The list of benefits that still require a prescription to initiate services has been revised as of December 21, 2011. Community Recovery Services do not require a prescription to initiate treatment. The change to the *Update* is indicated in red.

ForwardHealth
Wisconsin serving you

Update
November 2011

No. 2011-71

Affected Programs: BadgerCare Plus, Medicaid
To: Adult Mental Health Day Treatment Providers, Advanced Practice Nurse Prescribers with Psychiatric Specialty, Child/Adolescent Day Treatment Providers, Community Recovery Services Providers, Community Support Programs, Comprehensive Community Service Providers, Crisis Intervention Providers, Intensive In-Home Mental Health and Substance Abuse Treatment Services for Children Providers, Hospital Providers, Master's-Level Psychotherapists, Narcotic Treatment Services Providers, Nurse Practitioners, Outpatient Mental Health Clinics, Outpatient Substance Abuse Clinics, Physician Assistants, Physician Clinics, Physicians, Psychiatrists, Psychologists, Substance Abuse Counselors, Substance Abuse Day Treatment Providers, HMOs and Other Managed Care Programs

Prescription No Longer Required to Initiate Certain Mental Health and Substance Abuse Treatment Services

To conform with provisions of the 2009 Wisconsin biennial budget act (2009 Wisconsin Act 28), Wisconsin Medicaid and BadgerCare Plus no longer require a prescription from a physician or other health care provider to initiate certain psychotherapy or substance abuse treatment services for a Wisconsin Medicaid or BadgerCare Plus member.

Prescription No Longer Required to Initiate Certain Services

To conform with provisions of the 2009 Wisconsin biennial budget act (2009 Wisconsin Act 28), Wisconsin Medicaid and BadgerCare Plus no longer require a prescription from a physician or other health care provider to initiate certain psychotherapy or substance abuse treatment services for a Wisconsin Medicaid or BadgerCare Plus member. Per s. 49.45(30f), Wis. Stats., the department:

> ... may not require that a physician or other health care provider first prescribe psychotherapy or alcohol and other drug abuse services to be provided by a licensed mental health professional or licensed psychologist before the professional or psychologist may provide services to the recipient.

In light of the new legislation, conflicts exist with currently published Wisconsin Administrative Code. Wisconsin Statutes supersede current Wisconsin Administrative Code wherever applicable. The conflicts are identified in the Attachment of this *ForwardHealth Update*.

Benefits That No Longer Require a Prescription to Initiate Services

For services provided on and after January 1, 2011, Wisconsin Medicaid and BadgerCare Plus no longer require a prescription from a physician or other health care provider to initiate the following mental health and substance abuse treatment services for a Wisconsin Medicaid and BadgerCare Plus member:

- Outpatient mental health services provided in a Medicaid-certified outpatient mental health clinic.
- Outpatient substance abuse treatment provided in a Medicaid-certified substance abuse clinic.
- Adult mental health day treatment.

- Substance abuse day treatment.
- Outpatient mental health and substance abuse services in the home or community for adults.
- Outpatient mental health and substance abuse services performed in private practice by a Medicaid-certified psychiatrist, Ph.D. psychologist, Advanced Practice Nurse Prescriber with psychiatric specialty, or a licensed psychotherapist (referred to as licensed mental health professionals in Wisconsin law).

All other policies and procedures continue to apply for these mental health and substance abuse treatment services. For example, for substance abuse treatment, within 60 days prior to enrolling in a program a member must receive a complete medical evaluation including diagnosis, summary of present medical findings, and medical history.

Benefits That Still Require a Prescription to Initiate Services

The 2009 Wisconsin biennial budget act *did not* change requirements for a prescription prior to initiating certain community-based mental health services. Examples of these services include the following:

- ~~Community Recovery Services.~~
- Community Support Programs.
- Comprehensive Community Services.
- HealthCheck "Other Services" Child/Adolescent Day Treatment.
- HealthCheck "Other Services" Intensive In-Home Mental Health and Substance Abuse Treatment Services for Children.

Backdating Prior Authorization Requests

To facilitate implementation of this change in policy, prior authorization (PA) may be requested for backdating beyond the 14-day limitation to cover services that were provided to a member beyond the per provider limits of $825 or 15 visits during the period of January 1, 2011, through November 4, 2011. This special backdating of PA requests is limited to services for which PA was not requested because a physician prescription was not obtained prior to the initiation of services.

Providers may submit requests to backdate PA requests by submitting the following items via the ForwardHealth portal or by faxing or mailing paper PA requests:

- Prior Authorization Request Form (PA/RF), F-11018 (10/08), that indicates the date(s) of services (DOS) for which backdating is being requested. Providers are required to include "BACKDATED PA RELATED TO PHYSICIAN PRESCRIPTION" in Element 21 (Description of Service) for paper and fax PA requests or in the Additional Service Code Description field for Portal PA requests.
- A PA attachment appropriate to the service being requested. In the appropriate service attachment, providers are required to explain that the service was provided at a time when there was no physician prescription for the service and include the DOS the member was seen.

All other documentation requirements remain the same.

Prior authorizations requesting special backdating for services must be received by ForwardHealth on or before December 31, 2011.

Prior Authorization Forms and Instructions to Be Revised

The following PA forms and instructions for mental health and substance abuse treatment services will be revised at a later date to reflect the changes in this *Update*. On the forms listed below, providers may leave blank any elements where they are directed to indicate a prescription:

- Prior Authorization/Adult Mental Health Day Treatment Attachment (PA/AMHDTA) form and completion instructions, F-11038 and F11038A.
- Prior Authorization/Psychotherapy Attachment (PA/PSYA) Completion Instructions, F-11031A.

- Prior Authorization/Health and Behavior Intervention Attachment (PA/HBA) Completion Instructions, F-11088A.
- Prior Authorization/Substance Abuse Day Treatment Attachment (PA/SADT) form and completion instructions, F-11037 and F-11037A.
- Prior Authorization/Substance Abuse Attachment (PA/SAA) form and completion instructions, F-11032 and F-11032A.
- Outpatient Mental Health Assessment and Treatment/Recovery Plan Completion Instructions, F-11103A.

Claims Submission

Prescribing or Referring Provider No Longer Required on Claims

For the services no longer needing a prescription, providers are no longer required to complete Element 17 of the 1500 Health Insurance Claim Form or the referring provider information in loop 2310A or 2420A of the electronic 837 Health Care Claim: Professional (837P). This change affects the following services:

- Outpatient mental health.
- Outpatient substance abuse treatment.
- Adult mental health day treatment.
- Substance abuse day treatment.
- Outpatient mental health and substance abuse services in the home or community for adults.

Providers are reminded that to receive reimbursement, claims and adjustment requests must be received within 365 days of the DOS. This deadline applies to claims, corrected claims, and adjustments to claims. Claims with DOS within the 365-day timely filing limit must be resubmitted through the normal claims processing channels. Claims having a DOS that exceed the timely filing limit must be submitted through the Timely Filing Appeals process. Timely Filing Appeals Requests, F-13047 (10/08), for claims must be received by ForwardHealth Timely Filing on or before February 3, 2012.

Submitting Timely Filing Appeals Requests for Claims

When submitting Timely Filing Appeals Requests, providers are required to submit the following:

- A legible claim, completed according to the appropriate claim form completion instructions.
- A properly completed Timely Filing Appeals Request for each affected claim.

Providers are required to submit a separate Timely Filing Appeals Request form for each claim that is beyond the timely filing deadline. When completing the Timely Filing Appeals Request, providers should check the "ForwardHealth Reconsideration" box and write in the blank space provided immediately above the signature/date line, "Prescription No Longer Required per Update 2011-71."

Providers should refer to the Claims section and Timely Filing Appeals chapter of their Online Handbook for more information about timely filing appeals.

Refunding Payments to Members

The provider may have received payment from the member for the service(s). The provider is required to return to the member the full payment amount received from the member.

Information Regarding Managed Care Organizations

This *Update* contains fee-for-service policy and applies to services members receive on a fee-for-service basis only. For managed care policy, contact the appropriate managed care organization. Managed care organizations are required to provide at least the same benefits as those provided under fee-for-service arrangements.

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

Wisconsin Medicaid, BadgerCare Plus, SeniorCare, and Wisconsin Chronic Disease Program are administered by the Division of Health Care Access and Accountability, Wisconsin Department of Health Services (DHS). The Wisconsin Well Woman Program is administered by the Division of Public Health, Wisconsin DHS.

For questions, call Provider Services at (800) 947-9627 or visit our Web site at *www.forwardhealth.wi.gov/*.

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ATTACHMENT
Policy Changes to Wisconsin Administrative Code

Areas in which Wisconsin Statutes conflict with existing Wisconsin Administrative Code are noted below. Policies that are no longer enforced by Wisconsin Medicaid and BadgerCare Plus, per Wisconsin Statutes, are crossed out and highlighted in bold.

DHS 107.13, Wis. Admin. Code: Mental Health Services

(2) Outpatient Psychotherapy Services.

(a) Covered services.

Except as provided in par. (b), outpatient psychotherapy services shall be covered services ~~**when prescribed by a physician,**~~ when provided by a provider certified under s. DHS 105.22, and when the following conditions are met:

1. A strength-based assessment, including differential diagnostic examination, is performed by a certified psychotherapy provider. ~~**A physician's prescription is not necessary to perform the assessment.**~~ The assessment shall include:

a. The recipient's presenting problem.

b. Diagnosis established from the current Diagnostic and Statistical Manual of Mental Disorders including all 5 axes or, for children up to age four, the current Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood.

c. The recipient's symptoms which support the given diagnosis.

d. The recipient's strengths, and current and past psychological, social, and physiological data; information related to school or vocational, medical, and cognitive function; past and present trauma; and substance abuse.

e. The recipient's unique perspective and own words about how he or she views his or her recovery, experience, challenges, strengths, needs, recovery goals, priorities, preferences, values and lifestyle, areas of functional impairment, and family and community support.

f. Barriers and strengths to the recipient's progress and independent functioning.

g. Necessary consultation to clarify the diagnosis and treatment.

~~**2. Before the actual provision of psychotherapy services, a physician prescribes psychotherapy in writing;**~~

(b) Prior authorization.

4. A prior authorization request shall include the following information:

a. The names, addresses and MA provider or identifier numbers of the providers conducting the strength-based assessment, including diagnostic examination or medical evaluation and performing psychotherapy services.

~~**b. A copy of the physician's prescription for treatment.**~~

(c) Other limitations.

3. Emergency psychotherapy may be performed by a provider for a recipient without a ~~**prescription for treatment or**~~ prior authorization when the provider has reason to believe that the recipient may immediately injure himself or

herself or any other person. ~~A prescription for the emergency treatment shall be obtained within 48 hours of the time the emergency treatment was provided, excluding weekends and holidays.~~ Services shall be incorporated within the limits described in par. (b) and this paragraph, and subsequent treatment may be provided if par. (b) is followed.

(3) Alcohol and Other Drug Abuse Outpatient Treatment Services.

(a) Covered services.

Outpatient alcohol and drug abuse treatment services shall be covered when ~~prescribed by a physician,~~ provided by a provider who meets the requirements of s. DHS 105.23, and when the following conditions are met:

(b) Prior authorization.

4. A prior authorization request shall include the following information:

a. The names, addresses and MA provider or identifier numbers of the providers conducting the medical evaluation and performing AODA services;

~~b. A copy of the physician's prescription for treatment;~~

(3m) Alcohol and Other Drug Abuse Day Treatment Services.

(a) Covered services.

Alcohol and other drug abuse day treatment services shall be covered when ~~prescribed by a physician,~~ provided by a provider certified under s. DHS 105.25 and performed according to the recipient's treatment program in a non-residential, medically supervised setting, and when the following conditions are met:

(4) Mental Health Day Treatment or Day Hospital Services.

(a) Covered services.

Day treatment or day hospital services are covered services ~~when prescribed by a physician,~~ when provided by a provider who meets the requirements of s. DHS 105.24, and when the following conditions are met:

(b) Services requiring prior authorization.

2. The prior authorization request shall include:

a. The name, address, and MA number of the recipient;

b. The name, address, and provider number of the provider of the service and of the billing provider;

~~c. A photocopy of the physician's original prescription for treatment;~~