental health and substance abuse treatment services for children are located in Attachments 4 and 5.
- *Prior Authorization/In-Home Treatment Attachment*. The completion instructions and PA/ITA are located in Attachments 6 and 7 for photocopying and may also be downloaded and printed from the Medicaid Web site.
- Physician's prescription/order signed and dated not more than one year prior to the requested first DOS.
- Verification that a HealthCheck screen has been performed by a valid HealthCheck screener dated not more than one year prior to the requested DOS.
- Treatment plans. Both a multi-agency treatment plan and an in-home treatment plan are required. These plans may be combined, making sure the in-home treatment section covers all elements included in the Model Plan: In-Home Mental Health/Substance Abuse Treatment Services form, HCF 11105 (01/07).

  Providers may use their own treatment plan forms as long as all elements are included, or they may use the model treatment plan forms, HCF 11105 and the Model Multi-Agency Treatment Plan, HCF 11106 (01/07), which are included as Attachments 8 and 9.
- Achenbach Child Behavior Checklist or the Child and Adolescent Functional Assessment Scale.

Services are authorized based on the clinical documentation supplied by the provider. Services cannot be authorized earlier than the date of the prescription or HealthCheck screen.

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

The Prior Authorization section of the All-Provider Handbook includes information on procedures for obtaining PA, including submitting PA requests via mail, fax, or the Web.

All in-home mental health and substance abuse treatment services for children require PA before initiation of services.

Claims Submission

Coordination of Benefits

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

All diagnoses must be from the *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) coding structure and must be allowed for the DOS.

Diagnosis Codes

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

Refer to Attachment 10 for a list of allowable diagnosis code ranges for in-home mental health and substance abuse treatment services for children.

Procedure Codes

Healthcare Common Procedure Coding System (HCPCS) or *Current Procedural Terminology* (CPT) codes are required on all in-home mental health and substance abuse treatment claims. Claims or adjustments received without a HCPCS or CPT code are denied. Refer to Attachment 10 for allowable procedure codes and modifiers.

For procedure codes that do not indicate a time increment, providers are required to choose the time increment from the rounding guidelines in Attachment 11.

Place of Service Codes

Allowable place of service (POS) codes for in-home mental health and substance abuse treatment services for children are included in Attachment 10.

Electronic Claims Submission

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

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

Paper Claims Submission

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

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

Refer to Attachment 12 for claim form instructions for in-home mental health and substance abuse treatment services for children. Attachments 13 and 14 are samples of claims for in-home mental health and substance abuse treatment services for children.

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.

*Supervised clinical experience includes, but is not limited to, employment in residential treatment facilities, treatment foster homes, inpatient psychiatric units, and certified day treatment programs that are required to have clinical staff supervise the care of the clients. Schools, jails, and juvenile correction facilities are not considered clinical settings. The second team member must be able to substantiate his or her experience and identify the supervisor.

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/*.

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ATTACHMENT 1
Certification Requirements for In-Home Mental Health and Substance Abuse Treatment Services for Children Provided by Agencies

This attachment outlines Wisconsin Medicaid certification requirements for Medicaid in-home mental health and substance abuse treatment service providers. Prior to obtaining Wisconsin Medicaid certification, in-home mental health and substance abuse treatment 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 numbers and definitions for agencies providing in-home mental health and substance abuse treatment 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. Only a county/tribal social or human services agency can be a billing agency. This agency does not perform the service but contracts with a provider to perform the service on the billing agency's behalf. The contracted provider is required to be Medicaid certified.

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**	**Specific Certification Section of the Medicaid Mental Health/Substance Abuse Agency Packet to Be Completed**	**County/ Tribal Social or Human Services Agency Required?**	
Agency Providing the Service	The agency is required to obtain a Wisconsin DHFS certificate to provide outpatient mental health and substance abuse services as authorized under HFS 61.91-61.98, Wis. Admin. Code, or in situations where substance abuse counseling is the only service provided, as authorized under HFS 75.13, Wis. Admin. Code.	The agency is required to do the following: • 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 Mental Health Services	No	Outpatient mental health clinic billing/performing provider number or outpatient substance abuse clinic billing/performing provider number
Agency Only Allowed to Bill for the Service	None.	The agency is required to complete and submit a Mental Health/Substance Abuse Agency Certification Packet to be a billing-only provider for an outpatient mental health clinic or to be a billing-only provider for an outpatient substance abuse clinic in situations where substance abuse counseling is the only service provided. An allowable Medicaid performing provider is required to perform the service.	Outpatient Mental Health Services	Yes	Outpatient mental health clinic billing provider number or outpatient substance abuse clinic billing provider number

ATTACHMENT 2
Certification Requirements for In-Home Mental Health and Substance Abuse Treatment Services for Children Provided by Individuals

This attachment outlines Wisconsin Medicaid certification requirements for individuals. The first table identifies which individuals may perform in-home mental health and substance abuse treatment services. The second table includes definitions for provider numbers and the third table lists individual providers, prerequisites, and Medicaid certification requirements.

This attachment includes Ph.D. psychologists who perform in private practice. These providers may submit claims as well as perform these services. Ph.D. psychologists may also work within certified programs.

Allowable Individual Providers for In-Home Mental Health/Substance Abuse Treatment Services
Substance Abuse Counselor Without Master's Degree (In situations where substance abuse counseling is the only service provided.)
Substance Abuse Counselor with Master's Degree (In situations where substance abuse counseling is the only service provided.)
Master's Level Psychotherapist (Second team member is approved through the prior authorization process.)
Psychiatrist
Ph.D. Psychologist

Definitions for Provider Numbers	
Type of Provider Number	**Definition**
Nonbilling Performing Provider Number	Issued to those providers who practice under the professional supervision of another provider or in collaboration with other providers. 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.

Individual Providers and Prerequisites			
Type of Provider	**Prerequisite**	**Medicaid Certification Requirements**	**Type of Provider Number Assigned**
Substance Abuse Counselor Without Master's Degree	The provider is required to do the following: • Work in a certified clinic and meet the requirements listed under HFS 75.13, Wis. Admin. Code. • Have a certificate stating qualifications as a *certified* (not only registered) substance abuse counselor issued by the Wisconsin Certification Board on Alcohol and Other Drug Abuse counselors.	The provider is required to complete and submit a Mental Health/Substance Abuse Individual Packet.	Nonbilling performing provider number
Substance Abuse Counselor with Master's Degree	The provider is required to do the following: • Work in a certified clinic and meet the requirements listed under HFS 75.13, Wis. Admin. Code. • Have a certificate stating qualifications as a *certified* (not only registered) substance abuse counselor issued by the Wisconsin Certification Board on Alcohol and Other Drug Abuse counselors and have a clinical social worker's license, a marriage and family therapist's license, or a professional counselor's license from the Department of Regulation and Licensing (DR&L) **or** a Provider Status Approval Letter issued by the Office of the Secretary of the Department of Health and Family Services (DHFS), Office of Quality Assurance (OQA).	The provider is required to complete and submit a Mental Health/Substance Abuse Individual Packet.	Nonbilling performing provider number
Master's Level Psychotherapist	The provider is required to do the following: • Work in a certified mental health clinic as required under HFS 61.91-61.98, Wis. Admin. Code. • Have a clinical social worker's license, a marriage and family therapist's license, or a professional counselor's license from the DR&L **or** a Provider Status Approval Letter issued by the DHFS, OQA.	The provider is required to complete and submit a Mental Health/Substance Abuse Individual Packet.	Nonbilling performing provider number
Psychiatrist	The provider is required to do the following: • Have a license to practice as a physician, according to ch. 448.05 and 448.07, Wis. Stats. • Have proof that he or she completed psychiatric residency.	The provider is required to complete and submit a Physician/Osteopath/ Physician Assistant Certification Packet.	Billing/performing provider number
Ph.D. Psychologist	The provider is required to have a license to practice as a psychologist, according to ch. 455, Wis. Stats. This must be at the independent practice level. If the effective date of the license is prior to October 1, 1991, the provider is required to have one of the following: • 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 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 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, 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 In-Home Mental Health and Substance Abuse Treatment Services for Children

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

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

Under s. 49.45(4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to Medicaid administration such as determining eligibility of the applicant or processing provider claims for reimbursement. The Prior Authorization Request Form (PA/RF), 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/In-Home Treatment Attachment (PA/ITA), HCF 11036, to Wisconsin Medicaid by fax at (608) 221-8616 or by 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.*

Element 2 — Telephone Number — Billing Provider

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

Element 3 — Processing Type

Enter processing type "126" — Psychotherapy.

Element 4 — Billing Provider's Medicaid Provider Number

Enter the eight-digit Medicaid provider number of the billing provider. The provider number in this element must correspond with the provider name listed in Element 1.

SECTION II — RECIPIENT INFORMATION

Element 5 — Recipient Medicaid ID Number
Enter the recipient's 10-digit Medicaid identification number. Do not enter any other numbers or letters. Use the recipient's Medicaid identification card or the 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 relevant to the service requested, if applicable.

Element 14 — Requested Start Date
Enter the requested start date for service(s) in MM/DD/YY format, if a specific start date is requested. If backdating is requested, include the clinical rationale for starting before PA was received. Backdating is not allowed on subsequent PA requests.

Element 15 — Performing Provider Number
Enter the eight-digit Medicaid provider number of the certified psychotherapist/substance abuse counselor.

Element 16 — Procedure Code
Enter the appropriate procedure code for each service requested.

Element 17 — Modifiers
Enter the modifiers that correspond to the procedure code listed.

Element 18 — POS
Enter the appropriate place of service code designating where the requested service would be provided.

Element 19 — Description of Service
Enter a written description corresponding to the appropriate procedure code for services.

Element 20 — QR
Enter the appropriate quantity (e.g., number of units) requested for the procedure code listed.

Element 21 — Charge
Enter the usual and customary charge for each service requested. If the quantity is greater than "1," multiply the quantity by the charge for each service requested. Enter that total amount in this element.

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

Element 22 — Total Charge
Enter the anticipated total charge for this request.

Element 23 — Signature — Requesting Provider
The original signature of the provider requesting 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 In-Home Mental Health and Substance Abuse Treatment Services for Children

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

SECTION I — PROVIDER INFORMATION

1. Name and Address — Billing Provider (Street, City, State, Zip Code)	2. Telephone Number — Billing Provider	3. Processing Type
I.M. Provider **1 W. Williams** **Anytown WI 55555**	**(XXX) XXX-XXXX**	**126**
	4. Billing Provider's Medicaid Provider Number **87654321**	

SECTION II — RECIPIENT INFORMATION

5. Recipient Medicaid ID Number	6. Date of Birth — Recipient (MM/DD/YY)	7. Address — Recipient (Street, City, State, Zip Code)
1234567890	**MM/DD/YY**	**1234 Street St.** **Anytown WI 55555**
8. Name — Recipient (Last, First, Middle Initial) **Recipient, Im A.**	9. Sex — Recipient ☒ M ❑ F	

SECTION III — DIAGNOSIS / TREATMENT INFORMATION

10. Diagnosis — Primary Code and Description	11. Start Date — SOI	12. First Date of Treatment — SOI
313.81 - oppositional defiant disorder		
13. Diagnosis — Secondary Code and Description **N/A**	14. Requested Start Date **MM/DD/YY**	

15. Performing Provider Number	16. Procedure Code	17. Modifiers 1	2	3	4	18. POS	19. Description of Service	20. QR	21. Charge
98765432	**H0004**	**HA**	**HO**			**12**	**Behavioral health counseling and therapy, per 15 minutes**	**104**	**XXX.XX**
98765432	**H0004**	**HA**	**HO**			**12**	**Behavioral health counseling and therapy, per 15 minutes**	**212**	**XXX.XX**
98765432	**99082**	**HA**	**HO**			**99**	**Travel**	**13**	**XXX.XX**
98765432	**99082**	**HA**	**HO**			**99**	**Travel**	**26**	**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.

22. **Total Charges** **XXX.XX**

23. **SIGNATURE** — Requesting Provider I.M. Provider

24. Date Signed **MM/DD/YY**

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/In-Home Treatment Attachment (PA/ITA) Completion Instructions

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

DEPARTMENT OF HEALTH AND FAMILY SERVICES **STATE OF WISCONSIN**
Division of Health Care Financing
HCF 11036A (01/07)

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

The use of this form is voluntary; providers may develop their own form as long as it includes all of the information on this form and is formatted exactly like this form. If necessary, attach additional pages if more space is needed. Providers should refer to service-specific provider *Wisconsin Medicaid and BadgerCare Updates* 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/In-Home Treatment Attachment (PA/ITA), HCF 11036, to the Prior Authorization Request Form (PA/RF), HCF 11018, a physician prescription, and HealthCheck screen documentation dated within 365 days prior to the grant date being requested and send it to Wisconsin Medicaid. Providers may submit PA requests to Wisconsin Medicaid by fax at (608) 221-8616 or by mail to the following address:

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

GENERAL INSTRUCTIONS

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

Initial Prior Authorization Request

Complete the PA/RF and the entire PA/ITA. The initial authorization will be for a period of no longer than 13 weeks. Attach a copy of the HealthCheck verification and physician order dated not more than one year prior to the requested first date of service (DOS).

First Reauthorization

Complete the PA/RF and Sections I-III of the PA/ITA. Attach a copy of the HealthCheck verification and physician order dated not more than one year prior to the requested first DOS. (As long as the HealthCheck verification and physician order submitted in the initial request are timely, they may be used for subsequent requests.) Attach a brief summary of the treatment to date, including progress on treatment goals, and affirm that the family is appropriately involved in the treatment process. The treatment summary information should correspond specifically to the short-term and long-term goals of the previous treatment plan and reference the same measures of improvement. If changes were made to the treatment plan, send a copy of the amended or updated plan. Authorization may be granted for up to 13 weeks.

Subsequent Reauthorizations

Complete the PA/RF and Sections I-III of the PA/ITA. Attach a copy of the HealthCheck verification and physician order dated not more than one year prior to the requested first DOS. (As long as the HealthCheck verification and the physician order submitted in the initial request are timely, they may be used for subsequent requests.) Attach a brief summary of the treatment to date, including progress on treatment goals, and affirm that the family is appropriately involved in the treatment process. The treatment summary information should correspond specifically to the short-term and long-term goals of the previous treatment plan and reference the same measures of improvement. If changes were made to the treatment plan, send a copy of the amended or updated plan. Summarize the treatment since the previous authorization. The need for continued in-home treatment must be clearly documented. Where no change is noted in the treatment summary, justify the continued use of the in-home treatment or note how changes in the treatment plan address the lack of progress. Specifically address aftercare planning. Discuss plans for terminating in-home treatment and the services that the recipient/family will require. Authorization will be for a period of no longer than 13 weeks.

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

SECTION I — RECIPIENT INFORMATION

Element 1 — Name — Recipient
Enter the recipient's last name, followed by his or her first name and middle initial, exactly as it appears on the recipient's Medicaid identification card.

Element 2 — Age — Recipient
Enter the age of the recipient in numerical form (e.g., 16, 21).

Element 3 — Recipient Medicaid Identification Number
Enter the recipient's 10-digit Medicaid identification number exactly as it appears on the recipient's Medicaid identification card.

SECTION II — PROVIDER INFORMATION

Element 4 — Name — Medicaid-Certified Clinic
Enter the name of the Medicaid-certified psychotherapy/substance abuse clinic that will be billing for the services.

Element 5 — Clinic's Medicaid Provider Number
Enter the eight-digit Medicaid provider number of the Medicaid-certified psychotherapy/substance abuse clinic that will be billing for the services.

Element 6 — Name — Performing Psychotherapist/Substance Abuse Counselor
Enter the name of the Medicaid-certified psychotherapist/substance abuse counselor who will be the lead member of the team providing services. Master's-level psychotherapists must obtain a Medicaid performing provider number in order to bill for these services even if this is not ordinarily required for the type of facility by which they are employed.

Element 7 — Performing Psychotherapist's or Substance Abuse Counselor's Medicaid Provider Number
Enter the eight-digit Medicaid provider number of the certified psychotherapist/substance abuse counselor identified in Element 6.

Element 8 — Telephone Number — Psychotherapist/Substance Abuse Counselor
Enter the telephone number, including the area code, of the certified psychotherapist/substance abuse counselor identified in Element 6.

Element 9 — Discipline — Psychotherapist/Substance Abuse Counselor
Enter the discipline of the certified psychotherapist/substance abuse counselor identified in Element 6 (e.g., Ph.D.).

SECTION III

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

Element 11
Enter the total expected number of hours the family will receive direct treatment services over this PA grant period (e.g., the current 13-week period). When two therapists are present at the same time, this is still counted as one hour of treatment received by the family. Also indicate the anticipated pattern of treatment for each team member (e.g., a two-hour session once a week for 13 weeks by the certified psychotherapist, a two-hour session once a week for 13 weeks by the second team member with a certified therapist, plus a one-hour session twice a week for 13 weeks with the second team member independently). More than 104 hours of direct treatment to the family during a 13-week period will not be authorized.

Element 12
Indicate the number of hours that the certified psychotherapist/substance abuse counselor will provide direct treatment services to the family and the number of hours that the second team member will provide direct treatment to the family. If more than two providers will be involved in providing services, document that all individuals meet the criteria in these guidelines. Total hours of treatment must not exceed the limitation noted in Element 11. Reimbursement is not allowed for more than two providers for the same treatment session. Since two providers may be providing services at the same time on occasion, the total hours in this section may exceed the number of hours of treatment the family will receive as noted in Element 11. If the primary psychotherapist is involved in treatment more than 50 percent of the time (e.g., if the primary therapist's direct treatment hours exceed those of the second team member's), special justification should be noted on the request.

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

- An individual who possesses at least a Bachelor's degree in a behavioral science, a registered nurse, an occupational therapist, a Medicaid-certified substance abuse counselor, or a professional with equivalent training. The second team member must have at least 1,000 hours of supervised clinical experience working in a program whose primary clientele are emotionally disturbed youth.
- Other individuals who have had at least 2,000 hours of supervised clinical experience working in a program whose primary clientele are emotionally disturbed youth.

The second team member will be reimbursed at a lower rate, even if that person is a certified Medicaid psychotherapist. The second team member works under the supervision of the certified psychotherapy provider.

If the second team member is a Medicaid-certified psychotherapy/substance abuse provider, indicate his or her qualifications by entering his or her Medicaid performing provider number.

Element 13
Indicate the travel time required to provide the service. Travel time should consist of the time to travel from the provider's office to the recipient's home or from the previous appointment to the recipient's home. Travel time exceeding one hour one-way will generally not be authorized.

SECTION IV

Element 14
Present a summary of the mental health assessment and differential diagnosis. Diagnoses on all five axes of the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders,* or for children to age four, the *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood: 0-3,* are required. The assessment should address the level of reality testing, thought processes, drive control, relational capacity, and defense functioning. The assessment summary should provide documentation supporting the diagnosis. A psychiatrist or psychologist must review and sign the summary and diagnosis indicating his or her agreement with the results. In those cases, where the only, or primary, diagnosis is a substance abuse disorder, requests will be approved only if there is sufficient justification for the services to be provided in the home, rather than in another setting. Providers may attach copies of an existing assessment if it is no longer than two pages.

Element 15
Present a summary of the recipient's illness, treatment, and medication history. In those cases where the recipient has spent significant amounts of time out of the home, or is out of the home at the time of the request, the treatment plan must specifically address the transition, reintegration, and attachment issues. For individuals with significant substance abuse problems, the multi-agency treatment plan must explain how these will be addressed. For individuals 16 years and over who have spent significant amounts of time out of the home, the request must discuss why intensive in-home treatment is preferred over preparing the recipient for independent living. Providers may attach copies of illness/treatment/medication histories that are contained in their records if they do not exceed two pages.

Element 16
Complete the checklist for determination that an individual meets the criteria for severe emotional disturbance (SED).

a. List the primary diagnosis and diagnosis code in the space provided. Not all Medicaid-covered in-home mental health and substance abuse treatment services are appropriate or allowable. Professional consultants base approval of services on a valid diagnosis, acceptable child/adolescent practice, and clear documentation of the probable effectiveness of the proposed service. Federal regulations do not allow federal funding of rehabilitation services, such as child/adolescent day treatment or in-home or outpatient mental health and substance abuse services, for persons with a sole or primary diagnosis of a developmental disability or mental retardation.
b. Complete the checklist to determine whether an individual would substantially meet the criteria for SED.
c. Check those boxes that apply. The individual must have one symptom or two functional impairments described as follows.

Symptoms

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

Functional Impairments (Compared to Expected Developmental Level)

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

Eligibility criteria are waived under the following circumstances:

- The recipient substantially meets the criteria for SED, except the severity of the emotional and behavioral problems have not yet substantially interfered with the individual's functioning, but would likely do so without in-home mental health and substance abuse treatment services. Attach an explanation.
- The recipient substantially meets the criteria for SED, except the individual has not yet received services from more than one system and in the judgment of the medical consultant, would be likely to do so if the intensity of treatment requested was not provided.

Element 17

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

Element 18

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

Element 19

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

SECTION V

Element 20

The following materials must be attached and labeled:

a. The PA/RF may be obtained from Wisconsin Medicaid. Providers should use processing type “126” in Element 3. The words “HealthCheck Other Services” should be written *in red* across the top of the form. Providers should use the appropriate procedure codes, modifiers, and descriptions in Elements 16, 17, and 19 of the PA/RF.

   The quantity requested in Element 20 of the PA/RF should represent the total hours for the grant period requested and Element 21 of the PA/RF should represent charges for all hours indicated in Element 20.

b. Attach a physician’s prescription order for in-home treatment services dated not more than one year prior to the requested first DOS.

c. The request must include documentation that the recipient had a comprehensive HealthCheck screening within 365 days prior to the grant date being requested. This documentation must be one of the following:
   - Verification that a HealthCheck screen has been performed by a valid HealthCheck screener dated not more than one year prior to the requested first DOS.
   - A copy of the HealthCheck provider’s billing form showing a claim for a comprehensive HealthCheck screening.
   - A copy of the HealthCheck provider’s Remittance and Status Report showing a claim for a comprehensive HealthCheck screening.
   - A HealthCheck referral from the HealthCheck provider.
   - A letter on the HealthCheck provider’s letterhead indicating the date on which they performed a comprehensive HealthCheck screening of the recipient.

d. The multi-agency treatment plan must be developed by representatives from all systems identified on the SED eligibility checklist. The plan must address the role of each system in the overall treatment and the major goals for each agency involved. The plan should be signed by all participants, but to facilitate submission, the provider may document who was involved. Where some agency was not involved in the planning, the provider is required to document the reason and what attempts were made to include them. The plan should indicate why services in the home are necessary and desirable. The individual who is coordinating the multi-agency planning should be clearly identified. A psychiatrist or psychologist is required to sign either the multi-agency plan or in-home treatment plan. If the child is prescribed psychoactive medication, the prescriber is required to be identified in the multi-agency treatment plan. Providers may use the Model Multi-Agency Treatment Plan, HCF 11106.

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

e. The in-home treatment team is required to complete a treatment plan covering their services. A psychiatrist or psychologist is required to sign either the in-home treatment plan or the multi-agency treatment plan. The Model Plan: In-Home Mental Health/Substance Abuse Treatment Services, HCF 11105, may be used for this purpose. The plan must contain measurable goals, specific methods, and an expected time frame for achievement of the goals. The methods must allow for a clear determination that the services provided meet criteria for Medicaid-covered services. Services that are primarily social or recreational in nature are not reimbursable. The plan should clearly identify which team members are providing the Medicaid-covered services being requested.

   Services provided to the recipient’s parents, foster parents, siblings, or other individuals significantly involved with the recipient are deemed appropriate as part of the in-home treatment plan when these services are required to directly affect the recipient’s functioning at home or in the community. Such services include family therapy necessary to deal with issues of family dysfunctioning, behavior training with responsible adults to identify problem behaviors and develop appropriate responses, supervision of the child and family members in the home setting to evaluate the effect of behavioral intervention approaches and provide feedback to the family on implementing these interventions, and minimal supportive interventions with the family members to ensure their continued participation in the in-home treatment process. Interventions with family members or significant others that are primarily for the benefit of these individuals are not reimbursable under these guidelines, except where these individuals meet the criteria for intensive in-home treatment (e.g., they are 20 years of age or under) and authorization has been received for such services under these guidelines. For instance, intervention directed solely at a parent’s alcohol abuse is considered substance abuse treatment, is covered as a substance abuse treatment service, and is not reimbursable in the home. However, when the intervention is with the whole family and is focusing on the way in which the parent’s alcohol abuse is affecting the child and/or contributing to the problem behaviors, an in-home intervention may be authorized under these guidelines.

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

If an in-home mental health/substance abuse treatment plan other than the model plan is used, all information on the model must be included.

e. Providers are required to complete and attach the results of either the Achenbach Child Behavior Checklist or the Child and Adolescent Functional Assessment Scale. Information about these screening instruments is available on the Internet under "Achenbach Behavior Checklist" and "Child and Adolescent Functional Assessment Scale."

f. A substance abuse assessment must be included if substance abuse-related programming is part of the recipient's treatment program. The assessment may be summarized in Element 14 as part of the psychiatric assessment or illness history.

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

Element 21 — Signature — Certified Therapist
Enter the signature of the certified therapist.

Element 22 — Date Signed
Enter the month, day, and year the PA/ITA was signed (in MM/DD/YYYY format).

Element 23 — Signature — Supervising Therapist
Enter the signature of the supervising therapist.

Element 24 — Date Signed
Enter the month, day, and year the PA/ITA was signed (in MM/DD/YYYY format).

ATTACHMENT 7
Prior Authorization/In-Home Treatment Attachment (PA/ITA)
(for photocopying)

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

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DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Health Care Financing
HCF 11036 (01/07)

STATE OF WISCONSIN

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

Providers may submit prior authorization (PA) requests 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/In-Home Treatment Attachment (PA/ITA) Completion Instructions, HCF 11036A.

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

SECTION I — RECIPIENT INFORMATION

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

SECTION II — PROVIDER INFORMATION

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

SECTION III

10. Enter the requested start and end dates for this authorization request. On the initial PA request, if backdating is needed, it must be requested in writing, and the clinical rationale for starting services before authorization is obtained must be documented.

11. Enter the number of hours of treatment to be provided to the family over this PA grant period. Providers should indicate the anticipated pattern of treatment by provider (e.g., a two-hour session once a week by certified therapist, a two-hour session once a week by the second team member with a certified therapist, plus a one-hour session twice a week by the second team member independently).

Continued

SECTION III (Continued)

12. Indicate the following for the period covered by this request.

- The number of hours the certified psychotherapy / substance abuse counselor will provide treatment ___________________
- The number of hours the second team member will provide treatment ______________________________
- The name and credentials of the second team member. Include his or her degree and the number of hours of supervised clinical work he or she has done with severe emotional disturbance (SED) children in the space provided (attach résumé, if available).

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

Certified Psychotherapist / Substance Abuse Counselor		**Second Team Member**	
Anticipated Number of Visits	__________	Anticipated Number of Visits	__________
Travel Time per Visit	x_________	Travel Time per Visit	x_________
=	__________	=	__________

SECTION IV

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

14. Present a summary of the recipient's current psychiatric assessment and differential diagnosis. Diagnoses on all five axes of the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM), or for children to age four, the *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC:0-3),* are required. The summary must present the signs and symptoms present in the recipient that meet criteria for the given DSM or DC:0-3 diagnosis. The summary does not include the history of the child's illness; this history should be provided in Element 15. A psychiatrist or a Ph.D. psychologist* must review and sign the summary and diagnoses.

Continued

SECTION IV (Continued)

15. Present a summary of the recipient's illness, treatment, and medication history. Include all significant background information. Describe the potential for change. Indicate if the child is currently in out-of-home placement, and, if so, the timeline for family reunification.

Continued

SECTION IV (Continued)

16. Complete the checklist to determine whether an individual meets the criteria for SED. Criteria for meeting the functional symptoms and impairments are found in the instructions. The disability must be evidenced by a, b, c, and d listed below.

   a. A primary psychiatric diagnosis of mental illness or SED. Document diagnosis using the most recent version of the DSM or DC:0-3.

      ❏ ______________________________
      Primary Diagnosis

   b. The individual must meet all three of the following.
      - ❏ Be under the age of 21.
      - ❏ Have emotional and behavioral problems that are severe in nature.
      - ❏ This disability is expected to persist for a year or longer.

   c. Symptoms and functional impairments
      The individual must have one or two of the following.
      1. Symptoms (must have one)
         - ❏ Psychotic symptoms.
         - ❏ Suicidality.
         - ❏ Violence.
      2. Functional impairments (must have two)
         - ❏ Functioning in self care.
         - ❏ Functioning in the community.
         - ❏ Functioning in social relationships.
         - ❏ Functioning in the family.
         - ❏ Functioning at school / work.

   d. The individual is receiving services from two or more of the following service systems.
      - ❏ Mental Health.
      - ❏ Social Services.
      - ❏ Child Protective Services.
      - ❏ Juvenile Justice.
      - ❏ Special Education.

   Eligibility criteria may be waived under the following circumstances.

   - ❏ The recipient substantially meets the criteria for SED, except the severity of the emotional and behavioral problems have not yet substantially interfered with the individual's functioning, but would likely do so without in-home mental health and substance abuse treatment services. Attach an explanation.
   - ❏ The recipient substantially meets the criteria for SED, except the individual has not yet received services from more than one system and in the judgment of the medical consultant, would be likely to do so if the intensity of treatment requested was not provided.

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

Continued

SECTION IV (Continued)

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

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

SECTION V

20. Attach and label all of the following.

a. The Prior Authorization / Request Form (PA/RF), HCF 11018.
b. A copy of a physician's prescription / order for in-home treatment services dated not more than one year prior to the requested first date of service (DOS).
c. Documentation that the recipient had a comprehensive HealthCheck screening performed by a valid HealthCheck screener dated not more than one year prior to the first DOS. A copy of this documentation must be attached to all requests for reauthorizations (a copy of the original documentation may be used). **The initial request for these services must be received by Wisconsin Medicaid within one year of the date of the HealthCheck screening.**
d. A multi-agency treatment plan.
e. An in-home psychotherapy treatment plan.
f. Results of either the Achenbach Child Behavior Checklist or the Child and Adolescent Functional Assessment Scale (CAFAS).
g. A substance abuse assessment may be included. A substance abuse assessment **must** be included if substance abuse-related programming is part of the recipient's treatment program.

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

21. **SIGNATURE —** Certified Psychotherapist / Substance Abuse Counselor	22. Date Signed
23. **SIGNATURE —** Supervising Psychiatrist or Ph.D. Psychologist	24. Date Signed

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

ATTACHMENT 8
Model Plan: In-Home Mental Health/Substance Abuse Treatment Services

(A copy of the "Model Plan: In-Home Mental Health/Substance Abuse Treatment Services" is located on the following pages.)

DEPARTMENT OF HEALTH AND FAMILY SERVICES **STATE OF WISCONSIN**
Division of Health Care Financing
HCF 11105 (01/07)

MODEL PLAN: IN-HOME MENTAL HEALTH / SUBSTANCE ABUSE TREATMENT SERVICES

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 requests, or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of Medicaid payment for the services.

Providers may use their own treatment plan forms as long as all elements are included.

Name — Client	List agency team members developing and implementing this plan. (Include title indicating discipline.)
Birth Date — Client	1.
Client Medicaid Identification Number	2.
Date of This Plan	3.
Plan Review Date	4.
Name — Case Manager	5.
List family members involved in treatment.	6.
1.	7.
2.	8.
3.	
4.	
5.	
6.	

Continued

Problem 1	Short Term Goal (Measurable)
Description of the Problem	Long Term Goal (Measurable)
	Plan (Include the frequency of intervention and the team member[s] responsible.)
	Measurable Results of the Intervention at the Time of Plan Review

Continued

Problem 2	Short Term Goal (Measurable)
Description of the Problem	Long Term Goal (Measurable)
	Plan (include the frequency of intervention and the team member[s] responsible).
	Measurable Results of the Intervention at the Time of Plan Review

Continued

Problem 3	Short Term Goal (Measurable)
Description of the Problem	Long Term Goal (Measurable)
	Plan (Include the frequency of intervention and the team member[s] responsible.)
	Measurable Results of the Intervention at the Time of Plan Review

Continued

Problem 4	Short Term Goal (Measurable)
Description of the Problem	Long Term Goal (Measurable)
	Plan (Include the frequency of intervention and the team member[s] responsible.)
	Measurable Results of the Intervention at the Time of Plan Review

Continued

Problem 5	Short Term Goal (Measurable)
Description of the Problem	Long Term Goal (Measurable)
	Plan (Include the frequency of intervention and the team member[s] responsible.)
	Measurable Results of the Intervention at the Time of Plan Review

Continued

Program Discharge Criteria

SIGNATURE — Certified Psychotherapist / Substance Abuse Counselor	Date Signed
SIGNATURE — Psychologist / Psychiatrist *	Date Signed

*Either the in-home or multi-agency plan must be signed by a psychologist or psychiatrist.

ATTACHMENT 9
Model Multi-Agency Treatment Plan

(A copy of the "Model Multi-Agency Treatment Plan" is located on the following pages.)

DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Health Care Financing
HCF11106 (01/07)

STATE OF WISCONSIN

MODEL MULTI – AGENCY TREATMENT PLAN

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 Medicaid payment for the services.

Providers may use their own treatment plan forms as long as all elements are included.

Name — Client	List agency team members developing and implementing this plan. (Include title indicating discipline.)
Birth Date — Client	1.
Client Medicaid Identification Number	2.
Date of This Plan	3.
Plan Review Date	4.
Case Manager	5.
List family members involved in treatment.	6.
1.	7.
2.	8.
3.	9.
4.	10.
5.	11.
6.	12.
	Was parent or primary caregiver present? ❑ Yes ❑ No

Continued

Problem Summary: In the space provided below, describe the problems of the child and the family. Specify the elements of the problem that are to be addressed in treatment.

Continued

Mental Health Agency Response	Short Term Goal (Measurable)
	Long Term Goal (Measurable)
	Plan (Include the frequency of the intervention and the team member(s) responsible.)
	Measurable Results of the Intervention at the Time of Plan Review

Continued

Social Services Agency Response	Short Term Goal (Measurable)
	Long Term Goal (Measurable)
	Plan (Include the frequency of the intervention and the team member(s) responsible.)
	Measurable Results of the Intervention at the Time of Plan Review

Continued

School Agency Response	Short Term Goal (Measurable)
	Long Term Goal (Measurable)
	Plan (Include the frequency of the intervention and the team member(s) responsible.)
	Measurable Results of the Intervention at the Time of Plan Review

Continued

Juvenile Justice Agency Response	Short Term Goal (Measurable)
	Long Term Goal (Measurable)
	Plan (Include the frequency of the intervention and the team member(s) responsible.)
	Measurable Results of the Intervention at the Time of Plan Review

Continued

Health Agency Response	Short Term Goal (Measurable)
	Long Term Goal (Measurable)
	Plan (Include the frequency of the intervention and the team member(s) responsible.)
	Measurable Results of the Intervention at the Time of Plan Review

Continued

Services Recommended by the Treatment Plan

1.
2.
3.
4.
5.
6.

Program Discharge Criteria

SIGNATURE — Certified Psychotherapist / Substance Abuse Counselor	Date Signed
SIGNATURE — Psychologist / Psychiatrist*	Date Signed

I (we) have read the foregoing treatment plan and give my (our) consent for my (our) child to receive the treatment outlined above. I (we) will agree to participate in the treatment intervention outlined above.

SIGNATURE — Parent(s) or Primary Caregiver	Date Signed

*Either the in-home or multi-agency plan must be signed by a psychologist or psychiatrist.

ATTACHMENT 10
Procedure Codes for In-Home Mental Health and Substance Abuse Treatment Services for Children

The following table lists the Healthcare Common Procedure Coding System (HCPCS) or *Current Procedural Terminology* (CPT) procedure codes and modifiers that providers are required to use when submitting claims for in-home mental health and substance abuse treatment services.

Place of Service Codes	
04	Homeless Shelter
12	Home
99	Other Place of Service

HCPCS/ CPT Code	Description	Program Modifier Code	Certified Providers Who May Perform Service	Service Modifier Code	Max Fee Effective October 1, 2003	ICD-9-CM* Diagnosis Codes Allowed**	Allowable Place of Service Codes	Telehealth Services Covered?
H0004	Behavioral health counseling and therapy, per 15 minutes	**HA** Child/ adolescent program	Doctoral level	HP	$16.27	290.0-298.9; 300.00-316	04, 12, 99	Yes (use "GT" modifier)
			Masters degree level	HO	$16.27			
			Psychiatrist	UA	$16.27			
			Bachelors degree level	HN	$6.78			
			Less than Bachelor degree level	HM	$6.78			
H0022	Alcohol and/or drug intervention service (planned facilitation) [60 minutes]	**HA** Child/ adolescent program	Doctoral level	HP	$65.06	303-305.93; 308.9; 309.24; 309.28; 309.9; 312.31	04, 12, 99	Yes (use "GT" modifier)
			Masters degree level	HO	$65.06			
			Psychiatrist	UA	$65.06			
			Bachelors degree level	HN	$27.11			
			Less than Bachelor degree level	HM	$27.11			
T1006	Alcohol and/or substance abuse services, family/couple counseling [60 minutes] (This code should be used only when the primary diagnosis is alcohol or drug abuse related)	**HA** Child/ adolescent program	Doctoral level	HP	$65.06	303-305.93; 308.9; 309.24; 309.28; 309.9; 312.31	04, 12, 99	Yes (use "GT" modifier)
			Masters degree level	HO	$65.06			
			Psychiatrist	UA	$65.06			
			Bachelors degree level	HN	$27.11			
			Less than Bachelor degree level	HM	$27.11			
99082	Unusual travel (e.g., transportation and escort of patient) [60 minutes]	**HA** Child/ adolescent program	Doctoral level	HP	$65.06	290.0-298.9; 300.00-316	99***	No
			Masters degree level	HO	$65.06			
			Psychiatrist	UA	$65.06			
			Bachelors degree level	HN	$27.11			
			Less than Bachelor degree level	HM	$27.11			

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

**The list of ICD-9-CM diagnosis codes for in-home mental health and substance abuse treatment services is inclusive. However, not all Medicaid-covered in-home mental health and substance abuse treatment services are appropriate or allowable. Professional consultants base approval of services on a valid diagnosis, acceptable in-home mental health and substance abuse treatment practice, and clear documentation of the probable effectiveness of the proposed service. Federal regulations do not allow federal funding of rehabilitation services, such as child/adolescent day treatment or in-home or outpatient mental health and substance abuse services, for persons with a sole or primary diagnosis of a developmental disability or mental retardation. Approval of services is based on a valid diagnosis, acceptable in-home mental health and substance abuse treatment practice, and clear documentation of the probable effectiveness of the proposed service.

***When submitting claims with procedure code 99082, always use place of service code "99." This code should also be used when the service is provided in any place other than the home or homeless shelter and explained in the clinical information.

ATTACHMENT 11
Rounding Guidelines for In-Home Mental Health and Substance Abuse Treatment Services for Children

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

Use the following rounding guidelines for procedure code H0004.

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

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

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

ATTACHMENT 12
CMS 1500 Claim Form Instructions for In-Home Mental Health and Substance Abuse Treatment Services for Children

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 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 mental health and substance abuse services clinics
Enter claim sort indicator "M" in the Medicaid check box for the service billed.

Psychiatrists and Ph.D. psychologists in private practice and privately owned outpatient mental health and substance abuse services clinics
Enter claim sort indicator "P" in the Medicaid check box for the service billed.

Element 1a — Insured's I.D. Number

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

Element 2 — Patient's Name

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

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

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

Element 4 — Insured's Name (not required)

Element 5 — Patient's Address

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

Element 6 — Patient Relationship to Insured (not required)

Element 7 — Insured's Address (not required)

Element 8 — Patient Status (not required)

Element 9 — Other Insured's Name

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

If the EVS indicates that the recipient has dental ("DEN") 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"), TriCare ("CHA"), or some other ("OTH") commercial health insurance, *and* the service requires other insurance billing according to the Coordination of Benefits section of the All-Provider Handbook, then one of the following three other insurance (OI) explanation codes *must* be indicated in the *first* box of Element 9. The description is not required, nor is the policyholder, plan name, group number, etc. (Elements 9a, 9b, 9c, and 9d are not required.)

Code	Description
OI-P	PAID by commercial health insurance. In Element 29 of this claim form, indicate the amount paid by commercial health insurance to the provider or to the insured.
OI-D	DENIED by commercial health insurance or commercial HMO following submission of a correct and complete claim, or payment was applied towards the coinsurance and deductible. Do not use this code unless the claim was actually billed to the commercial health insurer.
OI-Y	YES, the recipient has commercial health insurance or commercial HMO coverage, but it was not billed for reasons including, but not limited to: ✓ The recipient denied coverage or will not cooperate. ✓ The provider knows the service in question is not covered by the carrier. ✓ The recipient's commercial health insurance failed to respond to initial and follow-up claims. ✓ Benefits are not assignable or cannot get assignment. ✓ Benefits are exhausted.

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

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

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

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

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

- Medicare never covers the procedure in any circumstance.
- Wisconsin Medicaid indicates the recipient does not have any Medicare coverage 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	**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: *For Medicare Part A (all three criteria must be met):* ✓ 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. *For Medicare Part B (all three criteria must be met):* ✓ 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	**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: *For Medicare Part A (all three criteria must be met):* ✓ 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. *For Medicare Part B (all three criteria must be met):* ✓ 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	**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: *For Medicare Part A (all three criteria must be met):* ✓ 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). *For Medicare Part B (all three criteria must be met):* ✓ 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

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

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

Element 19 — Reserved for Local Use (not required)

Element 20 — Outside Lab? (not required)

Element 21 — Diagnosis or Nature of Illness or Injury

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

Allowable diagnosis codes for in-home treatment services, with conditions, are listed in Attachment 10 of this *Wisconsin Medicaid and BadgerCare Update*.

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 procedure using the following guidelines:

- When billing for one DOS, enter the date in MM/DD/YY or MM/DD/YYYY format in the "From" field.
- When billing for two, three, or four DOS on the same detail line, enter the first DOS in MM/DD/YY or MM/DD/YYYY format in the "From" field and enter subsequent DOS in the "To" field by listing *only* the date(s) of the month. For example, for DOS on December 1, 8, 15, and 22, 2006, indicate 12/01/06 or 12/01/2006 in the "From" field and indicate 08/15/22 in the "To" field.

It is allowable to enter up to four DOS per line if 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. See Attachment 10 for a list of allowable POS codes.

Element 24C — Type of Service (not required)

Element 24D — Procedures, Services, or Supplies

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

Modifiers

Enter the appropriate (two per procedure code) modifiers in the "Modifier" column of Element 24D. Use a comma to separate modifiers.

Note: Wisconsin Medicaid has not adopted all national modifiers.

Refer to Attachment 10 for a list of appropriate procedure codes and modifiers.

Element 24E — Diagnosis Code

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

Element 24F — $ Charges

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

Element 24G — Days or Units

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

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

Element 24I — EMG

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

Element 24J — COB (not required)

Element 24K — Reserved for Local Use

Enter the eight-digit Medicaid provider number of the performing provider for each procedure. Use the performing provider number of the certified psychotherapist for both the certified psychotherapist and the second team member.

When the billing provider is a "biller only" provider, indicate the clinic's Medicaid performing provider number.

Any other information entered in this element may cause claim denial.

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

Element 26 — Patient's Account No. (not required)

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

Element 27 — Accept Assignment (not required)

Element 28 — Total Charge

Enter the total charges for this claim.

Element 29 — Amount Paid

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

Element 30 — Balance Due

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

Element 31 — Signature of Physician or Supplier

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

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

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

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

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

ATTACHMENT 13
Sample CMS 1500 Claim Form for In-Home Mental Health and Substance Abuse Treatment Services for Children for Mental Health Clinics

PICA **HEALTH INSURANCE CLAIM FORM** PICA

CARRIER

1. MEDICARE (Medicare #) / MEDICAID (Medicaid #) [P] / CHAMPUS (Sponsor's SSN) / CHAMPVA (VA File #) / GROUP HEALTH PLAN (SSN or ID) / FECA BLK LUNG (SSN) / OTHER (ID)

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: 01 12 82 SEX M [X] F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): 609 Willow

6. PATIENT RELATIONSHIP TO INSURED: Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY: Anytown STATE: WI

8. PATIENT STATUS: Single Married Other; Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE: 55555 TELEPHONE (Include Area Code): (XXX)XXX-XXXX

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? PLACE (State) YES NO

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes,* return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED ____ DATE ____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED ____

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: MM DD YY — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: I.M. Referring MD

17a. I.D. NUMBER OF REFERRING PHYSICIAN: 12345678

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 313.81 3. ___ . ___
2. ___ . ___ 4. ___ . ___

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 1234567

24.	A DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1	8	16	05				12		H0004	HA, HO	1	XX XX	4				11223344
2	8	16	05				12		H0004	HA, HN	1	XX XX	4				11223344
3	8	16	05				99		99082	HA, HO	1	XX XX	1				11223344
4	8	16	05				99		99082	HA, HO	1	XX XX	1				11223344
5																	
6																	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.: 1234JED

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $ XX XX

29. AMOUNT PAID $

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.)

SIGNED I.M. Authorized DATE MMDDYY

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 #

In-Home Treatment Provider
1 W. Williams
Anytown, WI 55555 87654321

PIN# GRP#

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) *PLEASE PRINT OR TYPE* APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

ATTACHMENT 14
Sample CMS 1500 Claim Form for In-Home Mental Health and Substance Abuse Treatment Services for Children for Billing-Only Agencies

PICA **HEALTH INSURANCE CLAIM FORM** PICA

CARRIER

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) [P] CHAMPUS (Sponsor's SSN) CHAMPVA (VA File #) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

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: 01 12 82 SEX M [X] F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): 609 Willow

CITY: Anytown STATE: WI

ZIP CODE: 55555 TELEPHONE (Include Area Code): (XXX) XXX-XXXX

6. PATIENT RELATIONSHIP TO INSURED: Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

8. PATIENT STATUS: Single Married Other; Employed Full-Time Student Part-Time Student

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

a. OTHER INSURED'S POLICY OR GROUP NUMBER

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

c. EMPLOYER'S NAME OR SCHOOL NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10. IS PATIENT'S CONDITION RELATED TO:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

b. AUTO ACCIDENT? YES NO PLACE (State)

c. OTHER ACCIDENT? YES NO

10d. RESERVED FOR LOCAL USE

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. EMPLOYER'S NAME OR SCHOOL NAME

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes,* return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED ______ DATE ______

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED ______

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: I.M. Referring MD

17a. I.D. NUMBER OF REFERRING PHYSICIAN: 12345678

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 313.81
2. ___ . ___
3. ___ . ___
4. ___ . ___

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 1234567

24.	A DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1	8	16	05				12		H0004	HA, HO	1	XX XX	4				65432109
2	8	16	05				12		H0004	HA, HN	1	XX XX	4				
3	8	16	05				99		99082	HA, HO	1	XX XX	1				
4	8	16	05				99		99082	HA, HN	1	XX XX	1				
5																	
6																	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.: 1234JED

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $ XX XX

29. AMOUNT PAID $

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.)

SIGNED I.M. Authorized DATE MMDDYY

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 #

In-Home Treatment Provider
1 W. Williams
Anytown, WI 55555

PIN# GRP# 87654321

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) *PLEASE PRINT OR TYPE* APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)