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.

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

PROVIDER INFORMATION

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

⑨ REFERRING/PRESCRIBING PROVIDER'S NAME	⑩ REFERRING/PRESCRIBING PROVIDER'S MEDICAL ASSISTANCE NUMBER
I.M. Referring/Prescribing	8763432

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
- Anticipated beginning treatment date MM/DD/YYYY
- Estimated intensive treatment termination date MM/DD/YYYY
- 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

Group 3 HR/day, 5 days/WK
Ind. two one-hour sessions/WK
Family two one-hour sessions/WK

☐ **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.

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.

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.

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

I.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:

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:

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

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 request 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.

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.

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.

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.

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)	
I.M. PERFORMING		(555) 555-5555	MSW (MS) MD PHD DO PSYCH Other:
Performing Provider Name	Performing Provider #	Performing Provider's Telephone Number	Discipline (circle one)

(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 depressive, recurrent, in partial remission (optional)

b) Adjustment disorder with depressed mood, 309.0 Axis V: (optional)

Axis II: Rule out Histrionic

Axis III: none

B. Date Treatment Began: MM/DD/YYYY with this provider.

C. Diagnosed By: X Clinical Exam __ Psychological Testing X Other (specify): MAST Hookings Symptom

D. Consultation: X Yes __ No Did consultant see recipient? X 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 X Moderate __ Severe

G. Is the recipient's intellectual functioning significantly below average? __ Yes X 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? X 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: X Psychodynamic __ Behavior Modification __ Biofeedback
__ Play Therapy __ Other (specify): _____

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

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

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

Q. Psychoactive Medication: X Yes __ No Has there been a medication check in the past three months?
X 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 _____ J.M. Authorized MM/DD/YYYY

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 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.)

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)
Last Name	First Name	MI	Medical Assistance Identification Number	Age

---

PROVIDER INFORMATION

(6)	(7)	(8)	
Performing Provider Name	Performing Provider #	Performing Provider's Telephone Number	MSW MS MD PHD DO PSYCH Other: _____ Discipline (circle one)

(9)	(10)	(11)	(12)
Supervising Provider's Name	Supervising Provider's Number	Prescribing Provider's Name	Prescribing Provider's Number

---

A. Diagnosis: Axis I: a)

b)

Axis II:

Axis III:

Axis IV: 1 2 3 4 5 6 7 8 9 0 (optional)

Axis V: (past year) (optional)

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)

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.

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.

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

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.

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).

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

APPROVED OMB NO. 0938-0279

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 032762	15 SEX / 16 MS	ADMISSION 17 DATE / 18 HR / 19 TYPE 3 / 20 SRC 1	21 D HR / 22 STAT / 23 MEDICAL RECORD NO. 11-598-99RZ
24 CONDITION CODES 25 26 27 28 29 30	31		
32 OCCURRENCE CODE / DATE	34 OCCURRENCE CODE / DATE	36 OCCURRENCE SPAN CODE / FROM / THROUGH	37 A / B / C
38	39 VALUE CODES CODE / AMOUNT		41 VALUE CODES CODE / AMOUNT

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	300	LABORATORY	81000		1	23 00		
2	306	LAB/BACT-MICRO	89050		1	46 00		
3	450	EMERG ROOM			1	39 00		
4								
5	001	TOTAL				108 00		
6–23								

50 PAYER	51 PROVIDER NO.	52 REL INFO / 53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
A 45009 — Blue Cross	BC111		25 00	83 00	
B T19 — WI Medicaid	88008800				
C					

57 DUE FROM PATIENT ▶

58 INSURED'S NAME	59 P.REL	60 CERT. - SSN - HIC. - ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.
A		1234567890		
B				
C				

63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION
A			
B			
C			

67 PRIN. DIAG. CD.	OTHER DIAG. CODES 68 / 70 / 72 / 74	76 ADM. DIAG. CD.	77 E-CODE	78
V288				

79 P.C	80 PRINCIPAL PROCEDURE CODE / DATE	81 OTHER PROCEDURE CODE / DATE		82 ATTENDING PHYS. ID
	OTHER PROCEDURE CODE / DATE	OTHER PROCEDURE CODE / DATE	OTHER PROCEDURE CODE / DATE	83 OTHER PHYS. ID A12345 I.M. Referring, M.D.
				OTHER PHYS. ID

84 REMARKS	85 PROVIDER REPRESENTATIVE	86 DATE
OI-P	X Ima Provider	060301

UB-92 HCFA-1450 OCR / Original

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

Appendix

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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 *Current Procedural Terminology* 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 *Note:* 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 state 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 entitlee 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

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).

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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