

Hospital Services

outpatient
services

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Important Telephone Numbers

Wisconsin Medicaid's Eligibility Verification System (EVS) is available through the following resources to verify checkwrite information, claim status, prior authorization status, provider certification, and/or recipient eligibility.

Service	Information Available	Telephone Number	Hours
Automated Voice Response (AVR) System (Computerized voice response to provider inquiries.)	Checkwrite Information Claim Status Prior Authorization Status Recipient Eligibility*	(800) 947-3544 (608) 221-4247 (Madison area)	24 hours a day/ 7 days a week
Personal Computer Software and Magnetic Stripe Card Readers	Recipient Eligibility*	Refer to Provider Resources section of the All-Provider Handbook for a list of commercial eligibility verification vendors.	24 hours a day/ 7 days a week
Provider Services (Correspondents assist with questions.)	Checkwrite Information Claim Status Prior Authorization Status Provider Certification Recipient Eligibility*	(800) 947-9627 (608) 221-9883	Policy/Billing and Eligibility: 8:30 a.m. - 4:30 p.m. (M, W-F) 9:30 a.m. - 4:30 p.m. (T) Pharmacy: 8:30 a.m. - 6:00 p.m. (M, W-F) 9:30 a.m. - 6:00 p.m. (T)
Direct Information Access Line with Updates for Providers (Dial-Up) (Software communications package and modem.)	Checkwrite Information Claim Status Prior Authorization Status Recipient Eligibility*	Call (608) 221-4746 for more information.	7:00 a.m. - 6:00 p.m. (M-F)
Recipient Services (Recipients or persons calling on behalf of recipients only.)	Recipient Eligibility Medicaid-Certified Providers General Medicaid Information	(800) 362-3002 (608) 221-5720	7:00 a.m. - 9:00 p.m. (M-F) 7:30 a.m. - 4:00 p.m. (Sat.)

*Please use the information exactly as it appears on the recipient's identification card or the EVS to complete the patient information section on claims and other documentation. Recipient eligibility information available through EVS includes:

- Dates of eligibility.
- Medicaid managed care program name and telephone number.
- Privately purchased managed care or other commercial health insurance coverage.
- Medicare coverage.
- Lock-In Program status.
- Limited benefit information.

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Preface

The Wisconsin Medicaid and BadgerCare Hospital Services Handbook is issued to hospital providers who are Wisconsin Medicaid certified. It contains information that applies to *fee-for-service* Medicaid providers. The Medicaid information in the handbook applies to both Medicaid and BadgerCare.

Wisconsin Medicaid and BadgerCare are administered by the Department of Health and Family Services (DHFS). Within the DHFS, the Division of Health Care Financing (DHCF) is directly responsible for managing Wisconsin Medicaid and BadgerCare. As of January 2003, BadgerCare extends Medicaid coverage to uninsured children and parents with incomes at or below 185% of the federal poverty level and who meet other program requirements. BadgerCare recipients receive the same health benefits as Wisconsin Medicaid recipients and their health care is administered through the same delivery system.

Medicaid and BadgerCare recipients enrolled in state-contracted HMOs are entitled to at least the same benefits as fee-for-service recipients; however, HMOs may establish their own requirements regarding prior authorization, billing, etc. If you are an HMO network provider, contact your managed care organization regarding its requirements. Information contained in this and other Medicaid publications is used by the DHCF to resolve disputes regarding covered benefits that cannot be handled internally by HMOs under managed care arrangements.

Verifying Eligibility

Wisconsin Medicaid providers should always verify a recipient's eligibility before providing services, both to determine eligibility for the current date and to discover any limitations to the recipient's coverage. Wisconsin Medicaid's Eligibility Verification System (EVS) provides eligibility information that providers can access a number of ways.

Refer to the Important Telephone Numbers page at the beginning of this section for detailed information on the methods of verifying eligibility.

Handbook Organization

The Hospital Services Handbook consists of the following sections:

- Inpatient Services.
- Outpatient Services.

In addition to the Hospital Services Handbook, each Medicaid-certified provider is issued a copy of the All-Provider Handbook. The All-Provider Handbook includes the following sections:

- Claims Submission.
- Coordination of Benefits.
- Covered and Noncovered Services.
- Prior Authorization.
- Provider Certification.
- Provider Resources.
- Provider Rights and Responsibilities.
- Recipient Rights and Responsibilities.

Legal Framework of Wisconsin Medicaid and BadgerCare

The following laws and regulations provide the legal framework for Wisconsin Medicaid and BadgerCare:

Federal Law and Regulation

- Law: United States Social Security Act; Title XIX (42 US Code ss. 1396 and following) and Title XXI.
- Regulation: Title 42 CFR Parts 430-498 — Public Health.

Wisconsin Law and Regulation

- Law: Wisconsin Statutes: Sections 49.43-49.499 and 49.665.
- Regulation: Wisconsin Administrative Code, Chapters HFS 101-108.

Handbooks and *Wisconsin Medicaid and BadgerCare Updates* further interpret and implement these laws and regulations.

Handbooks and *Updates*, maximum allowable fee schedules, helpful telephone numbers and addresses, and much more information about Wisconsin Medicaid and BadgerCare are available at the following Web sites:

www.dhfs.state.wi.us/medicaid/
www.dhfs.state.wi.us/badgercare/.

Medicaid Fiscal Agent

The DHFS contracts with a fiscal agent, which is currently EDS.

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P Provider Information

The Outpatient Services section of the Hospital Services Handbook includes information for outpatient hospital services providers regarding covered services, reimbursement methodology, and claims submission information.

Provider Eligibility and Certification

Wisconsin Medicaid certifies a hospital as either an acute care general hospital or institution for mental disease (IMD) and bases the hospital certification on the hospital's eligibility for certification with Medicare or with the Joint Commission on Accreditation of Healthcare Organizations.

Wisconsin Medicaid certifies acute care general hospitals and IMDs according to HES 105.07 and 105.21, Wis. Admin. Code, respectively. A facility determined by the Wisconsin Department of Health and Family Services to be an IMD may *not* be certified as an acute care general hospital.

Medicare certification does *not* automatically certify a hospital with Wisconsin Medicaid.

The Wisconsin Medicaid hospital certification packet contains detailed requirements for certification. Providers are required to meet these requirements and report necessary changes to Wisconsin Medicaid. For more information on becoming certified, or to obtain a certification packet, contact Provider Services at (800) 947-9627 or (608) 221-9883 or visit the Wisconsin Medicaid Web site at www.dhfs.state.wi.us/medicaid/.

Approved Hospital Facility

Only covered services provided by an approved hospital facility are eligible for payment under Wisconsin Medicaid's outpatient hospital payment formula. Wisconsin Medicaid defines "hospital facility" as the *physical entity*, surveyed and approved by the Division of Supportive Living, Bureau of Quality Assurance (BQA) under ch. 50, Wis. Stats. The BQA facility approval survey covers the building that the hospital identifies as constituting its operation.

This building must meet strict fire and life safety codes and administrative and program standards specifically required by the BQA for hospitals. Wisconsin Medicaid considers the unique costs of hospital functions, including safety code compliance in the determination of hospital outpatient services payment.

CLIA Certification

Congress implemented the Clinical Laboratory Improvement Act (CLIA) to improve the quality and safety of laboratory services. CLIA establishes standards and enforcement procedures.

CLIA requires all laboratories and providers performing tests for health assessment or for the diagnosis, prevention, or treatment of disease or health impairment to comply with specific federal quality standards.

Wisconsin Medicaid complies with the following federal regulations as initially published and subsequently updated:

- Public Health Service CLIA of 1988.
- 42 CFR Part 493.

Only covered services provided by an approved hospital facility are eligible for payment under Wisconsin Medicaid's outpatient hospital payment formula.

CLIA governs all laboratory operations, including the following:

- Accreditation.
- Certification.
- Equipment.
- Facility standards.
- Fees.
- Instrumentation.
- Materials.
- Patient test management.
- Personnel qualifications.
- Proficiency testing.
- Quality assurance.
- Quality control.
- Reagents.
- Records and information systems.
- Sanctions.
- Supplies.
- Test methods.
- Tests performed.

Claims for laboratory tests performed by hospital providers without valid CLIA certification, including an identification number, are subject to Medicaid denial or recoupment.

To obtain a CLIA certification application, write to the following address or call:

Bureau of Quality Assurance
Division of Supportive Living
Clinical Laboratory Unit
PO Box 2969
Madison WI 53701-2969
(608) 266-5753

Provider Responsibilities

Refer to the All-Provider Handbook for specific responsibilities as a Medicaid-certified provider. This information includes, but is not limited to, the following:

- Additional state and federal requirements.
- Fair treatment of the recipient.
- Grounds for provider sanctions.

- Maintenance of records.
- Recipient requests for noncovered services.
- Services provided to a recipient during periods of retroactive eligibility.

Verifying Recipient Eligibility

Wisconsin Medicaid hospital providers should *always* verify a recipient's eligibility before delivering services, both to determine eligibility for the current date and to discover any limitations to the recipient's coverage. Wisconsin Medicaid's Eligibility Verification System (EVS) provides eligibility information that providers can access a number of ways.

Refer to the Important Telephone Numbers page at the beginning of this section for detailed information on how to use the methods of verifying eligibility. Refer to the Recipient Rights and Responsibilities section of the All-Provider Handbook for information about these methods of verifying eligibility.

Special Benefit Categories

Some Medicaid recipients covered under special benefits categories have limited coverage.

Medical status codes received through the EVS identify recipients with limited benefits.

Providers may refer to the Recipient Rights and Responsibilities section of the All-Provider Handbook for more information on the different special benefits categories.

Medicaid Managed Care Coverage

The information in this handbook applies to fee-for-service recipients who receive hospital services. Medicaid HMOs may have different policies regarding hospital services. For Medicaid HMO or managed care policy, contact the appropriate managed care organization. Wisconsin Medicaid HMOs are required to provide at least the same benefits as those provided under fee-for-service arrangements.

Wisconsin Medicaid hospital providers should *always* verify a recipient's eligibility before delivering services, both to determine eligibility for the current date and to discover any limitations to the recipient's coverage.

Copayments and Billed Amounts

Except for the copayment exemptions noted in the Recipient Rights and Responsibilities section of the All-Provider Handbook, all recipients are responsible for paying part of the costs involved in obtaining hospital services. The copayment for outpatient hospital services is \$3.00 per encounter (per visit).

For more information on copayments and copayment exemptions, refer to the Recipient Rights and Responsibilities section of the All-Provider Handbook.

Collection of Copayment

Providers who perform services that require recipient copayment are required to make a reasonable attempt to collect that copayment from the recipient. Providers may not waive the recipient copayment requirement unless the provider determines that the cost of collecting the payment, coinsurance, or deductible exceeds the amount to be collected. Providers may not deny services to a recipient for failing to make a copayment.

Recipient Freedom from Liability for Covered Services

Providers may not charge a recipient for covered services and items furnished under Wisconsin Medicaid except for Wisconsin Medicaid recipient copayments, if applicable. At the same time, providers may not deny services to recipients who do not make copayments.

A provider may not charge a recipient for covered services if the provider fails to:

- Comply with Wisconsin Medicaid policy and is denied Medicaid reimbursement.
- Meet Wisconsin Medicaid program requirements.
- Seek or obtain necessary prior authorization to perform the services and is denied Medicaid reimbursement.

Newborn Reporting

Wisconsin Medicaid does not reimburse for infant claims submitted under the mother's identification number beyond the first 10 days of the infant's life.

Hospitals are required to promptly report newborns born to fee-for-service Medicaid recipients to Wisconsin Medicaid. Establishing a newborn's Medicaid eligibility results in better health outcomes and fewer delays in provider reimbursement.

Hospitals may report newborns born to Medicaid recipients by submitting a Wisconsin Medicaid Newborn Report, or another form developed by the hospitals that contains all the same information, to Wisconsin Medicaid. Refer to Appendix 11 of the Inpatient Services section of this handbook for a sample Newborn Report form.

Hospitals have the option of sending newborn reports in a summary format on a weekly basis to Wisconsin Medicaid or individual reports for each newborn. However, the summary report must contain all the information provided in the Newborn Report.

If possible, the Newborn Report should be submitted to Wisconsin Medicaid with the child's given name (first and last name), rather than "baby boy" or "baby girl" as the first name. The four-digit year should be included when reporting the child's date of birth. (To report a child's date of death, the two- or four-digit year format may be used). Wisconsin Medicaid still requires hospitals to submit the Newborn Report in instances in which the baby is born alive, but does not survive.

Submit the Newborn Report to Wisconsin Medicaid by mail or fax at the following address or fax number:

Wisconsin Medicaid
PO Box 6470
Madison WI 53716
Fax: (608) 224-6318

This information on newborn reporting pertains to the birth of a newborn to a Medicaid recipient who is not enrolled in an HMO.

Hospitals may report newborns born to Medicaid recipients by submitting a Wisconsin Medicaid Newborn Report, or another form developed by the hospitals that contains all the same information, to Wisconsin Medicaid.

Under the Medicaid managed care contract, HMOs are required to report to Wisconsin Medicaid the birth of a newborn to a mother enrolled in an HMO. Because of this requirement, hospitals and HMOs should coordinate the newborn reporting function to prevent duplicate reporting by the hospital and HMO of the same newborn. Following these procedures assures more timely reimbursement for services provided to infants.

Once the completed Newborn Report is submitted to Wisconsin Medicaid, the following procedures take place:

- A pseudo (temporary) Medicaid identification number is assigned to the newborn, regardless of whether the newborn is named (if Medicaid eligibility is not yet on file).
- A Medicaid Forward card is created for the child and sent to the mother as soon as the child's eligibility is put on file.

- Wisconsin Medicaid sends a letter to the mother, notifying her of this eligibility. The letter also contains a statement that the mother is required to sign, stating that the baby has continued to live with her since birth. She must send this statement to her county or tribal eligibility worker in the envelope provided and is required to tell her eligibility worker that she has a new baby with a temporary Medicaid identification number.
- A copy of this letter is also sent to the county economic support agency.
- Once the mother notifies her worker, a permanent Medicaid number is assigned to the infant.
- The hospital receives a copy of the eligibility notification letter sent to the child's mother as confirmation.

Providers with questions regarding newborn eligibility may contact Provider Services at (800) 947-9627 or (608) 221-9883.

Providers with questions regarding newborn eligibility may contact Provider Services at (800) 947-9627 or (608) 221-9883.

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Covered Services and Related Limitations

Outpatient Services Requirements

In accordance with HFS 107.08(3)(b), Wis. Admin. Code, hospitals providing outpatient hospital services are required to meet the same requirements that apply to Medicaid-certified, nonhospital providers performing the same services. Outpatient services performed *outside* the hospital facility are not reimbursed as hospital outpatient services.

Wisconsin Medicaid requires that outpatient services meet all of the following criteria:

- The care is directed by a physician or dentist.
- The care is medically necessary.
- The recipient is not an inpatient.
- The service is provided in an approved hospital facility.

Medically Necessary Care

Covered hospital outpatient services are those medically necessary preventative, diagnostic, rehabilitative, or palliative items or services. HFS 101.03(96m), Wis. Admin. Code, defines “medically necessary” as a Medicaid-covered service that is:

- (a) Required to prevent, identify or treat a recipient’s illness, injury or disability; and,
- (b) Meets the following standards:
 1. Is consistent with the recipient’s symptoms or with prevention, diagnosis or treatment of the recipient’s illness, injury or disability;
 2. Is provided consistent with standards of acceptable quality of care applicable to the type of service, the type of provider and the setting in which the service is provided;
 3. Is appropriate with regard to generally accepted standards of medical practice;
 4. Is not medically contraindicated with regard to the recipient’s diagnoses, the recipient’s symptoms or other

medically necessary services being provided to the recipient;

5. Is of proven medical value or usefulness and consistent with s. HFS 107.035, is not experimental in nature;
6. Is not duplicative with respect to other services being provided to the recipient;
7. Is not solely for the convenience of the recipient, the recipient’s family or a provider;
8. With respect to prior authorization of a service and to other prospective coverage determinations made by the department, is cost-effective compared to an alternative medically necessary service which is reasonably accessible to the recipient; and,
9. Is the most appropriate supply or level of service that can safely and effectively be provided to the recipient.

Care Must be Physician or Dentist Directed

Wisconsin Medicaid requires that covered hospital outpatient services be performed by, or under the direction of, a physician or dentist, and be provided in a hospital certified under HFS 105.07 or 105.21, Wis. Admin. Code.

Outpatient Status

On any given calendar day, a patient in a hospital may be either an inpatient or an outpatient, but not both. Covered outpatient hospital services are those services provided for a recipient who is not a hospital inpatient.

A recipient who is admitted as an inpatient and counted in the midnight census is considered an inpatient. If a recipient has not been officially admitted to the hospital as an inpatient and counted in the midnight census, the recipient is considered an outpatient.

Wisconsin Medicaid considers all covered outpatient services provided during one calendar day as one outpatient visit.

Wisconsin Medicaid requires that covered hospital outpatient services be performed by, or under the direction of, a physician or dentist, and be provided in a hospital certified under HFS 105.07 or 105.21, Wis. Admin. Code.

Emergency Room Services

Wisconsin Medicaid considers emergency room services to be outpatient services unless the recipient is admitted to the hospital and counted in the midnight census.

Inpatient and Outpatient Services for Same Date of Service

In accordance with HFS 107.08(4)(a)4, Wis. Admin. Code, if inpatient and outpatient services are provided for the same recipient, at the same hospital, on the same date of service (DOS) as the date of the inpatient hospital admission or discharge, the outpatient services are not separately reimbursed and must be included on the inpatient claim. This does not include reference laboratory services. Include outpatient claims for the hospital on the same date of admission or date of discharge on the inpatient claim.

Under HFS 107.08(3)(c)4, Wis. Admin. Code, Wisconsin Medicaid does not reimburse outpatient claims for services provided to an inpatient in another hospital, except on the date of admission or the date of discharge. For any other day during the inpatient stay, the hospital providing the outpatient services must arrange payment with the inpatient hospital.

Admission for Observation Purposes

In some cases, an outpatient recipient may be admitted for observation for a portion of a day. Because the recipient is *not* admitted as an inpatient, he or she is not an inpatient.

Maternity Stays

Wisconsin Medicaid does not have a policy on length of maternity stays. The length of stay is based on physician's judgement of what is medically necessary. A woman may elect to be discharged on the same day she delivers. A hospital stay is considered an inpatient stay when a recipient is admitted to a hospital and delivers a baby, even when the mother and baby are discharged on the date of admission (i.e., they are not included in the midnight census). This Medicaid policy applies to the baby's stay, as well as the mother's stay.

Service-Specific Requirements

Abortions

Coverage Policy

In accordance with s. 20.927, Wis. Stats., Wisconsin Medicaid covers abortions when one of the following situations exists:

1. The abortion is directly and medically necessary to save the life of the woman, provided that prior to the abortion the physician attests, based on his or her best clinical judgement, that the abortion meets this condition by signing a certification.
2. In a case of sexual assault or incest, provided that prior to the abortion the physician attests to his or her belief that sexual assault or incest has occurred by signing a certification, and provided that the crime has been reported to the law enforcement authorities.
3. Due to a medical condition existing prior to the abortion, the physician determines that the abortion is directly and medically necessary to prevent grave, long-lasting physical health damage to the woman, provided that prior to the abortion, the physician attests, based on his or her best clinical judgement, that the abortion meets this condition by signing a certification.

Covered Services

When an abortion meets the state and federal requirements for Medicaid payment, Wisconsin Medicaid covers office visits and all other medically necessary related services. Wisconsin Medicaid covers treatment for complications arising from an abortion, regardless of whether the abortion itself was a covered service. Because the complications represent new conditions and thus the services are not directly related to the performance of an abortion.

Wisconsin Medicaid considers emergency room services to be outpatient services unless the recipient is admitted to the hospital and counted in the midnight census.

Coverage of Mifeprex

Wisconsin Medicaid reimburses for Mifeprex (known as RU-486 in Europe) under the same coverage policy that it reimburses other surgical or medical abortion procedures under s. 20.927, Wis. Stats. Under federal law, only physicians may obtain and dispense Mifeprex.

When submitting claims for Mifeprex, providers are required to:

- Use the Healthcare Common Procedure Coding System (HCPCS) code S0190 (Mifepristone, oral, 200 mg), type of service (TOS) “1,” for the first dose of Mifeprex, along with the evaluation and management (E&M) code that reflects the service provided.
- Use the HCPCS code S0191 (Misoprostol, oral, 200 mcg), TOS “1,” for the drug given during the second visit, along with the E&M code that reflects the service provided.
- For the third visit, use the E&M code that reflects the service provided.
- Include the appropriate *International Classification of Diseases, Ninth Revision, Clinical Modification* abortion diagnosis code with each claims submission.
- Attach to each claim a completed abortion certification statement that includes information showing the situation is one where Wisconsin Medicaid covers abortion.

Note: Wisconsin Medicaid denies claims for Mifeprex reimbursement when billed with a National Drug Code.

Physician Counseling Visits Under s. 253.10, Wis. Stats.

Section 253.10, Wis. Stats., provides that a woman’s consent to an abortion is not considered informed consent unless at least 24 hours prior to an abortion a physician has personally provided the woman with certain

information. That information includes, among other things, all the following:

- Whether the woman is pregnant.
- Medical risks associated with the woman’s pregnancy.
- Details of the abortion method that would be used.
- Medical risks associated with the particular abortion procedure.
- “Any other information that a reasonable patient would consider material and relevant to a decision of whether or not to carry a child to birth or to undergo an abortion.”

Wisconsin Medicaid will cover an office visit during which a physician provides the information required under s. 253.10, Wis. Stats., even if the woman decides to undergo an abortion and even if the abortion is not Medicaid covered.

Pursuant to s. 253.10, Wis. Stats., the Department of Health and Family Services (DHFS) has issued preprinted material summarizing the statutory requirements under s. 253.10, Wis. Stats. Providers may contact their local health departments for these materials.

Services Incidental to a Noncovered Abortion

Services incidental to a noncovered abortion are not covered by Wisconsin Medicaid. Such services include, but are not limited to, any of the following services when directly related to the performance of a noncovered abortion:

- Laboratory testing and interpretation.
- Recovery room services.
- Transportation.
- Routine follow-up visits.
- Ultrasound services.

Section 253.10, Wis. Stats., provides that a woman’s consent to an abortion is not considered informed consent unless at least 24 hours prior to an abortion a physician has personally provided the woman with certain information.

Services Performed by Providers of a Noncovered Abortion

A Medicaid provider performs a noncovered abortion on a Medicaid recipient. The provider claims reimbursement for other services that were provided to the same recipient between nine months prior to and six weeks after the noncovered abortion. Wisconsin Medicaid requires the provider in this situation to comply with the following requirements:

- All claims must be submitted on paper, not electronically.
- Each claim must have the following signed written statement and information:
 - ✓ No service billed to Wisconsin Medicaid on the attached claim form was directly related to the performance of a non-Medicaid-covered abortion procedure. I understand that this statement is a representation of a material fact made in a claim for payment under Wisconsin Medicaid within the meaning of s. 49.49, Wis. Stats., and HFS 106.06(17), Wis. Admin. Code. Accordingly, if this statement is false, I understand that I am subject to criminal prosecution for Medicaid fraud or termination as a Medicaid provider, or both.
 - ✓ Provider's name.
 - ✓ Provider's Medicaid number.
 - ✓ Provider's signature and date.

Dental Services

Outpatient hospitalization for dental services is allowed on an emergency and nonemergency (elective) basis for some dental services. Hospitalization for the express purpose of controlling apprehension is not a Medicaid-covered service. This policy applies to outpatient hospital and ambulatory surgical centers. For information on criteria for Medicaid-covered nonemergency hospitalization for dental services, refer to the Wisconsin Medicaid Dental Handbook.

Emergency hospitalization, hospital calls, and emergency outpatient dental service (emergency room and day surgery) do not require prior

authorization (PA). All elective nonemergency dental procedures require PA if they require PA in other places of service. It is the responsibility of the dentist, not the hospital, to obtain PA.

Wisconsin Medicaid reimburses hospitals providing outpatient dental services by the rate-per-visit payment specific to each hospital.

Diagnostic Testing, Laboratory, and Therapeutic Services

Diagnostic testing, laboratory, and therapeutic services are considered outpatient hospital services when provided by a hospital certified under s. HFS 105.07 or 105.21, Wis. Admin. Code, and ordered by a physician for a recipient who is not a hospital inpatient.

End-Stage Renal Disease Services

Wisconsin Medicaid covers dialysis for recipients with end-stage renal disease (ESRD). Hospitals are required to assist any patient with ESRD to obtain Medicare eligibility. Refer to the Claims Submission chapter of this section for more information on Medicaid/Medicare dual-entitlees, and refer to the Inpatient Services section of this handbook for information on other ESRD services.

HealthCheck "Other Services"

Medically necessary services that are not otherwise covered by Wisconsin Medicaid may be covered if they are provided to a recipient under age 21 as a result of a HealthCheck screening. These are called HealthCheck "Other Services" and most require PA. Refer to the Prior Authorization chapter of this section for more PA information.

Outpatient Hospital Therapy Services

Outpatient hospital therapy services (physical therapy, occupational therapy, and speech and language pathology services) are required to be provided within an approved hospital facility. Refer to "Approved Hospital Facility" in the Provider Information chapter of this section for more information on approved hospital facility criteria.

Diagnostic testing, laboratory, and therapeutic services are considered outpatient hospital services when provided by a hospital certified under s. HFS 105.07 or 105.21, Wis. Admin. Code, and ordered by a physician for a recipient who is not a hospital inpatient.

A sterilization is any surgical procedure performed with the *primary* purpose of rendering an individual permanently incapable of reproducing.

Wisconsin Medicaid requires therapy services provided outside the approved hospital facility or in an unapproved portion of a hospital facility to obtain separate provider certification from Wisconsin Medicaid and use that provider number for submitting PA requests and claims. Refer to the Physical Therapy/Occupational Therapy Handbook and the Speech and Language Pathology Handbook for further information.

Unapproved facility services include services provided at sheltered workshops, nursing homes, and satellite offices. Refer to the Claims Submission chapter of this section for information on submitting claims for therapy services provided at unapproved facilities.

Substance Abuse and Mental Health Outpatient Clinic Services

Providers may submit claims for substance abuse (alcohol and other drug abuse) and mental health outpatient clinic services on the UB-92 claim form only if the services are performed *within the approved hospital facility*. Mental health and substance abuse programs must obtain certification from the Bureau of Quality Assurance (BQA) before they can be certified as Medicaid programs.

Outpatient Surgery

Wisconsin Medicaid covers surgical procedures as an outpatient hospital service when the recipients are not admitted as inpatients and are not counted in the midnight census.

Sterilizations

A sterilization is any surgical procedure performed with the *primary* purpose of rendering an individual permanently incapable of reproducing. This does not include procedures that, while they may result in sterility, have a different purpose such as the surgical removal of a cancerous uterus or cancerous testicles.

Medicaid reimbursement for sterilizations is dependent on providers fulfilling all federal and state requirements cited below and satisfactory completion of an informed consent statement. Federal and state regulations require that the informed consent statement meet the following criteria:

- The recipient is not an institutionalized individual.
- The recipient is at least 21 years old on the date the informed written consent is obtained.
- The recipient gives voluntary informed written consent for sterilization.
- The recipient is not a mentally incompetent individual. Wisconsin Medicaid defines a “mentally incompetent” individual as a person who is declared mentally incompetent by a federal, state, or local court of competent jurisdiction for any purposes, unless the individual has been declared competent for purposes which include the ability to consent to sterilization.
- At least 30 days, excluding the consent and surgery dates, but not more than 180 days, have passed between the date of written consent and the sterilization date, except in the case of premature delivery or emergency abdominal surgery if:
 - ✓ In the case of premature delivery, the sterilization is performed at the time of premature delivery *and* written informed consent was given at least 30 days before the expected date of delivery *and* at least 72 hours before the premature delivery. The 30 days excludes the consent and surgery dates.
 - ✓ The sterilization is performed during emergency abdominal surgery *and* at least 72 hours have passed since the recipient gave written informed consent for sterilization.

Documentation Requirements

If the performing physician has not done so, hospitals are required to attach a copy of the sterilization consent form to the UB-92 claim form for Medicaid payment of sterilizations. Refer to the Claims Submission chapter of this section for more information on submitting sterilization claims.

Hospitals are encouraged to use the Medicaid Informed Consent Form *before* all sterilizations to ensure payment in the event that the patient receives Medicaid retroactive eligibility. Refer to the Wisconsin Medicaid Physician Handbook for a sample form.

Sterilization Informed Consent Statement

The recipient is required to give voluntary written consent on a federally required informed consent statement. Sterilization coverage requires accurate and thorough completion of a consent form. The performing physician is responsible for obtaining consent. Any corrections to the statement are required to be signed by the physician and/or recipient, as appropriate. Refer to the Physician Handbook for more information on informed consent statements.

Signatures and signature dates of the recipient, physician, and the person obtaining the consent are mandatory. Surgeons' failure to comply with all the sterilization requirements results in denial of the sterilization claims.

Related Services That Are Not Hospital Outpatient Services

Hospital-Based Ambulance

All air, water, or land hospital-based ambulance services are required to meet the ambulance certification standards in HFS 105.38, Wis. Admin. Code. Hospitals providing these services are required to be individually certified as ambulance providers in order to receive reimbursement.

Services Provided in Unapproved Facilities

Outpatient rate-per-visit reimbursement is paid only for services provided in a facility that is approved by the BQA as a hospital. Claims for services provided outside a Medicaid-certified and BQA-approved hospital must be submitted under a separate Medicaid provider number using the claim form appropriate to the type of Medicaid service and provider category. For example, a freestanding facility that provides services on the same property as a Medicaid-certified hospital or is affiliated with a Medicaid-certified hospital must submit claims under its own Medicaid provider number, not under a Medicaid hospital provider number as outpatient hospital services.

Substance Abuse and Mental Health Outpatient Clinic Services

If substance abuse and mental health outpatient clinic services are performed in an unapproved portion of a hospital, they are not outpatient hospital services. If this is the case, the facility must be separately certified by Wisconsin Medicaid for Medicaid outpatient psychotherapy/substance abuse services. Mental health and substance abuse programs must obtain certification from the BQA before they can be certified as Medicaid programs.

Substance Abuse Day Treatment and Mental Health Day Treatment

Substance abuse day treatment and mental health day treatment are not considered outpatient services; they are considered separate Medicaid services. For more information on these services, refer to the Substance Abuse Day Treatment and Mental Health Day Treatment Services Handbook.

Outpatient rate-per-visit reimbursement is paid only for services provided in a facility that is approved by the BQA as a hospital.

As specified in HFS 107.035, Wis. Admin. Code, Wisconsin Medicaid does not cover outpatient hospital experimental services.

Noncovered Services

Under HFS 107.08(4)(a)4 and 6, Wis. Admin. Code, Wisconsin Medicaid does not cover the following:

- Inpatient and outpatient services for the same recipient, on the same DOS, unless the recipient is admitted to a hospital other than the facility providing the outpatient care.
- Hospital laboratory, diagnostic, radiology, and imaging tests not ordered by a physician, except in emergencies.

Experimental Services

As specified in HFS 107.035, Wis. Admin. Code, Wisconsin Medicaid does not cover outpatient hospital experimental services. The DHFS considers a service experimental when the procedure is not generally recognized by the professional medical community as effective or proven for the condition for which it is being used.

The DHFS may consider a service experimental in one setting or institution, but effective, proven, and nonexperimental in another setting, depending on the facility's experience and capabilities.

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Prior Authorization

In accordance with HFS 107.02(3), Wis. Admin. Code, Wisconsin Medicaid requires prior authorization (PA) for certain services in order to:

- Prevent unnecessary or inappropriate care and services.
- Safeguard against excess payments.
- Assess the quality and timeliness of services.
- Determine if less expensive alternative care, services, or supplies are usable.
- Promote the most effective and appropriate use of available services and facilities.
- Curtail misutilization practices of providers and recipients.

Providers are required to obtain PA for certain specified services before providing the services, unless the service is an emergency. For more information on PA, refer to the All-Provider Handbook.

Services Requiring Prior Authorization

Covered hospital services require PA if provided out-of-state under nonemergency circumstance by nonborder status providers.

Substance Abuse and Mental Health Outpatient Clinic Services

Hospitals certified in providing substance abuse (alcohol and other drug abuse) and mental health outpatient services require PA for services exceeding \$500 of Medicaid-allowed charges per recipient per calendar year. Hospitals seeking PA for substance abuse and mental health outpatient services provided to

outpatient recipients must indicate on the Prior Authorization Request Form (PA/RF) the expected cost, multiply the number of requested visits by the Medicaid billed amount of the requested services. Refer to the Mental Health Provider Handbook for more information.

HealthCheck "Other Services"

When requesting PA, providers must indicate the descriptions of the service and the number of hours of service requested for HealthCheck "Other Services" on the PA/RF. Leave the section requesting the procedure code blank; if a provider is unable to find an appropriate code, Wisconsin Medicaid will assign one. To expedite processing of the request, write "HealthCheck Other Services" or "HOS" in red ink at the top of the PA/RF.

Procedures for Obtaining Prior Authorization

Providers may request PA using the PA/RF and other PA forms. Refer to Appendices 1-8 of this section for sample PA forms and completion instructions.

Providers requesting PA for substance abuse services are required to include the Prior Authorization/Alcohol and Other Drug Abuse Attachment (PA/AA) with the PA/RF. Refer to Appendices 3-5 of this section for sample PA/AAs and completion instructions.

Providers requesting PA for psychotherapy services are required to include the Prior Authorization Psychotherapy Attachment (PA/PSYA) with the PA/RF. Refer to Appendices 6-8 of this section for sample PA/PSYAs and completion instructions.

Hospitals certified in providing substance abuse (alcohol and other drug abuse) and mental health outpatient services require PA for services exceeding \$500 of Medicaid-allowed charges per recipient per calendar year.

Prior Authorization Requests by Fax

Providers may submit their PA requests to Wisconsin Medicaid by fax at (608) 221-8616. To avoid delayed adjudication, do not fax and mail duplicate copies of the same PA/RFs. Refer to Appendix 9 of this handbook for further guidelines on submitting PAs by fax.

Written Prior Authorization Requests

Send completed PA forms to:

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

Providers may order PA forms by writing to:

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

Please specify the type and quantity of forms needed. Reorder forms are included with each shipment; do not reorder by telephone.

For more information on PA, including responses to PA requests, emergency situations, appeal procedures, supporting materials, retroactive authorization, and recipient loss of eligibility during treatment, refer to the Prior Authorization section of the All-Provider Handbook.

To avoid delayed adjudication, do not fax and mail duplicate copies of the same PA/RFs.

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Claims Submission

Submitting Claims for Outpatient Services

Providers have the option of submitting either one claim per date of service (DOS) or submitting one claim for a series of outpatient services. Submit all outpatient claims with a bill type of “131,” with the exception of Medicare crossovers where the appropriate Medicare bill type is accepted.

A single outpatient claim must not contain DOS spanning more than one calendar month. The revenue description and code are required to be on the same line, with the respective individual DOS on subsequent lines.

All claims that providers submit, whether paper or electronic, are subject to the same Medicaid processing and legal requirements.

Providers have the option of submitting either one claim per date of service (DOS) or submitting one claim for a series of outpatient services.

Electronic Claims Submission

As an alternative to submission of paper claims, Wisconsin Medicaid can process claims submitted on magnetic tape (tape-to-tape) or through telephone transmission via modem. Providers submitting electronically usually reduce their claims submission errors. Wisconsin Medicaid provides software for billing claims electronically. For more information on obtaining electronic billing capabilities, providers may:

- Refer to the Claims Submission section of the All-Provider Handbook.
- Contact the Wisconsin Medicaid Electronic Media Claims (EMC) unit at (608) 221-4746 and ask to speak with an EMC coordinator.

Providers who currently use the software and have technical questions may contact Wisconsin Medicaid software customer service at (800) 822-8050.

Paper Claims Submission

Submit claims for hospital services on the UB-92 claim form. Refer to Appendices 10 and 11 of this section for a sample UB-92 claim form and completion instructions. Nonhospital providers use claim forms appropriate to their type of service.

For a complete set of UB-92 claim form instructions, refer to the UB-92 Billing Manual. To purchase the UB-92 Billing Manual, contact the Wisconsin Hospital Association at:

Wisconsin Hospital Association
5721 Odana Rd
Madison WI 53719-1289
(608) 274-1820 or
(800) 362-7121

Wisconsin Medicaid does not provide UB-92 claim forms; they *cannot* be purchased from the Wisconsin Hospital Association. UB-92 claim forms are available from many suppliers.

Mail completed UB-92 claim forms to:

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

Claims Submission Deadline

Wisconsin Medicaid must receive all claims for services provided to eligible recipients within 365 days from the DOS. This policy applies to all initial claims submissions, resubmissions, and adjustment requests.

Refer to the All-Provider Handbook for exceptions to the claims submission deadline and requirements for submission to Late Billing Appeals.

Crossover Claims Submission Deadline

Claims for services provided to recipients covered by both Medicare and Medicaid (dual entitlements) are considered crossover claims. For

services provided to dual entitlements, claims for coinsurance and deductible must be received by Wisconsin Medicaid within 365 days of the DOS, or within 90 days of the Explanation of Medicare Benefits date or the Remittance Advice date, whichever is later. This timeline applies to all initial claims submissions and resubmissions.

Claim Components

Revenue Codes

Providers are required to enter revenue codes for accommodation and ancillary services in Item 42 of the UB-92 claim form. Refer to the UB-92 Billing Manual or Appendix 12 of this handbook section for a list of allowable revenue codes.

Outpatient laboratory services identified by revenue codes 30X, 31X, 923, and 925 also require a *Current Procedural Terminology* procedure code in Item 44 of the UB-92 claim form.

Diagnosis Codes

All diagnoses entered in Item 67 of the UB-92 claim form are required to be from the *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) coding structure.

Providers may order the complete ICD-9-CM code book by writing to the address indicated in the Provider Resources section of the All-Provider Handbook.

Coordination of Benefits

Health Insurance Coverage

Wisconsin Medicaid is generally the payer of last resort for any Medicaid-covered service. Refer to the Coordination of Benefits section of the All-Provider Handbook for more information on programs that pay after Wisconsin Medicaid. If the recipient is covered under other health insurance, such as Medicare or commercial health insurance, Wisconsin

Medicaid reimburses that portion of the allowable cost remaining after exhausting all other health insurance sources. Refer to the Coordination of Benefits section of the All-Provider Handbook for more information on services requiring other health insurance billing and other payers.

Medicaid Managed Care Coverage

For recipients enrolled in a Medicaid managed care program, the contract between the managed care program and certified provider establishes all conditions of payment and prior authorization (PA) for hospital services. Wisconsin Medicaid denies claims for services covered by a Medicaid managed care program.

Medicare/Medicaid Dual Entitlement

Hospitals are required to send claims for Medicare-covered services provided to dual-entitlements to Medicare before submitting the claims to Wisconsin Medicaid.

Medicare-allowed claims may be submitted to Wisconsin Medicaid for payment of the coinsurance and deductible. Provider-submitted crossover claims must indicate the number of covered days being billed on the claim in Item 7 of the UB-92 claim form. When providers submit crossover claims to Wisconsin Medicaid, they are required to complete Item 7 (covered days) on the claim form.

If the service for a dual-entitlement is covered by Medicare, but Medicare denies the claim for any reason besides code "M7," indicate a Medicare disclaimer code in Item 84 of the UB-92 claim form. Refer to the All-Provider Handbook for more information about crossover claims.

Medicare does not require PA for its covered services, but providers are strongly encouraged to obtain Wisconsin Medicaid PA for hospital services that require PA before the services are provided to dual-entitlements. Wisconsin Medicaid requires a PA number on noncrossover institutional claims submitted for dual-entitlements if the services provided require Medicaid PA.

Hospitals are required to send claims for Medicare-covered services provided to dual-entitlements to Medicare before submitting the claims to Wisconsin Medicaid.

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Crossover Claims

Paper claims for certain services to dual-entitlees, such as end-stage renal disease services, automatically crossover to Wisconsin Medicaid from Medicare. Claims submitted to Medicare must indicate the following items on the UB-92 claim form to ensure proper claims processing with Wisconsin Medicaid:

- Indicate covered days in Item 7.
- Indicate “T-19” in Item 50.
- Indicate the recipient’s Medicaid identification number in Item 60.

Spenddown and Medicare Part B Charges

Indicate the value code “22” and the actual amount in Item 39, 40, or 41 for recipient spenddown. Refer to the UB-92 Billing Manual for more information.

Usual and Customary Charges

Providers are required to bill their usual and customary charge for services provided. The usual and customary charge is the amount the provider charges for the same service when provided to a private-pay patient.

For providers using a sliding fee scale for specific services, the usual and customary charge is the provider’s charge for the service when provided to a non-Medicaid patient. Providers shall not discriminate against a Medicaid recipient by charging a higher fee for the service than is charged to a private-pay patient.

Special Circumstances

Dilation and Curettage

When submitting claims for dilation and curettage surgical procedures, hospitals are required to attach a copy of the preoperative history and physical exam document and an operative and pathology report with the UB-92 claim form.

Inpatient and Outpatient Services for the Same Date of Service

If inpatient and outpatient services are provided for the same recipient, at the same hospital, on the same DOS as the date of the inpatient hospital admission or discharge, the outpatient services are not separately reimbursed and are required to be included on the inpatient claim. This does not include reference laboratory services.

Wisconsin Medicaid does not reimburse for outpatient claims for services provided at one hospital to an inpatient in another hospital, except on the date of admission or the date of discharge. For any other day during the inpatient stay, the hospital providing the outpatient services must arrange payment with the inpatient hospital.

Obstetrical and Newborn Stays

Claims for One-Day Mother/Baby Stays

Providers are required to submit a UB-92 inpatient claim form for the mother or the baby by following these procedures:

- Indicate bill type “111” for inpatient services in Item 4.
- Indicate the “From” and “To” dates in Item 6 (they must be the same).
- Indicate the covered days as “1” in Item 7.

The diagnosis codes and procedure codes must result in the claim being assigned to one of the diagnosis-related groups (DRGs) in range 601-680 (newborn) or any delivery including Cesarean section transfers. For more information on DRGs, refer to the “Claims Submission” chapter of the Inpatient Services section of this handbook.

Claims for Newborns Using Mothers’ Medicaid Identification Numbers

Submit a newborn’s claim using the mother’s Medicaid identification number if the baby’s outpatient visit is 10 days or less from the baby’s date of birth and a Medicaid

Wisconsin Medicaid does not reimburse for outpatient claims for services provided at one hospital to an inpatient in another hospital, except on the date of admission or the date of discharge.

identification number has not yet been assigned to the baby. If the baby's outpatient visit is 11 or more days, submit the claim with the baby's Medicaid identification number when assigned.

Wisconsin Medicaid requires hospitals to indicate the following information when submitting a newborn claim:

- The baby's name in Item 12 of the UB-92 claim form (i.e., Smith, Newborn).
- The occurrence code (50 — male, 51 — female) in Items 32-35.
- The baby's date of birth with the occurrence code.
- The mother's name and her date of birth in Item 58.
- The mother's Wisconsin Medicaid identification number in Item 60.

Claims submitted under the baby's identification number do not need an occurrence code with a date of birth and do not need to indicate the mother's identification number.

Establishing Continuous Eligibility of Newborns

According to federal law, an infant who remains in his or her mother's household may continue to receive Wisconsin Medicaid benefits until the end of the month in which the child turns one year old, regardless of changes in family size or income. Once the infant is one year old, eligibility will be based on family income and size. The family is responsible for reporting these changes.

Wisconsin Medicaid applies Medicaid eligibility for newborns from the date of birth through the month in which the child turns one year of age. These policies are for newborns born to mothers who are eligible for Wisconsin Medicaid, including Healthy Start, and whose birth is reported by hospitals.

If a mother was not a Medicaid recipient when the baby was born, she can retroactively apply for Wisconsin Medicaid. If her dates of eligibility include the date of the baby's birth, her baby may also receive retroactive and continuous eligibility for the first year of his or her life.

Outpatient Hospital Therapy Services

Use the UB-92 claim form to submit claims for outpatient hospital therapy services provided at an approved hospital facility. Wisconsin Medicaid reimburses these services using the outpatient hospital rate-per-visit.

Separately certified therapy providers who provide services at unapproved locations use the CMS 1500 claim form when submitting claims to Wisconsin Medicaid according to policies and procedures given in the Physical Therapy and Occupational Therapy Handbook or the Speech and Language Pathology Handbook.

Substance Abuse and Mental Health Outpatient Clinic Services

Substance abuse (alcohol and other drug abuse) day treatment and mental health day treatment are not reimbursed as outpatient hospital services. They are considered separate Medicaid services and require separate provider certification.

If services are performed in an unapproved portion of a hospital or an off-site location, the facility is required to be separately certified for Medicaid outpatient psychotherapy/substance abuse services. The facility is also required to obtain a unique performing provider number. Services performed in an unapproved portion of a hospital are required to be submitted on the CMS 1500 claim form.

Payment Methods

Wisconsin Medicaid Inpatient and Outpatient State Plans

The Hospital Inpatient and Outpatient State Plans are Wisconsin Medicaid's federally approved description of methods and standards for establishing payment rates to hospitals. The State Plans include all hospital inpatient and outpatient rate-setting methodologies. The State Plans are effective from July 1 to June 30. Each year, Wisconsin Medicaid amends the State Plans. Hospitals are allowed an opportunity to comment on proposed amendments before

If a mother was not a Medicaid recipient when the baby was born, she can retroactively apply for Wisconsin Medicaid.

Only medically necessary covered services provided within the physical premises of an approved hospital facility are eligible for the outpatient hospital payment rate.

Wisconsin Medicaid requests approval from the federal Centers for Medicare and Medicaid Services (CMS) for state plan changes. Providers may obtain copies of the state plan on the Wisconsin Medicaid Web site at www.dhfs.state.wi.us/medicaid/.

Wisconsin Medicaid reimburses outpatient hospital services at a hospital-specific all-inclusive rate-per-visit. Only one rate-per-visit per DOS is reimbursable. Refer to the Outpatient Hospital State Plan for the methods used in the outpatient rate-per-visit calculation.

Only medically necessary covered services provided within the physical premises of an approved hospital facility are eligible for the outpatient hospital payment rate. Medically necessary covered services provided in a facility that is not an approved hospital facility or that is in an unapproved portion of a hospital facility are not covered by the Medicaid outpatient hospital payment.

Medicare Crossover Claims

Wisconsin Medicaid reimburses Medicare coinsurance on crossover claims for dual entitlements according to s. 49.46, Wis. Stats. Medicare determines a total coinsurance amount for each claim. Wisconsin Medicaid prorates the total coinsurance across all allowed

claim details or services. Then, for each allowed claim detail, Wisconsin Medicaid pays the lesser of the Medicare coinsurance amount allocated to the detail or the Medicaid hospital-specific outpatient rate-per-visit. Wisconsin Medicaid pays the Medicare deductible in full.

Follow-Up to Claims Submission

The provider is responsible for initiating follow-up procedures on claims submitted to Wisconsin Medicaid. Processed claims appear on the Remittance and Status Report either as paid, pending, or denied. Wisconsin Medicaid will take no further action on a denied claim until the provider corrects the information and resubmits the claim for processing.

If a claim was paid incorrectly, the provider is responsible for submitting an Adjustment Request Form to Wisconsin Medicaid. Refer to the Claims Submission section of the All-Provider Handbook for more information on:

- Adjustments to paid claims.
- Denied claims.
- Duplicate payments.
- Good Faith claims filing procedures.
- Remittance and Status Reports.
- Return of overpayments.

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Appendix 1

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

Element 1 — Processing Type

Enter the appropriate three-digit processing type from the list below. The “processing type” is a three-digit code used to identify the category of service being submitted for reimbursement.

127 — Psychotherapy (UB-92 billing providers only)

128 — Substance Abuse Services

999 — Other (use only if the requested category of services is not listed above)

Element 2 — Recipient’s Medical Assistance ID Number

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

Element 3 — Recipient’s Name

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

Element 4 — Recipient Address

Enter the complete address (street, city, state, and ZIP code) of the recipient’s place of residence. If the recipient is a resident of a nursing home or other facility, also include the name of the nursing home or facility.

Element 5 — Date of Birth

Enter the recipient’s date of birth in MM/DD/YYYY format (e.g., September 25, 1975, would be 09/25/1975).

Element 6 — Sex

Enter an “X” to specify the recipient’s gender as male or female.

Element 7 — Billing Provider Name, Address, and ZIP Code

Enter the billing provider’s name and complete address (street, city, state, and ZIP code). *No other information should be entered into this element since it also serves as a return mailing label.*

Element 8 — Billing Provider Telephone Number

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

Element 9 — Billing Provider No.

Enter the billing provider’s eight-digit Medicaid provider number.

Element 10 — Dx: Primary

Enter the appropriate *International Classification of Diseases, Ninth Edition, Clinical Modification* (ICD-9-CM) diagnosis code most relevant to the service/procedure requested for the recipient.

Element 11 — Dx: Secondary

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

Element 12 — Start Date of SOI (not required)

Element 13 — First Date Rx (not required)

Element 14 — Procedure Code

Enter the appropriate revenue code, Healthcare Common Procedure Coding System, *Current Procedural Terminology* code, National Drug Code (NDC), or Wisconsin Medicaid-assigned five-digit procedure code for each service/procedure/item requested.

Appendix 1 (Continued)

Element 15 — MOD

Enter the modifier corresponding to the procedure code (if a modifier is required by Wisconsin Medicaid policy and the coding structure used) for each service/procedure/item requested.

Element 16 — POS

Enter the appropriate Medicaid single-digit place of service code designating where the requested service/procedure/item would be provided/performed/dispensed.

<i>Code</i>	<i>Description</i>
2	Outpatient Hospital

Element 17 — TOS

Enter the appropriate Medicaid single-digit type of service code for each service/procedure/item requested.

<i>Numeric Code</i>	<i>Description</i>
0	Blood
1	Medical (Physician's Medical Services, Home Health, Independent Nurses, Audiology, Physical Therapy, Occupational Therapy, Speech and Language Pathology, Personal Care, Mental Health Day Treatment, and Substance Abuse [alcohol and other drug abuse] Day Treatment)
2	Surgery
3	Consultation
4	Diagnostic X-Ray — Total Charge
5	Diagnostic Lab — Total Charge
6	Radiation Therapy — Total Charge
7	Anesthesia
8	Assistant Surgery
9	Other, including: Transportation Family Planning Clinic Rehabilitation Agency Nurse Midwife Chiropractic

<i>Alpha Code</i>	<i>Description</i>
C	Hospital Outpatient Services, Ancillaries, Mental Health Psychotherapy and Evaluations, Diagnostic Testing, Substance Abuse Services, and Nursing Home

Element 18 — Description of Service

Enter a written description corresponding to the appropriate 11-digit NDC, five-digit procedure code, or three-digit revenue code for each service/procedure/item requested.

Element 19 — QR

Enter the quantity (e.g., number of services, dollar amount) requested for each service/procedure/item requested.

- Psychotherapy (UB-92 billing providers only) (number of sessions).
- Substance Abuse (UB-92 billing providers only) (number of sessions).

Element 20 — Charges

Enter your usual and customary charge for each service/procedure/item requested. If the quantity is greater than "1," multiply the quantity by the charge for each service/procedure/item requested. Enter that total amount in this element.

Note: The charges indicated on the Prior Authorization Request Form (PA/RF) should reflect the provider's usual and customary charge for the procedure requested. Providers are reimbursed for authorized services according to the Department of Health and Family Service's *Terms of Provider Reimbursement*.

Appendix 1 (Continued)

Element 21 — Total Charge

Enter the anticipated total charge for this request.

Element 22 — Billing Claim Payment Clarification Statement

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

Element 23 — Date

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

Element 24 — Requesting Provider Signature

The signature of the provider requesting/performing/dispensing the service/procedure/item must appear in this element.

DO NOT ENTER ANY INFORMATION BELOW THE SIGNATURE OF THE REQUESTING PROVIDER — THIS SPACE IS USED BY WISCONSIN MEDICAID CONSULTANTS AND ANALYSTS.

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Appendix 2

Sample Prior Authorization Request Form (PA/RF)

MAIL TO: E.D.S. FEDERAL CORPORATION PRIOR AUTHORIZATION UNIT 6406 BRIDGE ROAD SUITE 88 MADISON, WI 53784-0088		PRIOR AUTHORIZATION REQUEST FORM <div style="border: 1px solid black; padding: 2px; display: inline-block;">PA/RF</div> (DO NOT WRITE IN THIS SPACE) ICN # A.T. # P.A. # 0123456		1 PROCESSING TYPE <div style="border: 1px solid black; padding: 5px; display: inline-block; font-size: 1.2em;">128</div>		
2 RECIPIENT'S MEDICAL ASSISTANCE ID NUMBER 1234567890			4 RECIPIENT ADDRESS (STREET, CITY, STATE, ZIP CODE) 609 Willow Anytown, WI 55555			
3 RECIPIENT'S NAME (LAST, FIRST, MIDDLE INITIAL) Recipient, Ima D.						
5 DATE OF BIRTH 09/25/1975		6 SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>		8 BILLING PROVIDER TELEPHONE NUMBER (555) 555-5555		
7 BILLING PROVIDER NAME, ADDRESS, ZIP CODE: I.M. Hospital 1 W. Williams Anytown, WI 55555				9 BILLING PROVIDER NO. 12345678		
				10 DX: PRIMARY 303.92		
				11 DX: SECONDARY 304.9		
				12 START DATE OF SOI: 		
		13 FIRST DATE RX: 				
14 PROCEDURE CODE	15 MOD	16 POS	17 TOS	18 DESCRIPTION OF SERVICE	19 QR	20 CHARGES
945		2	C	3 individual sessions at 60 minutes each	120.00	\$360.00
					TOTAL CHARGE	21 \$360.00

22. 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 authorization expiration date. Reimbursement will be in accordance with Wisconsin Medical Assistance Program payment methodology and Policy. If the recipient is enrolled in a Medical Assistance HMO at the time a prior authorized service is provided, WMAP reimbursement will be allowed only if the service is not covered by the HMO.

23 MM/DD/YYYY
DATE

24 REQUESTING PROVIDER SIGNATURE

(DO NOT WRITE IN THIS SPACE)

AUTHORIZATION: <input type="checkbox"/> APPROVED <input type="checkbox"/> MODIFIED REASON: _____ <input type="checkbox"/> DENIED REASON: _____ <input type="checkbox"/> RETURN REASON: _____	<div style="border: 1px solid black; height: 20px; margin: 0 auto; width: 100px;"></div> <small>GRANT DATE</small>	<div style="border: 1px solid black; height: 20px; margin: 0 auto; width: 100px;"></div> <small>EXPIRATION DATE</small>	PROCEDURE(S) AUTHORIZED 	QUANTITY AUTHORIZED
--	--	---	--	------------------------------------

482-120
DATE

CONSULTANT/ANALYST SIGNATURE

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Appendix 3

Prior Authorization Alcohol and Other Drug Abuse Attachment (PA/AA) Completion Instructions

To avoid delays in prior authorization (PA) request approval, providers should ensure that all clerical information is correctly entered on the Prior Authorization Request Form (PA/RF) and that all clinical information necessary to document that the service is medically necessary is included. Carefully complete the Prior Authorization Alcohol and Other Drug Abuse Attachment (PA/AA), attach it to the PA/RF, and submit it to:

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

Questions regarding the completion of the PA/RF and/or the PA/AA may be directed to Provider Services at (800) 947-9627 or (608) 221-9883.

Recipient Information

Element 1 — Last Name

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

Element 2 — First Name

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

Element 3 — Middle Initial

Enter the recipient's middle initial from the recipient's identification card.

Element 4 — Medical Assistance ID Number

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

Element 5 — Age

Enter the age of the recipient in numerical form (e.g., 21, 45, 60)

Provider Information

Element 6 — Performing Provider's Name and Credentials

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

Element 7 — Performing Provider's Medical Assistance Provider Number (not required)

Element 8 — Performing Provider's Telephone Number

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

Element 9 — Referring/Prescribing Provider's Name

Enter the name of the provider referring/prescribing treatment.

Element 10 — Referring/Prescribing Provider's Medical Assistance Number

Enter the referring/prescribing provider's eight-digit provider number, if available. The remaining portion of this attachment is to be used to document the medical necessity for the service requested.

- **Part A — Type of Treatment Requested**

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

If a certified psychotherapist is requesting specific *psychotherapy* services for the substance abuse (alcohol and other drug abuse)-affected recipient that are not represented by the categories of treatment listed, complete the Prior Authorization Psychotherapy Attachment (PA/PSYA).

- **Part B**

Providers may attach copies of assessments, treatment summaries, treatment plans or other documentation in response to the information requested on the form. Providers are responsible for ensuring that the information attached adequately responds to what is requested.

1. Attach a copy of the signed and dated prescription for substance abuse services (unless the physician is the performing provider). The initial prescription must be signed and dated within three months of receipt by Medicaid. Subsequent prescriptions must be dated within twelve months of receipt by Wisconsin Medicaid.
2. Read the 'Prior Authorization Statement' before signing and dating the attachment.
3. The recipient's signature is optional.
4. The attachment must be signed and dated by the provider requesting/providing the service.

Note: The name and signature of the supervising provider is not required if the performing provider is a physician or psychologist.

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Refer to the Online Handbook
for current policy

Appendix 4

Sample Prior Authorization Alcohol and Other Drug Abuse Attachment (PA/AA)

Mail To:

E.D.S. FEDERAL CORPORATION
Prior Authorization Unit
Suite 88
6406 Bridge Road
Madison, WI 53784-0088

PA/AA

PRIOR AUTHORIZATION AODA SERVICES ATTACHMENT

1. Complete this form
2. Attach to PA/RF
(Prior Authorization Request Form)
3. Mail to EDS

RECIPIENT INFORMATION

①	②	③	④	⑤
Recipient	Im	A	1234567890	29
LAST NAME	FIRST NAME	MIDDLE INITIAL	MEDICAL ASSISTANCE ID NUMBER	AGE

PROVIDER INFORMATION

⑥	⑦	⑧
I.M. Performing, AC		(XXX) XXX - XXXX
PERFORMING PROVIDER'S NAME AND CREDENTIALS	PERFORMING PROVIDER'S MEDICAL ASSISTANCE PROVIDER NUMBER	PERFORMING PROVIDER'S TELEPHONE NUMBER

⑨	⑩
I.M. Referring/Prescribing	87654321
REFERRING/PRESCRIBING PROVIDER'S NAME	REFERRING/PRESCRIBING PROVIDER'S MEDICAL ASSISTANCE NUMBER

PART A

TYPE OF TREATMENT REQUESTED:

☒ PRIMARY INTENSIVE OUTPATIENT TREATMENT

- ☒ Individual ☒ Group ☒ Family
- Number of minutes per session: 60 Individual 180 Group 60 Family
- Sessions will be: ☐ Twice/month ☐ Once/week ☐ Once/month ☒ Other (specify) 5X/WK
- Requesting 19 hrs/week, for 4 weeks Group 3 HR/day, 5 days/WK
- Anticipated beginning treatment date MM/DD/YYYY Ind. two one-hour sessions/WK
- Estimated intensive treatment termination date MM/DD/YYYY Family two one-hour sessions/WK
- Attach a copy of treatment design, which includes the following:
 - (a) Schedule of treatment (day, time of day, length of session and service to be provided during that time)
 - (b) Description of aftercare/follow-up component

☐ AFTERCARE/FOLLOWUP SERVICE

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

Appendix 4
(Continued)

☐ AFFECTED FAMILY MEMBER/CO-DEPENDENCY TREATMENT

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

PART B

1. Was the recipient in primary AODA treatment in the last 12 months? ☐ Yes ☒ No ☐ Unknown
If "yes," provide dates, problem(s), outcome and provider of service:

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2. Dates of diagnostic evaluation(s) or medical examination(s):
MM/DD/YYYY

3. Specify diagnostic procedures employed:
MM/DD/YYYY — Intake alcoholism checklist and clinical interview

Appendix 4 (Continued)

4. Provide current primary and secondary diagnosis (DSM-III) codes and descriptions:

303.91 alcohol dependence — continuous as manifested by maladaptive pattern of use for three years: blackouts, loss of control, legal and family problems associated with drinking.

296.2 major depressive disorder

5. Describe the recipient's current clinical problems and relevant history; include AODA history:

Client has decided to receive treatment and committed himself to abstinence from all mind/mood-altering chemicals. Client has had a patterned use which included drinking four to five times/week consuming six to 18 beers per drinking bout. Client reports being intoxicated at least one time/week. Client began trying to control his drinking about two years ago after being arrested for drunk driving. Since that time he has received one other DWI conviction. Client reports guilt and shame about his behavior. He reports periods of violence while intoxicated which occurred in his family. In addition, client reports a positive genetic history for alcoholism, claiming that his father is alcoholic.

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for current policy

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

Client lives with his family. His wife reports she has been concerned about his drinking for six years and has only recently reported her concern to her spouse. The children in the family consist of a 13-year-old son and a 10-year-old daughter. The son was very quiet during the family assessment and denied any concern about his dad's drinking. The daughter was able to express her worry and attempts to discontinue her dad's drinking. (e.g., hiding his beer). The family agreed to attend our educational night and also agreed to periodic family sessions. They decided at this time not to be involved with more intensive treatment.

Appendix 4 (Continued)

7. Provide a detailed description of treatment objectives and goals:

1. Client will learn basic information on alcoholism.
2. Client will be able to share his drinking history with group by the second week.
3. Client will verbalize and identify self as alcoholic.
4. Client will continue abstinence from alcohol.
5. Client will develop a self-help program.
6. Client will verbalize in his family his own history with alcohol.
7. Client will begin to identify and express feelings.
8. Client will obtain a sponsor by termination date.

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

Client will continue to develop and maintain a sober lifestyle. Client will also participate in our 12-week Aftercare program. Client will return to gainful employment.

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for current policy

Recipient Authorization

9. I have read the attached request for prior authorization of AODA services and agree that it will be sent to the Medicaid Program for review.

Signature of Recipient or Representative
(If representative, state relationship to recipient)

Relationship

Attach a photocopy of the physician's prescription for treatment. The prescription must be signed and dated within 3 months of receipt by EDS (initial request) or within 12 months of receipt by EDS (subsequent request). (Physician providers need not attach a prescription unless treatment is prescribed by another physician).

THE PROVISION OF SERVICES WHICH ARE GREATER THAN OR SIGNIFICANTLY DIFFERENT FROM THOSE AUTHORIZED MAY RESULT IN NON-PAYMENT OF THE BILLING CLAIM(S).

10.

I.M. Provider

Signature of Performing Provider

Alcohol and Drug Counselor

Discipline of Performing Provider

I.M. Authorized

Name of Supervising Provider

87654321

Provider Number of Supervising Provider

J.M. Authorized

Signature of Supervising Provider

MM/DD/YYYY

Date

Appendix 5
Prior Authorization Alcohol and Other Drug Abuse Attachment (PA/AA)
(for photocopying)

(A copy of the Prior Authorization Alcohol and Other Drug Abuse Attachment [PA/AA] is located on the following pages.)

ARCHIVAL USE ONLY
Refer to the Online Handbook
for current policy

(This page intentionally left blank.)

ARCHIVAL USE ONLY
Refer to the Online Handbook
for current policy

Mail To:

E.D.S. FEDERAL CORPORATION
Prior Authorization Unit
Suite 88
6406 Bridge Road
Madison, WI 53784-0088

PA/AA

**PRIOR AUTHORIZATION
AODA SERVICES ATTACHMENT**

1. Complete this form
2. Attach to PA/RF
(Prior Authorization Request Form)
3. Mail to EDS

RECIPIENT INFORMATION

① [] LAST NAME	② [] FIRST NAME	③ [] MIDDLE INITIAL	④ [] MEDICAL ASSISTANCE ID NUMBER	⑤ [] AGE
-----------------------	------------------------	----------------------------	--	-----------------

PROVIDER INFORMATION

⑥ [] PERFORMING PROVIDER'S NAME AND CREDENTIALS	⑦ [] PERFORMING PROVIDER'S MEDICAL ASSISTANCE PROVIDER NUMBER	⑧ [] PERFORMING PROVIDER'S TELEPHONE NUMBER
⑨ [] REFERRING/PRESCRIBING PROVIDER'S NAME	⑩ [] REFERRING/PRESCRIBING PROVIDER'S MEDICAL ASSISTANCE NUMBER	

PART A

TYPE OF TREATMENT REQUESTED:

- ☐ **PRIMARY INTENSIVE OUTPATIENT TREATMENT**
- ☐ Individual ☐ Group ☐ Family
 - Number of minutes per session: _____ Individual _____ Group _____ Family
 - Sessions will be: ☐ Twice/month ☐ Once/week ☐ Once/month ☐ Other (specify) _____
 - Requesting _____ hrs/week, for _____ weeks
 - Anticipated beginning treatment date _____
 - Estimated intensive treatment termination date _____
 - Attach a copy of treatment design, which includes the following:
 - (a) Schedule of treatment (day, time of day, length of session and service to be provided during that time)
 - (b) Description of aftercare/follow-up component
- ☐ **AFTERCARE/FOLLOWUP SERVICE**
- ☐ Individual ☐ Group ☐ Family
 - Number of minutes per session: _____ Individual _____ Group _____ Family
 - Sessions will be: ☐ Twice/month ☐ Once/week ☐ Once/month ☐ Other (specify) _____
 - Requesting _____ hrs/week, for _____ weeks
 - Estimated discharge date from this component of care _____

☐ **AFFECTED FAMILY MEMBER/CO-DEPENDENCY TREATMENT**

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

PART B

1. Was the recipient in primary AODA treatment in the last 12 months? ☐ Yes ☐ No ☐ Unknown
If "yes," provide dates, problem(s), outcome and provider of service:

ARCHIVAL USE ONLY
Refer to the Online Handbook
for current policy

2. Dates of diagnostic evaluation(s) or medical examination(s):

3. Specify diagnostic procedures employed:

4. Provide current primary and secondary diagnosis (**DSM-III**) codes and descriptions:

5. Describe the recipient's current clinical problems and relevant history; include AODA history:

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Refer to the Online Handbook
for current policy

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

7. Provide a detailed description of treatment objectives and goals:

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

Recipient Authorization

9. I have read the attached request for prior authorization of AODA services and agree that it will be sent to the Medicaid Program for review.

Signature of Recipient or Representative (If representative, state relationship to recipient)	Relationship
--	--------------

Attach a photocopy of the physician's prescription for treatment. The prescription must be signed and dated within 3 months of receipt by EDS (initial request) or within 12 months of receipt by EDS (subsequent request). (Physician providers need not attach a prescription unless treatment is prescribed by another physician).

THE PROVISION OF SERVICES WHICH ARE GREATER THAN OR SIGNIFICANTLY DIFFERENT FROM THOSE AUTHORIZED MAY RESULT IN NON-PAYMENT OF THE BILLING CLAIM(S).

10.

Signature of Performing Provider	Discipline of Performing Provider
----------------------------------	-----------------------------------

Name of Supervising Provider	Provider Number of Supervising Provider
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Signature of Supervising Provider	Date
-----------------------------------	------

Appendix 6

Prior Authorization Psychotherapy Attachment (PA/PSYA) Completion Instructions

Since having to return a prior authorization (PA) request for corrections or additional information can delay the prompt approval and delivery of services to a recipient, providers should ensure that all clerical information is correctly entered on the Prior Authorization Request Form (PA/RF) and that all clinical information necessary to document that the service is medically necessary is included. Carefully complete the Prior Authorization Psychotherapy Attachment (PA/PSYA), attach it to the PA/RF, and submit to:

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

Questions regarding the completion of the PA/RF and/or the PA/PSYA may be directed to Provider Services at (800) 947-9627 or (608) 221-9883.

General Instructions

The information contained in the PA/PSYA is used to make a decision about the amount and type of psychotherapy that is approved for Wisconsin Medicaid reimbursement. Thoroughly complete each section and include any material that would be helpful to understand the necessity of the services being requested. Where noted in these instructions, material from personal records may be substituted for the information requested on the form.

When submitting the first PA request for a particular individual, please fill out both pages. For continuing PA on the same individual, it is not necessary to rewrite the first page, unless new information has caused a change in any of the information on this page (e.g., a different diagnosis, belief that intellectual functioning is, in fact, significantly below average). When there has been no change in page one information, please submit a photocopy of page one along with the updated page two. Medical consultants reviewing the PA requests have a file containing the previous requests, but they must base their decisions on the clinical information submitted, so it is important to present all current relevant clinical information. For example, a depressed person may overeat or eat too little, or may sleep a lot or very little; therefore, recording simply that the recipient is depressed does not present the relevant clinical picture. The documentation should include details on the signs and symptoms the recipient presents due to the diagnosis.

Prior authorization for psychotherapy is not granted when another provider already has an approved PA for psychotherapy services for the same recipient. In these cases, Wisconsin Medicaid recommends that the recipient request that previous providers notify Wisconsin Medicaid that they have discontinued treatment with this recipient. The recipient may also submit a signed statement of his or her desire to change providers and include the date of the change. The new provider's PA may not overlap with the previous provider's PA.

Recipient Information

Element 1 — Last Name

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

Element 2 — First Name

Enter the recipient's first name. 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 — MI

Enter the recipient's middle initial.

Element 4 — Medical Assistance Identification Number

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

Appendix 6 (Continued)

Element 5 — Age

Enter the age of the recipient in numerical form (e.g., 45, 60, 21).

Provider Information

Element 6 — Performing Provider Name

Enter the name of the therapist who will be providing treatment. Circle or enter discipline (credentials) of the therapist who will be providing treatment at the right of Element 8 (e.g., I.M. Provider, MD., or I.M. Provider Ph.D.).

Element 7 — Performing Provider # (not required)

Element 8 — Performing Provider's Telephone Number

Enter the telephone number, including area code, of the performing provider.

Element 9 — Supervising Provider's Name

Enter the name of the physician or psychologist who is supervising the treatment if the performing provider is a Master's-level therapist.

Element 10 — Supervising Provider's Number (not required)

Element 11 — Prescribing Provider's Name

Enter the name of the physician who wrote the prescription for psychotherapy.

Element 12 — Prescribing Provider's Number

Enter the eight-digit Medicaid provider identification number of the physician who wrote the prescription for psychotherapy.

Documentation

A — Diagnosis

Enter the diagnosis codes and descriptions from the most recent version of the Diagnostic and Statistical Manual of Mental Disorders (DSM), using all five axes.

B — Date Treatment Began

Date of first treatment by this provider.

C — Diagnosed By

Indicate the procedure(s) used to make the diagnosis.

D — Consultation

Indicate whether there was a consultation done with respect to the recipient's diagnosis and/or treatment needs. Indicate why the consultation was needed.

E — Result(s) of Consultation

Summarize the results of this consultation or attach a copy of the consultant's report.

F — Presenting Symptoms

Enter the presenting symptoms and indicate the degree of severity. This information may be provided as a part of an intake summary that may be attached to this request form.

G-H — Intellectual Functioning

Indicate whether intellectual functioning is significantly below average (e.g., an I.Q. below 80). If "yes," indicate the I.Q. or intellectual functioning level.

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Appendix 6 (Continued)

I — Historical Data

This information may be submitted in the form of an intake summary, case history, or mental status exam as long as all information relevant to the request for treatment authorization is included.

J — Present GAF (DSM)

Enter the global assessment of functioning scale score from the most recent version of the DSM. For continuing PA requests, indicate whether the recipient is progressing in treatment, using measurable indicators when appropriate.

K — Present Mental Status/Symptomatology

Indicate the recipient's current mental status and symptoms. For continuing authorization requests, indicate the progress that has been made since the beginning of treatment or since the previous authorization. This information may be supplied in the form of an intake summary or a treatment summary as long as the summary presents a crystallization of the progress to date. It is not acceptable to send progress notes which do not summarize the progress to date.

L — Updated/Historical Data

For continuing requests, indicate any new information about the recipient's history which may be relevant to determine the need for continued treatment.

M — Treatment Modalities

Indicate the treatment modalities to be used.

N — Number of Minutes Per Session

Indicate the length of session for each modality.

O-P — Frequency of Requested Sessions and Total Number of Sessions Requested

If requesting sessions at a higher frequency, please indicate why they are needed. If a series of treatments that are not regular is anticipated (e.g., frequent sessions for a few weeks, with treatment tapering off thereafter), indicate the total number of hours of treatment requested, the time period over which the treatment is requested, and the expected pattern of treatment. The total hours must match the quantity(ies) indicated on the PA/RF.

Example: A provider requests 15 hours of treatment over a 12-week period. The recipient attends a one and one-half hour group every other week (six groups for a total of nine hours). There are one-hour weekly individual sessions for four weeks and every other week for the following four weeks (six individual sessions for a total of six hours).

Q — Psychoactive Medication

Indicate all the medications the recipient is taking which may affect the recipient's symptoms that are being treated. Indicate whether a medication review has been done in the past three months.

R — Rationale for Further Treatment

Indicate the symptoms or problems in functioning that require further treatment. If recipient has not progressed in treatment thus far, indicate reasons for believing that continued treatment is helping.

S — Goals/Objectives of Treatment

Summarize current goals/objectives of treatment. A treatment plan may be attached in response to this item.

T — Steps to Termination

Indicate how you are preparing the recipient for termination. When available, indicate a planned date of termination.

U — Family Members

Adequate justification is required if an individual provider provides services to more than one family member in individual psychotherapy.

Appendix 6 (Continued)

Signature of Performing Provider

Wisconsin Medicaid requires the performing provider's signature to process the PA request. Read the Prior Authorization Statement before dating and signing the attachment.

Recipient Signature

Signature indicates the signer has read the form. Signature is optional.

Signature of Supervising Provider

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

Other Required Information

In addition to the above information, Wisconsin Medicaid requires the following to process the PA request:

- Attach a copy of the signed and dated prescription for psychotherapy*. The initial prescription must be dated within three months of receipt by Wisconsin Medicaid. Subsequent prescriptions must be dated within 12 months of receipt by Wisconsin Medicaid.

* If the performing provider is a physician, a prescription need not be attached.

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Refer to the Online Handbook
for current policy

Appendix 7

Sample Prior Authorization Psychotherapy Attachment (PA/PSYA)

MAIL TO:
E.D.S. Federal Corporation
Prior Authorization Unit
Suite 88
6406 Bridge Road
Madison, WI 53784-0088

PA/PSYA

**PRIOR AUTHORIZATION
PSYCHOTHERAPY ATTACHMENT**

1. Complete this form.
2. Attach to PA/RF (Prior Authorization Request Form)
3. Attach physician prescription.
4. Attach additional information if necessary.
5. Mail to EDS

RECIPIENT INFORMATION

(1)	(2)	(3)	(4)	(5)
RECIPIENT	IMA	D	1234567891	26
26 Last Name	First Name	MI	Medical Assistance Identification Number	Age

PROVIDER INFORMATION

(6)	(7)	(8)	MSW (MS) MD PHD DO PSYCH Other: _____ Discipline (circle one)
I.M. PERFORMING		(555) 555-5555	
Performing Provider Name	Performing Provider #	Performing Provider's Telephone Number	
(9)	(10)	(11)	(12)
I.M. SUPERVISING		I.M. PRESCRIBING	01234567
Supervising Provider's Name	Supervising Provider's Number	Prescribing Provider's Name	Prescribing Provider's Number

- A. Diagnosis: DSM-IV Axis I: a) major depression, recurrent, in partial 296.35 remission (optional) Axis IV: 1 2 3 4 5 6 7 8 9 0
b) Adjustment disorder with depressed mood. 309.00 Axis V: (past year) (optional)
Axis II: Rule out Histrionic Axis III: none
- B. Date Treatment Began: MM/DD/YYYY with this provider.
- C. Diagnosed By: ☒ Clinical Exam ☐ Psychological Testing ☒ Other (specify): MAST Hookings Symptom
- D. Consultation: ☒ Yes ☐ No Did consultant see recipient? ☒ Yes ☐ No
- E. Result(s) of Consultation: Medication & assessed for ability to progress in psychotherapy which was seen as positive.
- F. Presenting Symptoms: Insomnia, anergy; suicidal ideation, history of 1 attempt 2 years ago, much guilt and self reproach.
Severity: ☐ Mild ☒ Moderate ☐ Severe
- G. Is the recipient's intellectual functioning significantly below average? ☐ Yes ☒ No
- H. If yes to "G", what is the recipient's IQ score or intellectual functioning level? N/A
- I. Historical Data. Give relevant social and school history including development (if under 18), treatment history, past mental status, diagnosis(es), etc. (attach additional sheets if necessary):

Ima is from a step-family home with the stepfather being "alcoholic." She was 14 years old when her stepbrother committed suicide. Reported history of physical & sexual abuse in family of origin. Long history of depressed mood. Diagnosed as having major depression 1 year ago when hospitalized at Anytown Hospital in Anytown, WI (MM/DD/YY-MM/DD/YY). No further treatment history. Seeking out help at this time due to husband being accused of abusing her 3 children. At time of hospitalization, reported being very suicidal & having some auditory hallucinations. Denies substance abuse usage. Currently well-groomed, pleasant, no signs of psychomotor retardation. Thought and speech intact. Very tearful. Admits suicidal thoughts; no plans. Oriented in all spheres.

Appendix 7 (Continued)

J. Present GAF (DSM): 50 Is the recipient progressing in treatment? ☒ Yes ☐ No
If "no", explain:

K. Present mental status/symptomatology (include progress since treatment was initiated, or since last authorization):
Since treatment started 4 weeks ago, recipient is able to sleep most of the night. Continues to be tearful & hurt about abuse situation. Having more energy to care for self. Some lack of appetite continues. Periods of anxiety are often noted.

L. Updated/historical data (family dynamics, living situation, etc.):

Client is considering divorce. Still separated at this time. Client's 3 children live with her and this has increased stress. We will begin to see her with children on an as-needed basis.

M. Treatment Modalities: ☒ Psychodynamic ☐ Behavior Modification ☐ Biofeedback
☐ Play Therapy ☐ Other (specify): _____

N. Number of minutes per session: Individual: 60 Group: _____ Family: _____

O. Frequency of requested sessions: ☐ monthly ☒ once/week ☒ twice/month ☐ other (specify): _____
(as needed)

P. Total number of sessions requested: 13 Individual 6 Family

Q. Psychoactive Medication: ☒ Yes ☐ No Has there been a medication check in the past three months?
☒ Yes ☐ No

Names and dosage(s): Desipramine 150 mg h.s. and 200 mg Dilantin for seizure disorder (total daily dose).

R. Rationale for further treatment:
1. Continues to have many life stressors (i.e., separation, child abuse).
2. Ongoing mild suicidal risk.
3. Beginning to explore own decisions around divorce with these stressors.
4. Therapy is essential to prevent rehospitalization.

S. Goals/objectives of treatment:
1. Continue to support & monitor mood; promote a positive self-image.
2. Continue to help in dealing with stress through teaching cognitive and relaxation techniques for stress management.
3. Increase self-awareness of own past abuse and its relationship to current reality.

T. What steps have been taken to prepare recipient for termination of treatment:
Have referred recipient to ongoing self-help group to deal with past issues around family alcoholism. It is too early to start termination process at this time; however, we have discussed the time-limited nature of the psychotherapy and have set a goal of terminating in 6 months.

U. Do you see other family members in a separate process? If yes, give rationale for seeing multiple family members:
No, not at this time. A family session for diagnostic purposes is planned in the near future.

I.M. Provider

Signature of Performing Provider

J.M. Authorized

Recipient Signature (optional)

Signature of Supervising Provider

MM/DD/YYYY

Date

*The provision of services which are greater than or significantly different from those authorized may result in non-payment of the claim(s).

Appendix 8
Prior Authorization Psychotherapy Attachment (PA/PSYA)
(for photocopying)

(A copy of the Prior Authorization Psychotherapy Attachment [PA/PSYA] is located on the following pages.)

ARCHIVAL USE ONLY
Refer to the Online Handbook
for current policy

(This page intentionally left blank.)

ARCHIVAL USE ONLY
Refer to the Online Handbook
for current policy

MAIL TO:
E.D.S. Federal Corporation
Prior Authorization Unit
Suite 88
6406 Bridge Road
Madison, WI 53784-0088

PA/PSYA

**PRIOR AUTHORIZATION
PSYCHOTHERAPY ATTACHMENT**

1. Complete this form.
2. Attach to PA/RF (Prior Authorization Request Form)
3. Attach physician prescription.
4. Attach additional information if necessary.
5. Mail to EDS

RECIPIENT INFORMATION

(1)	(2)	(3)	(4)	(5)
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Last Name	First Name	MI	Medical Assistance Identification Number	Age

PROVIDER INFORMATION

(6)	(7)	(8)	MSW MS MD PHD DO PSYCH Other: _____ Discipline (circle one)
<input type="text"/>	<input type="text"/>	<input type="text"/>	
Performing Provider Name	Performing Provider #	Performing Provider's Telephone Number	
(9)	(10)	(11)	(12)
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Supervising Provider's Name	Supervising Provider's Number	Prescribing Provider's Name	Prescribing Provider's Number

A. Diagnosis: Axis I: a) _____ Axis IV: 1 2 3 4 5 6 7 8 9 0
(optional)

b) _____
Axis II: _____ Axis V: (past year)
(optional)

Axis III: _____

B. Date Treatment Began: _____

C. Diagnosed By: _____ Clinical Exam _____ Psychological Testing _____ Other (specify): _____

D. Consultation: _____ Yes _____ No Did consultant see recipient? _____ Yes _____ No

E. Result(s) of Consultation: _____

F. Presenting Symptoms: _____

Severity: _____ Mild _____ Moderate _____ Severe

G. Is the recipient's intellectual functioning significantly below average? _____ Yes _____ No

H. If yes to "G", what is the recipient's IQ score or intellectual functioning level? _____

I. Historical Data. Give relevant social and school history including development (if under 18), treatment history, past mental status, diagnosis(es), etc. (attach additional sheets if necessary):

J. Present GAF (DSM): _____ Is the recipient progressing in treatment? ☐ Yes ☐ No
If "no", explain:

K. Present mental status/symptomatology (include progress since treatment was initiated, or since last authorization):

L. Updated/historical data (family dynamics, living situation, etc.):

M. Treatment Modalities: ☐ Psychodynamic ☐ Behavior Modification ☐ Biofeedback
☐ Play Therapy ☐ Other (specify): _____

N. Number of minutes per session: Individual: _____ Group: _____ Family: _____

O. Frequency of requested sessions: ☐ monthly ☐ once/week ☐ twice/month ☐ other (specify): _____

P. Total number of sessions requested: _____

Q. Psychoactive Medication: ☐ Yes ☐ No Has there been a medication check in the past three months?
☐ Yes ☐ No

Names and dosage(s): _____

R. Rationale for further treatment:

S. Goals/objectives of treatment:

T. What steps have been taken to prepare recipient for termination of treatment:

U. Do you see other family members in a separate process? If yes, give rationale for seeing multiple family members:

Signature of Performing Provider Recipient Signature (optional) Signature of Supervising Provider Date

*The provision of services which are greater than or significantly different from those authorized may result in non-payment of the claim(s).

Appendix 9

Prior Authorization by Fax Guidelines

Providers may fax prior authorization (PA) requests to Wisconsin Medicaid at (608) 221-8616. Prior authorization requests sent to any Wisconsin Medicaid fax number other than (608) 221-8616 may result in processing delays.

When faxing PA requests to Wisconsin Medicaid, providers should be aware of the following:

- Faxing a PA request eliminates one to three days of mail time. However, the adjudication time of the PA request has not changed. All actions regarding PA requests are made within the time frames outlined in the Prior Authorization section of the All-Provider Handbook.
- Faxed PA requests must be received by 1:00 p.m., otherwise, they will be considered as received the following business day. Faxed PA requests received on Saturday, Sunday, or a holiday will be processed on the next business day.
- After faxing a PA request, providers should not send the original paperwork, such as the carbon Prior Authorization Request Form (PA/RF), by mail. Mailing the original paperwork after faxing the PA request will create duplicate PA requests in the system and may result in a delay of several days to process the faxed PA request.
- Providers should not photocopy and reuse the same PA/RF for other requests. When submitting a new request for PA, it must be submitted on a new PA/RF so that the request is processed under a new PA number. This requirement applies whether the PA request is submitted by fax or by mail.
- When resubmitting a faxed PA request, providers are required to resubmit the faxed copy of the PA request, including attachments, which includes Wisconsin Medicaid's 15-digit internal control number located on the top half of the PA/RF. This will allow the provider to obtain the earliest possible grant date for the PA request (apart from backdating for retroactive eligibility). If any attachments or additional information that was requested is received without the rest of the PA request, the information will be returned to the provider.
- When faxing information to Wisconsin Medicaid, providers *should not* reduce the size of the PA/RF to fit on the bottom half of the cover page. This makes the PA request difficult to read and leaves no space for consultants to write a response if needed or to sign the request.
- If a photocopy of the original PA request and attachments is faxed, the provider should make sure these copies are clear and legible. If the information is not clear, it will be returned to the provider.
- Refaxing a PA request before the previous PA request has been returned will create duplicate PA requests and may result in delays.
- If the provider does not indicate his or her fax number, Wisconsin Medicaid will mail the decision back to the provider.
- Wisconsin Medicaid will attempt to fax a PA request response to a provider three times. If unsuccessful, the PA request will be mailed to the provider.

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Appendix 10

UB-92 Claim Form Completion Instructions for Outpatient Hospital Services

Use these billing instructions to avoid denied claims or inaccurate claim payment. Enter all required data on the UB-92 claim form in the appropriate data item. Do not include attachments. UB-92 items are required unless “optional” or “not required” is specified.

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

American Hospital Association
National Uniform Billing Committee
29th Fl
1 N Franklin
Chicago IL 60606
(312) 422-3390

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

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

Item 1* — Provider Name, Address, and Telephone Number

Enter the name of the hospital submitting the claim and the complete mailing address to which the hospital wishes payment sent. Include the hospital's city, state, and ZIP code.

Item 2 — ERO Assigned Number (not required)

Item 3 — Patient Control No. (not required)

Item 4 — Type of Bill

Enter the three-digit type of bill number. The bill number for outpatient hospital claims is:

131 = Hospital, Outpatient, Admit through Discharge Claim

Item 5 — Fed. Tax No. (not required)

Item 6 — Statement Covers Period (From - Through)

Enter both dates in MMDDYY format (e.g., May 9, 2003, would be 050903).

Item 7 — COV D.

Covered days must represent the actual number of visits (days of service) in the “from - through” period.

Item 8 — N-C D. (not required)

Item 9 — C-I D. (not required)

Item 10 — L-R D. (not required)

Item 11 — Unlabeled Field (reserved for state use)

Appendix 10 (Continued)

Item 12 — Patient Name

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

*Items are also referred to as "Form Locators" in the UB-92 Billing Manual.

Item 13 — Patient Address (not required)

Item 14 — Birthdate (not required)

Item 15 — Sex (not required)

Item 16 — MS (not required)

Item 17 — Admission Date (not required)

Item 18 — Admission HR (not required)

Item 19 — Admission Type (not required)

Item 20 — Admission SRC (required for bill types 11X, 13X, and 21X)

Enter the code indicating the source of this admission. Refer to the UB-92 Billing Manual for more information on this item.

Item 21 — D HR (not required)

Item 22 — STAT (not required)

Item 23 — Medical Record No. (not required)

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

Item 31 — Unlabeled Field (reserved for state use)

Items 32-35 a-b — Occurrence (Codes and Dates) (required, if applicable)

Item 36 — Occurrence Span (Code/From - Through) (required, if applicable)

Item 37 — Unlabeled Field (reserved for state use)

Item 38 — Unlabeled Field (reserved for state use)

Items 39-41 a-d — Value Codes (Codes and Amounts) (required, if applicable)

Refer to the UB-92 Manual for more information.

Item 42 — REV. CD.

Enter the revenue code which identifies a specific outpatient service. Refer to the UB-92 Billing Manual for a list of revenue codes and their descriptions.

Item 43 — Description (not required)

Item 44 — HCPCS/Rates (required, if applicable)

Enter the procedure code applicable to outpatient laboratory services identified by revenue codes 30X, 31X, 923, and 925.

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Appendix 10 (Continued)

Item 45 — Serv. Date (required, if applicable)

Enter the date the service was provided in the format of MMDDYY.

Item 46 — Serv. Units

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

Item 47 — Total Charges (by revenue code category)

Enter the total charges pertaining to the related revenue code for the current billing period as entered in Item 6.

Item 48 — Non-covered Charges (not required)

Item 49 — Unlabeled Field (reserved for state use)

Item 50 A-C — Payer

Identify all third-party payers (including Medicare and commercial health insurance). Enter “T19” for Wisconsin Medicaid and “MED” for Medicare. For a list of identifiers for commercial health insurance, refer to the UB-92 Billing Manual.

Item 51 A-C — Provider No.

Enter the number assigned to the provider by the payer indicated in Item 50 A, B, and C.

Item 52 A-C — Rel Info (not required)

Item 53 A-C — Asg Ben (not required)

Item 54 A-C — Prior Payments (required, if applicable)

There must be a dollar amount or \$0.00 reported here for the third-party payer identified in Item 50. Do not include any Medicare payments.

Item 55 A-C — Est Amount Due (not required)

Item 56 — Unlabeled Field (reserved for state use)

Item 57 — Unlabeled Field (reserved for state use)

Item 58 A-C — Insured's Name

If submitting a claim for a newborn and using the mother's Medicaid identification number, both the mother's name and birth date should be indicated here.

Item 59 A-C — P. Rel (not required)

Item 60 A-C — Cert. — SSN — HIC. — ID No.

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

Note: The hospital may submit a claim for the baby during the baby's first ten days of life using the mother's Medicaid identification number, identifying the baby's sex with occurrence code “50” or “51” and indicating the occurrence (birth) date. Otherwise, the claim should be submitted using the baby's Medicaid identification number, once assigned.

Item 61 A-C — Group Name (not required)

Item 62 A-C — Insurance Group No. (not required)

Item 63 A-C — Treatment Authorization Codes (required, if applicable)

Indicate the approved seven-digit Medicaid prior authorization number.

Appendix 10 (Continued)

Item 64 A-C — Esc (not required)

Item 65 A-C — Employer Name (not required)

Item 66 A-C — Employer Location (not required)

Item 67 — Prin. Diag. CD.

The principal diagnosis code identifies the condition chiefly responsible for the patient's visit or treatment. Enter the full *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) code (up to five digits) describing the principal diagnosis (e.g., the condition established after study to be chiefly responsible for causing the admission or other health care episode). Any condition which is not manifested upon admission or that develops subsequently should not be selected as the principal diagnosis.

Manifestation codes are not to be recorded as the principal diagnosis; code the underlying disease first. The principal diagnosis code may not include "E" codes. "V" codes may be used as the principal diagnosis, *unless restricted by the payer*.

Items 68-75 — Other Diag. Codes (required, if applicable)

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

Item 76 — Adm. Diag. CD. (not required)

Item 77 — E-Code (not required)

Item 78 — Unlabeled Field (reserved for state use)

Item 79 — P.C. (not required)

Item 80 — Principal Procedure Code and Date (not required)

Item 81 — Other Procedure Codes and Dates (not required)

Item 82 a-b — Attending Phys. ID

Enter the Unique Physician Identification Number (UPIN) or license number and name.

Item 83 a-b — Other Phys. ID

Enter the UPIN or license number and name.

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

Enter third-party insurance (commercial insurance coverage) unless the service does not require third-party billing. Third-party insurance must be billed before billing Wisconsin Medicaid.

Other Insured's Name

Providers must bill commercial health insurance before billing Wisconsin Medicaid unless the service does not require health insurance billing according to the Coordination of Benefits section of the All-Provider Handbook. Leave this item blank when the following applies:

- The provider has not billed the commercial health insurance because eligibility verification did not indicate other coverage.
- The service does not require commercial health insurance billing according to the Coordination of Benefits section of the All-Provider Handbook.
- Eligibility verification indicates "DEN" only.
- When eligibility verification indicates "HPP," "BLU," "WPS," "CHA," or "OTH," and the service requires

Appendix 10 (Continued)

commercial health insurance billing according to the Coordination of Benefits section of the All-Provider Handbook, indicate one of the following codes:

Code Description

- OI-P** Use the OI-P disclaimer code when the recipient's health insurance pays any portion. The claim indicates the amount paid by the health insurance company to the provider or the insured.
- OI-D** Use the OI-D disclaimer code only when these three criteria are met:
- ✓ Eligibility verification indicates "HPP," "BLU," "WPS," "CHA," "DEN," or "OTH."
 - ✓ The service requires billing health insurance before Wisconsin Medicaid.
 - ✓ The charges have been billed to the health insurance company and the insurance company has denied them.
- OI-Y** Use the OI-Y disclaimer code when the insurance card indicates other coverage but the insurance company was not billed for reasons including:
- ✓ The provider knows the service in question is not covered by the insurer (i.e., has a previous denial).
 - ✓ Insurance failed to respond to a follow-up claim.

When eligibility verification indicates "HMO" or "HMP," one of the following disclaimer codes must be indicated, if applicable:

Code Description

- OI-P** Use the OI-P disclaimer code when the health insurance pays any portion. The amount paid is indicated on the claim.
- OI-H** Use the OI-H disclaimer code only when these two criteria are met:
- ✓ Eligibility verification indicates "HMO" or "HMP."
 - ✓ The HMO or HMP does not cover the service or the billed amount does not exceed the coinsurance or deductible amount.

Note: Providers may *not* use OI-H if the HMO or HMP denied payment because an otherwise covered service was not provided by a designated provider. Wisconsin Medicaid does not reimburse services covered by an HMO or HMP except for the copayment and deductible amounts. Providers who receive a capitation payment from the HMO may not bill Wisconsin Medicaid for services which are included in the capitation payment.

Medicare must be billed before Wisconsin Medicaid. Indicate a Medicare disclaimer code if all the following statements are true:

- Medicare covers the procedure at least sometimes.
- The recipient's Wisconsin Medicaid eligibility verification shows he or she has Medicare coverage for the service performed. For example, the service is covered by Medicare Part A and the recipient has Medicare Part A.
- The nonphysician provider's Wisconsin Medicaid file shows he or she is Medicare certified. (If necessary, Medicare will retroactively certify physicians for the date and the service provided if they held a valid license when the service was performed.)

Code Description

- M-1** Medicare benefits exhausted. Use this code when Medicare has denied the claim because the recipient's lifetime benefit, spell of illness, or yearly allotment of available benefits is exhausted.
- Use M-1 in these two instances only:
- 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 performed is covered by Medicare Part A but is not payable due to benefits being exhausted.

Appendix 10 (Continued)

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 procedure provided is covered by Medicare Part B but is not payable due to benefits being exhausted.

- M-5 Provider is not Medicare-certified. Use this code when the provider is identified in Wisconsin Medicaid files as being Medicare certified but the provider is billing for dates of service before or after his or her Medicare certification effective dates.

Use M-5 in these two instances only:

For Medicare Part A (all three criteria must be met):

- The provider is not certified for Medicare Part A.
- 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 not certified for Medicare Part B.
- The recipient is eligible for Medicare Part B.
- The procedure provided is covered by Medicare Part B.

- M-6 Recipient not Medicare-eligible. Use this code when Medicare denies payment for services related to chronic renal failure because the recipient is not eligible for Medicare. Bill Medicare first even when the recipient is identified in Wisconsin Medicaid files as not eligible for Medicare.

Use M-6 in these two instances only:

For Medicare Part A (all three criteria must be met):

- The provider is identified in Wisconsin Medicaid files as certified for Medicare Part A.
- Medicare denies the recipient eligibility.
- The service is related to chronic renal failure.

For Medicare Part B (all three criteria must be met):

- The provider is identified in Wisconsin Medicaid files as certified for Medicare Part B.
- Medicare denies the recipient eligibility.
- The service is related to chronic renal failure.

- M-7 Medicare disallowed or denied payment. Use this code when Medicare denies the claim for reasons related to policy, not billing errors. Use M-7 in these two instances only:

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.

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.

- M-8 Noncovered Medicare service. Use this code when Medicare was not billed because the service, under certain circumstances (for example, diagnosis), is not covered.

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 under certain circumstances (for example, diagnosis).

Appendix 10 (Continued)

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 under certain circumstances (for example, diagnosis).

Leave the element blank if Medicare is not billed because eligibility verification indicated no Medicare coverage.

If Medicare allows an amount on the recipient's claim, attach the Explanation of Medicare Benefit to the claim and leave this element blank. Do not enter Medicare paid amounts on the claim form. Refer to the Claims Submission section of the All-Provider Handbook for more information about submitting claims for dual-entitlees.

Item 85 — Provider Representative

Enter an authorized signature indicating that the information entered on the face of this claim is in conformance with the certification on the back of this claim. A facsimile signature is acceptable.

Item 86 — Date

Enter the date on which the claim is submitted to the payer.

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Appendix 11

Sample UB-92 Claim Form — Outpatient Services

IM BILLING HOSPITAL 327 HOSPITAL RD ANYTOWN WI 55555 (555) 327-5555										2		3 PATIENT CONTROL NO. 55555ABCD				4 TYPE OF BILL 131																			
5 FED. TAX NO.				6 STATEMENT COVERS PERIOD FROM 032101 THROUGH 032101		7 COV D 1		8 N-C-D		9 C-I-D		10 L-R-D		11																					
12 PATIENT NAME RECIPIENT IMA D.										13 PATIENT ADDRESS																									
14 BIRTHDATE		15 SEX		16 MS		17 DATE		18 HPI		19 TYPE		20 SRC		21 D HR		22 STAT		23 MEDICAL RECORD NO.		24		25		26		27		28		29		30		31	
032762										3		1						11-598-99RZ																	
32 CODE		OCCURRENCE DATE		34 CODE		OCCURRENCE DATE		36 CODE		OCCURRENCE SPAN FROM		THROUGH		37		A		B		C		D		E		F		G		H		I			
39 CODE		VALUE CODES AMOUNT		41 CODE		VALUE CODES AMOUNT		43 CODE		VALUE CODES AMOUNT		45 CODE		VALUE CODES AMOUNT		47 CODE		VALUE CODES AMOUNT		49 CODE		VALUE CODES AMOUNT		51 CODE		VALUE CODES AMOUNT		53 CODE		VALUE CODES AMOUNT					
42 REV. CD.		43 DESCRIPTION				44 HCPCS / RATES				45 SERV. DATE				46 SERV. UNITS				47 TOTAL CHARGES				48 NON-COVERED CHARGES				49									
300		LABORATORY				81000								1				23 00																	
306		LAB/BACT-MICRO				89050								1				46 00																	
450		EMERG ROOM												1				39 00																	
001		TOTAL																108 00																	
50 PAYER		51 PROVIDER NO.				52 REL INFO				53 ASG BEN				54 PRIOR PAYMENTS				55 EST AMOUNT DUE				56													
45009 — Blue Cross T19 — WI Medicaid		BC111 88008800												25 00				83 00																	
57		DUE FROM PATIENT ▶																																	
58 INSURED'S NAME		59 P REL				60 CERT. - SSN - HIC - ID NO.				61 GROUP NAME				62 INSURANCE GROUP NO.																					
						1234567890																													
63 TREATMENT AUTHORIZATION CODES		64 ESC				65 EMPLOYER NAME				66 EMPLOYER LOCATION																									
67 PRIN DIAG CD		68 CODE		69 CODE		70 CODE		OTHER DIAG. CODES		72 CODE		74 CODE		76 ADM. DIAG. CD		77 E-CODE		78																	
V288																																			
79 P.C.		80		81		82		83		84		85		86		87		88																	
PRINCIPAL PROCEDURE CODE DATE		OTHER PROCEDURE CODE DATE		OTHER PROCEDURE CODE DATE		OTHER PROCEDURE CODE DATE		OTHER PROCEDURE CODE DATE		OTHER PROCEDURE CODE DATE		OTHER PROCEDURE CODE DATE		OTHER PROCEDURE CODE DATE		OTHER PROCEDURE CODE DATE		OTHER PROCEDURE CODE DATE																	
84 REMARKS		85 PROVIDER REPRESENTATIVE				86 DATE				87				88																					
O-I-P		X Ima Provider				060301																													

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Appendix 12

Revenue Codes for Hospitals

The following is a complete list of Medicaid-allowable revenue codes for inpatient and outpatient hospital claims.

Policy	Specific Revenue Codes
Revenue codes that require a service-specific third digit from the UB-92 Billing Manual	11X, 12X, 13X, 15X, 16X, 17X, 20X, 21X, 25X, 36X, 51X, 71X, 90X, 91X, 92X, 94X, 96X
Revenue codes that require a <i>Current Procedural Terminology</i> laboratory procedure code for outpatient services	30X, 31X, 923, 925
Revenue codes for dental services	512 (Use when providing dental services as part of an outpatient visit.)
Revenue codes for vision care services	519 (Use when providing vision care services as part of an outpatient visit.)
Outpatient observation room	719 (Use when recipient is under observation after recovering from ambulatory surgery.)
Revenue codes exempt from recipient copayment	820-859, 901, 918 <i>Note:</i> Revenue code 253 is exempt from recipient copayment on crossover claims. Revenue code 450 is exempt from copayment for outpatient services.
Noncovered revenue codes	140-149, 180-189, 220-221, 229, 294, 374, 547-548, 550, 609, 624, 637, 660-669, 670-679, 780-789, 880, 990-999
Noncovered revenue codes for psychiatric hospitals	520, 529, 940, 949
Noncovered revenue codes for general hospitals billing psychiatric or substance abuse services	520, 529, 940, 949
Nonbillable revenue codes	Nonbillable for bill type 11X: 100-101, 115, 135, 155, 240, 249, 253, 259, 279, 291-293, 299, 479, 530-531, 539, 540-546, 549, 551-552, 559, 570-572, 579, 580-582, 589, 590, 599, 600-604, 650-657, 659, 912-913, 960-964, 969, 971-979, 981-989 Nonbillable for bill type 13X: 180-239, 240, 249, 259, 279, 299, 540-546, 549, 550-552, 559, 570-572, 579, 580-582, 589, 590, 599, 600-604, 650-657, 659, 912-913, 990-999
Billable, noncovered revenue code	180
Restricted revenue codes	110-114, 116-117, 119
Revenue code for medication checks	510

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Glossary of Common Terms

Adjustment

A modified or changed claim that was originally allowed, at least in part, by Wisconsin Medicaid.

Allowed status

A Medicaid or Medicare claim that has at least one service that is reimbursable.

BadgerCare

BadgerCare extends Medicaid coverage through a Medicaid expansion under Titles XIX and XXI to uninsured children and parents with incomes at or below 185% of the federal poverty level and who meet other program requirements. The goal of BadgerCare is to fill the gap between Medicaid and private insurance without supplanting or “crowding out” private insurance.

BadgerCare benefits are identical to the benefits and services covered by Wisconsin Medicaid and recipients’ health care is administered through the same delivery system.

BQA

Bureau of Quality Assurance. The BQA surveys hospital facilities to ensure they meet strict fire and life safety codes, and administrative and program standards specifically required by the Department of Health and Family Services (DHFS) for hospitals.

CLIA

Clinical Laboratory Improvement Act. Congress implemented CLIA to improve the quality and safety of laboratory services. CLIA establishes standards and enforcement procedures.

CMS

Centers for Medicare and Medicaid Services. An agency housed within the U.S. Department of Health and Human Services (DHHS), CMS administers Medicare, Medicaid, related quality assurance programs, and other programs. Formerly known as the Health Care Financing Administration (HCFA).

CPT

Current Procedural Terminology. A listing of descriptive terms and codes for reporting medical, surgical, therapeutic, and diagnostic procedures. These codes are developed, updated, and published annually by the American Medical Association and adopted for billing purposes by the Centers for Medicare and Medicaid Services (CMS), formerly HCFA, and Wisconsin Medicaid.

Crossover claim

A Medicare-allowed claim for a dual entitlement sent to Wisconsin Medicaid for possible additional payment of the Medicare coinsurance and deductible.

DHCF

Division of Health Care Financing. The DHCF administers Wisconsin Medicaid for the Department of Health and Family Services (DHFS) under statutory provisions, administrative rules, and the state’s Medicaid plan. The state’s Medicaid plan is a comprehensive description of the state’s Medicaid program that provides the Centers for Medicare and Medicaid Services (CMS), formerly HCFA, and the U.S. Department of Health and Human Services (DHHS), assurances that the program is administered in conformity with federal law and CMS policy.

DHFS

Wisconsin Department of Health and Family Services. The DHFS administers the Wisconsin Medicaid program. Its primary mission is to foster healthy, self-reliant individuals and families by promoting independence and community responsibility; strengthening families; encouraging healthy behaviors; protecting vulnerable children, adults, and families; preventing individual and social problems; and providing services of value to taxpayers.

DHHS

Department of Health and Human Services. The United States government’s principal agency for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves. The DHHS includes more than 300 programs, covering a wide spectrum of activities, including overseeing Medicare and Medicaid; medical

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Glossary (Continued)

and social science research; preventing outbreak of infectious disease; assuring food and drug safety; and providing financial assistance for low-income families.

DOS

Date of service. The calendar date on which a specific medical service is performed.

Dual entitlee

A recipient who is eligible for both Medicaid and Medicare, either Medicare Part A, Part B, or both.

ECS

Electronic Claims Submission. Claims transmitted via the telephone line and fed directly into Wisconsin Medicaid's claims processing subsystem.

Emergency services

Those services which are necessary to prevent death or serious impairment of the health of the individual. (For the Medicaid managed care definition of emergency, refer to the Managed Care Guide or the Medicaid managed care contract.)

EOB

Explanation of Benefits. Appears on providers' Remittance and Status (R/S) Reports and informs Medicaid providers of the status of or action taken on their claims.

EVS

Eligibility Verification System. The EVS allows providers to verify recipient eligibility prior to providing services. Providers may access recipient eligibility information through the following methods:

- Commercial magnetic stripe card readers.
- Commercial personal computer software and Internet access.
- Wisconsin Medicaid's Automated Voice Response (AVR) system.
- Wisconsin Medicaid's Direct Information Access Line with Updates for Providers (Dial-Up).
- Wisconsin Medicaid's Provider Services (telephone correspondents).

Fee-for-service

The traditional health care payment system under which physicians and other providers receive a payment for each unit of service provided rather than a capitation payment for each recipient.

Fiscal agent

The Department of Health and Family Services (DHFS) contracts with Electronic Data Systems (EDS) to provide health claims processing services for Wisconsin Medicaid, including provider certification, claims payment, provider services, and recipient services. The fiscal agent also issues identification cards to recipients, publishes information for providers and recipients, and maintains the Wisconsin Medicaid Web site.

HCFA

Health Care Financing Administration. *Please refer to definition under CMS.*

HCPCS

Healthcare Common Procedure Coding System. A listing of services, procedures, and supplies offered by physicians and other providers. HCPCS includes *Current Procedural Terminology* (CPT) codes, national alphanumeric codes, and local alphanumeric codes. The national codes are developed by the Centers for Medicare and Medicaid Services (CMS), formerly HCFA, to supplement CPT codes. Formerly known as HCFA Common Procedure Coding System.

HealthCheck

A program which provides Medicaid-eligible children under age 21 with regular health screenings.

ICD-9-CM

International Classification of Diseases, Ninth Revision, Clinical Modification. Nomenclature for medical diagnoses required for billing. Available through the American Hospital Association.

IMD

Institution for Mental Disease. Wisconsin Medicaid certifies hospitals as IMDs in accordance with HFS 105.21, Wis. Admin. Code, and based on the hospital's eligibility for certification with Medicare or the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

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Glossary (Continued)

Inpatient

A recipient who is admitted to the hospital as an inpatient and is counted in the midnight census.

Maximum allowable fee schedule

A listing of all procedure codes allowed by Wisconsin Medicaid for a provider type and Wisconsin Medicaid's maximum allowable fee for each procedure code.

Medicaid

Medicaid is a joint federal/state program established in 1965 under Title XIX of the Social Security Act to pay for medical services for people with disabilities, people 65 years and older, children and their caretakers, and pregnant women who meet the program's financial requirements.

The purpose of Medicaid is to provide reimbursement for and assure the availability of appropriate medical care to persons who meet the criteria for Medicaid. Medicaid is also known as the Medical Assistance Program, Title XIX, or T19.

Medically necessary

According to HFS 101.03(96m), Wis. Admin. Code, a Medicaid service that is:

- a) Required to prevent, identify or treat a recipient's illness, injury or disability; and
- b) Meets the following standards:
 1. Is consistent with the recipient's symptoms or with prevention, diagnosis or treatment of the recipient's illness, injury or disability;
 2. Is provided consistent with standards of acceptable quality of care applicable to type of service, the type of provider and the setting in which the service is provided;
 3. Is appropriate with regard to generally accepted standards of medical practice;
 4. Is not medically contraindicated with regard to the recipient's diagnoses, the recipient's symptoms or other medically necessary services being provided to the recipient;
 5. Is of proven medical value or usefulness and, consistent with s. HFS 107.035, is not experimental in nature;

6. Is not duplicative with respect to other services being provided to the recipient;
7. Is not solely for the convenience of the recipient, the recipient's family or a provider;
8. With respect to prior authorization of a service and to other prospective coverage determinations made by the department, is cost-effective compared to an alternative medically necessary service which is reasonably accessible to the recipient; and
9. Is the most appropriate supply or level of service that can safely and effectively be provided to the recipient.

Outpatient

A recipient who has not been officially admitted to the hospital as an inpatient and has not been counted in the midnight census.

PA

Prior authorization. The written authorization issued by the Department of Health and Family Services (DHFS) to a provider prior to the provision of a service.

POS

Place of service. A single-digit code which identifies the place where the service was performed.

R/S Report

Remittance and Status Report. A statement generated by the Medicaid fiscal agent to inform providers regarding the processing of their claims.

State Plan

Wisconsin Medicaid's federally approved description of methods and standards for establishing payment rates to hospitals.

TOS

Type of service. A single-digit code which identifies the general category of a procedure code.

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