Medical Assistance Provider Bulletin

Attention: All Title XIX Certified Occupational Therapy Providers

Subject: New Claim Form; Place of Service, Type of Service and HCPCS Codes; and New Prior Authorization Request Form

Date: September 1, 1987

Code: MAPB-087-013-D

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This bulletin should be used in conjunction with the All Provider Bulletin, MAPB-087-037-X, dated September 1, 1987.

I. INTRODUCTION

The Wisconsin Medical Assistance Program (WMAP) has signed a new fiscal agent contract with E.D.S. Federal Corporation (EDS). Under this new contract, there will be major enhancements in the processing of Medical Assistance claims received by EDS on or after January 1, 1988. These enhancements are discussed in detail in the above referenced All Provider Bulletin.

In addition to the changes resulting from the new contract with EDS, the Health Care Financing Administration (HCFA) has mandated that all State Medical Assistance agencies implement use of a new claim form, the National Health Insurance Claim Form, HCFA 1500. The WMAP is implementing use of the National HCFA 1500 claim form for most providers. Many providers already use the Wisconsin version of the HCFA 1500 claim form to bill the WMAP and some are using the National HCFA 1500 claim form to bill Medicare and other third party payors. To facilitate consistent billing procedures, the WMAP is implementing the National HCFA 1500 claim form and national and local Place of Service and Type of Service codes.

Concurrent with the claim form change, the WMAP is also implementing the HCFA Common Procedure Coding System (HCPCS) currently used by Medicare. Use of HCPCS codes is also federally mandated.

NOTE: Due to the above mentioned changes, EDS will be converting the claims processing system at the end of 1987. Providers are advised to submit to EDS for receipt by no later than December 24, 1987, all claims, adjustments and prior authorization requests which are completed in accordance with billing instructions and claim forms in use in 1987. EDS will return, unprocessed, any claims received after December 24 which are in the 1987 format.

Past experience has shown that delivery of claims mailed during the holiday season is delayed due to heavy holiday mail. Please allow ample mailing time to ensure that claims mailed in 1987 are received no later than December 24. If there is a likely possibility that claims prepared and mailed in late December will not be received by EDS by December 24, it may be to the provider's advantage to hold such claims and mail them in the new format on or after January 1, 1988.

Providers are also advised that no checks will be issued on January 3, 1988. Claims which would have finalized processing during that week will appear on the following week's Remittance and Status Report.

II. PROVIDER BILLING WORKSHOPS

EDS is conducting provider workshops which focus on the WMAP requirements for the National HCFA 1500 claim form. These workshops are intended for billing personnel. See Attachment 9 for times and locations in your area.

III. NATIONAL HEALTH INSURANCE CLAIM FORM - HCFA 1500

All Occupational Therapy providers are required to use the National HCFA 1500 claim form for all claims received by EDS on or after January 1, 1988. Claims, including resubmission of any previously denied claims, received on a form other than the National HCFA 1500 claim form will be denied by EDS. Modifications to or use of modified versions of the National HCFA 1500 claim form may also result in claims denial.

A sample claim form and detailed billing instructions are included in Attachments 1 and 2 of this bulletin. Effective January 1, 1988, these instructions should be used to replace those currently included in the Occupational Therapy Provider Handbook, Part P, dated July 1, 1984. Providers should pay special attention to the following areas on the National HCFA 1500 claim form itself and to the changes in the type of information required for completion of the claim form.

1. Program Block (Claim Sort Indicator). A new element, the claim sort indicator, must be entered in the program block for Medicaid which is located on the top line of the claim form. This indicator identifies the general kinds of services being billed and is essential to processing of the claim form by EDS. Claim sort indicators for each type of service are included in the billing instructions. The sample claim form included in Attachment 1 indicates where on the claim form this information is to be entered. Claims received on or after January 1, 1988 without this claim sort indicator will be denied.

2. Element 1. The recipient's last name is required first, then the first name, and middle initial.

3. Element 6. The 10 digit Medical Assistance Recipient Identification Number must be entered.

4. Element 9. Revised "Other Insurance" (OI) disclaimer codes, identified in the claim form completion instructions, must be entered in this element.

5. Element 10. This is an addition to the element which requests "other" accident information.

6. Element 11. Medicare disclaimer codes, identified in the claim form completion instructions, must be entered in this element.

7. Element 24. There are two (2) fewer line items than on the current HCFA 1500 claim form.

8. Element 24H. Recipient spenddown amount, when applicable, must be entered in this element.

Providers should reference the All Provider Bulletin, MAPB-087-037-X, dated September 1, 1987, for additional details on claims processing changes.

Effective January 1, 1988, the National HCFA 1500 claim form will not be provided by either the WMAP or EDS. It is a national form that can be obtained at the provider's expense from a number of forms suppliers and other sources. One such source is:

State Medical Society Services, Inc.
P.O. Box 1109
MADISON WI 53701

(608) 257-6781 (Madison area)
1-800-362-9080 (Toll free)

IV. PLACE OF SERVICE CODES

Claims received by EDS on or after January 1, 1988 must include national place of service (POS) codes in element #24B on the National HCFA 1500 claim form. Claims/adjustments submitted without POS codes or with incorrect POS codes will be denied. POS codes are listed on the back of the claim form. Allowable POS codes for Occupational Therapy providers are included in Attachment 5. Allowable POS codes for Durable Medical Equipment provided by Occupational Therapists are included in Attachment 5a.

V. TYPE OF SERVICE CODES

Effective January 1, 1988, the WMAP is converting currently used type of service (TOS) codes to coincide with the National TOS codes, which are located on the back of the National HCFA 1500 claim form, and with the additional codes used by Medicare and the WMAP. All providers are required to indicate the appropriate TOS code in element 24G on the claim form for each line item billed on all claims received on or after January 1, 1988. Claims/adjustments submitted without TOS codes will be denied. Claims/adjustments submitted with incorrect TOS codes are subject to incorrect reimbursement or denial. Allowable TOS codes for Occupational Therapy providers are included in Attachment 5. Allowable TOS codes for Durable Medical Equipment provided by Occupational Therapists are included in Attachment 5a.

VI. HCFA COMMON PROCEDURE CODING SYSTEM (HCPCS)

The Health Care Financing Administration has also mandated state Medical Assistance agencies to use HCPCS. HCPCS is a procedure coding system that is currently used by Medicare.

HCPCS codes are composed of:

- Physician's Current Procedural Terminology - Fourth Edition (CPT-4) codes which are updated annually;
- Nationally assigned codes which are five (5) characters in length (alpha/numeric) and begin with any of the alpha characters A through V, e.g., A1234 - V5678; and

- Codes locally assigned by the WMAP or the Medicare Intermediary which are five (5) characters in length (alpha/numeric), and begin with the alpha characters W through Z, e.g., W1111 - Z9999.

HCPCS codes and their narrative descriptions are required on all claims/adjustments received by EDS on or after January 1, 1988. Claims/adjustments submitted without HCPCS codes and narrative descriptions will be denied. Allowable HCPCS codes and their descriptions for Occupational Therapy providers are listed in Attachment 3. Allowable HCPCS codes for Durable Medical Equipment billable by Occupational Therapists are included in Attachment 4.

VII. PRIOR AUTHORIZATION REQUEST FORM

The WMAP has developed a standard prior authorization (PA) request cover form for use by most providers. All Occupational Therapy providers are required to use this form for all PA requests received by EDS on or after January 1, 1988.

The prior authorization request consists of two (2) parts, the standard prior authorization form, PA/RF, and the service specific attachment. Occupational Therapy providers must request prior authorization for therapy services on the standard form, PA/RF, and on the therapy attachment, form PA/TA. Prior Authorization for Durable Medical Equipment (DME) must be requested on the standard form, PA/RF, and the DME attachment, form PA/DMEA. Spell of Illness requests must be requested on the standard form, PA/RF, and the Spell of Illness attachment for physical, occupational and speech therapy, form PA/SOIA. Prior authorization requests received on any other form will be returned to the provider.

A Prior Authorization Request Form and Usage Table is included in Attachment 6. Sample Prior Authorization request forms and detailed instructions for completing them are included in Attachments as follows:

	Attachment Numbers
Form PA/RF and Completion Instructions	7 and 7a
Form PA/TA and Completion Instructions	7b and 7c
Form PA/RF and Completion Instructions for Spell of Illness	8 and 8a
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Summary Instructions for Therapy Spell of Illness	8d

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OCCUPATIONAL THERAPY SERVICES

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ATTACHMENT 1

MAPB-087-013-D
Date: 9/1/87

FORM APPROVED
OMB NO. 0938-0008

Occupational Therapy Services

HEALTH INSURANCE CLAIM FORM

(CHECK APPLICABLE PROGRAM BLOCK BELOW)

[ ] MEDICARE (MEDICARE NO.) [T] MEDICAID (MEDICAID NO.) [ ] CHAMPUS (SPONSOR'S SSN) [ ] CHAMPVA (VA FILE NO.) [ ] FECA BLACK LUNG (SSN) [ ] OTHER (CERTIFICATE SSN)

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

1. PATIENT'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL): Recipient Im A.
2. PATIENT'S DATE OF BIRTH: MM | DD | YY
3. INSURED'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL): Same
4. PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE): 609 Willow, Anytown WI 53725
   TELEPHONE NO.
5. PATIENT'S SEX: MALE [ ] FEMALE [X]
6. INSURED'S I.D. NO. (FOR PROGRAM CHECKED ABOVE INCLUDE ALL LETTERS): 1234567890
7. PATIENT'S RELATIONSHIP TO INSURED: SELF [X] SPOUSE [ ] CHILD [ ] OTHER [ ]
8. INSURED'S GROUP NO. (OR GROUP NAME OR FECA CLAIM NO.)
   [ ] INSURED IS EMPLOYED AND COVERED BY EMPLOYER HEALTH PLAN
9. OTHER HEALTH INSURANCE COVERAGE (ENTER NAME OF POLICYHOLDER AND PLAN NAME AND ADDRESS AND POLICY OR MEDICAL ASSISTANCE NUMBER): OI - S
10. WAS CONDITION RELATED TO:
   A. PATIENT'S EMPLOYMENT: YES [ ] NO [X]
   B. ACCIDENT: AUTO [ ] OTHER [X]
11. INSURED'S ADDRESS (STREET, CITY, STATE, ZIP CODE): M-1
   TELEPHONE NO.
11a. CHAMPUS SPONSOR'S STATUS: [ ] ACTIVE DUTY [ ] DECEASED [ ] RETIRED; BRANCH OF SERVICE
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (READ BACK BEFORE SIGNING) I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM. I ALSO REQUEST PAYMENT OF GOVERNMENT BENEFITS EITHER TO MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGNMENT BELOW
   SIGNED / / / / / DATE / / / /
13. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED BELOW
   SIGNED (INSURED OR AUTHORIZED PERSON) / / / /

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)
15. DATE FIRST CONSULTED YOU FOR THIS CONDITION
16. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS OR INJURY, GIVE DATES / / / /
16a. IF EMERGENCY CHECK HERE
17. DATE PATIENT ABLE TO RETURN TO WORK / / / /
18. DATES OF TOTAL DISABILITY FROM / / / / THROUGH / / / /
    DATES OF PARTIAL DISABILITY FROM / / / / THROUGH / / / /
19. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE (e.g. PUBLIC HEALTH AGENCY): I. M. Referring/Prescribing 12345678
20. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES: ADMITTED / DISCHARGED
21. NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN HOME OR OFFICE): I. M. Nursing Home 12345678
22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? YES [ ] NO [ ] CHARGES
23. A. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE NUMBERS 1, 2, 3, ETC. OR DX CODE
   1. 342
   2. 436
   3.
   4.
   B. EPSDT YES [ ] NO [X]
   FAMILY PLANNING YES [ ] NO [X]
   PRIOR AUTHORIZATION NO. 1234567

24. A. DATE OF SERVICE FROM / TO	B.* PLACE OF SERVICE	C. PROCEDURE CODE (IDENTIFY)	(EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)	D. DIAGNOSIS CODE	E. CHARGES	F. DAYS OR UNITS	G.* TOS	H. LEAVE BLANK
03/02/88	7	W9529	Activities of daily living 60 min.	1,2	XX XX	2.0	1	
03/15, 17/88	7	W9523	Motor Skills 30 min. ea.	1,2	XX XX	2.0	1	
03/21,23,29/88	7	W9523	Motor Skills 90 min. ea.	1,2	XX XX	9.0	1	
03/16/88	7	W9512	Group occupational therapy 30 min. ea. 5 in group	1,2	XX XX	1.0	1	
			I. M. Performing-COTA 12345678					
			I. M. Supervising 12345678					Patient Spenddown $

25. SIGNATURE OF PHYSICIAN OR SUPPLIER (INCLUDING DEGREE(S) OR CREDENTIALS) (I CERTIFY THAT THE STATEMENTS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART THEREOF)
   DATE MM/DD/YY I.M. PROVIDER
26. ACCEPT ASSIGNMENT (GOVERNMENT CLAIMS ONLY) (SEE BACK) YES [ ] NO [ ]
27. TOTAL CHARGE: XX XX
28. AMOUNT PAID: XX XX
29. BALANCE DUE: XX.XX
30. YOUR SOCIAL SECURITY NO.
31. PHYSICIAN'S, SUPPLIER'S, AND/OR GROUP NAME, ADDRESS, ZIP CODE AND TELEPHONE NO.: I.M. Billing, 1 W Williams, Anytown WI 53725
   I.D. NO. 87654321
32. YOUR PATIENT'S ACCOUNT NO.: 1234JED
33. YOUR EMPLOYER I.D. NO. / / / /

*PLACE OF SERVICE AND TYPE OF SERVICE (T.O.S.) CODES ON THE BACK
REMARKS

APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 6/83

Form HCFA-1500 (C-2) (1-84) Form OWCP-1500
Form CHAMPUS-501 Form RRB-1500

ATTACHMENT 2
NATIONAL HCFA 1500 CLAIM FORM
COMPLETION INSTRUCTIONS
FOR OCCUPATIONAL THERAPY

* *

To avoid unnecessary denial or inaccurate claim payment, providers must utilize the following claim form completion instructions. Enter all required data on the face of the claim form in the appropriate element. Do not include attachments unless instructed to do so. All elements are required unless 'optional' or 'not required' is specified.

Wisconsin medical assistance recipients receive a medical assistance ID card upon initial enrollment into the Wisconsin Medical Assistance Program (WMAP) and at the beginning of each month thereafter. This card should always be presented prior to rendering the service. Please use the information exactly as it appears on the ID card to complete the Patient and Insured (subscriber) Information section.

Program Block/Claim Sort Indicator
Enter the appropriate **CLAIM SORT INDICATOR** for the service billed in the Medicaid check box in the upper left-hand corner of the claim form. Claims submitted without this indicator are denied.

'D' - Corrective Shoes
- Durable Medical Equipment
- Hearing Aids

'M' - Independent Nurse
- Mental Health - 51.42 Board Operated AODA, Day Treatment, Psychotherapy
- Nurse Midwife
- Rehabilitation Agency
- Community Care Organization

'P' - Chiropractor
- Family Planning
- Free Standing Ambulatory Surgery Center

**ATTACHMENT 2
NATIONAL HCFA 1500 CLAIM FORM
COMPLETION INSTRUCTIONS
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'P' - Independent Laboratory and Radiology
- Mental Health - Non-51.42 Board Operated AODA, Day Treatment, Psychotherapy
- Physician
- Rural Health Agency

'T' - Therapy - Occupational, Physical, Speech and Hearing
- Durable Medical Equipment Dispensed by Occupational, Physical or Speech Therapist

'V' - Vision - Optometrist, Optician, Dispensing Ophthalmologist

ELEMENT 1 - PATIENT NAME
Enter the recipient's last name, first name and middle initial as it appears on his/her current medical assistance identification card.

ELEMENT 2 - PATIENT'S DATE OF BIRTH
Enter the recipient's date of birth in MM/DD/YY format (e.g., January 5, 1978 would be 01/05/78) as it appears on his/her medical assistance identification card.

ELEMENT 3 - INSURED'S NAME
If the recipient's name (element #1) and insured's name (element #3) are the same, enter 'SAME' or leave the element blank. When billing for a newborn, enter the mother's last name, first name, middle initial and date of birth in MM/DD/YY format.

ELEMENT 4 - PATIENT'S ADDRESS
Enter the complete address of the recipient's place of residence; if the recipient is a resident of a nursing home, enter the name and address of the nursing home.

ATTACHMENT 2
NATIONAL HCFA 1500 CLAIM FORM
COMPLETION INSTRUCTIONS
FOR OCCUPATIONAL THERAPY

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ELEMENT 5 - PATIENT'S SEX
Specify if male or female with an 'X'.

ELEMENT 6 - INSURED'S ID NUMBER
Enter the recipient's ten digit medical assistance ID number as found on his/her medical assistance identification card.

ELEMENT 7 - PATIENT'S RELATIONSHIP TO INSURED (not required)

ELEMENT 8 - INSURED'S GROUP NUMBER (not required)

ELEMENT 9 - OTHER INSURANCE
Third party insurance (commercial insurance coverage) must be billed prior to billing the WMAP if the service is one of those identified in the Billing Information section of the WMAP Provider Handbook, Part A. When the recipient's medical assistance card indicates other coverage, one of the following codes MUST be indicated. The description is not required, nor is the policyholder, plan name, group number, etc.

Code	Description
OI-P	PAID by other insurance
OI-D	DENIED by other insurance, benefits exhausted, deductible not reached, non-covered service, etc.
OI-C	Recipient or other party will NOT COOPERATE
OI-S	SENT claim, but insurance company did not respond
OI-R	RECIPIENT denies coverage
OI-E	ERISA plan denies being prime
OI-A	Benefits NOT ASSIGNABLE
OI-H	Denied payment. Private health maintenance organization (HMO) or health maintenance plan (HMP) denied payment due to one of

ATTACHMENT 2
NATIONAL HCFA 1500 CLAIM FORM
COMPLETION INSTRUCTIONS
FOR OCCUPATIONAL THERAPY

* *

the following: non-covered/family planning service, or paid amount applied to the recipient's coinsurance/deductible.

If the recipient's medical assistance card indicates no other coverage, the element may be left blank.

ELEMENT 10 - IS CONDITION RELATED TO
If the condition is the result of an employment-related, auto or other accident, enter an 'X' in the appropriate box for items 'A' and 'B'.

ELEMENT 11 - INSURED'S ADDRESS
This element is used by the WMAP for Medicare information. Medicare must be billed prior to the WMAP. When the recipient's medical assistance card indicates Medicare coverage, one of the following Medicare disclaimer codes MUST be indicated. The description is not required.

Code	Description
M-1	Medicare benefits exhausted
M-5	Provider not Medicare certified
M-6	Recipient not Medicare eligible
M-7	Service denied/rejected by Medicare
M-8	Not a Medicare benefit

If the recipient's medical assistance card indicates no Medicare coverage, this element may be left blank.

ELEMENT 11A - (not required)

ELEMENTS 12 - 13
(Not required, provider automatically accepts assignment through medical assistance certification.)

ATTACHMENT 2
NATIONAL HCFA 1500 CLAIM FORM
COMPLETION INSTRUCTIONS
FOR OCCUPATIONAL THERAPY

* *

ELEMENT 14 - DATE OF ILLNESS OR INJURY (not required)

ELEMENT 15 - DATE FIRST CONSULTED FOR CONDITION (not required)

ELEMENT 16 - (not required)

ELEMENT 16A - EMERGENCY
Enter an 'X' if emergent.

ELEMENT 17 - (not required)

ELEMENT 18 - (not required)

ELEMENT 19 - REFERRING PHYSICIAN
This is a required element if the billed services were the result of a referral or were ordered by another practitioner. Enter the referring/prescribing physician's name and eight digit medical assistance number, if available.

ELEMENT 20 - HOSPITALIZATION DATES (not required)

ELEMENT 21 - NAME AND ADDRESS OF FACILITY
If the services billed were performed at a facility other than the recipient's home or the provider's office (i.e., nursing home or hospital), enter the name, address and, if available, the eight digit medical assistance provider number.

ELEMENT 22 - LAB WORK, PLACE OF SERVICE (not required)

ELEMENT 23A - DIAGNOSIS

ATTACHMENT 2
NATIONAL HCFA 1500 CLAIM FORM
COMPLETION INSTRUCTIONS
FOR OCCUPATIONAL THERAPY

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The International Classification of Disease, 9th Edition, Clinical Modification (ICD-9-CM) diagnosis code must be entered for each symptom or condition related to the services provided. List the primary diagnosis first. Etiology ('E') codes may not be used as a primary diagnosis.

ELEMENT 23B - EPSDT/FAMILY PLANNING INDICATOR/PRIOR AUTHORIZATION NUMBER

EPSDT

If the services were performed as a result of an EPSDT/HealthCheck referral, check 'YES'; otherwise check 'NO'. EPSDT/HealthCheck indicators may not be left blank; a positive or negative response must be indicated.

Family Planning

If the recipient is receiving family planning services only, enter an 'X' in 'YES'. If none of the services are related to family planning, enter an 'X' in 'NO'.

Prior Authorization

The seven digit prior authorization number from the approved prior authorization/SOIA form must be entered in element 23B. Do not attach a copy of the prior authorization to the claim. Services authorized under multiple prior authorizations must be billed on separate claims.

ELEMENT 24 - SERVICES

Element 24A - Date of Service

In column A, enter the month, day and year in MMDDYY format for each procedure. It is allowable to enter up to four dates of service per line item for each procedure if:

* All dates of service are in the same calendar month.

ATTACHMENT 2
NATIONAL HCFA 1500 CLAIM FORM
COMPLETION INSTRUCTIONS
FOR OCCUPATIONAL THERAPY

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* All procedures performed are identical.
* All procedures were performed by the same provider.
* The place and type of service is identical for all procedures.
* The same diagnosis is applicable for each procedure.
* The charge for all procedures is identical. (Enter the charge per service following the description in element 24C.)
* The number of services performed on each date of service is identical.

Element 24B - Place of Service

Enter the appropriate place of service code in column B for each service. Refer to Attachment 5 and 5A of this bulletin for a list of allowable place of service codes for occupational therapy providers.

Element 24C - Procedure Code and Description

Enter the appropriate procedure code and matching description for each service performed. Enter a written description which is concise, complete and specific for each billed service.

Enter the total number of minutes involved for each procedure code (e.g., 30 minutes).

Beneath the description of service, enter the name and eight digit provider number of the performing provider if different than the billing provider indicated in element 31.

Element 24D - Diagnosis Code Reference

When multiple procedures/diagnoses are submitted, column D must be utilized to relate the procedure performed (element 24C) to a specific diagnosis in element 23A.

ATTACHMENT 2
NATIONAL HCFA 1500 CLAIM FORM
COMPLETION INSTRUCTIONS
FOR OCCUPATIONAL THERAPY

* *

The diagnosis code itself may be entered in column D, or enter the line number from element 23A (i.e., 1, 2, 3 or 4) of the appropriate diagnosis as shown on the claim example.

Element 24E - Charges
Enter the total charge for each line item.

Element 24F - Days or Units
Enter the total number of therapy services (e.g., 1, 1.5, 2, etc.,) involved for each procedure code.

Element 24G - Type of Service (TOS)
Enter the appropriate type of service code. Refer to Attachment 5 and 5A of this bulletin for a list of allowable type of service codes for occupational therapy providers.

Element 24H - Recipient Spenddown
Enter the spenddown amount, when applicable, on the last detail line of element 24H directly above element 29. Refer to MAPB-087-037-X dated September 1, 1987 for information on recipient spenddown.

ELEMENT 25 - PROVIDER SIGNATURE AND DATE
The provider or the authorized representative must sign in element 25. The month, day and year the form is signed must also be entered.

NOTE: This may be a computer printed name and date, or a signature stamp.

ELEMENT 26 -
(Not required, provider automatically accepts assignment through medical assistance certification.)

ATTACHMENT 2
NATIONAL HCFA 1500 CLAIM FORM
COMPLETION INSTRUCTIONS
FOR OCCUPATIONAL THERAPY

* *

ELEMENT 27 - TOTAL CHARGE

Enter the total charges for this claim.

ELEMENT 28 - AMOUNT PAID

Enter the amount paid by other insurance. If the other insurance denied the claim, enter $0.00.

ELEMENT 29 - BALANCE DUE

Enter the balance due as determined by subtracting the amount in element 24H and element 28 from the amount in element 27.

ELEMENT 30 - (not required)

ELEMENT 31 - PROVIDER NAME AND ID NUMBER

Enter the name, address, city, state and zip code of the billing provider. At the bottom of element 31 enter the billing provider's eight digit provider number. If the provider number indicated in element 31 is not the actual provider of service, the performing provider's number must be entered beneath the description of service in element 24C.

ELEMENT 32 - PATIENT ACCOUNT NUMBER

Optional - provider may enter the patient's internal office account number. This number will appear on the EDS Remittance and Status Report (maximum of twelve characters).

ELEMENT 33 - (not required)

ATTACHMENT 3

ALLOWABLE HCPCS PROCEDURE CODE AND COPAYMENT CONVERSION TABLE
FOR OCCUPATIONAL THERAPY SERVICES

* *

The new HCFA Common Procedure Code System (HCPCS) is required for claims submitted on and after January 1, 1988. Please refer to the following table.

PROCEDURE CODE				
PRIOR TO 01/01/88	EFFECTIVE 01/01/88	MOD.	NEW DESCRIPTION	COPAYMENT
09509	W9509	n/a	Evaluation/Re-evaluation	$1.00/30 minutes
09512	W9512	n/a	Group Occupational Therapy (each 30 minute segment per person)	$1.00/30 minutes
09520	W9520	n/a	Social Inter. and Psych. Intrapersonal Skills	$1.00/30 minutes
09522	W9522	n/a	Group Social Inter. and Psych. Intrapersonal Skills (each 30 minute segment per person)	$1.00/30 minutes
09523	W9523	n/a	Motor Skills	$1.00/30 minutes
09525	W9525	n/a	Sensory Integrative Skills	$1.00/30 minutes
09527	W9527	n/a	Cognitive Skills	$1.00/30 minutes
09529	W9529	n/a	Activities of Daily Living Skills	$1.00/30 minutes
09531	W9531	n/a	Preventative Skills	$1.00/30 minutes
09533	W9533	n/a	Therapeutic Adaptions	$1.00/30 minutes

ATTACHMENT 4

ALLOWABLE HCPCS PROCEDURE CODE AND COPAYMENT CONVERSION TABLE
DME ITEMS BILLABLE BY OCCUPATIONAL THERAPISTS

* *

The new HCFA Common Procedure Code System (HCPCS) is required for claims submitted on and after January 1, 1988. All items are for purchase unless rental is specified in the description.

PROCEDURE CODE						
PRIOR TO 01/01/88	EFFECTIVE 01/01/88	MOD.	NEW DESCRIPTION	LIFE EXPECTANCY	COPAYMENT	*
05867	L3960	n/a	Shoulder-elbow-wrist-hand orthosis (SEWHO), abduction positioning, airplane design	2 years	$1.00	R
05868	L3960	n/a	Shoulder-elbow-wrist-hand orthosis (SEWHO), abduction positioning, airplane design	2 years	$1.00	R
05870	W6845	n/a	Infant splint, airplane design	1 year	$1.00	R
05871	L3670	n/a	SO, acromio/clavicular (canvas and webbing type)	1 year	$1.00	R
05888	L3740	n/a	EO, double upright with forearm/arm cuffs adjustable position lock with active control	2 years	$1.00	R
05984	L3700	n/a	Elbow orthosis (EO), elastic with stays	2 years	$1.00	R
05895	L3710	n/a	EO, elastic with metal joints	2 years	$1.00	R
05931	L3914	n/a	WHFO, wrist extension, cock-up	1 year	$1.00	R
05932	L3936	n/a	WHFO, Palmer	1 year	$1.00	R
05933	L3938	n/a	WHFO, dorsal wrist	1 year	$1.00	R
05934	L3940	n/a	WHFO, dorsal wrist, with out-rigger attachment	1 year	$1.00	R

* Denotes items reimburseable for nursing home recipient.

ATTACHMENT 4

ALLOWABLE HCPCS PROCEDURE CODE AND COPAYMENT CONVERSION TABLE
DME ITEMS BILLABLE BY OCCUPATIONAL THERAPISTS

* *

PROCEDURE CODE						
PRIOR TO 01/01/88	EFFECTIVE 01/01/88	MOD.	NEW DESCRIPTION	LIFE EXPECTANCY	COPAYMENT	*
05937	L3908	n/a	WHFO, wrist extension control (cock-up)	1 year	$1.00	R
05938	L3800	n/a	Wrist-hand-finger-orthosis WHFO short opponens, no attachments	1 year	$1.00	R
05939	L3805	n/a	WHFO, long opponens, no attach.	1 year	$1.00	R
05940	L3906	n/a	WHFO, wrist (gauntlet), molded to patient model	1 year	$1.00	R
05941	L3908	n/a	WHFO, wrist extension control (cock-up), canvas or leather design, non-molded	1 year	$1.00	R
05942	L3916	n/a	WHFO, wrist extension (cock-up) with othrigger	1 year	$1.00	R
05943	L3922	n/a	WHFO, knuckle bender, two segment to flex joints	1 year	$1.00	R
05944	L3924	n/a	WHFO, Oppenheimer	1 year	$1.00	
05945	L3926	n/a	WHFO, Thomas suspension	1 year	$1.00	R
05946	L3928	n/a	WHFO, finger extension, with clock spring	1 year	$1.00	R
05947	L3930	n/a	WHFO, finger extension, with wrist support	1 year	$1.00	
R05948	L3932	n/a	WHFO, safety pin, spring wire	1 year	$1.00	R
05949	L3934	n/a	WHFO, safety pin, modified	1 year	$1.00	R

* Denotes items reimburseable for nursing home recipient.

ATTACHMENT 4

ALLOWABLE HCPCS PROCEDURE CODE AND COPAYMENT CONVERSION TABLE
DME ITEMS BILLABLE BY OCCUPATIONAL THERAPISTS

* *

PROCEDURE CODE						
PRIOR TO 01/01/88	EFFECTIVE 01/01/88	MOD.	NEW DESCRIPTION	LIFE EXPECTANCY	COPAYMENT	*
05950	L3918	n/a	WHFO, knuckle bender	1 year	$1.00	R
05951	W6606	n/a	Spring cock-up to Dorsiflex (Bunnell)	1 year	$1.00	R
05952	L3942	n/a	WHFO, reverse knuckle bender	1 year	$1.00	R
05953	L3944	n/a	WHFO, reverse knuckle bender, with outrigger	1 year	$1.00	R
05954	L3946	n/a	WHFO, composite elastic	1 year	$1.00	R
05955	L3948	n/a	WHFO, finger knuckle elastic	1 year	$1.00	R
05956	L3950	n/a	WHFO, combination Oppenheimer, with knuckle bender and two attachments	1 year	$1.00	R
05957	L3952	n/a	WHFO, combination Oppenheimer with reverse knuckle and two attachments	1 year	$1.00	R
05958	L3910	n/a	WHFO, Swanson design	1 year	$1.00	R
05959	W6608	n/a	Finger PIP orthosis to control flexion and/or extension	1 year	$1.00	R
05960	W6609	n/a	Finger DIP orthosis to control flexion and/or extension	1 year	$1.00	R
05961	W6610	n/a	Ulnar deviation with wrist extension	1 year	$1.00	R
05962	L3920	n/a	WHFO, knuckle bender, with outrigger	1 year	$1.00	R

* Denotes items reimburseable for nursing home recipient.

ATTACHMENT 4

ALLOWABLE HCPCS PROCEDURE CODE AND COPAYMENT CONVERSION TABLE
DME ITEMS BILLABLE BY OCCUPATIONAL THERAPISTS

* *

PROCEDURE CODE PRIOR TO 01/01/88	PROCEDURE CODE EFFECTIVE 01/01/88	MOD.	NEW DESCRIPTION	LIFE EXPECTANCY	COPAYMENT	*
05963	W6611	n/a	Ulnar deviation without wrist extension	1 year	$1.00	
05964	L3954	n/a	WHFO, spreading hand	1 year	$1.00	R
05966	L3900	n/a	WHFO, dynamic flexor hinge, reciprocal wrist extension flexion, finger flexion/ extension wrist or finger driven	1 year	$1.00	R
05968	W6612	n/a	Ulnar deviation splint (thermoplastic)	1 year	$1.00	R
05969	W6613	n/a	Web space splint (thermo-plastic)	1 year	$1.00	R
05970	W6614	n/a	Con splint (orthokinetic)	1 year	$1.00	R
05971	W6615	n/a	Futuro wrist brace	6 months	$1.00	R
05972	W6616	n/a	Spasticity hand splint	6 months	$1.00	R
05999	L3810	n/a	WHFO, additions to short and long opponens, thumb abduction ('C') bar	1 year	$1.00	R
06002	L3840	n/a	WHFO, additions to short and long opponens, spring swivel thumb	1 year	$0.00	R
06003	L3820	n/a	WHFO, additions to short and long opponens I.P. extension assist, with M.P. extension stop	1 year	$0.00	R

* Denotes items reimburseable for nursing home recipient.

ATTACHMENT 4

ALLOWABLE HCPCS PROCEDURE CODE AND COPAYMENT CONVERSION TABLE
DME ITEMS BILLABLE BY OCCUPATIONAL THERAPISTS

* *

PROCEDURE CODE						
PRIOR TO 01/01/88	EFFECTIVE 01/01/88	MOD.	NEW DESCRIPTION	LIFE EXPECTANCY	COPAYMENT	*
06005	L3825	n/a	WHFO, additions to short and long opponens, M.P. extension stop	1 year	$0.00	R
06006	L3845	n/a	WHFO, additions to short and long opponens, thumb I.P. extension assist, with M.P. stop	1 year	$0.00	R
06156	W6619	n/a	Static thermoplastic over cast, knee	2 years	$1.00	R
06206	L1960	n/a	AFO, posterior solid ankle, molded to patient model, plastic	2 years	$1.00	R
06215	L1930	n/a	AFO, custom fitted, plastic	2 per year	$1.00	R
07073	W6634	n/a	Orthosis custom fabricated additions/modifications	PA over $300.00	$0.00	R
07074	L4200	n/a	Repair of orthotic device, hourly rate	n/a	$0.00	R
07074	L4210	n/a	Repair of orthotic device, repair or replace minor	PA over $300.00	$0.00	R
08871	W6831	n/a	Lapboard/lap tray	3 years	$1.00	R
08877	E0977	n/a	Wedge cushion, wheelchair	3 years	$1.00	
08883	W6832	n/a	Hand cone	6 months	$1.00	
08886	W6833	n/a	Knee separator	2 years	$1.00	
08889	W6834	n/a	Cuff arm/double latex sling	6 months	$1.00	

* Denotes items reimburseable for nursing home recipient.

ATTACHMENT 4

ALLOWABLE HCPCS PROCEDURE CODE AND COPAYMENT CONVERSION TABLE
DME ITEMS BILLABLE BY OCCUPATIONAL THERAPISTS

* *

PROCEDURE CODE						
PRIOR TO 01/01/88	EFFECTIVE 01/01/88	MOD.	NEW DESCRIPTION	LIFE EXPECTANCY	COPAYMENT	*
08895	W6835	n/a	Adaptive eating utensils	3 years	$1.00	
08898	W6836	n/a	Rocker knife	3 years	$1.00	
08901	W6845	n/a	Adaptive cup/glass	3 years	$1.00	
08904	W6837	n/a	Adaptive scoop dish	3 years	$1.00	
08907	W6838	n/a	Universal cuff	6 months	$1.00	
08910	W6846	n/a	Plate guard/foot guard	3 years	$1.00	
08913	W6839	n/a	Dycem mat	3 years	$1.00	
08916	W6840	n/a	Adaptive dressing aid	1 year	$1.00	
08919	W6841	n/a	Reacher	1/lifetime	$1.00	
08922	W6842	n/a	Stocking aid	1/lifetime	$1.00	
08925	W6843	n/a	Adaptive hygiene equipment	6 months	$1.00	
08926	W6844	n/a	Adaptive typing aid	1 year	$1.00	
05422	W6600	n/a	Casting, ankle, foot	2 per orthosis	$1.00	R

* Denotes items reimburseable for nursing home recipient.

ATTACHMENT 5

OCCUPATIONAL THERAPY SERVICES

* *

PLACE OF SERVICE (POS) CONVERSION TABLE

Prior to 01/01/88	Effective 01/01/88	New Description
1	3	Office
2	4	Home
4	7	Nursing Home
4	8	Skilled Nursing Facility

TYPE OF SERVICE (TOS) CONVERSION TABLES

Prior to 01/01/88	Effective 01/01/88	New Description
1	1	Medical

ATTACHMENT 5 A

DME SERVICES PROVIDED BY OCCUPATIONAL THERAPISTS

* *

PLACE OF SERVICE (POS) CONVERSION TABLE

Prior to 01/01/88	Effective 01/01/88	New Description
1	3	Office
2	4	Home
4	7	Nursing Home
4	8	Skilled Nursing Facility

TYPE OF SERVICE (TOS) CONVERSION TABLES

Prior to 01/01/88	Effective 01/01/88	New Description
J	P	Purchase
H	R	Rental

PRIOR AUTHORIZATION REQUEST FORMS AND USAGE

All requests for prior authorization received on and after January 1, 1988 must be submitted on the following revised forms. Refer to the following chart for the appropriate request and attachment forms to be used when requesting authorization for specific services.

Service	Prior Authorization Form Required	Special Consideration
Chiropractic	Prior Authorization Request Form (PA/RF) & Chiropractic (PA/CA)	Use when requesting prior authorization to extend treatment beyond twenty manipulations per spell of illness.
Dental/Orthodontia	Dental Prior Authorization Request Form (PA/DRF) & Dental Services Attachment (PA/DA)	Do not complete PA/DA if requesting orthodontic services.
	Dental Prior Authorization Request Form (PA/DRF) & Orthodontic Services Attachment (PA/OA)	Use to report orthodontic services only.
Drug DME DMS (includes PT, OT, Speech and Home Health DME)	Prior Authorization Request Form (PA/RF) & Drug/Disposable Medical Supplies Attachment (PA/DGA)	- Use to request any drug requiring prior authorization. - Use to request disposable medical supply item requiring prior authorization.
	Prior Authorization Request Form (PA/RF) & Durable Medical Equipment (PA/DMEA)	Use to request any DME item requiring prior authorization.
Hearing Aid	Physicians Otological Report (PA/OF)	Must be completed by referring physician. Audiologist must submit PA/OF with PA/ARF1 and PA/ARF2 when requesting authorization for hearing aid(s).

Service	Prior Authorization Form Required	Special Consideration
Hearing Aid (continued)	Audiological Report for Hearing Aid Request (PA/ARF1) & Hearing Aid Request Form (PA/ARF2)	Audiologists uses PA/ARF1 and PA/ARF2 to request hearing aid (must also include PA/OF).
Home Health (includes Independent Nurses)	Prior Authorization Request Form (PA/RF) & Home Health Attachment (PA/HHSA)	- Use to request home health aide/RN/LPN services provided by a home health agency. - Use to request nursing services provided by RN/LPN in independent practice.
	Prior Authorization Request Form (PA/RF) & Home Health Attachment (PA/HHTA)	- Use to request therapy (PT, OT, Speech) services provided by a home health agency.

NOTE:

1. If recipient will receive only home health therapy services, attach to the Prior Authorization Request Form (PA/RF) and submit to EDS.

2. If recipient will receive home health services in addition to home health therapy services, attach both attachment forms (PA/HHSA and PA/HHTA) to the Prior Authorization Request Form (PA/RF) and submit to EDS.

Service	Prior Authorization Form Required	Special Consideration
Hospital	Prior Authorization Request Form (PA/RF) & Physician Attachment (PA/PA)	Use when requesting prior authorization for - transplants - AIDS services - ventilator services
Mental Health	Prior Authorization Request Form (PA/RF) & Psychotherapy Attachment (PA/PSYA)	Use to request all psycho-therapy services requiring prior authorization.

Service	Prior Authorization Form Required	Special Consideration
Mental Health (continued)	Prior Authorization Request Form (PA/RF) & AODA Attachment (PA/AA) (Alcohol and Other Drug Abuse)	Use to request all AODA services requiring prior authorization.
	Prior Authorization Request Form (PA/RF) & Day Treatment Attachment (PA/DTA)	Use to request day treatment services requiring prior authorization.
Out-of-State	Prior Authorization Request Form (PA/RF) & Physician Attachment (PA/PA)	Use when requesting out-of-state nursing home services (process type 999).
Personal Care	Prior Authorization Request Form (PA/RF) & Personal Care Attachment (PA/PCA)	Use to request any personal care services requiring prior authorization.
Physician (includes family planning and rural health clinics)	Prior Authorization Request Form (PA/RF) & Physician Attachment (PA/PA)	Use when requesting any physician service requiring prior authorization.
Therapy (includes Rehabilitation Agencies)	Prior Authorization Request Form (PA/RF) & Therapy Attachment (PA/TA) (physical, occupational, speech and audiological)	Do not complete PA/TA when requesting a spell of illness (complete PA/SOI). Use PA/TA when requesting prior authorization to extend treatment beyond forty-five treatment days for the same spell of illness.
	Prior Authorization Request Form (PA/RF) & Spell of Illness Attachment (PA/SOIA) (physical, occupational, speech)	Use to request a new spell of illness only.

Service	Prior Authorization Form Required	Special Consideration
Transportation	Prior Authorization Request Form (PA/RF) & Physician Attachment (PA/PA)	Use when requesting any transportation service requiring prior authorization (process type 999).
Vision	Prior Authorization Request Form (PA/RF) & Vision Attachment (PA/VA)	Use to request any vision service requiring prior authorization.

The timely determination of authorization is significantly enhanced by the completeness and quality of the documentation submitted by providers when requesting prior authorization. Carefully complete the Prior Authorization Request Form (PA/RF), attach appropriate prior authorization attachment form and submit to the following address:

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

MAIL TO
E.D.S. FEDERAL CORPORATION
PRIOR AUTHORIZATION UNIT
6406 BRIDGE ROAD
SUITE 88
MADISON, WI 53784-0088

PRIOR AUTHORIZATION REQUEST FORM

PA/RF (DO NOT WRITE IN THIS SPACE)

ICN #
A.T. #
P.A. # 1234567

1 PROCESSING TYPE
112

2 RECIPIENT'S MEDICAL ASSISTANCE I.D. NUMBER
1234567890

3 RECIPIENT'S NAME (LAST, FIRST, MIDDLE INITIAL)
Recipient, Im. A.

4 RECIPIENT ADDRESS (STREET, CITY, STATE, ZIP CODE)
I. M. Nursing Home
609 Willow
Anytown, WI 53725

5 DATE OF BIRTH
MM/DD/YY

6 SEX
M [ ] F [X]

7 BILLING PROVIDER TELEPHONE NO
(XXX) XXX-XXXX

8 BILLING PROVIDE NAME, ADDRESS, ZIP CODE
I. M. Provider
1 W. Williams
Anytown, WI 53725

9 BILING PROVIDER NO
12345678

10 DX PRIMARY
720 Rheumatoid Spondylitis

11 DX SECONDARY
345.1 Epilepsy

12 START DATE OF SOI:
N/A

13 FIRST DATE RX
N/A

14 PROCEDURE CODE	15 MOD	16 POS	17 TOS	18 DESCRIPTION OF SERVICE	19 QR	20 CHARGES
W9523		8	1	Range of Motion, Strengthening	1	XX.XX
W9529		8	1	Activities of Daily Living	1	XX.XX
					TOTAL CHARGE	21 XX.XX

An approved authorization does not guarantee payment. Reimbusement 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.

22 MM/DD/YY
DATE

23 I. M. Provider I. M. Provider
REQUESTING PROVIDER SIGNATURE

(DO NOT WRITE IN THIS SPACE)

AUTHORIZATION:

[ ] APPROVED

GRANT DATE

EXPIRATION DATE

PRODEDURE(S) AUTHORIZED QUANTITY AUTHORIZED

[ ] MODIFIED — REASON:

[ ] DENIED — REASON:

[ ] RETURN — REASON:

DATE

CONSULTANT/ANALYST SIGNATURE

INSTRUCTIONS FOR THE COMPLETION OF THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF)

ELEMENT 1 - PROCESSING TYPE
Enter the appropriate three digit processing type from the attached table. The 'process type' is a three digit code used to identify the type of service requested. Use 999 - 'Other' only if the request cannot reference any of the process types listed. Prior Authorization/Spell of Illness requests will be returned without adjudication if no processing type is indicated.

- **111 - Physical Therapy
- **112 - Occupational Therapy
- **113 - Speech Therapy/Audiology
- **114 - Physical Therapy (spell of illness only)
- **115 - Occupational Therapy (spell of illness only)
- **116 - Speech Therapy (spell of illness only)
- 117 - Physician Services (includes Family Planning and Rural Health)
- 118 - Chiropractic
- *120 - Home Health/Independent Nurses Services/Home Health Therapy
- 121 - Personal Care Services
- 122 - Vision
- 126 - Psychotherapy (HCFA 1500 billing providers only)
- 127 - Psychotherapy (UB82 billing providers only)
- 128 - AODA Services
- 129 - Day Treatment Services
- 130 - Durable Medical Equipment
- 131 - Drugs
- 132 - Disposable Medical Supplies
- 133 - Transplant Services
- 134 - AIDS Services (hospital and nursing home)
- 135 - Ventilator Services (hospital and nursing home)
- 999 - Other (use only if the request cannot reference any of the processing types listed)

* Includes PT, OT, Speech
** Includes Rehabilitation Agencies

ELEMENT 2 - RECIPIENT'S MEDICAL ASSISTANCE IDENTIFICATION NUMBER
Enter the ten digit medical assistance recipient number as found on the recipient's medical assistance identification card.

ELEMENT 3 - RECIPIENT'S NAME
Enter the recipient's last name, followed by first name and middle initial, exactly as it appears on the recipient's medical assistance identification card.

ELEMENT 4 - RECIPIENT'S ADDRESS
Enter the address of the recipient's place of residence, the street, city, state and zip code must be included. 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 - RECIPIENT'S DATE OF BIRTH
Enter the recipient's date of birth in MM/DD/YY format (i.e., June 8, 1941 would be 06/08/41), as it appears on the recipient's medical assistance identification card.

ELEMENT 6 - RECIPIENT'S SEX
Enter an 'X' to specify male or female.

ELEMENT 7 - BILLING PROVIDER'S NAME, ADDRESS AND ZIP CODE
Enter the name and complete address (street, city, state and zip code) of the billing provider. No other information should be entered in this element, as this element also serves as your return address label.

ELEMENT 8 - BILLING PROVIDER'S TELEPHONE NUMBER
Enter the telephone number, including the area code, of the office, clinic, facility or place of business of the billing provider.

ELEMENT 9 - BILLING PROVIDER'S MEDICAL ASSISTANCE PROVIDER NUMBER
Enter the eight digit WMAP provider number of the billing provider.

ELEMENT 10 - RECIPIENT'S PRIMARY DIAGNOSIS
Enter the appropriate International Classification of Disease, 9th Edition, Clinical Modification (ICD-9-CM) diagnosis code and description most relevant to the service/procedure requested.

> **NOTE:**
> Pharmacists, medical vendors and individual medical suppliers may provide a written description only.

ELEMENT 11 - RECIPIENT'S SECONDARY DIAGNOSIS
Enter the appropriate International Classification of Disease, 9th Edition, Clinical Modification (ICD-9-CM) diagnosis code and description additionally descriptive of the recipient's clinical condition.

> **NOTE:**
> Pharmacists, medical vendors and individual medical suppliers may provide a written description only.

ELEMENT 12 - START DATE OF SPELL OF ILLNESS*
DO NOT COMPLETE THIS ELEMENT UNLESS REQUESTING A THERAPY (PT, OT, SPEECH) SPELL OF ILLNESS. Enter the date of onset for the spell of illness in MM/DD/YY format (i.e., March 1, 1988 would be 03/01/88).

* Therapy spell of illness requests only.

Instructions for the Completion of the
Prior Authorization Request Form (PA/RF)
Page 3

ELEMENT 13 - FIRST DATE OF TREATMENT*
DO NOT COMPLETE THIS ELEMENT UNLESS REQUESTING A THERAPY (PT, OT, SPEECH) SPELL OF ILLNESS. Enter the date of the first treatment for the spell of illness in MM/DD/YY format (i.e., March 1, 1988 would be 03/01/88).

* Therapy spell of illness requests only.

ELEMENT 14 - PROCEDURE CODE(S)
Enter the appropriate revenue, HCPCS or national drug code (NDC) procedure code for each service/procedure/item requested, in this element. DO NOT COMPLETE THIS ELEMENT IF REQUESTING A THERAPY (PT, OT, SPEECH) SPELL OF ILLNESS.

ELEMENT 15 - MODIFIER
Enter the modifier for the procedure code (if a modifier is required by Bureau of Health Care Financing policy and the coding structure used) for each service/procedure/item requested. DO NOT COMPLETE THIS ELEMENT IF REQUESTING A THERAPY (PT, OT, SPEECH) SPELL OF ILLNESS.

ELEMENT 16 - PLACE OF SERVICE
Enter the appropriate place of service code designating where the requested service/procedure/item will be provided/performed/dispensed.

Code	Description
1	Inpatient Hospital
2	Outpatient Hospital
3	Office
4	Home
7	Nursing Home
8	Skilled Nursing Facility
9	Ambulance

Alpha	Description
A	Independent Lab

NOTE:
Mental health services may not be provided in the recipient's home (POS 4).

ELEMENT 17 - TYPE OF SERVICE
Enter the appropriate type of service code for each service/procedure/item requested. DO NOT COMPLETE THIS ELEMENT IF REQUESTING A THERAPY (PT, OT, SPEECH) SPELL OF ILLNESS.

Numeric	Description
0	Blood
1	Medical (including: Physician's Medical Services, Home Health, Independent Nurses, Audiology, PT, OT, ST, Personal Care, AODA, and 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 *Non-MD Psych Family Planning Clinic Rehabilitation Agency Nurse Midwife Chiropractic

* non-board operated only

Alpha	
B	Diagnostic Medical - Total
C	Ancillaries, Hospital and Nursing Home
D	Drugs
E	Accommodations, Hospital and Nursing Home
F	Free Standing Ambulatory Surgical Center
G	Dental
J	Vision Care and Cataract Lens
K	Nuclear Medicine - Total Charge
P	Purchase New DME
Q	Diagnostic X-Ray - Professional
R	DME Rental
S	Radiation Therapy - Professional
T	Nuclear Medicine - Professional
U	Diagnostic X-Ray, Medical - Technical
W	Diagnostic Medical - Professional
X	Diagnostic Lab - Professional

ELEMENT 18 - DESCRIPTION OF SERVICE
Enter a written description corresponding to the appropriate revenue, HCPCS or National Drug Code (NDC) procedure code for each service/procedure/item requested.

> **NOTE:**
> If you are requesting a therapy spell of illness, enter 'Spell of Illness' in this element.

ELEMENT 19 - QUANTITY OF SERVICE REQUESTED
Enter the quantity (sessions, number of services, etc.) requested for each service/procedure/item requested.

AODA Services (number of services)
Chiropractic (number of adjustments)
Day Treatment Services (number of services)
Dental (number of services)
Disposable Medical Supplies (number of days supply)
Drugs (number of days supply)
Durable Medical Equipment (number of services)
Hearing Aid (number of services)
Home Health (number of units)/Independent Nurses (number of units)
Services/Home Health Therapy-PT, OT, Speech (number of visits)
Hospital Transplant Services (per hospital stay)
Hospital and Nursing Home AIDS Services (number of days)
Hospital and Nursing Home Ventilator Services (number of days)
Occupational Therapy (number of services)
Occupational Therapy (spell of illness only) (enter 45)
Orthodontics (dollar amount)
Personal Care Services (number of hours)
Physical Therapy (number of services)
Physical Therapy (spell of illness only) (enter 45)
Physician Services (number of services)
Psychotherapy (HCFA 1500 billing providers only) (number of services)
Psychotherapy (UB82 billing providers only) (dollar amount)
Speech Therapy (number of services)
Speech Therapy (spell of illness only) (enter 45)
Vision (number of services)

> **NOTE:**
> If requesting a therapy spell of illness, enter '45' in this element.

ELEMENT 20 - CHARGES
Enter your usual and customary charge for each service/procedure/item requested. DO NOT COMPLETE THIS ELEMENT IF REQUESTING A THERAPY (PT, OT, SPEECH) SPELL OF ILLNESS.

> **NOTE:**
> The charges indicated on the request form should reflect the provider's usual and customary charge for the procedure requested. Approval of a prior authorization is for the service only. Providers are reimbursed for authorized services according to Terms of Provider Reimbursement issued by the Department of Health & Social Services.

ELEMENT 21 - TOTAL CHARGE
Enter the anticipated total charge for this request. DO NOT COMPLETE THIS ELEMENT IF REQUESTING A THERAPY (PT, OT, SPEECH) SPELL OF ILLNESS.

ELEMENT 22 - BILLING CLAIM CLARIFICATION STATEMENT
'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 date 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.'

ELEMENT 23 - DATE
Enter the month, day and year (in MM/DD/YY format) the prior authorization request form was completed and signed.

ELEMENT 24 - REQUESTING PROVIDER'S 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 RESERVED FOR THE WISCONSIN MEDICAL ASSISTANCE PROGRAM CONSULTANT(S) AND ANALYST(S).

MAPB-087-013-D
Date: 9/1/87

Attachment 7b

Mail To:

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

PA/TA

THERAPY ATTACHMENT

(Physical- Occupational-Speech Therapy)

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	19

PROVIDER INFORMATION

⑥ THERAPIST'S NAME AND CREDENTIALS	⑦ THERAPIST'S MEDICAL ASSISTANCE PROVIDER NUMBER	⑧ THERAPIST'S TELEPHONE NUMBER
I.M. PERFORMING, O.T.R.	12345678	(XXX) XXX-XXXX

⑨ REFERRING/PRESCRIBING PHYSICIAN'S NAME: I.M. REFERRING/PRESCRIBING

A. Requesting: ☐ Physical Therapy ☒ Occupational Therapy ☐ Speech Therapy

B. Total time per day requested 60 minutes

Total Sessions per week requested 3 for each procedure requested.

Total number of weeks requested 16

C. Provide a description of the recipient's diagnosis and problems and date of onset.

PRIMARY DIAGNOSIS	ICD9 CODE	DATE OF ONSET
Rheumatoid Spondylitis	720	Age 16

SECONDARY DIAGNOSIS	ICD9 CODE	DATE OF ONSET
1. Epilepsy (Major Motor)	345.1	Age 4

Attachment 7b

D. Brief Pertinent History:

Client lived at home with family prior to last nursing home admission.
Client has completed high school and is a part-time student at XYZ University in Data Processing.

E. Therapy History

		Location	Date	Problem Treated
P.T.	ABC Hospital	Anytown, WI	1985	Spinal Involvement of Rheumatoid Spondylitis
	XYZ Nursing Home	Anytown, WI	7/1 - 8/15/86	Gait, Balance and Dependence in ADL
OT	ABC Hospital	Anytown, WI	6/1986	Balance and Transfers
	XYZ Nursing Home	Anytown, WI	7/1 - 8/15/86	Dependence in self care.
SP	N/A			

F. Evaluations: (Indicate Dates/Tests Used/Results) (Provide Date of Initial Evaluation).

1) 5/18/87 Comprehensive Functional Evaluation upon admission to nursing home. ADL-dependence in all areas of self care. Motor Skills - see attached ROM, M.M.T., and Coordination Tests. Perceptual Skills - assessment attached.

2) 6/22/87 ADL - can perform oral, facial hygiene, dress upper extremity with physical assist. Motor Skills - Refer to attached chart with ROM, M.M.T., and Coordination.

3) 7/27/87 ADL - dress upper and lower extremities, but needs assistance with buttons and zippers. Homemaking Eval. - see attached. Motor Skills - refer to attached chart with ROM, M.M.T., and Coordination.

G. Describe progress in measurable/functional terms since treatment was initiated or last authorized:

1. Client is now able to button 1" buttons, but lacks finger dexterity to accomplish smaller sizes.

2. Client can perform all other areas of personal care including dressing, hygiene, toileting, bathing.

3. Range of motion has improved significantly in most areas - see attached charts 5/18; 6/22; and 7/27/87.

Attachment 7b

H. Plan of Care (Indicate specific measurable goals and procedures to meet those goals).

1. Client will manage 1/2" and 3/4" buttons and zippers.
2. Client will increase and maintain ROM to functional limits for his disability. A home program of exercises will also be initiated.
3. Client will prepare all meals independently with adaptations. Laundry and light cleaning skills will also be initiated.

I. Rehabilitation Potential:

Expect discharge to adapted apartment by December 15, 1987.

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

J. I. M. Prescribing
Signature of Prescribing Physician
(A copy of the Physician's order sheet is acceptable)

I. M. Performing
Signature of Therapist Providing Treatment

MM/DD/YY
Date

MM/DD/YY
Date

INSTRUCTIONS FOR THE COMPLETION OF THE PRIOR AUTHORIZATION THERAPY ATTACHMENT (PA/TA) (Physical, Occupational, Speech Therapy)

Do not use this attachment to request a spell of illness, use the Prior Authorization Spell of Illness Attachment (PA/SOIA).

The timely determination of authorization is significantly enhanced by the completeness and quality of the documentation submitted by providers when requesting prior authorization to extend treatment beyond forty-five treatment days for the same spell of illness. Carefully complete this attachment form, attach it to the Prior Authorization Request Form (PA/RF) and submit to the following address:

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

Questions regarding completion of the Prior Authorization Request Form (PA/RF) and/or the Prior Authorization Therapy Attachment (PA/TA) or the Prior Authorization Spell of Illness Attachment (PA/SOIA) may be addressed to EDS' Telephone/Written Correspondence Unit.

RECIPIENT INFORMATION:

ELEMENT 1 - RECIPIENT'S LAST NAME
Enter the recipient's last name exactly as it appears on the recipient's medical assistance identification card.

ELEMENT 2 - RECIPIENT'S FIRST NAME
Enter the recipient's first name exactly as it appears on the recipient's medical assistance identification card.

ELEMENT 3 - RECIPIENT'S MIDDLE INITIAL
Enter the recipient's middle initial exactly as it appears on the recipient's medical assistance identification card.

ELEMENT 4 - RECIPIENT'S MEDICAL ASSISTANCE NUMBER
Enter the recipient's ten digit medical assistance number exactly as it appears on the recipient's medical assistance identification card.

ELEMENT 5 - RECIPIENT'S AGE
Enter the age of the recipient in numerical form (i.e., 45, 60, 21, etc.).

Instructions for the Completion of the Prior
Authorization Therapy Attachment (PA/TA)
(Physical, Occupational, Speech Therapy)
Page 2

PROVIDER INFORMATION:

ELEMENT 6 - THERAPIST'S NAME AND CREDENTIALS
Enter the name and credentials of the primary therapist who would be responsible for and participate in therapy services for the recipient. If the performing provider will be a therapy assistant, enter the name of the supervising therapist.

ELEMENT 7 - THERAPIST'S MEDICAL ASSISTANCE PROVIDER NUMBER
Enter the eight digit medical assistance provider number of the therapist who would provide the authorized service (performing provider). If the performing provider will be a therapy assistant, enter the medical assistance provider number of the supervising therapist.

ELEMENT 8 - THERAPIST'S TELEPHONE NUMBER
Enter the telephone number, including area code, of the therapist who would provide the authorized service (performing provider). If the performing provider would be a therapy assistant, enter the telephone number of the supervising therapist.

ELEMENT 9 - REFERRING/PRESCRIBING PHYSICIAN'S NAME
Enter the name of the physician referring/prescribing evaluation/ treatment.

* *

The remaining portions of this attachment are to be used to document the justification for the requested service.

1. Complete elements A through J.

2. Element E - Provide a brief past history based on available information.

   Element I - Provide the recipient's perceived potential to meet therapy goals.

3. Read the Prior Authorization Statement before dating and signing the attachment.

---

4. The attachment must be signed and dated by the primary therapist who will be responsible for and participate in therapy services for the recipient. If the performing provider will be a therapy assistant, the attachment must be signed by the supervising therapist.

   The form must be signed and dated by the prescribing physician. **NOTE:** A copy of the signed physician's order sheet is acceptable in lieu of the physician's signature.

Attachment 8

MAIL TO
E.D.S. FEDERAL CORPORATION
PRIOR AUTHORIZATION UNIT
6406 BRIDGE ROAD
SUITE 88
MADISON, WI 53784-0088

PRIOR AUTHORIZATION REQUEST FORM

PA/RF (DO NOT WRITE IN THIS SPACE)

ICN #
A.T. #
P.A. # 1234567

1. PROCESSING TYPE: 115

2. RECIPIENT'S MEDICAL ASSISTANCE I.D. NUMBER: 1234567890

3. RECIPIENT'S NAME (LAST, FIRST, MIDDLE INITIAL): RECIPIENT, Im A.

4. RECIPIENT ADDRESS (STREET, CITY, STATE, ZIP CODE): I. M. Nursing Home, 609 Willow, Anytown, WI 53725

5. DATE OF BIRTH: MM/DD/YY

6. SEX: M [ ] F [X]

7. BILLING PROVIDER TELEPHONE NO.: (XXX) XXX-XXXX

8. BILLING PROVIDE NAME, ADDRESS, ZIP CODE:
I. M. PROVIDER
1 W. Williams
Anytown, WI 53725

9. BILING PROVIDER NO.: 12345678

10. DX: PRIMARY: 720 Rheumetoid Spondylitis

11. DX: SECONDARY: 345.1 Epilepsy

12. START DATE OF SOI: MM/DD/YY

13. FIRST DATE RX: MM/DD/YY

14 PROCEDURE CODE	15 MOD	16 POS	17 TOS	18 DESCRIPTION OF SERVICE	19 QR	20 CHARGES
		8	1	OT Spell of Illness	45	

TOTAL CHARGE 21

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.

22 MM/DD/YY
DATE

23 I. M. Provider I. M. Provider
REQUESTING PROVIDER SIGNATURE

(DO NOT WRITE IN THIS SPACE)

AUTHORIZATION:

[ ] APPROVED

GRANT DATE

EXPIRATION DATE

PRODEDURE(S) AUTHORIZED QUANTITY AUTHORIZED

[ ] MODIFIED — REASON

[ ] DENIED — REASON

[ ] RETURN — REASON

DATE

CONSULTANT/ANALYST SIGNATURE

INSTRUCTIONS FOR THE COMPLETION OF THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF) FOR A SPELL OF ILLNESS (Physical, Occupational, Speech Therapy)

ELEMENT 1 - PROCESS TYPE
Enter the appropriate three digit process type in this element. Spell of illness requests will be returned without adjudication if no process type is indicated.

114 - Physical Therapy Spell of Illness
115 - Occupational Therapy Spell of Illness
116 - Speech Therapy Spell of Illness

ELEMENT 2 - RECIPIENT'S MEDICAL ASSISTANCE NUMBER
Enter the ten digit medical assistance recipient number exactly as it appears on the recipient's medical assistance identification card.

ELEMENT 3 - RECIPIENT'S NAME
Enter the recipient's last name, followed by first name and middle initial, exactly as it appears on the recipient's medical assistance identification card.

ELEMENT 4 - RECIPIENT'S ADDRESS
Enter the address of the recipient's place of residence; the street, city, state and zip code must be included. 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 - RECIPIENT'S DATE OF BIRTH
Enter the recipient's date of birth in MM/DD/YY format (i.e., June 8, 1941 would be 06/08/41) exactly as it appears on the recipient's medical assistance identification card.

ELEMENT 6 - RECIPIENT'S SEX
Enter an 'X' to specify male or female.

ELEMENT 7 - BILLING PROVIDER'S NAME, ADDRESS AND ZIP CODE
Enter the name and complete address (street, city, state and zip code) of the billing provider. No other information should be entered in this element as it also serves as a return mailing label.

ELEMENT 8 - BILLING PROVIDER'S TELEPHONE NUMBER
Enter the telephone number, including the area code, of the office, clinic, facility or place of business of the billing provider.

ELEMENT 9 - BILLING PROVIDER'S MEDICAL ASSISTANCE PROVIDER NUMBER
Enter the eight digit medical assistance provider number of the billing provider.

Instructions for the Completion of the
Prior Authorization Request Form (PA/RF)
for a Spell of Illness
(Physical, Occupational, Speech Therapy)
Page 2

ELEMENT 10 - RECIPIENT'S PRIMARY DIAGNOSIS
Enter the appropriate International Classification of Disease, 9th Edition, Clinical Modification (ICD-9-CM) diagnosis code and description most relevant to the spell of illness.

ELEMENT 11 - RECIPIENT'S SECONDARY DIAGNOSIS
Enter the appropriate International Classification of Disease, 9th Edition, Clinical Modification (ICD-9-CM) diagnosis code and description additionally descriptive of the recipient's condition.

ELEMENT 12 - START DATE OF SPELL OF ILLNESS
Enter the date of onset for the new spell of illness in MM/DD/YY format (i.e., March 1, 1988 would be 03/01/88).

ELEMENT 13 - FIRST DATE OF TREATMENT (SPELL OF ILLNESS)
Enter the date of the first treatment or evaluation for the new spell of illness in MM/DD/YY format (i.e., March 9, 1988 would be 03/09/88).

ELEMENT 14 - PROCEDURE CODE(S)
(leave this element blank)

ELEMENT 15 - MODIFIERS
(leave this element blank)

ELEMENT 16 - PLACE OF SERVICE
Enter the appropriate place of service code (3 - Office, 4 - Home, 7- Nursing Home, 8 - Skilled Nursing Facility).

ELEMENT 17 - TYPE OF SERVICE
(leave this element blank)

ELEMENT 18 - DESCRIPTION OF SERVICE
Enter the description 'Spell of Illness' in this element.

ELEMENT 19 - QUANTITY OF SERVICE REQUESTED
Enter '45' in this element, signifying forty-five treatment days.

ELEMENT 20 - CHARGES
(leave this element blank)

ELEMENT 21 - TOTAL CHARGES
(leave this element blank)

Instructions for the Completion of the
Prior Authorization Request Form (PA/RF)
for a Spell of Illness
(Physical, Occupational, Speech Therapy)
Page 3

ELEMENT 22 - BILLING CLAIM PAYMENT CLARIFICATION STATEMENT
Please read the 'Billing Claim Payment Clarification Statement' printed on the request before dating and signing the prior authorization request form.

'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 date or after authorization expiration date. Reimbursement will be in accordance with Wisconsin Medical Assistance Program (WMAP) 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.'

ELEMENT 23 - DATE
Enter the month, day and year the request form was completed and signed.

ELEMENT 24 - REQUESTING PROVIDER'S SIGNATURE
The signature of the provider (therapist) requesting the spell of illness must appear in this element.

Attachment 8b

Mail To:

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

PA/SOIA

PRIOR AUTHORIZATION SPELL OF ILLNESS ATTACHMENT

(Physical, Occupational, Speech Therapy)

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	19

PROVIDER INFORMATION

⑥ THERAPIST'S NAME AND CREDENTIALS	⑦ THERAPIST'S MEDICAL ASSISTANCE PROVIDER NUMBER	⑧ THERAPIST'S TELEPHONE NUMBER
I.M. PERFORMING, O.T.R.	87654321	(XXX) XXX - XXXX

⑨ I.M. REFERRING
REFERRING/PRESCRIBING PHYSICIAN'S NAME

A. ☐ Physical Therapy SOI ☒ Occupational Therapy SOI ☐ Speech Therapy SOI

Provide a description of the recipient's diagnosis and problems.
Indicate the functional regression which has occurred and the potential to reachieve the previous skill.

Client received the diagnosis of Rheumatoid Spondylitis at age 16. His condition has been progressive with involvement of the small joints of the spine to peripheral involvement of both upper extremities at this time. Discharge from nursing home to his own adapted apartment with minimal help from his family is planned once his condition stabilizes. A program of range of motion, gentle stretch, gradual strengthening and activities of daily living for personal needs and adapted homemaking are possible with this intelligent, well motivated young man.

C. Attach a copy of the recipient's Therapy Plan of Care, including a current evaluation.

D. What is the anticipated end date of the spell of illness.

E. Supply the physician's dated signature on either the Therapy Plan of Care or the Physician's Order Sheet.

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

F. I.M. Prescribing — Signature of Prescribing Physician (A copy of the Physician's Order Sheet is acceptable) — MM/DD/YY Date

G. I.M. Performing — Signature of Therapist Providing Treatment Providing Evaluation/Treatment — MM/DD/YY Date

INSTRUCTIONS FOR THE COMPLETION OF THE PRIOR AUTHORIZATION SPELL OF ILLNESS ATTACHMENT (PA/SOIA) (Physical, Occupational, Speech Therapy)

Do not use this attachment to request prior authorization to extend treatment beyond forty-five treatment days for the same spell of illness, use the Prior Authorization Therapy Attachment (PA/TA).

The timely determination of authorization is significantly enhanced by the completeness and quality of the documentation submitted by providers when requesting prior authorization for a spell of illness. Carefully complete this attachment form, attach it to the Prior Authorization Request Form (PA/RF) and submit to the following address:

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

Questions regarding completion of the Prior Authorization Request Form (PA/RF) and/or the Prior Authorization Spell of Illness Attachment (PA/SOIA) may be addressed to EDS' Telephone/Written Correspondence Unit.

RECIPIENT INFORMATION:

ELEMENT 1 - RECIPIENT'S LAST NAME
Enter the recipient's last name exactly as it appears on the recipient's medical assistance identification card.

ELEMENT 2 - RECIPIENT'S FIRST NAME
Enter the recipient's first name exactly as it appears on the recipient's medical assistance identification card.

ELEMENT 3 - RECIPIENT'S MIDDLE INITIAL
Enter the recipient's middle initial exactly as it appears on the recipient's medical assistance identification card.

ELEMENT 4 - RECIPIENT'S MEDICAL ASSISTANCE NUMBER
Enter the recipient's ten digit medical assistance number exactly as it appears on the recipient's medical assistance identification card.

ELEMENT 5 - RECIPIENT'S AGE
Enter the age of the recipient in numerical form (i.e., 45, 60, 21, etc.).

PROVIDER INFORMATION:

ELEMENT 6 - THERAPIST'S NAME AND CREDENTIALS
Enter the name and credentials of the primary therapist who would be responsible for and participate in therapy services for the recipient. If the performing provider will be a therapy assistant, enter his/her name and credentials, also enter the name of the supervising therapist.

ELEMENT 7 - THERAPIST'S MEDICAL ASSISTANCE PROVIDER NUMBER
Enter the eight digit medical assistance provider number of the therapist who would provide the authorized service (performing provider). If the performing provider will be a therapy assistant, enter his/her medical assistance provider number, also enter the medical assistance provider number of the supervising therapist.

ELEMENT 8 - THERAPIST'S TELEPHONE NUMBER
Enter the telephone number, including area code, of the therapist who would provide the authorized service (performing provider). If the performing provider would be a therapy assistant, enter his/her telephone number and the telephone number of the supervising therapist.

ELEMENT 9 - REFERRING/PRESCRIBING PHYSICIAN'S NAME
Enter the name of the physician referring/prescribing evaluation/ treatment.

PART A
Enter an 'X' in the appropriate box to indicate a physical, occupational or speech therapy spell of illness request.

PART B
Enter a description of the recipient's diagnosis and problems. Indicate what functional regression has occurred and what the potential to reachieve the previous skill is.

PART C
Attach a copy of the recipient's Therapy Plan of Care, including a current dated evaluation to the Spell of Illness Attachment before submitting the spell of illness request.

Instructions for the Completion of the
Prior Authorization Spell of Illness
Attachment (PA/SOIA)
(Physical, Occupational, Speech Therapy)
Page 3

PART D
Enter the anticipated end date of the spell of illness in the space provided.

PART E
Attach the physician's dated signature on either the Therapy Plan of Care or copy of physician's order sheet to this attachment.

Read the Prior Authorization Statement before dating and signing the Attachment.

PART F
The signature of the prescribing physician and the date must appear in the space provided. (A signed copy of the Physician's order sheet is acceptable.)

PART G
The dated signature of the therapist providing evaluation/treatment must appear in the space provided.

**INSTRUCTIONS FOR THE REQUEST
OF A THERAPY SPELL OF ILLNESS
(Physical, Occupational, Speech)**

A. Complete the Prior Authorization Request Form (PA/RF).

- Required Elements: 1-13, 16, 18, 19, 23 and 24
- Leave these Elements Blank: 14, 15, 17, 20 and 21
- Refer to the attached instructions for completing the Prior Authorization Request Form (PA/RF).

B. Complete the Prior Authorization Spell of Illness Attachment (PA/SOIA).

- Required Elements: 1-9 and Parts A thru G
- Refer to the attached instructions for completing the Spell of Illness Attachment (PA/SOIA).

C. Submit the Prior Authorization Request Form (PA/RF) and the Spell of Illness Attachment (PA/SOIA) to the following address:

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

Mail To:

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

PRIOR AUTHORIZATION HOME HEALTH 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
LAST NAME	FIRST NAME	MIDDLE INITIAL	MEDICAL ASSISTANCE ID NUMBER	AGE

PROVIDER INFORMATION

6	7	8
		( ) -
PERFORMING PROVIDER'S NAME AND CREDENTIALS	PERFORMING PROVIDER'S MEDICAL ASSISTANCE PROVIDER NUMBER	PERFORMING PROVIDER'S TELEPHONE NUMBER

9	10
REFERRING PROVIDER'S NAME	REFERRING PROVIDER'S MEDICAL ASSISTANCE PROVIDER NUMBER

A. Clinical condition and recipient history relative to the service requested: (including mobility, independence, cognitive ability, special problems, etc.)

B. Is the recipient confined to place of residence? ☐ Yes ☐ No

C. Is a primary care giver available? ☐ Yes ☐ No Explain:

D. Identify Home Health Aide services to be provided as they relate to the recipient's medical condition (be specific): (Include hours per day/days per week)

E. Identify the nursing services to be provided as they relate to the recipient's medical condition (be specific): (Include hours per day/days per week)

F. How long have requested service(s) been provided?

G. Identify the estimated duration of need:

H. Indicate progress/status since care was initiated or last authorized, and estimate the need for continued service:

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

I. ____________________ ____

Date Requesting Provider's Signature