

Medical Assistance Provider Bulletin

Attention: All Title XIX
Certified Speech & Audiology
Providers and Hearing Aid
Dealers

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

Date: September 1, 1987

Code: MAPB-087-015-D
MAPB-087-002-HA

TABLE OF CONTENTS

This bulletin contains important information on the following:

- I. INTRODUCTION
- II. PROVIDER BILLING WORKSHOPS
- III. NATIONAL HEALTH INSURANCE CLAIM FORM - HCFA 1500
- IV. PLACE OF SERVICE CODES
- V. TYPE OF SERVICE CODES
- VI. HCFA COMMON PROCEDURE CODING SYSTEM (HCPCS)
- VII. COPAYMENTS
- VIII. PRIOR AUTHORIZATION REQUEST FORM
- IX. ATTACHMENTS

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 (WMAF) 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.

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 D for times and locations in your area.

III. NATIONAL HEALTH INSURANCE CLAIM FORM - HCFA 1500

All Speech and Audiology providers and Hearing Aid Dealers 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 Speech and Hearing Services Provider Handbook, Part O, issued in April, 1985. 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 form 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 form. Allowable POS codes are included in Attachment A-5 for Therapy services; Attachment B-4 for Audiology services; and Attachment C-5 for Hearing Aid services.

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 are included in Attachment A-5 for Therapy services; Attachment B-4 for Audiology services; and Attachment C-5 for Hearing Aid services.

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:

- o Physician's Current Procedural Terminology - Fourth Edition (CPT-4) codes which are updated annually;
- o 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
- o 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 are included in Attachment A-3 for Speech Therapy services; Attachment B-3 for Audiology services; and Attachment C-3 for Hearing Aid Dealers.

VII. COPAYMENTS

Effective January 1, 1988 and after, there will be no copayment for hearing aid batteries.

VIII. PRIOR AUTHORIZATION REQUEST FORMS

Effective with all Prior Authorization (PA) requests received by EDS on or after January 1, 1988, providers of speech therapy, audiology and hearing aid services must use the PA request forms as indicated below. Requests received on any other forms will be returned to the provider.

A. Speech Therapy and Audiology Services

The WMAP has developed a standard PA cover form (PA/RF) which must be used by most providers. Providers of speech and audiology services must use this standard cover form and the therapy attachment (form PA/TA). Prior authorization requests for Spell of Illness must be made on the Spell of Illness attachment for physical, occupational and speech therapy (form PA/SOIA).

B. Hearing Aid Services

Prior authorization requests for Hearing Aid services must be made on the Physician's Otological Report (form PA/OF), the Audiological PA Request (form PA/ARF1) and the Hearing Aid Request (form PA/ARF2).

Sample PA Request forms and completion instructions are included in Attachment Sections A (Speech Therapy), B (Audiology), and C (Hearing Aid Services) as follows:

	<u>Attachment Numbers</u>
1. PA Request Form and Usage Table _____	A-6; B-5
2. Form PA/RF and Completion Instructions _____	A-7 & 7a; B-6 & 6a
Form PA/TA and Completion Instructions _____	A-7b & c; B-7 & 7a
Form PA/RF for Spell of Illness and _____	A-8 & 8a
Completion Instructions	
Form PA/SOIA and Completion Instructions _____	A-8b, 8c & 8d
Summary Instructions for Completion of PA _____	B-8; C-6
for Hearing Aids	
Form PA/OF _____	B-8a
Form PA/ARF1 and Completion Instructions _____	B-8b & 8c
Form PA/ARF2 and Completion Instructions _____	B-8d & 8e

**ATTACHMENTS
A-SPEECH THERAPY SERVICES**

Page No.

1.	Claim Form Sample.....	1
2.	Claim Form Completion Instructions.....	2
3.	Procedure Code and Copayment Table for Speech Therapy Services..	12
4.	DME Procedure Codes Billable by Speech Therapists.....	13
5.	Place of Service (POS) and Type of Service (TOS) Codes For Therapy Services.....	14
5a.	Place of Service (POS) and Type of Service (TOS) Codes For DME Services.....	15
6.	Prior Authorization Request Form and Usage Table.....	16
	Prior Authorization Request for Speech Therapy Services	
7.	Form PA/RF Sample.....	20
7a.	Form PA/RF Completion Instructions.....	21
7b.	Form PA/TA Sample.....	27
7c.	Form PA/TA Completion Instructions.....	31
	Prior Authorization Request for Spell of Illness	
8.	Form PA/RF Sample.....	34
8a.	Form PA/RF Completion Instructions.....	35
8b.	Form PA/SOIA Sample.....	38
8c.	Form PA/SOIA Completion Instructions.....	39
8d.	Summarize Instructions for Therapy Spell of Illness.....	42
NOTE:	Attachment B - Audiology Services.....	43
	Attachment C - Hearing Aid Services.....	83
	Attachment D - Provider Billing Workshop Invitation.....	101

**ATTACHMENT A-2
NATIONAL HCFA 1500 CLAIM FORM
COMPLETION INSTRUCTIONS
FOR SPEECH THERAPY, AUDIOLOGY AND HEARING AID SERVICES**

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 (WMAAP) 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 information in 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 (unless dispensed by a therapist)
 - 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

ATTACHMENT A-2
NATIONAL HCFA 1500 CLAIM FORM
COMPLETION INSTRUCTIONS
FOR SPEECH THERAPY, AUDIOLOGY AND HEARING AID SERVICES

- 'P' - Free Standing Ambulatory Surgery Center
- Independent Laboratory and Radiology
- Mental Health - Non-51.42 Board Operated AODA, Day treatment, Psychotherapy
- Physician
- Rural Health Agency
- 'T' - Therapy - Occupational, Physical, Speech, Audiology
- 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 A-2
NATIONAL HCFA 1500 CLAIM FORM
COMPLETION INSTRUCTIONS
FOR SPEECH THERAPY, AUDIOLOGY AND HEARING AID SERVICES

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 A-2
NATIONAL HCFA 1500 CLAIM FORM
COMPLETION INSTRUCTIONS
FOR SPEECH THERAPY, AUDIOLOGY AND HEARING AID SERVICES**

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 A-2
NATIONAL HCFA 1500 CLAIM FORM
COMPLETION INSTRUCTIONS
FOR SPEECH THERAPY, AUDIOLOGY AND HEARING AID SERVICES

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 A-2
NATIONAL HCFA 1500 CLAIM FORM
COMPLETION INSTRUCTIONS
FOR SPEECH THERAPY, AUDIOLOGY AND HEARING AID SERVICES

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.

HEARING AID DEALERS enter Diagnosis Code 389.9

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 form/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:

ATTACHMENT A-2
NATIONAL HCFA 1500 CLAIM FORM
COMPLETION INSTRUCTIONS
FOR SPEECH THERAPY, AUDIOLOGY AND HEARING AID SERVICES

- * All dates of service are in the same calendar month.
- * 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 A-5 and A-5a of this bulletin for a list of allowable place of service codes for speech therapy.

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.

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.

Speech and Audiology Providers:

Enter the total number of therapy/services for this line item and the total number of minutes for each therapy (e.g., 30 or 60 minutes for each).

**ATTACHMENT A-2
NATIONAL HCFA 1500 CLAIM FORM
COMPLETION INSTRUCTIONS
FOR SPEECH THERAPY, AUDIOLOGY AND HEARING AID SERVICES**

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.

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 services billed on each line item.

Speech Providers:

Enter the total number of therapy services involved for each procedure (e.g., 1, 1.5, 2).

Hearing Aid Providers:

For a hearing aid rental service, the total number of days the item was rented should be entered as the quantity. This must coincide with the service date range indicated. For hearing aid batteries, enter the number of batteries.

Element 24G - Type of Service (TOS)

Enter the appropriate type of service code. Refer to Attachment A-5 and A-5a of this bulletin for a list of allowable type of service codes for speech therapy.

ATTACHMENT A-2
NATIONAL HCFA 1500 CLAIM FORM
COMPLETION INSTRUCTIONS
FOR SPEECH THERAPY, AUDIOLOGY AND HEARING AID SERVICES

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.)

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)

ATTACHMENT A-2
NATIONAL HCFA 1500 CLAIM FORM
COMPLETION INSTRUCTIONS
FOR SPEECH THERAPY, AUDIOLOGY AND HEARING AID SERVICES

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 A-3

HCPCS PROCEDURE CODE AND COPAYMENT CONVERSION TABLE
 FOR SPEECH/LANGUAGE SERVICES

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

Copayment amounts for services provided for less than 30 minutes should be prorated.

PROCEDURE CODE		MOD.	NEW DESCRIPTION	COPAYMENT
PRIOR TO 01/01/88	EFFECTIVE 01/01/88			
92506	92506	n/a	Speech/Language Evalutation (30 Minutes)	\$1.00 30 minutes
92507	92507	n/a	Speech/Language Therapy (30 Minutes)	\$1.00 30 minutes
92508	92508	n/a	Group Speech/Language Therapy (each 30 min. segment per person)	\$1.00 30 minutes

ATTACHMENT A-4

HCPCS PROCEDURE CODE AND COPAYMENT CONVERSION TABLE
 DME ITEMS BILLABLE BY SPEECH PATHOLOGISTS

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. All DME items are for purchase only unless rental is specified in the description.

PROCEDURE CODE		MOD.	NEW DESCRIPTION	LIFE EXPECTANCY	COPAYMENT	*
PRIOR TO 01/01/88	EFFECTIVE 01/01/88					
08497	**W6808	n/a	Communicator (including acces.)	10 years	\$1.00	R
08538	**W6813	n/a	Electrolarynx	3 years	\$1.00	R
08851	E1350	n/a	Repair or non-routine service (e.g., breaking down sealed components/requiring the skill of a technician	n/a	\$0.00	

* 'R' denotes items reimbursable for nursing home patients.
 ** Prior authorization required

ATTACHMENT A-5
SPEECH/LANGUAGE 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 TABLE

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

ATTACHMENT A-5 a

DURABLE MEDICAL EQUIPMENT (DME) SERVICES
PROVIDED BY SPEECH THERAPIST

PLACE OF SERVICE (POS) CONVERSION TABLE

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

TYPE OF SERVICE (TOS) CONVERSION TABLE

<u>Prior to</u> <u>01/01/88</u>	<u>Effective</u> <u>01/01/88</u>	<u>New Description</u>
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.

<u>Service</u>	<u>Prior Authorization Form Required</u>	<u>Special Consideration</u>
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 <u>not</u> complete PA/DA if requesting orthodontic services.
	Dental Prior Authorization Request Form (PA/DRF) & Orthodontic Services Attachment (PA/OA)	Use to report orthodontic services <u>only</u> .
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).

Prior Authorization
Request Forms and Usage
Page 2

<u>Service</u>	<u>Prior Authorization Form Required</u>	<u>Special Consideration</u>
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)	<ul style="list-style-type: none"> - 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)	<ul style="list-style-type: none"> - Use to request therapy (PT, OT, Speech) services provided by a home health agency.
NOTE:		
1. If recipient will receive <u>only</u> 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 <u>in addition</u> to home health therapy services, attach <u>both</u> attachment forms (PA/HHSA and PA/HHTA) to the Prior Authorization Request Form (PA/RF) and submit to EDS.		
Hospital	Prior Authorization Request Form (PA/RF) & Physician Attachment (PA/PA)	Use when requesting prior authorization for <ul style="list-style-type: none"> - transplants - AIDS services - ventilator services
Mental Health	Prior Authorization Request Form (PA/RF) & Psychotherapy Attachment (PA/PSYA)	Use to request all psychotherapy services requiring prior authorization.

Prior Authorization
Request Forms and Usage
Page 3

<u>Service</u>	<u>Prior Authorization Form Required</u>	<u>Special Consideration</u>
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 <u>same</u> spell of illness.
	Prior Authorization Request Form (PA/RF) & Spell of Illness Attachment (PA/SOI) (physical, occupational, speech)	Use to request a new spell of illness <u>only</u> .

Prior Authorization
Request Forms and Usage
Page 4

<u>Service</u>	<u>Prior Authorization Form Required</u>	<u>Special Consideration</u>
Transportation	Prior Authorization Request Form (PA/RF) & Physician Attachment (PA/PA)	Use when requesting any transportation service requiring prior authori- zation (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

113

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

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

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

5. DATE OF BIRTH
MM/DD/YY

6. SEX
M F

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

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

9. BILLING PROVIDER NO.
12345678

10. DX: PRIMARY
436 - Cerebral Palsy

11. DX: SECONDARY
389.9 - Hearing Loss

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
92507		8	1	Speech Therapy, Individual	52	XX.XX

TOTAL CHARGE ²¹ XX.XX

An approved authorization does not guarantee payment. Reimbursement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after 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

PRODEURE(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.

Instructions for the Completion of the
Prior Authorization Request Form (PA/RF)
Page 2

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).

Instructions for the Completion of the
Prior Authorization Request Form (PA/RF)
Page 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,
2	Surgery Independent Nurses, Audiology, PT, OT, ST, Personal
3	Consultation Care, AODA, and Day Treatment)
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 Clinics
	Rehabilitation Agency
	Nurse Midwife
	Chiropractic

* non-board operated only

Alpha	Description
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

Instructions for the Completion of the
Prior Authorization Request Form (PA/RF)
Page 5

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)
Audiology Services (number of services)
Chiropractic (number of manipulations)
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.

Attachment A-7a

Instructions for the Completion of the
Prior Authorization Request Form (PA/RF)
Page 6

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).

Mail To:

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



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	②	③	④	⑤
RECIPIENT LAST NAME	IMA FIRST NAME	 MIDDLE INITIAL	1234567890 MEDICAL ASSISTANCE ID NUMBER	64 AGE

PROVIDER INFORMATION

⑥	⑦	⑧
I.M. PERFORMING, M.S. THERAPIST'S NAME AND CREDENTIALS	12345678 THERAPIST'S MEDICAL ASSISTANCE PROVIDER NUMBER	(XXX) XXX - XXXX THERAPIST'S TELEPHONE NUMBER
⑨		
I.M. REFERRING/PRESCRIBING REFERRING/PRESCRIBING PHYSICIAN'S NAME		

A. Requesting: Physical Therapy Occupational Therapy Speech Therapy

B. Total time per day requested 30 min.

Total Sessions per week requested 2

Total number of weeks requested 26

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

CEREBRAL PALSY SINCE BIRTH. SUFFERS FROM VASCULAR HYPERTENSION, DEGENERATIVE JOINT DISEASE, DIVERTICULOSIS OF COLON, SUBACUTE CHOLECYSTITIS AND CHOLELITHIASIS.

D. BRIEF PERTINENT HISTORY:

Attachment A-7b

MAPB-087-015-D/002-H
Date: 9/1/37

64 YEAR OLD FEMALE WITH CEREBRAL PALSY. SHE HAS BEEN A RESIDENT OF I.M. PROVIDER NURSING HOME SINCE 11/82. SHE IS INVOLVED IN MANY ACTIVITIES IN THE NURSING HOME AND ATTENDS SCHOOL 3 DAYS A WEEK WHERE THEY CALL HER A "LEADER". SHE IS MOTIVATED AND STRIVES TO BE THE BEST SHE CAN.

	Location	Date	Problem Treated
--	----------	------	-----------------

E. Therapy History

PT

N.A.

OT

N.A.

SP

RECEIVED SPEECH THERAPY SINCE 1/86. P.T. SINCE 2/86, also at I.M. PROVIDER NURSING HOME.

Date: 9/1/87

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

NO FORMAL EVALUATIONS FOUND IN HER CHART PRIOR TO 11/86.

2/87 - ORAL MECHANISM EXAMINATION REVEALED REDUCED TONGUE, LIP AND JAW MOVEMENTS. NORMAL PHONATION FOR THIS POPULATION IS 16.0 SECONDS (CAMPBELL AND BLESS 1980). DIADOCKOKINETIC RATES (AMR AND SMK) WERE SLOW, DYSRHYTHMIC UNEVEN IN LOUDNESS AND COUNTABLE. THIS REDUCED HER INTELLIGIBILITY SIGNIFICANTLY.

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

SHE WAS GIVEN A COMMUNICATION BOOKLET TO USE IN NOV. 1986. SHE REPORTS THAT HER USE OF THE BOOKLET IS MINIMAL DUE TO THE FACT THAT SHE DOESN'T LIKE IT. THERAPY FOCUSED ON ARTICULATION ONLY PREVIOUS TO 11/86.

SINCE 2/87 THERAPY HAS FOCUSED ON ORAL EXERCISES TO INCREASE ORAL MUSCULATIVE STRENGTH AND CONTROL. HER LIP AND TONGUE MOVEMENTS HAVE INCREASED SIGNIFICANTLY IN THAT SHE IS NOW 70% INTELLIGIBLE ON THE PHONEMES.

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

- 1) IMPROVE ORAL MUSCULATURE STRENGTH AND CONTROL.
- 2) IMPROVE COMPENSATED INTELLIGIBILITY TO 80%.
- 3) INCREASE USE OF COMMUNICATION BOOKLET TO STAFF AND SCHOOL TEACHERS FOR BETTER COMMUNICATION.

I. Rehabilitation Potential:

GOOD - SHE IS MOTIVATED TO IMPROVE HER SPEECH.

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.

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

J.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.

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

-
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.

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

**PRIOR AUTHORIZATION
REQUEST FORM**

PARF (DO NOT WRITE IN THIS SPACE)
ICN #
A.T. #
P.A. # 1234567

1. PROCESSING TYPE

116

2. RECIPIENT'S MEDICAL ASSISTANCE I.D. NUMBER 1234567890		4. RECIPIENT ADDRESS (STREET, CITY, STATE, ZIP CODE) 609 Willow Anytown, WI 53725	
3. RECIPIENT'S NAME (LAST, FIRST, MIDDLE INITIAL) Recipient, Ima		7. BILLING PROVIDER TELEPHONE NO. (XXX) XXX-XXXX	
5. DATE OF BIRTH 02/06/00	6. SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>	9. BILLING PROVIDER NO. 12345678	
8. BILLING PROVIDER NAME, ADDRESS, ZIP CODE: I. M. Provider 1 W. Williams Anytown, WI 53725		10. DX: PRIMARY 343.9 - Cerebral Palsy	
		11. DX: SECONDARY 389.9 - Hearing Loss	
		12. START DATE OF SOI: MM/DD/YY	13. FIRST DATE RX: MM/DD/YY

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

An approved authorization does not guarantee payment. Reimbursement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after 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.

TOTAL CHARGE ²¹ XX.XX

22. MM/DD/YY DATE 23. I. M. Provider REQUESTING PROVIDER SIGNATURE *I.M. Provider*

(DO NOT WRITE IN THIS SPACE)

AUTHORIZATION:

APPROVED GRANT DATE EXPIRATION DATE PRODEURE(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.

**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.).

Instructions for the Completion of the
Prior Authorization Spell of Illness
Attachment (PA/SOIA)
(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 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 reach 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

**ATTACHMENTS
B-AUDIOLOGY SERVICES**

Page No.

1.	Claim Form Sample.....	44
2.	Claim Form Completion Instructions.....	45
3.	Procedure Code and Copayment Table For Audiology Services.....	55
4.	Place of Service (POS) and type of Service (TOS) Codes For Audiology Services.....	57
5.	Prior Authorization Request Form and Usage Table.....	58
6.	Prior Authorziation Request Form PA/RF Sample.....	62
6a.	Prior Authorization Request Form PA/RF Completion Instructions..	63
7.	Prior Authorization Request Form PA/TA Sample.....	69
7a.	Prior Authorization Request Form PA/TA Completion Instructions..	73
8.	Summary Instructions for Completion of Prior Authorization For Hearing Aids.....	76
8a.	Physician Otological Report for Hearing Aid Evaluation Form PA/OF Sample.....	77
8b.	Prior Authorization Request Form PA/ARF1 Sample.....	78
8c.	Prior Authorization Request Form PA/ARF1 Completion Instructions.....	79
8d.	Prior Authorization Request Form PA/ARF2 Sample.....	81
8e.	Prior Authorization Request Form PA/ARF2 Completion Instructions.....	82
NOTE:	Attachment A - Speech Therapy Services.....	6
	Attachment C - Hearing Aid Services.....	83
	Attachment D - Provider Billing Workshop.....	100

Audiology Services

HEALTH INSURANCE CLAIM FORM

(CHECK APPLICABLE PROGRAM BLOCK BELOW)

<input type="checkbox"/> MEDICARE (MEDICARE NO.)	<input checked="" type="checkbox"/> MEDICAID (MEDICAID NO.)	<input type="checkbox"/> CHAMPUS (SPONSOR'S SSN)	<input type="checkbox"/> CHAMPVA (VA FILE NO.)	<input type="checkbox"/> FECA BLACK LUNG (SSN)	<input type="checkbox"/> 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	5. PATIENT'S SEX MALE <input type="checkbox"/> FEMALE <input checked="" type="checkbox"/>	6. INSURED'S I.D. NO. (FOR PROGRAM CHECKED ABOVE INCLUDE ALL LETTERS) 1234567890
7. PATIENT'S RELATIONSHIP TO INSURED SELF <input checked="" type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER <input type="checkbox"/>	8. INSURED'S GROUP NO. (OR GROUP NAME OR FECA CLAIM NO.) <input type="checkbox"/> 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 - C	10. WAS CONDITION RELATED TO A. PATIENT'S EMPLOYMENT YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> B. ACCIDENT AUTO <input type="checkbox"/> OTHER <input type="checkbox"/>	11. INSURED'S ADDRESS (STREET, CITY, STATE, ZIP CODE) TELEPHONE NO. 11a. CHAMPUS SPONSOR'S STATUS: <input type="checkbox"/> ACTIVE DUTY <input type="checkbox"/> DECEASED <input type="checkbox"/> RETIRED BRANCH OF SERVICE

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (READ BACK BEFORE SIGNING).
13. AUTHORITY TO PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED BELOW.

SIGNED: _____ DATE: _____ 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 <input type="checkbox"/>
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 (OR PUBLIC HEALTH AGENCY) I. M. Referring/Prescribing 12345677		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)		22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? YES <input type="checkbox"/> NO <input type="checkbox"/> CHARGES	

23. A. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE NUMBERS 1, 2, 3
V41.2

B. EPDT YES NO
FAMILY PLANNING YES NO
C. MAJOR AUTHORIZATION NO

A. DATE OF SERVICE FROM TO	B. PLACE OF SERVICE	C. FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN PROCEDURE CODE IDENTIFY EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES	D. DIAGNOSIS CODE	E. CHARGES	F. DAYS OR UNITS	G. LOS	H. LEAVE BLANK
02/20/88	3	92553 Pure tone air & bone	1	XX XX	1.0	W	
02/20/88	3	92567 Tympanometry	1	XX XX	1.0	W	
		I. M. Performing 12345678					

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 <input type="checkbox"/> NO <input type="checkbox"/> ///	27. TOTAL CHARGE XX XX	28. AMOUNT PAID XX XX	29. BALANCE DUE XX XX
32. YOUR PATIENT'S ACCOUNT NO. 1234JED	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 87654321		
33. YOUR EMPLOYER I.D. NO. ///	10. NO. 87654321			

**ATTACHMENT B-2
NATIONAL HCFA 1500 CLAIM FORM
COMPLETION INSTRUCTIONS
FOR SPEECH THERAPY, AUDIOLOGY AND HEARING AID SERVICES**

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 (WMAAP) 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 information in 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 (unless dispensed by a therapist)
 - 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

ATTACHMENT B-2
NATIONAL HCFA 1500 CLAIM FORM
COMPLETION INSTRUCTIONS
FOR SPEECH THERAPY, AUDIOLOGY AND HEARING AID SERVICES

- 'P' - Free Standing Ambulatory Surgery Center
 - Independent Laboratory and Radiology
 - Mental Health - Non-51.42 Board Operated AODA, Day Treatment, Psychotherapy
 - Physician
 - Rural Health Agency
- 'T' - Therapy - Occupational, Physical, Speech, Audiology
 - 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 B-2
NATIONAL HCFA 1500 CLAIM FORM
COMPLETION INSTRUCTIONS
FOR SPEECH THERAPY, AUDIOLOGY AND HEARING AID SERVICES

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 B-2
NATIONAL HCFA 1500 CLAIM FORM
COMPLETION INSTRUCTIONS
FOR SPEECH THERAPY, AUDIOLOGY AND HEARING AID SERVICES

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 B-2
NATIONAL HCFA 1500 CLAIM FORM
COMPLETION INSTRUCTIONS
FOR SPEECH THERAPY, AUDIOLOGY AND HEARING AID SERVICES

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 B-2
NATIONAL HCFA 1500 CLAIM FORM
COMPLETION INSTRUCTIONS
FOR SPEECH THERAPY, AUDIOLOGY AND HEARING AID SERVICES

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.

HEARING AID DEALERS enter Diagnosis Code 389.9

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 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:

ATTACHMENT B-2
NATIONAL HCFA 1500 CLAIM FORM
COMPLETION INSTRUCTIONS
FOR SPEECH THERAPY, AUDIOLOGY AND HEARING AID SERVICES

- * All dates of service are in the same calendar month.
- * 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 B-4 of this bulletin for a list of allowable place of service codes for audiology 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.

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.

Speech and Audiology Providers:

Enter the total number of therapy/services for this line item and the total number of minutes for each therapy (e.g., 30 or 60 minutes for each).

ATTACHMENT B-2
NATIONAL HCFA 1500 CLAIM FORM
COMPLETION INSTRUCTIONS
FOR SPEECH THERAPY, AUDIOLOGY AND HEARING AID SERVICES

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.

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 services billed on each line item.

Speech Providers:

Enter the total number of therapy services involved for each procedure (e.g., 1, 1.5, 2).

Hearing Aid Providers:

For a hearing aid rental service, the total number of days the item was rented should be entered as the quantity. This must coincide with the service date range indicated. For hearing aid batteries, enter the number of batteries.

Element 24G - Type of Service (TOS)

Enter the appropriate type of service code. Refer to Attachment B-4 of this bulletin for a list of allowable type of service codes for audiology providers.

ATTACHMENT B-2
NATIONAL HCFA 1500 CLAIM FORM
COMPLETION INSTRUCTIONS
FOR SPEECH THERAPY, AUDIOLOGY AND HEARING AID SERVICES

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.)

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)

ATTACHMENT B-2
NATIONAL HCFA 1500 CLAIM FORM
COMPLETION INSTRUCTIONS
FOR SPEECH THERAPY, AUDIOLOGY AND HEARING AID SERVICES

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 B-3

HCPCS PROCEDURE CODE AND COPAYMENT CONVERSION TABLE
 FOR AUDIOLOGY 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		MOD.	NEW DESCRIPTION	COPAYMENT
PRIOR TO 01/01/88	EFFECTIVE 01/01/88			
92552	92552	n/a	Pure tone audiometry (threshold); air only	\$1.00/proc.
92553	92553	n/a	Air and bone, with or without masking	\$1.00/proc.
92555	92555	n/a	Speech audiometry; threshold only	\$1.00/proc.
92556	92556	n/a	Speech reception threshold and discrimination	\$1.00/proc.
92557	92557	n/a	Basic comprehensive audiometry (92553 & 92556 combined), (pure tone, air & bone, and speech, threshold and discrimination)	\$1.00/proc.
92561	92561	n/a	Bekesy audiometry; diagnostic	\$1.00/proc.
92562	92562	n/a	Loudness balance test, alternate binaural/monaural	\$1.00/proc.
92563	92563	n/a	Tone decay test	\$1.00/proc.
92564	92564	n/a	Short increment sensitivity index (SISI)	\$1.00/proc.
92565	92565	n/a	Stenger test, pure tone	\$1.00/proc.
92566	92566	n/a	Impedance testing to include tympanometry with or without acoustic reflex testing	\$1.00/proc.
92567	92567	n/a	Tympanometry	\$1.00/proc.

* Prior authorization required

ATTACHMENT B-3

HCPCS PROCEDURE CODE AND COPAYMENT CONVERSION TABLE
 FOR AUDIOLOGY SERVICES

PROCEDURE CODE		MOD.	NEW DESCRIPTION	COPAYMENT
PRIOR TO 01/01/88	EFFECTIVE 01/01/88			
92581*	92581*	n/a	Evoked response (EEG) audiometry	\$1.00/proc.
92585*	92585*	n/a	Brain-stem evoked response recording	\$1.00/proc.
92589	92589	n/a	Central auditory function test(s) - by report concerning education evaluation	\$1.00/proc.
92590	92590	n/a	Hearing aid examination and selection; monaural, following 92557	\$1.00/proc.
92591	92591	n/a	Hearing aid examination and selection; binaural, following 92557	\$1.00/proc.
92592	92592	n/a	Hearing aid check; monaural	\$1.00/proc.
92593	92593	n/a	Hearing aid check; binaural	\$1.00/proc.
92599	92599	n/a	Other audiological procedures, by report	\$1.00/proc.
			Special Audiometric Techniques	
92582*	92582*	n/a	Conditioning play audiometry to include visual reinforcement and observational audiometry (30 minute session)	\$1.00/ 30 minutes
92583*	92583*	n/a	Select picture audiometry (30 minute session)	\$1.00/ 30 minutes
			Aural Rehabilitation	
92507*	92507*	n/a	Speech, language or hearing therapy, individual (30 minute session)	\$1.00/ 30 minutes
92508*	92508*	n/a	Speech, language or hearing therapy, group (30 minute session per person)	\$1.00/ 30 minutes

* Prior authorization required

ATTACHMENT B-4
AUDIOLOGY SERVICES

PLACE OF SERVICE (POS) CONVERSION TABLE

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

TYPE OF SERVICE (TOS) CONVERSION TABLE

Prior to 01/01/88	Effective 01/01/88	New Description
1	W	Diagnostic Medical
H	R	Rental
J	P	Purchase

**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.

<u>Service</u>	<u>Prior Authorization Form Required</u>	<u>Special Consideration</u>
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 <u>not</u> complete PA/DA if requesting orthodontic services.
	Dental Prior Authorization Request Form (PA/DRF) & Orthodontic Services Attachment (PA/OA)	Use to report orthodontic services <u>only</u> .
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).

Prior Authorization
Request Forms and Usage
Page 2

<u>Service</u>	<u>Prior Authorization Form Required</u>	<u>Special Consideration</u>
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) Prior Authorization Request Form (PA/RF) & Home Health Attachment (PA/HHTA)	- 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. - Use to request therapy (PT, OT, Speech) services provided by a home health agency.
NOTE:		
1. If recipient will receive <u>only</u> 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 <u>in addition</u> to home health therapy services, attach <u>both</u> attachment forms (PA/HHSA and PA/HHTA) to the Prior Authorization Request Form (PA/RF) and submit to EDS.		
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 psychotherapy services requiring prior authorization.

<u>Service</u>	<u>Prior Authorization Form Required</u>	<u>Special Consideration</u>
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 and Audiologists)	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 <u>same</u> spell of illness and audiology services which require PA
	Prior Authorization Request Form (PA/RF) & Spell of Illness Attachment (PA/SOI) (physical, occupational, speech)	Use to request a new spell of illness <u>only</u> .

Prior Authorization
Request Forms and Usage
Page 4

<u>Service</u>	<u>Prior Authorization Form Required</u>	<u>Special Consideration</u>
Transportation	Prior Authorization Request Form (PA/RF) & Physician Attachment (PA/PA)	Use when requesting any transportation service requiring prior authori- zation (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

Attachment B-6a

**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.

Instructions for the Completion of the
Prior Authorization Request Form (PA/RF)
Page 2

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).

Instructions for the Completion of the
Prior Authorization Request Form (PA/RF)
Page 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,
2	Surgery Independent Nurses, Audiology, PT, OT, ST, Personal
3	Consultation Care, AODA, and Day Treatment)
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 Clinics
	Rehabilitation Agency
	Nurse Midwife
	Chiropractic

* non-board operated only

Alpha	Description
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

Instructions for the Completion of the
Prior Authorization Request Form (PA/RF)
Page 5

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)
Audiology Services (number of services)
Chiropractic (number of manipulations)
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.

Instructions for the Completion of the
Prior Authorization Request Form (PA/RF)
Page 6

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).

Date: 9/1/87

Attachment B-7

Mail To:

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

PATA

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	②	③	④	⑤
RECIPIENT	IMA		1234567890	1
<small>LAST NAME</small>	<small>FIRST NAME</small>	<small>MIDDLE INITIAL</small>	<small>MEDICAL ASSISTANCE ID NUMBER</small>	<small>AGE</small>

PROVIDER INFORMATION

⑥	⑦	⑧
I.M. PERFORMING, M.S.	12345678	(XXX) XXX . XXXX
<small>THERAPIST'S NAME AND CREDENTIALS</small>	<small>THERAPIST'S MEDICAL ASSISTANCE PROVIDER NUMBER</small>	<small>THERAPIST'S TELEPHONE NUMBER</small>

⑨
I.M. REFERRING
<small>REFERRING/PRESCRIBING PHYSICIAN'S NAME</small>

A. Requesting: Physical Therapy Occupational Therapy Speech Therapy (AUDIOLOGY)

J. Total time per day requested 2-3 hours

Total Sessions per week requested 1

Total number of weeks requested 1

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

HEARING DEFICIT

D. Brief Pertinent History:

SEIZURES IN NEONATAL PERIOD
INTERCRANIAL BLEED

E. Therapy History	Location	Date	Problem Treated
--------------------	----------	------	-----------------

PT

OT

SP

PHENOBARBITAL

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

NEEDS AUDITORY EVOKE POTENTIAL

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

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

I. Rehabilitation Potential:

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

J. 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.

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

-
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 B8

SUMMARY INSTRUCTIONS FOR COMPLETION
OF PRIOR AUTHORIZATION FOR HEARING AIDS

1. Following the performance of an otological examination and evaluation by a Wisconsin medical assistance certified physician, the recipient will present a copy of the Physician's Report (PA/OF) to the audiologist for audiological testing, evaluation and recommendation. The audiologist must receive this report prior to performance of audiological testing.
2. The audiologist completes forms PA/ARF1 and PA/ARF2. These forms are a summation of the audiologist's testing, evaluation and recommendations.
3. The audiologist submits the physician's Otological Report (PA/OF) and forms PA/ARF1 and PA/ARF2 to the Prior Authorization Unit.
4. A copy of the PA/ARF1 and PA/ARF2 will be returned to the audiologist with notification of the decision rendered by the program consultant. The recipient will also receive a copy of WMAP forms with notification of the request approval or denial. The recipient will present his/her copy of forms PA/ARF1 and PA/ARF2 to a Wisconsin medical assistance certified hearing aid dealer for procurement of the hearing aid.
5. The hearing aid dealer advises the recipient to return within thirty days of receiving the hearing aid for a hearing aid performance check.
6. The hearing aid dealer must notify the Prior Authorization Unit of the results of the hearing aid performance check.

Attachment B-8a

PHYSICIAN OTOLOGICAL REPORT
FOR HEARING AID EVALUATION

PA/OF

- COMPLETE EACH ITEM ON FORM.
- GIVE FIRST PAGE TO THE RECIPIENT TO TAKE TO THE AUDIOLOGICAL CENTER.
- RETAIN SECOND PAGE FOR YOUR FILES.

1. PHYSICIAN NAME, ADDRESS, ZIP CODE I.M. REFERRING 1 W. WILLIAMS ANYTOWN, WI 53725		2. PHYSICIAN'S TELEPHONE NO. (XXX) XXX-XXXX	4. DATE OF EVALUATION AND PHYSICIAN'S SIGNATURE	
		3. PHYSICIAN'S MEDICAL ASSISTANCE NO. 12345678	MM/DD/YY DATE	<u>J.M. Referring M.D.</u> SIGNATURE
5. RECIPIENT'S MEDICAL ASSISTANCE I.D. NUMBER 1234567890	6. RECIPIENT'S NAME (LAST, FIRST, M.I.) RECIPIENT, IMA		7. RECIPIENT ADDRESS (STREET, CITY, STATE, ZIP CODE) 609 WILLOW ANYTOWN, WI 53725	
8. SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>	9. DATE OF BIRTH MM/DD/YY			

1. Pertinent medical history regarding hearing loss: 78 YEAR OLD WITH LOSS OF HEARING IN RIGHT EAR.

2. Pertinent otological findings:

EAR CANALS	NORMAL	DISCHARGE	EXTERNAL OTITIS		OBSTRUCTED	OTHER
Right	_____	_____	_____	wax	_____	_____
				other	_____	_____
Left	_____	_____	_____	wax	_____	_____
				other	_____	_____
EAR DRUMS	NORMAL	PERFORATED	DISCHARGE			OTHER
Right	_____	_____	_____			_____
Left	_____	_____	_____			_____
MIDDLE EAR	NORMAL	SECRETORY	CHRONIC OTITIS			OTHER
Right	_____	_____	_____			_____
Left	_____	_____	_____			_____

ADDITIONAL OTOLOGICAL FINDINGS: Please indicate results of special studies such as caloric and postural tests, recruitment tests, etc.

3. Significant nose and throat pathology: Yes No

4. Clinical Diagnosis of Hearing Status: PROFOUND HEARING LOSS. RF
MOD. SEVERE HEARING LOSS LF

5. Additional Information and Comments: _____

6. Other Known Medical Problems: HYPERTENSION

7. Medical Contraindications to the Use of an Air Conduction Type Hearing Aid in Either Ear: DO NOT AMPLIFY RT EAR

8. The use of Non-allergenic Earmold Material (is) (is not) recommended: _____

9. Physician's Recommendations: Audiological Testing Other Comments: CONSIDER AMPLIFICATION LEFT

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

**AUDIOLOGICAL PRIOR
AUTHORIZATION REQUEST FORM**

PA/ARF1 (DO NOT WRITE IN THIS SPACE)

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

1. PROCESSING TYPE

123

2. AUDIOLOGICAL CENTER NAME I.M. PROVIDER		3. PROVIDER NO. 12345678		4. REQUESTING AUDIOLOGIST NAME/NO I.M. REQUESTING 12345678	
5. CENTER ADDRESS 1 W. WILLIAMS ANYTOWN, WI 53725		6. CENTER TELEPHONE NO. (XXX) XXX-XXXX			
8. RECIPIENT'S MEDICAL ASSISTANCE I.D. NUMBER: 1234567890		7. REFERRING PHYSICIAN NAME/NO. I.M. REFERRING 12345678			
9. RECIPIENT'S NAME (LAST, FIRST, MIDDLE INITIAL) RECIPIENT, IMA		11. DATE OF BIRTH MM/DD/YY		12. SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>	
10. RECIPIENT ADDRESS: 609 WILLOW ANYTOWN, WI 53725		13. DIAGNOSIS: 389.10 SENSORINEURAL HEARING LOSS			

14 POS	15 TOS	16 PROCEDURE CODE	17 TYPE OR LIKE MODEL	18 QUANTITY	19 CHARGES
3	P	W6901	STANDARD HEARING AID	1	XX.XX
3	P	V5090	HEARING AID DISPENSING	1	XX.XX
				TOTAL CHARGES	20 XX.XX

An approved authorization does not guarantee payment. Reimbursement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after 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.

21. MM/DD/YY
DATE

22. *S. M. Requesting*
REQUESTING AUDIOLOGIST SIGNATURE

(DO NOT WRITE IN THIS SPACE)

AUTHORIZATION:

APPROVED

GRANT DATE

EXPIRATION DATE

PRODEURE(S) AUTHORIZED QUANTITY AUTHORIZED

MODIFIED - REASON:

DENIED - REASON:

RETURN - REASON:

DATE

CONSULTANT/ANALYST SIGNATURE

**INSTRUCTIONS FOR THE COMPLETION OF
THE HEARING AID REQUEST FORM
(PA/ARF1)**

ELEMENT 1 - PROCESS TYPE

Enter process type 123 when requesting service.

ELEMENT 2 - AUDIOLOGICAL CENTER NAME

Enter the name of the audiological center.

ELEMENT 3 - PROVIDER NUMBER

Enter the eight digit provider number of the audiological center.

ELEMENT 4 - REQUESTING AUDIOLOGIST'S NAME/NUMBER

Enter the requesting audiologist's name and eight digit provider number in this element.

ELEMENT 5 - AUDIOLOGICAL CENTER ADDRESS

Enter the address, including zip code, of the audiological center.

ELEMENT 6 - AUDIOLOGICAL CENTER TELEPHONE NUMBER

Enter the telephone number, including area code, of the audiological center.

ELEMENT 7 - REFERRING PHYSICIAN'S NAME/NUMBER

Enter the name and provider number of the referring physician indicated on the PA/OF form.

ELEMENT 8 - RECIPIENT'S MEDICAL ASSISTANCE NUMBER

Enter the recipient's complete ten digit medical assistance number as it appears on his/her medical assistance identification card.

ELEMENT 9 - RECIPIENT'S NAME

Enter the recipient's last name, first name and middle initial as they appear on his/her medical assistance identification card..

ELEMENT 10 - RECIPIENT'S ADDRESS

Enter the complete address of the recipient's place of residence. If the recipient is a nursing home resident, indicate the name of the nursing home.

ELEMENT 11 - DATE OF BIRTH

Enter the recipient's date of birth in MM/DD/YY format (i.e., January 2, 1932 would be 01/02/32).

ELEMENT 12 - RECIPIENT'S SEX

Enter an 'X' in the appropriate box relating to the sex of the recipient.

ELEMENT 13 - DIAGNOSIS

Enter an ICD-9-CM (International Classification of Disease, 9th Revision, Clinical Modification) diagnosis code and written narrative description of the recipient's diagnoses.

Instructions for Completion of the
Hearing Aid Request Form (PA/ARF1)
Page 2

ELEMENT 14 - PLACE OF SERVICE

Enter the appropriate place of service as listed on the table below:

Inpatient Hospital	1
Outpatient Hospital	2
Office	3
Home	4
Nursing Home	7
Skilled Nursing Facility	8
Independent Lab	A

ELEMENT 15 - TYPE OF SERVICE

Enter type of service 'P' for purchase of hearing aid and 'R' for rental of hearing aid.

ELEMENT 16 - PROCEDURE CODE

Enter the appropriate procedure code of the hearing aid requested.

ELEMENT 17 - TYPE OR LIKE MODEL

Enter a narrative description of the type or like model of hearing aid requested.

ELEMENT 18 - QUANTITY

Enter the quantity to be dispensed.

ELEMENT 19 - CHARGES

Enter your usual and customary charge for each item requested. NOTE: Reimbursement will be in accordance with Wisconsin Medical Assistance Program payment methodology and policy.

ELEMENT 20 - DATE

The date the requesting audiologist signed the request must be entered in this element.

ELEMENT 21 - SIGNATURE

The signature of the requesting audiologist is required in this element.

PRIOR AUTHORIZATION REQUEST FORM

PA/ARF2

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

1. REQUESTING AUDIOLOGIST'S NAME, ADDRESS, ZIP CODE I.M. REQUESTING 1 W. WILLIAMS ANYTOWN, WI 53725		2. REQUESTING AUDIOLOGIST'S TELEPHONE NO. (XXX) XXX-XXXX	4. DATE OF TESTING MM/DD/YY
		3. AUDIOLOGIST'S PROVIDER NO. 12345678	
		5. RECIPIENT'S MEDICAL ASSISTANCE I.D. NUMBER 1234567890	6. RECIPIENT'S NAME (LAST, FIRST, M.I.) RECIPIENT, IMA
		7. SEX F	8. DATE OF BIRTH MM/DD/YY

EAR: (CHECK ONE) RIGHT LEFT BOTH

EAR MOLD: HEARING AID:
GAIN: 45-55 db OUTPUT: LESS THAN 30db SP
FREQ. RESP. AVERAGE TYPE (OR LIKE MODEL): EAR LEVEL
SETTINGS/MODIFICATIONS OF RECOMMENDED AID:
NEED FOR HEARING AID ORIENTATION: BY DEALER
NEED FOR SPEECH READING: POSSIBLY
NUMBER OF HOURS PER DAY RECIPIENT SHOULD USE AID: MAXIMAL

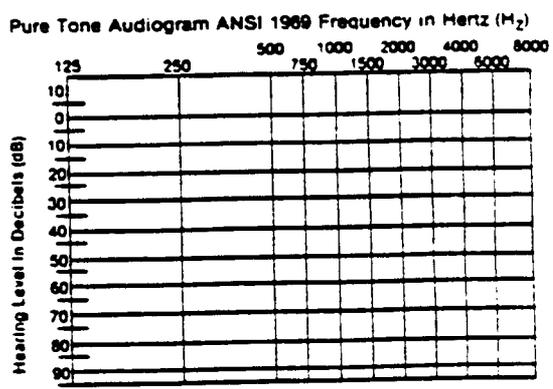
RECIPIENT HAS AID NOW, OR HAS USED ONE PREVIOUSLY? YES NO
MAKE: MODEL:
HOW OLD: CONDITION:
COMMENTS: (INCLUDE ANY PERTINENT SOCIAL BACKGROUND INFORMATION)

Estimated Reliability: Good Fair Poor

Legend

Ear	Color	Air		Bone		NA
		Un Masked	Masked	Un Masked	Masked	
Right	Red	o-o	△-△	<	[↙
Left	Blue	s-s	□□	>]	↘

SPEECH AUDIOMETRY	Aided		
	R	L	SF
Threshold (SRT)			
Discrimination in quiet			
Discrimination in noise			
Uncomfortable level (dB SPL)			



ADDITIONAL COMMENTS:

MM/DD/YY _____
DATE REQUESTING AUDIOLOGIST'S SIGNATURE *I.M. Requesting*

**INSTRUCTIONS FOR THE COMPLETION OF
THE HEARING AID REQUEST FORM
(PA/ARF2)**

ELEMENT 1 - REQUESTING AUDIOLOGIST'S NAME AND ADDRESS

Enter the requesting audiologist's name and address, including zip code.

ELEMENT 2 - REQUESTING AUDIOLOGIST'S TELEPHONE NUMBER

Enter the requesting audiologist's telephone number, including area code.

ELEMENT 3 - AUDIOLOGIST'S PROVIDER NUMBER

Enter the eight digit provider number of the requesting audiologist.

ELEMENT 4 - DATE OF TESTING

Enter the date of audiological testing/evaluation in this element.

ELEMENT 5 - RECIPIENT'S MEDICAL ASSISTANCE NUMBER

Enter the recipient's ten digit medical assistance number as it appears on his/her medical assistance identification card.

ELEMENT 6 - RECIPIENT'S NAME

Enter the recipient's last name, first name and middle initial as they appear on his/her medical assistance identification card.

ELEMENT 7 - SEX

Enter 'M' for male or 'F' for female.

ELEMENT 8 - DATE OF BIRTH

Enter the recipient's date of birth in MM/DD/YY format (i.e., January 5, 1978 would be 01/05/78).

The remainder of the form is used to document your audiological testing and comments.

IT IS ESSENTIAL THAT THE DATE AND YOUR SIGNATURE APPEAR AT THE BOTTOM OF THIS FORM.

**ATTACHMENTS
C -HEARING AID SERVICES**

Page No.

1.	Claim Form Sample.....	84
2.	Claim Form Completion Instructions.....	85
3.	Procedure Code and Copayment Table for Hearing Aid Services.....	95
4.	Procedure Code and Copayment Table for Hearing Aid Batteries....	98
5.	Place of Service (POS) and Type of Service (TOS) Codes for Hearing Aid Services.....	99
6.	Summary Instructions for Completion of Prior Authorization for Hearing Aids.....	100
NOTE:	Attachment A - Speech Therapy Services.....	6
	Attachment B - Audiology Services.....	43
	Attachment D - Provider Billing Workshop Invitation.....	101

ATTACHMENT C-2
NATIONAL HCFA 1500 CLAIM FORM
COMPLETION INSTRUCTIONS
FOR SPEECH THERAPY, AUDIOLOGY AND HEARING AID SERVICES

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 information in 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 (unless dispensed by a therapist)
 - 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

ATTACHMENT C-2
NATIONAL HCFA 1500 CLAIM FORM
COMPLETION INSTRUCTIONS
FOR SPEECH THERAPY, AUDIOLOGY AND HEARING AID SERVICES

- 'P' - Free Standing Ambulatory Surgery Center
- Independent Laboratory and Radiology
- Mental Health - Non-51.42 Board Operated AODA, Day Treatment, Psychotherapy
- Physician
- Rural Health Agency
- 'T' - Therapy - Occupational, Physical, Speech, Audiology
- Durable Medical Equipment Dispensed by Occupational, Physical or Speech Therapist
- 'S' - 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 C-2
NATIONAL HCFA 1500 CLAIM FORM
COMPLETION INSTRUCTIONS
FOR SPEECH THERAPY, AUDIOLOGY AND HEARING AID SERVICES

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 C-2
NATIONAL HCFA 1500 CLAIM FORM
COMPLETION INSTRUCTIONS
FOR SPEECH THERAPY, AUDIOLOGY AND HEARING AID SERVICES**

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 C-2
NATIONAL HCFA 1500 CLAIM FORM
COMPLETION INSTRUCTIONS
FOR SPEECH THERAPY, AUDIOLOGY AND HEARING AID SERVICES

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 C-2
NATIONAL HCFA 1500 CLAIM FORM
COMPLETION INSTRUCTIONS
FOR SPEECH THERAPY, AUDIOLOGY AND HEARING AID SERVICES

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.

HEARING AID DEALERS enter Diagnosis Code 389.9

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 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:

ATTACHMENT C-2
NATIONAL HCFA 1500 CLAIM FORM
COMPLETION INSTRUCTIONS
FOR SPEECH THERAPY, AUDIOLOGY AND HEARING AID SERVICES

- * All dates of service are in the same calendar month.
- * 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 C-5 of this bulletin for a list of allowable place of service codes for hearing aid 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.

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.

Speech and Audiology Providers:

Enter the total number of therapy/services for the line item and the total number of minutes for each therapy (e.g., 30 or 60 minutes for each).

ATTACHMENT C-2
NATIONAL HCFA 1500 CLAIM FORM
COMPLETION INSTRUCTIONS
FOR SPEECH THERAPY, AUDIOLOGY AND HEARING AID SERVICES

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.

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 services billed on each line item.

Speech Providers:

Enter the total number of therapy services involved for each procedure (e.g., 1, 1.5, 2).

Hearing Aid Providers:

For a hearing aid rental service, the total number of days the item was rented should be entered as the quantity. This must coincide with the service date range indicated. For hearing aid batteries, enter the number of batteries.

Element 24G - Type of Service (TOS)

Enter the appropriate type of service code. Refer to Attachment C-5 of this bulletin for a list of allowable type of service codes for hearing aid providers.

ATTACHMENT C-2
NATIONAL HCFA 1500 CLAIM FORM
COMPLETION INSTRUCTIONS
FOR SPEECH THERAPY, AUDIOLOGY AND HEARING AID SERVICES

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.)

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)

ATTACHMENT C-2
NATIONAL HCFA 1500 CLAIM FORM
COMPLETION INSTRUCTIONS
FOR SPEECH THERAPY, AUDIOLOGY AND HEARING AID SERVICES

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 C-3

HCPCS PROCEDURE CODE AND COPAYMENT CONVERSION TABLE
 FOR HEARING AID DEALER SERVICES

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

PROCEDURE CODE		MOD.	NEW DESCRIPTION	COPAYMENT
PRIOR TO 01/01/88	EFFECTIVE 01/01/88			
06901	*W6901	n/a	Hearing aid standard (includes ear mold and one pkg. of batteries)	\$3.00
06903	W6903	n/a	Hearing aid accessories; harness	\$.50
06904	W6904	n/a	Hearing aid accessories; single cord	\$.50
06905	W6905	n/a	Hearing aid accessories; Y-cord	\$.50
06906	W6906	n/a	Ear mold; new/extra, standard hearing aid	\$.50
06907	W6907	n/a	New receiver; standard hearing aid	\$.50
06908	W6908	n/a	Bone condition receiver with head band	\$.50
06909	W6909	n/a	Cross fitting	\$.50
06945	*V5160	n/a	Dispensing fee, binaural	n/a
06946	*W6946	n/a	Binaural hearing aid (includes two ear molds and two pkg. batteries)	\$3.00
06947	W6947	n/a	Ear mold for intubation	\$.50
06948	*W6948	n/a	Special modifications	\$.50

* Prior authorization required

ATTACHMENT C-3

HCPCS PROCEDURE CODE AND COPAYMENT CONVERSION TABLE
FOR HEARING AID DEALER SERVICES

PROCEDURE CODE		MOD.	NEW DESCRIPTION	COPAYMENT
PRIOR TO 01/01/88	EFFECTIVE 01/01/88			
06950	W6950	n/a	Standard hearing aid repair; major	\$.50
06951	W6951	n/a	Standard hearing aid repair; minimal	\$.50
06952	W6952	n/a	Standard hearing aid repair; recasing	\$.50
06960	W6960	n/a	Binaural hearing aid repair; major, right ear	\$.50
06961	W6961	n/a	Binaural hearing aid repair; major, left ear	\$.50
06962	W6962	n/a	Binaural hearing aid repair; minimal, right ear	\$.50
06963	W6963	n/a	Binaural hearing aid repair; minimal, left ear	\$.50
06964	W6964	n/a	Binaural hearing aid repair; recasing, right ear	\$.50
06965	W6965	n/a	Binaural hearing aid repair; recasing, left ear	\$.50
06966	W6966	n/a	Binaural hearing aid; ear mold, new/extra, right ear	\$.50
06967	W6967	n/a	Binaural hearing aid; ear mold, new/extra, left ear	\$.50
06968	W6968	n/a	Binaural hearing aid; new receiver, right ear	\$.50
06969	W6969	n/a	Binaural hearing aid; new receiver, left ear	\$.50

* Prior authorization required

ATTACHMENT C-3

HCPCS PROCEDURE CODE AND COPAYMENT CONVERSION TABLE
 FOR HEARING AID DEALER SERVICES

PROCEDURE CODE		MOD.	NEW DESCRIPTION	COPAYMENT
PRIOR TO 01/01/88	EFFECTIVE 01/01/88			
06999	*V5090	n/a	Dispensing fee	n/a
06901	W6901	n/a	HEARING AID RENTAL Hearing aid standard; (includes ear mold and one pkg. of batteries)	\$3.00
06946	W6946	n/a	Binaural hearing aid; (includes two ear molds and two pkg. of batteries)	\$3.00

* Prior authorization required

ATTACHMENT C-4

HPCPS PROCEDURE CODE AND COPAYMENT CONVERSION TABLE
 FOR HEARING AID BATTERIES

The 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		MOD.	NEW DESCRIPTION	COPAYMENT
PRIOR TO 01/01/88	EFFECTIVE 01/01/88			
06911	W6911	n/a	Silver 76	**
06912	W6912	n/a	Silver 13	**
06913	W6913	n/a	Silver 41	**
06914	W6914	n/a	Silver 312	**
06915	W6915	n/a	Mercury 13	**
06916	W6916	n/a	Mercury 41	**
06917	W6917	n/a	Mercury 132	**
06918	W6918	n/a	Mercury 312	**
06919	W6919	n/a	Mercury 401	**
06920	W6920	n/a	Mercury 502	**
06922	W6922	n/a	Mercury 675	**
06923	W6923	n/a	Zinc-Carbon	**
06942	W6942	n/a	Alkaline 500	**
06943	W6943	n/a	Zinc Air 13 ZA	**
06944	W6944	n/a	Zinc Air 675 ZA	**

** Effective 01/01/88 and after, copayment for hearing aid batteries has been eliminated.

ATTACHMENT C-5
HEARING AID DEALER 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 TABLE

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

Attachment C6

SUMMARY INSTRUCTIONS FOR COMPLETION
OF PRIOR AUTHORIZATION FOR HEARING AIDS

1. Following the performance of an otological examination and evaluation by a Wisconsin medical assistance certified physician, the recipient will present a copy of the Physician's Report (PA/OF) to the audiologist for audiological testing, evaluation and recommendation. The audiologist must receive this report prior to performance of audiological testing.
2. The audiologist completes forms PA/ARF1 and PA/ARF2. These forms are a summation of the audiologist's testing, evaluation and recommendations.
3. The audiologist submits the physician's Otological Report (PA/OF) and forms PA/ARF1 and PA/ARF2 to the Prior Authorization Unit.
4. A copy of the PA/ARF1 and PA/ARF2 will be returned to the audiologist with notification of the decision rendered by the program consultant. The recipient will also receive a copy of WMAP forms with notification of the request approval or denial. The recipient will present his/her copy of forms PA/ARF1 and PA/ARF2 to a Wisconsin medical assistance certified hearing aid dealer for procurement of the hearing aid.
5. The hearing aid dealer advises the recipient to return within thirty days of receiving the hearing aid for a hearing aid performance check.

NOTE: Form PA/OF is completed by the physician.
Forms PA/ARF1 and PA/ARF2 are completed by the audiologist.
Hearing aid dealers should refer to Section B of this bulletin for examples of these forms.