

Medical Assistance Provider Bulletin

Attention: Providers of Intensive In-Home Treatment Services and Mental Health Day Treatment Services for Severely Emotionally Disturbed Children and Adolescents

Subject: WMAP Reimbursement for Intensive In-Home Treatment And Mental Health Day Treatment for Severely Emotionally Disturbed Children and Adolescents

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Department of Health and Social Services, Division of Health,
Bureau of Health Care Financing, P.O. Box 309, Madison, Wisconsin 53701

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I. INTRODUCTION

This Medical Assistance Provider Bulletin (MAPB) contains information on reimbursement through the Wisconsin Medical Assistance Program (WMA) for intensive in-home treatment and day treatment services for severely emotionally disturbed (SED) children and adolescents through the HealthCheck "Other Services" option.

Please review all materials carefully. These materials will give you background information on who may provide HealthCheck "Other Services", provider certification, services which may be reimbursed, recipient eligibility criteria, prior authorization, and billing. References will be made to the various attachments and to other resources available through the WMA.

The instructions and guidelines in this MAPB apply to recipients who are eligible for fee-for-service Medical Assistance. Coverage of services for individuals enrolled in WMA-contracted Health Maintenance Organizations (HMOs) are subject to the requirements of the enrolling HMO. Providers must contact the recipient's HMO, as identified on the Medical Assistance identification card, prior to delivering services to determine whether the services are covered.

All prior authorization requests received by EDS on or after December 1, 1992, must be submitted on the prior authorization request forms included in this MAPB.

If you have further questions after reviewing these materials you may contact:

Bureau of Health Care Financing
Attn: Mental Health/AODA Policy Analyst
P.O. Box 309
Madison, WI 53701

(608) 266-8473

II. THE HEALTHCHECK PROCESS

A. *What is HealthCheck?*

HealthCheck is the name that the WMA has given to a federally mandated Medical Assistance benefit known federally as Early and Periodic Screening, Diagnosis, and Treatment (EPSDT). HealthCheck is designed to ensure regular, comprehensive medical screening of Medical Assistance recipients under the age of 21. The screening includes review of growth and development, identification of potential physical or developmental problems, preventive health education, and referral and assistance to appropriate providers of service. The screens must be performed by, or under the supervision of a physician, physician's assistant, nurse practitioner, public health nurse, or registered nurse. A variety of agencies employing these individuals may be certified to provide HealthCheck screenings.

B. *What are HealthCheck "Other Services"?*

Although HealthCheck screeners are required to make referrals for the treatment of conditions discovered during a HealthCheck exam, the required services may or may not be covered by the WMA. Congress recognized that states differ significantly in the scope of their Medical Assistance coverage since many services are available at a

state's option (such as dental services, prescription drugs, and physical therapy). As a result, the federal Omnibus Budget Reconciliation Act (OBRA) of 1989 mandated that states make available any services allowable under federal Medicaid regulations which are necessary to correct or ameliorate a condition or defect discovered during a HealthCheck exam. HealthCheck "Other Services" are only available to HealthCheck-eligible recipients. While it was believed that this mandate was directed primarily toward states which did not cover many of the optional services, it was recognized that Wisconsin's fairly comprehensive Medical Assistance program did not cover some services which are allowable under the federal regulations. It is these services, which are not part of our regular Medical Assistance benefit, which are referred to as HealthCheck "Other Services."

C. Covered HealthCheck "Other Services"

The federal mandate for HealthCheck "Other Services" allows reimbursement for any federally allowable services. However, states retain the discretion to develop criteria for determining when services are medically necessary, and for determining the amount, duration, and scope of the services provided. States may also develop reasonable criteria regarding the qualifications providers must possess to provide the services.

The WMAP, in consultation with Wisconsin's Office of Mental Health and Office of Alcohol and Other Drug Abuse, has identified in-home treatment services (for emotional problems or alcohol and other drug abuse problems) and mental health day treatment services, which are often necessary for SED youth, as potential HealthCheck "Other Services." (AODA day treatment is already covered by the WMAP for youth.) While other services may be covered under the "Other Services" mandate, these two services are seen as supportive of the development of a community-based system of care for SED youth. Therefore, the WMAP has developed unique prior authorization attachments and instructions for providers seeking authorization for these services. (Refer to Attachments 3 through 6 of this MAPB).

When treatment for conditions discovered through a HealthCheck screening is available through the regular WMAP benefit package, then the services must be provided through the regular benefit. It is important, therefore, for providers to address why the regular mental health or AODA benefits are not appropriate for those individuals for whom in-home treatment or day treatment are being requested.

Providers interested in learning more about the HealthCheck process or becoming certified as a HealthCheck screener should contact:

Bureau of Health Care Financing
Attn: HealthCheck Outreach Coordinator
P.O. Box 309
Madison, WI 53701 (608) 266-9438

Providers interested in receiving a listing of HealthCheck screeners in their area should contact:

EDS
Attn: EDS Correspondence Unit for Policy/Billing Information
6406 Bridge Road
Madison, WI 53784-0006

1-800-947-9627 or 608-221-9883

III. RECIPIENT ELIGIBILITY FOR HEALTHCHECK "OTHER SERVICES"

Recipients are eligible for mental health-related HealthCheck "Other Services" when the following conditions are met:

1. The recipient is Medical Assistance-eligible on the date of service. Providers are reminded to check the recipient's Medical Assistance identification card to verify eligibility. Prior authorization does not guarantee payment if a recipient loses eligibility. Providers are referred to the Medical Assistance Provider Handbook, Part A, Section V for more information on recipient eligibility.
2. The recipient has had a comprehensive HealthCheck screening and has been referred either to the particular treatment service being requested, or for further evaluation of the mental health or AODA conditions. If the referral is to the particular treatment service and the HealthCheck screener is not a physician, then a physician's prescription is also required. If the referral is for further evaluation, a physician's prescription is required for the particular service subsequent to the evaluation.
3. The recipient meets the definition of severely emotionally disturbed as it is outlined in the Prior Authorization In-Home Treatment or Day Treatment Attachments. (Refer to Attachments 4 and 6 of this MAPB.)
4. The provider receives prior authorization from the WMAP.

IV. PRIOR AUTHORIZATION

All HealthCheck "Other Services" require prior authorization. In-home treatment providers must complete the Prior Authorization Request Form (PA/RF), the Prior Authorization In-Home Treatment Attachment (PA/ITA) and attach the required documentation. Refer to Attachments 1, 2, 3, and 4 of this MAPB for sample prior authorization forms and completion instructions.

Child/Adolescent Day Treatment providers must complete the Prior Authorization Form (PA/RF), the Prior Authorization Child/Adolescent Day Treatment Attachment (PA/CADTA) and attach the required documentation. Refer to Attachments 1, 2, 5, and 6 of this MAPB for sample prior authorization forms and completion instructions.

Completed requests must be mailed to:

EDS
Attn: Prior Authorization Unit--Suite 88
6406 Bridge Road
Madison, WI 53784-0088

Providers should carefully review the prior authorization instructions to ensure that all the requested information is correctly provided. Missing or incomplete information results in requests being returned to the provider for corrections or additional information.

When requested, initial prior authorization requests may be backdated up to two weeks prior to the initial date they were received at EDS if the clinical information supports the need for treatment to begin before obtaining approval (even if requests are returned to the provider for additional information). However, no requests are approved for a start date which precedes the date of the HealthCheck referral. The prior authorization instructions describe the normative authorization amounts and instructions for requesting a continuation of a prior authorization request. Requests for continuation of an authorization must be received at EDS prior to the expiration of the previous authorization.

V. DOCUMENTATION

Providers must maintain a clinical record for each recipient which contains the recipient's treatment plan and progress notes, signed by the performing provider, for all services billed to the WMAP. The notes must clearly indicate the date the services were provided, the nature of the services provided, and the professional staff involved in the provision of services. Documentation must be sufficient to allow a determination that the services provided were consistent with the services outlined in the treatment plan, and that the services meet WMAP requirements.

VI. ADDITIONAL INFORMATION

Providers of HealthCheck "Other Services" have the same rights and responsibilities as all other WMAP providers. Providers should carefully review the Medical Assistance Provider Handbook, Part A for general program policy and information.

VII. INTENSIVE IN-HOME TREATMENT

A. *General Description of Service*

Intensive in-home treatment is a combination of individual and family treatment modalities. Treatment services must be identified in the recipient's in-home treatment plan. Measurable goals and the intensity of treatment should be consistent with the assessment conducted on the child and with a multi-agency treatment plan. (See the Prior Authorization In-Home Treatment Attachment instructions in Attachment 3 of this MAPB for more information on the multi-agency plan requirement.) Methods of intervention should meet professional standards of practice.

Services which are primarily social or recreational are not reimbursable by the WMAP. However, this should not be construed as implying that appropriate clinical interventions that employ social or recreational activities to augment the therapeutic process, such as play therapy, are not covered. The treatment plan should be used to clearly identify the relationship of the planned interventions to the treatment goals.

The WMAP reimburses up to eight hours per week of direct treatment services to the family (some of these treatment hours may involve more than one therapist). Reasonable travel time is separately reimbursed. All services provided must be directly related to the recipient's emotional disturbance. Services delivered to other family members, either as a group or individually, must relate directly to the SED

child's mental illness. Services to the parent or primary caregiver which relate to parenting skills are appropriate when the documentation shows that behavioral problems may be related to inadequate or inappropriate parenting skills. The treatment plan must outline the measurable goals of this intervention.

Services directed at the primary mental health or AODA problems in the parent or caregiver are not reimbursable under HealthCheck "Other Services" even though such treatment may indirectly benefit the child. These treatment services may be covered under the other WMAP mental health or AODA benefits and are subject to the policy associated with these other benefits.

B. *Who May Provide Services*

Intensive in-home treatment services must be provided by an outpatient psychotherapy clinic certified under Chapter HSS 61.91-61.98, Wis. Adm. Code and certified with the WMAP under HSS 105.22, Wis. Adm. Code. Clinics may be 51.42 Board-operated or private.

The in-home treatment team must consist of two individuals, at least one of whom is a WMAP-certified psychotherapy provider. Please see the WMAP Provider Handbook, Part H, Division I or II for a description of eligibility to become a WMAP-certified psychotherapy provider. Providers at 51.42 Board-operated clinics or hospital outpatient facilities, who are not required to receive their own performing provider number for outpatient services, must receive a performing provider number in order for the clinic to be reimbursed for in-home treatment services. Providers in private clinics use the provider number already assigned to them.

The second team member must meet one of the following qualifications:

- An individual who possesses at least a bachelor's degree in a behavioral science, an RN, an occupational therapist, a WMAP-certified AODA counselor or a professional with equivalent training. In addition, the second team member must have at least 1,000 hours of supervised clinical experience working in a program whose primary clientele are emotionally disturbed youth, or;
- Other individuals who have had at least 2,000 hours of supervised clinical experience working in a program whose primary clientele are emotionally disturbed youth.

The second team member does not need separate WMAP certification but must work under the supervision of the certified psychotherapy provider. The certified psychotherapy provider's performing provider number is used to bill for services performed by the second team member.

The second team member may also be a WMAP-certified psychotherapy provider. However, for billing purposes, this person is identified as the second team member and is reimbursed at a lower rate.

C. Certification

Providers meeting the eligibility criteria outlined above must be appropriately certified with the WMAP in order to obtain reimbursement for in-home treatment services.

WMAP-certified private outpatient psychotherapy clinics wishing to provide in-home treatment do not require any additional certification.

Board-operated clinics wishing to provide in-home services can use their outpatient clinic billing number. However, performing providers with these agencies who do not currently have a performing provider number need to contact EDS to obtain a provider number.

Hospitals providing outpatient mental health services which are being billed under their hospital provider number must become separately certified by the WMAP as an outpatient psychotherapy clinic provider in order to provide HealthCheck "Other Services."

Providers who meet the eligibility criteria and who wish to become certified in order to provide in-home treatment must contact:

EDS
Attn: Provider Maintenance
6406 Bridge Road
Madison, WI 53784-0006

Prior authorization requests from providers not appropriately certified for in-home treatment or with the WMAP are accepted. However, determination of the provider's eligibility to provide the service occurs concurrently with the review of the prior authorization materials which may delay approval of the request. Providers are strongly encouraged to obtain the appropriate WMAP certification prior to submitting a prior authorization request for one of these services.

D. Billing Instructions

Non-board operated (private) outpatient psychotherapy clinics must use the billing instructions found in Part H, Division I of the Medical Assistance Provider Handbook except for the following :

- The following procedure codes, type of service (TOS) codes, and place of service (POS) codes must be indicated:

<u>Procedure Code</u>	<u>TOS</u>	<u>POS</u>	<u>Description</u>
W7027	1	4	In-home treatment, certified psychotherapist
W7028	1	4	In-home treatment, second team member
W7029	1	0	Travel to Intensive In-home Psychotherapy (certified psychotherapist)
W7030	1	0	Travel to Intensive In-home Psychotherapy second team member

- The performing provider number indicated for all procedure codes must be the performing provider number for the certified psychotherapy provider who heads the in-home team, unless the second team member is a WMAP-certified provider. In this instance, the performing provider number of the second team member may be indicated when billing procedure codes W7028 and W7030.

Refer to Attachment 8a of this MAPB for a sample HCFA 1500 claim form for in-home treatment.

Board-operated outpatient psychotherapy clinics must use the billing instructions found in Part H, Division II of the Medical Assistance Provider Handbook except for the following:

- The provider will use the procedure codes, type of service codes and place of service codes noted above.
- A performing provider number must be indicated in element 24K of the HCFA 1500 claim form. For all procedure codes noted above this will be the performing provider number of the certified psychotherapy provider who heads the in-home team.

Refer to Attachment 8b of this MAPB for a sample HCFA 1500 claim form for in-home treatment.

VIII. CHILD/ADOLESCENT MENTAL HEALTH DAY TREATMENT

A. *General Description of Service*

Day treatment services are provided by a multi-disciplinary team as described in HSS 61.75, 61.78 and 61.81, Wis. Adm. Code. These sections describe the Division of Community Services' (DCS) requirements for child/adolescent day treatment providers.

Up to 5 hours per day and 25 hours per week of day treatment services may be reimbursed by the WMAP.

Treatment services must be identified in the recipient's day treatment program treatment plan. Measurable goals must be consistent with the assessment conducted on the child and with a multi-agency treatment plan. (See the Prior Authorization Child/Adolescent Day Treatment Attachment instructions for information on the multi-agency plan requirement). Methods of intervention should meet professional standards of practice. The level of intensity of services must be justifiable based on the psychiatric assessment and the severity of the recipient's condition.

Services which are primarily social or recreational are not reimbursable by the WMAP. However, this should not be construed as implying that appropriate clinical interventions that employ social or recreational activities to augment the therapeutic process are not covered. For example, a group may use a recreational activity to provide a focus for a discussion of styles of relating or communication skills. The treatment plan should be used to clearly identify the relationship of the planned interventions to the treatment goals.

Time spent in day treatment programs associated with public educational activities, including homework time, is not reimbursable by the WMAP. Providers should coordinate these educational activities with their local education authority.

B. *Who May Provide Services*

Day Treatment services must be provided by a provider who is certified under Chapter HSS 61.75, 61.78 and 61.81 Wis. Adm. Code.

Performing providers in day treatment programs do not need individual certification.

C. *Certification*

Providers meeting the eligibility criteria outlined above must be appropriately certified with the WMAP in order to obtain reimbursement for day treatment services.

All providers wishing to provide child/adolescent day treatment must apply to EDS for a unique billing provider number for this purpose even if the provider has a WMAP provider number for adult day treatment or AODA day treatment. Providers must send a copy of their DCS certification under HSS 61.75, 61.78 and 61.81, Wis. Adm. Code, with their application as proof that they meet the eligibility criteria.

Providers meeting the eligibility criteria who wish to become certified in order to provide day treatment services must contact:

EDS
Attn: Provider Maintenance
6406 Bridge Road
Madison, WI 53784-0006

Prior authorization requests from providers not appropriately certified with the WMAP to provide day treatment are accepted. However, determination of the provider's eligibility to provide the service occurs concurrently with the review of the prior authorization materials and this may delay approval of the request. Providers are strongly encouraged to obtain the appropriate WMAP certification prior to submitting a prior authorization request for one of these services.

D. *Billing Instructions*

Claim form completion instructions and a sample claim form for child/adolescent day treatment are found in Attachments 7 and 8c of this MAPB . All providers must use procedure code W7081 (TOS 9) for billing all day treatment services. A performing provider number is not required. The place of service is "2" for a hospital based program or "3" for a free-standing program. A referring/prescribing provider number is always required.

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**ATTACHMENT 1
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 list below. The "process type" is a three-digit code used to identify a category of service requested. Prior Authorization and Spell of Illness requests will be returned without adjudication if no processing type is indicated.

- 129 - Child/Adolescent Mental Health Day Treatment and In-Home Treatment Services (not AODA Day Treatment)

ELEMENT 2 - RECIPIENT'S MEDICAL ASSISTANCE IDENTIFICATION NUMBER

Enter the recipient's 10-digit Medical Assistance identification number from the recipient's Medical Assistance identification card.

ELEMENT 3 - RECIPIENT'S NAME

Enter the recipient's last name, 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 (e.g., June 8, 1941, would be 06/08/41), from 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 billing provider's name and complete address (street, city, state, and zip code). *No other information should be entered in this element since it also serves as a return mailing label.*

ELEMENT 8 - BILLING PROVIDER'S TELEPHONE NUMBER

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

ELEMENT 9 - BILLING PROVIDER'S MEDICAL ASSISTANCE PROVIDER NUMBER

Enter the billing provider's eight-digit Medical Assistance provider number.

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.

ELEMENT 11 - RECIPIENT'S SECONDARY DIAGNOSIS

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

ELEMENT 12 - START DATE OF SPELL OF ILLNESS (Not required)

ELEMENT 13 - FIRST DATE OF TREATMENT (Not required)

ELEMENT 14 - PROCEDURE CODE(S)

Enter the appropriate procedure code for each service requested, in this element.

ELEMENT 15 - MODIFIER (Not required)

ELEMENT 16 - PLACE OF SERVICE

Enter the appropriate place of service code designating where the requested service would be provided.

<u>Day Treatment</u>		<u>In-Home Treatment</u>	
Code	Description	Code	Description
2	Outpatient Hospital	0*	Other
3	Office	4	Home

* Use place of service "0" when requesting prior authorization for travel time.

ELEMENT 17 - TYPE OF SERVICE

Enter the appropriate type of service code for each service requested.

Numeric	Description
1	In-Home Treatment
9	Child/Adolescent Day Treatment

ELEMENT 18 - DESCRIPTION OF SERVICE

Enter a written description corresponding to the appropriate procedure code for each service requested.

ELEMENT 19 - QUANTITY OF SERVICE REQUESTED

Enter the number of services requested.

Child/Adolescent Day Treatment (number of hours)
In-Home Treatment (number of hours)

ELEMENT 20 - CHARGES

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

NOTE: The charges indicated on the request form should reflect the provider's usual and customary charge for the procedure requested. Providers are reimbursed for authorized services according to the Department of Health and Social Services's Terms of Provider Reimbursement.

ELEMENT 21 - TOTAL CHARGE

Enter the anticipated total charge for this request.

ELEMENT 22 - BILLING CLAIM PAYMENT CLARIFICATION STATEMENT

An approved authorization does not guarantee payment. Reimbursement is contingent upon the recipient's and provider's eligibility at the time the service is provided and the completeness of the claim information. Payment is not made for services initiated prior to approval or after authorization expiration. Reimbursement is in accordance with 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 is only allowed 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 the service must appear in this element.

DO NOT ENTER ANY INFORMATION BELOW THE SIGNATURE OF THE REQUESTING PROVIDER – THIS SPACE IS USED BY THE WISCONSIN MEDICAL ASSISTANCE PROGRAM CONSULTANT(S) AND ANALYST(S).

ATTACHMENT 2a

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
129

2 RECIPIENT'S MEDICAL ASSISTANCE ID NUMBER 1234567890		4 RECIPIENT ADDRESS (STREET, CITY, STATE, ZIP CODE) 609 Willow Anytown, WI 55555	
3 RECIPIENT'S NAME (LAST, FIRST, MIDDLE INITIAL) Recipient, Im A.			
5 DATE OF BIRTH 01/12/82	6 SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>	8 BILLING PROVIDER TELEPHONE NUMBER (XXX) XXX-XXXX	
7 BILLING PROVIDER NAME, ADDRESS, ZIP CODE: In-Home Treatment Provider 1 W. Williams Anytown, WI 55555		9 BILLING PROVIDER NO 87654321	
		10 DX: PRIMARY 313.81	
		11 DX: SECONDARY N/A	
		12 START DATE OF SOL:	13 FIRST DATE RX:

14 PROCEDURE CODE	15 MOD	16 POS	17 TOS	18 DESCRIPTION OF SERVICE	19 QR	20 CHARGES
W7027		4	1	In-home: Certified Therapist	16	
W7028		4	1	In-home: Second Team Member	32	
W7029		0	1	In-home Travel: Certified Tx	4	
W7030		0	1	In-home Travel: Second Tx	12	

22 An approved authorization does not guarantee payment. Reimbursement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after authorization expiration date. Reimbursement will be in accordance with Wisconsin Medical Assistance Program payment methodology and Policy. If the recipient is enrolled in a Medical Assistance HMO at the time a prior authorized service is provided, WMAP reimbursement will be allowed only if the service is not covered by the HMO.

23 MMDDYY DATE 24 _____ REQUESTING PROVIDER SIGNATURE

(DO NOT WRITE IN THIS SPACE)

AUTHORIZATION:

APPROVED

MODIFIED - REASON:

DENIED - REASON:

RETURN - REASON:

GRANT DATE: _____ EXPIRATION DATE: _____

PROCEDURE(S) AUTHORIZED: _____ QUANTITY AUTHORIZED: _____

DATE: _____ CONSULTANT ANALYST SIGNATURE: _____

ATTACHMENT 3

PRIOR AUTHORIZATION INTENSIVE IN-HOME TREATMENT ATTACHMENT (PA/ITA)

COMPLETION INSTRUCTIONS

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 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

GENERAL INSTRUCTIONS

The information contained on this prior authorization in-home treatment attachment (PA/ITA) will be used to make a decision about the amount of intensive in-home treatment which will be approved for Medical Assistance reimbursement. Please complete each section as completely as possible. Where noted in these instructions, you may attach material which you may have in your records.

In-home services are generally deemed appropriate for children who meet the criteria of being severely emotionally disturbed (see Section III-C). The provider must also justify the appropriateness of providing the services in the home rather than in the clinic setting. The unique needs of an SED child and his or her family necessitate a team approach. For purposes of Medical Assistance reimbursement this team must be led by an MA certified psychotherapy provider.

Initial prior authorization request: Please complete the PA/RF and the entire in-home treatment attachment. The initial authorization will be for a period of no longer than eight weeks and will allow the provider to further assess the family and determine their willingness and ability to continue in treatment.

First reauthorization: Please complete the PA/RF and pages 1 and 2 of the prior authorization in-home treatment attachment. Attach a copy of the HealthCheck referral form which was included with the initial authorization. Attach a brief summary of the treatment to date, including progress on treatment goals, and affirm that the family is appropriately involved in the treatment process. If changes were made to the treatment plan, send a copy of the amended or updated plan. Authorization may be granted up through the sixth month of treatment.

Six month reauthorization: Please complete the PA/RF and pages 1 and 2 of the PA/ITA. Attach a copy of the HealthCheck referral form which was included with the initial authorization request. There should also be an updated multi-agency treatment plan and an updated screening (Achenbach or CAFAS) using the same screening tool used for the initial request. Summarize the treatment since the previous authorization. The need for continued in-home treatment must be clearly documented. Where no change is noted in the treatment summary, justify the continued use of in-home treatment or note how changes in the treatment plan address the lack of progress. Specifically address aftercare planning. Authorization will be for a period of no longer than three months.

Subsequent reauthorizations: Please complete the PA/RF and pages 1 and 2 of the prior authorization in-home treatment attachment. Attach a summary of the treatment to date and a revised in-home treatment plan. Note progress on short- and long-term goals from the original plan. Discuss the plans for terminating in-home treatment and what services will be required following the completion of in-home treatment. The need for continued in-home treatment must be clearly documented. Where no change is noted in the treatment summary justify the continued use of in-home treatment or note how changes in the treatment plan address the lack of progress. Authorizations for up to three months may be allowed.

Please check the appropriate box at the top of the PA/TTA to indicate whether this request is an initial, first reauthorization, second reauthorization or subsequent request. Make sure that the appropriate materials are included for the type of request indicated.

Additional Considerations for In-Home Treatment for AODA: When alcohol and other drug abuse treatment issues are identified as part of the in-home treatment plan, an appropriately qualified AODA counselor must be identified as part of the treatment team. In-home treatment by a team headed by an AODA counselor (without a certified psychotherapist participating) will generally not be approved. In these instances the provider must document the absence of significant psychopathology and the primary goal of intervention must be motivational with a goal of getting the recipient and/or family involved in traditional outpatient services.

Multiple services. When a recipient will require prior authorization for other services concurrent to the in-home treatment (e.g., mental health or AODA day treatment), a separate PA/RF must be submitted for those services and the appropriate prior authorization attachment and all required materials must be submitted for that other service. Please indicate on this prior authorization request that services will be coordinated with the other service provider (if the service will be provided by a different agency). These other services must be identified on the multi-agency treatment plan.

SECTION I. RECIPIENT INFORMATION

Elements 1-4. Enter the recipient's last name, first name, middle initial, and 10-digit Medical Assistance identification 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 (e.g., 21,45,60, etc.).

PROVIDER INFORMATION

Element 6. CERTIFIED CLINIC NAME

Enter the name of the Medical Assistance certified psychotherapy clinic which will be billing for the services.

Element 7. CLINIC PROVIDER NUMBER

Enter the eight-digit Medical Assistance provider number of the clinic which will be billing for in-home treatment.

Element 8. CERTIFIED PSYCHOTHERAPIST'S NAME

Enter the name of the Medical Assistance certified psychotherapist who will be the lead member of the team providing services. Master's level psychotherapists must obtain an MA performing provider number in order to bill for these services even if this is not ordinarily required for the type of facility by which they are employed.

Element 9. THERAPIST'S PROVIDER NUMBER

Enter the eight-digit Medical Assistance provider number of the certified psychotherapist identified in element 8.

Element 10. THERAPIST'S PHONE NUMBER

Enter the telephone number, including area code, of the certified psychotherapist identified in element 8.

Element 11. THERAPIST'S DISCIPLINE

Enter the discipline of the certified psychotherapist identified in element 8 (e.g., MSW, PhD., etc.).

SECTION II.

A. Enter the requested start date and end date for this authorization request. The initial authorization may be backdated up to 10 working days prior to the receipt of the request at EDS if the provider documents the clinical need for beginning services immediately. Please note guidelines for length of authorizations under the "General Instructions" above.

B. Enter the total expected number of hours the family will receive direct treatment services over this prior authorization grant period. When two therapists are present at the same time, this is still counted as one hour of treatment received by the family. Also indicate the anticipated pattern of treatment for each team member, e.g., 2 hours-one time a week for 8 weeks by the certified psychotherapist, 2 hours one time per week by the second team member with certified therapist plus 1 hour-2 times a week for 8 weeks for the second team member independently. More than eight hours per week of direct treatment to the family will generally not be authorized.

C. Indicate the number of hours the certified psychotherapist will provide direct treatment services to the family and the number of hours that the second team member will provide direct treatment to the family. Reimbursement is limited to two individuals for any family. Since both providers may be providing services at the same time, on occasion, the total hours in this section may exceed the number of hours of treatment the family will receive as noted in B. It is expected that the primary psychotherapist will be involved in treatment about 30% of the time. If the primary psychotherapist is involved in treatment more than 50% of the time, special justification should be noted on the request.

Please indicate the name and qualifications of the second team member. Attach a resume, if available. The minimal qualifications must be:

An individual who possesses at least a bachelor's degree in a behavioral science, an RN, an OT, an MA certified AODA counselor or a professional with equivalent training. The second team member must have at least 1000 hours of supervised clinical experience working in a program whose primary clientele are emotionally disturbed youth, or;

Other individuals who have had at least 2000 hours of supervised clinical experience working in a program whose primary clientele are emotionally disturbed youth.

The second team member will be reimbursed at a lower rate, even if that person is a certified MA psychotherapist. The second team member works under the supervision of the certified psychotherapy provider.

D. Indicate the travel time required to provide the service. Travel time should consist of the time to travel from the provider's office to the recipient's home or from the previous appointment to the recipient's home. Travel time exceeding one hour one-way will generally not be authorized.

SECTION III.

A. Present a summary of the mental health assessment and differential diagnosis. Diagnoses on all five axes of the DSM-III-R are required. The assessment should address the level of reality testing, thought processes, drive control, relational capacity, and defensive functioning. If not conducted by a psychiatrist, a psychiatrist must review and sign the summary and diagnosis indicating their agreement with the results. In those cases where the only, or primary, diagnosis is a conduct disorder, the request must provide sufficient justification for the appropriateness of in-home treatment. In those cases where the only, or primary, diagnosis is a psychoactive substance abuse disorder, requests will generally not be approved unless there is sufficient justification for the appropriateness of an in-home intervention (see "Additional Considerations for In-Home Treatment for AODA" in the General Instructions). Providers may attach copies of an existing assessment if it is no longer than two pages.

B. Present a summary of the recipient's illness/treatment/medication history. In those cases where the recipient has spent significant amounts of time out of the home, or is out of the home at the time of the request, the treatment plan must specifically address the transition, reintegration and attachment issues. For individuals with significant substance abuse problems, the multi-agency treatment plan must address how these will be addressed. For individuals 16 years and over who have spent significant amounts of time out of the home, the request must discuss why intensive in-home treatment is preferred over preparing the recipient for independent living. Providers may attach copies of illness/treatment/medication histories that are contained in their records if they do not exceed two pages.

C. Complete the checklist for determining that an individual meets the criteria for severe emotional disturbance. The following information defines the allowable conditions for parts 2 and 3 of the checklist:

For part 2 the individual must have one of the following DSM-III-R diagnoses:

Adult diagnostic categories appropriate for children and adolescents are:

- organic mental syndromes and disorders (292.00* - 292.90*, 294.80)
- psychoactive substance use disorders (303.90, 304.00 - 304.90*, 305.00, 305.20* - 305.90*)
(use codes for *abuse only*)
- schizophrenia (295.1x, 295.2x, 295.3x, 295.6x, 295.9x)
- schizoaffective disorders (295.70)
- mood disorders (296.2x - 296.70, 300.40, 301.13, 311.00)
- somatoform disorders (300.11, 300.70*, 300.81, 307.80)
- dissociative disorders (300.12 - 300.15, 300.60)
- sexual disorders (302.20 - 302.40, 302.70 - 302.79, 302.81 - 302.84, 302.89, 302.90, 306.51)
- intermittent explosive disorder (312.34)
- pyromania (312.33)
- adjustment disorder (309.00, 309.23 - 309.90)
- personality disorders (coded on Axis II: 301.00, 301.20 - 301.50, 301.60 - 301.90)
- psychological factors affecting physical condition (316.00 - *and specify physical condition on Axis III*)

Disorders usually first evident in infancy, childhood and adolescence include:

- pervasive developmental disorders (coded on Axis II: 299.00, 299.80)
- disruptive behavior disorders (312.00, 312.20, 312.90, 313.81, 314.01)
- anxiety disorders of childhood or adolescence (309.21, 313.00, 313.21)
- eating disorders (307.10, 307.50, 307.51, 307.52, 307.53)
- gender identity disorders (302.50, 302.60, 302.85*)
- tic disorders (307.20 - 307.23)
- reactive attachment disorder of infancy or early childhood (313.89)

For part 3 the symptoms and impairments are defined as follows:

SYMPTOMS

- 1) Psychotic symptoms - serious mental illness (e.g. schizophrenia) characterized by defective or lost contact with reality, often with hallucinations or delusions.
- 2) Suicidality - The individual must have made one attempt within the last three months or have significant ideation about or have a plan for suicide within the past month.
- 3) Violence - The individual must be at risk for causing injury to persons or significant damage to property as a result of emotional disturbance.

FUNCTIONAL IMPAIRMENT (compared with expected developmental level):

- 1) Functioning in self care - Impairment in self care is manifested by a person's consistent inability to take care of personal grooming, hygiene, clothes and meeting of nutritional needs.
- 2) Functioning in community - Impairment in community function is manifested by a consistent lack of age appropriate behavioral controls, decision-making, judgment and value systems which results in potential involvement or involvement the juvenile justice system.
- 3) Functioning in social relationships - Impairment of social relationships is manifested by the consistent inability to develop and maintain satisfactory relationships with peers and adults.
- 4) Functioning in the family - Impairment in family function is manifested by a pattern of significantly disruptive behavior exemplified by repeated and/or unprovoked violence to siblings and/or parents, disregard for safety and welfare of self or others, e.g.- fire setting, serious and chronic destructiveness, inability to conform to reasonable limitations and expectations which may result in removal from the family or its equivalent.
- 5) Functioning at school/work - impairment in any *one* of the following:
 - a) Impairment in functioning at school is manifested by the inability to pursue educational goals in a normal time frame - e.g. consistently failing grades, repeated truancy, expulsion, property damage or violence toward others; or
 - b) meeting the definition of "child with exceptional educational needs" under ch. PI 11 and 115.76(3) Wis. Stats.; or
 - c) Impairment at work is the inability to be consistently employed at a self- sustaining level - e.g. inability to conform to work schedule, poor relationships with supervisor and other workers, hostile behavior on the job.

D. Present an assessment of the family's strengths and weaknesses. Present evidence that the family is willing to be involved in treatment and is capable of benefiting from treatment. Where the presence of significant psychological dysfunctioning or alcohol and other drug abuse problems is indicated among family members, please indicate how these problems will be addressed outside of the in-home treatment process (reimbursement for treatment services primarily directed at recipients over the age of 20 are not available through HealthCheck other services, except as noted in Section IV-D). Indicate which family members will be involved in treatment. If an assessment of the family's willingness and ability to be involved in treatment is an initial treatment goal please indicate this with at least minimal justification for believing this to be the case. If a family assessment is contained in the psychiatric evaluation or illness/treatment history, please indicate this.

E. The provider must specifically identify the rationale for providing services in the home for this child/family. A significant history of failed outpatient treatment along with documentation which identifies a significant risk of out-of-home placement will support such a request. Strong justification is needed if outpatient clinic services have not been previously utilized. The provider should identify specific barriers to the family receiving treatment in a clinic setting or specific advantages for this family receiving services in the home (not simply general advantages of in-home treatment). The provider should present this justification in their own words and not assume that the consultant can infer this from other information submitted with this request.

F. Indicate the expected duration of in-home treatment. Describe services expected to be needed following completion of in-home treatment and transition plans. While providers are expected to indicate their expectations on the initial requests it is critical that plans for terminating in-home treatment be discussed in any authorizations for services at and beyond six months of treatment.

SECTION IV

A. The prior authorization request form (PA/RF) may be obtained from EDS. The words "HealthCheck Other Services" should be written in red across the top of the form. Providers should use the following procedure codes and descriptions in elements 14 and 18:

W7027	In-Home Treatment: Certified Psychotherapist
W7028	In-Home Treatment: Second Team Member
W7029	Travel Time: Certified Psychotherapist
W7030	Travel Time: Second Team Member

B. A HealthCheck referral must accompany the request. When the request is for a reauthorization the provider should attach a copy of the initial HealthCheck referral. The initial request for this recipient must be received by EDS within six months of the date of the HealthCheck referral.

C. The multi-agency treatment plan must be developed by representatives from all systems identified on the SED eligibility checklist. The plan must address the role of each system in the overall treatment and the major goals for each agency involved. The plan should be signed by all participants, but to facilitate submission, the provider may document who was involved. Where some agency was not involved in the planning the provider must document the reason and what attempts were made to include them. The plan should indicate why services in the home are necessary and desirable. The individual who is coordinating the multi-agency planning should be clearly identified. A psychiatrist must sign either the multi-agency plan or in-home treatment plan. A model plan may be obtained by writing to the SED coordinator at:

SED Coordinator
Division of Community Services
Office of Mental Health
P.O. Box 7851
Madison, WI 53707-7851
(608) 266-6838; Fax: (608) 266-0036

If a plan other than the model plan is used, all the information on the model must be included.

D. The in-home treatment team must complete a treatment plan covering their services. A psychiatrist must sign either the in-home treatment plan or the multi-agency treatment plan. Providers may obtain a copy of a model plan from the SED Coordinator or use one of their own which provides equivalent information. The plan must contain measurable goals, specific methods, and an expected time frame for achievement of the goals. The methods must allow for a clear determination that the services provided meet criteria for Medical Assistance covered services. Services which are primarily social or recreational in nature are not reimbursable.

Services provided to the recipient's parents, foster parents, siblings, or other individuals significantly involved with the recipient are deemed appropriate as part of the in-home treatment plan when these services are required to directly affect the recipient's functioning at home or in the community. Such services include family therapy necessary to deal with issues of family dysfunctioning, behavior training with responsible adults to identify problem behaviors and develop appropriate responses, supervision of the child and family members in the home setting to evaluate the effect of behavioral intervention approaches and provide feedback to the family on implementing these interventions, and minimal supportive interventions with the family members which are necessary to ensure their ability to continue their participation in the in-home treatment process. Interventions with family members or significant others which are primarily for the benefit of these others are not reimbursable under these guidelines, except where these other individuals meet the criteria for intensive in-home treatment (e.g., they are 20 years of age or under) and authorization has been received for these other services under these guidelines. For instance, intervention directed solely at a parent's alcohol abuse is considered AODA treatment, is covered by the policy for AODA treatment service, and is not reimbursable in the home. However, when the intervention is with the whole family and is focusing on the way in which the parent's alcohol abuse is affecting the child and/or contributing to the problem behaviors, this may be authorized under these guidelines.

Initial treatment goals may include assessment of the recipient and family in the home and these goals may be procedural, e.g., complete assessment, have all members of family attend 75% of meetings, complete AODA assessment. Where an assessment is part of the initial intervention, be concrete as to the components of the assessment, e.g. psychiatrist will complete psychiatric evaluation, AODA counselor with complete substance abuse assessment. Where appropriate identify any standardized assessment tools that will be utilized.

E. Providers must complete and attach the results of either the Achenbach Child Behavior Checklist or the Child and Adolescent Functional Assessment Scale (CAFAS). Additional information about these screening instruments can be obtained from the SED Coordinator at the address noted above.

F. An AODA assessment must be included if AODA related programming is part of the recipient's treatment program. The assessment may be summarized in Section III- A or -B as part of the psychiatric assessment or illness history.

The request must be signed by the certified psychotherapy provider who is leading the in-home treatment team. It must also be signed by the supervising therapist if the certified psychotherapy provider is not a PhD. psychologist or psychiatrist. In signing, these individuals accept responsibility for supervising the other individuals who are part of the in-home treatment team. In signing they provide assurance that an individual who meets the criteria for an MA certified psychotherapy provider will be available to the other team members when they are in the home alone with the child/family.

- B. Number of hours of treatment to be provided to family over this PA grant period. Please note anticipated pattern of treatment by provider, e.g., two hours - one time per week by certified therapist, two hours - one time per week by family aide with certified therapist plus one hour - two times a week by family aide independently.

Certified Therapist: 2 Hrs., 1 x week
Second Team Member: 2 Hrs., 1 x wk., (with Cert. Tx)
1 Hr., 2 x wk. (alone)

- C. Please indicate for the period covered by this request:

The number of hours the certified psychotherapist will provide treatment 16

The number of hours the second team member will provide treatment 32

The name and credentials of the second team member (attach resume, if available):

I. M. Bachelor, B. S. in Psychology
3 yrs. experience working with severely emotionally disturbed kids.

- D. Please indicate the travel time for the period covered by this request:

certified psychotherapist

anticipated number of visits 8

X travel time per visit .5

= 4

other therapist

anticipated number of visits 24

X travel time per visit .5

= 12

SECTION III.

The following additional information must be provided. If you attach copies of existing records to provide the information requested please limit attachments to two pages for the psychiatric evaluation and illness/treatment history. Highlighting relevant information is helpful. Do not attach M-team summaries, additional social service reports, court reports, or other similar documents unless directed to do so following initial review of the documentation.

- A. Present a summary of the recipient's psychiatric assessment and differential diagnosis. Diagnoses on all five axes of DSM-III-R are required. If not conducted by a psychiatrist, a psychiatrist must review and sign the summary and diagnoses.

Im was referred for in-home treatment by the social services department following his return to home from a foster placement. The foster placement was necessitated by his mother's neglectful and dangerous behavior resulting from her abuse of alcohol. Her alcohol abuse has also resulted in inconsistent parenting and limit-setting in the home.

Im presents as a personable boy of appropriate appearance for his age. His medical record shows no significant medical problems. There is no evidence of disordered or psychotic thinking. He is oriented to reality. There is evidence of difficulty in maintaining his attention to tasks both at home and in school: he has difficulty following through on instructions at school (although this may be related to his oppositional behavior); he has difficulty completing activities; he often intrudes on others and has difficulty remaining seated.

Aggressive acting out and oppositional behavior have existed for about two years and have increased over the past six months since his return home from the foster placement. Im engages in physical fights with siblings and neighbors often resulting in injury. He has been reported to tease younger children at school, often taking things from them. He defies his mother's attempts to enforce rules in the home. Mother reports that he uses foul language frequently. He also argues with teachers at school and refuses to follow rules there. Social acting out with peers has resulted in destruction of property.

His mother, though concerned and caring, has a significant history of alcohol abuse. She has been treated both inpatient and outpatient in the past but has returned to drinking after the conclusion of treatment. She currently reports that she is not drinking and has a desire to remain sober. Mother appears to have some symptoms that suggest an abnormal loss of short term and long term memory which may be associated with her drinking. She expresses a desire to parent more effectively but lacks the knowledge to do so.

Diagnosis:

- Axis 1: 313.81 Oppositional Defiant Disorder, severe r/o 314.01 Attention-Deficit Hyperactivity Disorder
Axis 2: No diagnosis
Axis 3: None
Axis 4: 4, severe: foster placement, inconsistent parenting
Axis 5: Current GAF: 37
Highest past year: 62

E. M. Provider

- B. Present a summary of the recipient's illness/treatment/medication history and other significant background information. Define the potential for change.

Im has demonstrated oppositional behavior and aggressive acting out during the past two years. This behavior has increased since his return to home after being placed in foster care for four months while his mother received inpatient treatment for alcohol abuse. The aggressive acting out is directed towards his siblings, who are 8 and 5 years of age, and other kids at school. Three months ago he broke his brother's finger during a fight. Mother reports that Im does not follow rules at home and she is frustrated with her own inability to know how to enforce rules.

Im is not currently on medications, nor is there a history of medication use. Im has not had formal treatment although there has been some limited counseling by his school psychologist. Mother has a history of alcohol abuse and has received both inpatient and outpatient treatment many times in the past. She has not been able to follow through with outpatient treatment, however, and has returned to drinking. She reports being abstinent currently and expresses a desire to remain so.

Im is the oldest of 3 children. Mother was divorced three years ago. All three children are from her marriage. Im has erratic contact with his father, who also has a history of alcohol abuse. Father was reported to be physically abusive towards Mother and Im may have witnessed some of this abuse. Mother reports that Im's early development appeared normal. He did show increased levels of aggressive behavior following the birth of each sibling, but Mother did not think this unusual. About four years ago Im started to show less ability to concentrate and pay attention. Mother said he would not follow instructions and would not complete chores she gave him to do at home. Although she thought he was just being willful she said that the school psychologist thought this might be associated with hyperactivity. There was a previous instance of neglect in 1989 resulting in out-of-home placement for the three children. This was also associated with Mother's alcohol abuse.

Although Mother expresses a genuine desire to parent more effectively her dysfunctional childhood (her father abused alcohol and physically abused her) and her own alcohol abuse have left her with little concept of how to do so. Because of these limitations Im appears to have little reason to trust her ability to be a parent. If acting out may be a way to get her to affirm her commitment to him.

Because of the absence of previous treatment, the potential to change appears fair. Mother has a genuine concern, despite her limitations. There is an opportunity to further evaluate Im with regard to the attention-deficit and possibly pursue medication management. To the degree that Im gets appropriate limits he may learn to trust his mother and find less of a need to act out.

C. Complete the checklist for determination that an individual meets the criteria for severe emotional disturbance (SED). Criteria for meeting the functional symptoms and impairments are found in the instructions. SED in an individual under the age of 21 requires acute treatment and may lead to institutional care. The disability must be evidenced by 1, 2, 3 and 4 listed below.

1. **The individual must meet all three of the following:**

- a. be under the age of 21, and
- b. have an emotional disability that has persisted for at least 6 months; and
- c. that same disability must be expected to persist for a year or longer.

2. **A condition of severe emotional disturbance as defined by a mental or emotional disturbance listed in the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders, III, Revised (DSM III-R).**

313.81 Oppositional Defiant Disorder

Primary Diagnosis

3. **Functional Symptoms and Impairments**

The individual must have A. or B.

a. **Symptoms (must have one)**

- 1. Psychotic symptoms
- 2. Suicidality
- 3. Violence

b. **Functional impairments (must have two)**

- 1. Functioning in self care
- 2. Functioning in the community
- 3. Functioning in social relationships
- 4. Functioning in the family
- 5. Functioning at school/work

4. **The individual is receiving services from two or more of the following service systems.**

- Mental Health
- Social Services
- Child Protective Services
- Juvenile Justice
- Special Education

Eligibility Criteria Waived Under Certain Circumstances:

- This individual would otherwise meet the definition of SED, but has not yet received services from more than one system, but would be likely to do so were the intensity of treatment requested not provided. Attach explanation.
- This individual would otherwise meet the definition of SED except that functional impairment has not persisted for six months, but the nature of the acute episode is such that impairment in functioning is likely to be evident without the intensity of treatment requested. Attach explanation.

- D. Present an assessment of the family's strengths and weaknesses.

Major strengths: mother's desire to do better, mother's current sobriety, absence of apparent pathology in siblings.

Major weaknesses: lack of trust between Im and Mother, mother's limited parenting skills, apparent memory loss by mother.

- E. Indicate the rationale for in-home treatment. Elaborate on this choice where prior outpatient treatment is absent or limited.

Im's acting out has its roots in the home. By treating the issues in the home staff can better evaluate appropriate treatment strategies and their success and adapt treatment to their needs as the environment changes. Though Im has had no previous treatment history, Mother has. She has a history of poor follow-through with outpatient treatment suggesting that the family may benefit most by bringing the treatment to them. Since the family does express a willingness to participate they are more likely to participate, and therefore benefit, if treatment is in the home.

- F. Indicate the expected date for termination of in-home treatment. Describe anticipated services needs following completion of in-home treatment and transition plans.

Treatment in-home is anticipated to last for six months. It is hoped that by this time family can be engaged in outpatient treatment. The in-home team will attempt to have mother become consistently involved in outpatient AODA groups and AA. The school counselor will be setting up regular meetings with Im at school.

SECTION IV.

Please attach and label the following:

- A. The prior authorization request form (PA/RF).
- B. One of the following (check which is attached):
 - A copy of the signed and dated HealthCheck referral for in-home psychotherapy from a physician; or
 - A copy of the signed and dated HealthCheck referral for in-home psychotherapy from a provider other than a physician, and a physician's prescription for intensive in-home psychotherapy, or
 - A copy of the signed and dated HealthCheck referral for a psychiatric evaluation/diagnosis if there has not been a differential diagnosis within the past 12 months and a physician's prescription for intensive in-home psychotherapy, or,
 - If there has been a differential diagnosis within the past twelve months, a physician's prescription for intensive in-home psychotherapy and a copy of the signed and dated HealthCheck referral.

A copy of the HealthCheck referral must be attached to all requests. For reauthorizations, a copy of the original HealthCheck referral may be used. The initial request for these services must be received by EDS within six months of when the HealthCheck referral was dated.

- C. A multi-agency treatment plan.
- D. An in-home psychotherapy treatment plan.
- E. Results of either the Achenbach Child Behavior Checklist or the Child and Adolescent Functional Assessment Scale (CAFAS).
- F. An AODA assessment may be included. An AODA assessment must be included if AODA related programming is part of the recipient's treatment program.

I attest to the accuracy of the information on this prior authorization request. I understand that I am responsible for the supervision of the other team member(s) identified on this attachment. I, or someone with comparable qualifications, will be available to the other team member(s) at all times they are in the home alone working with the child/family.

J. M. Certified
Signature of Certified Therapist

J. M. Supervising
Signature of Supervising Therapist

mm/dd/yy
Date

mm/dd/yy
Date

WMAF Provider Handbook Park A
Issued 01/01/91

A11-085

APPENDIX 32

WMAF HEALTHCHECK/EPSDT REFERRAL FORM

DATE OF SCREENING: 2/10/92

RECIPIENT NAME: Im A. Recipient MA-ID # 1234567890

DATE OF REFERRAL APPOINTMENT: 2/10/92

REASON FOR REFERRAL: General Health Review/Hyperactivity

REFERRED TO: Psychiatric Evaluation

Provider Name, Address, and/or Specialty

COMMENTS: Aggressive behavior, family problems need further evaluation. Evaluate for ADHD.

SIGNATURE: *L. M. Screening* DATE: 2/10/92
Screening Provider

NOTE: This form is acceptable in lieu of the WMAF HealthCheck (EPSDT) Services claim form when it is used as a referral form.

Prescription for In-Home Treatment

I have examined the following individual and their medical record:

Im A. Recipient
name

609 Willow, Anytown
address

1234567890
medical assistance identification number

I find Im A. Recipient to be appropriate for in-home treatment for severe emotional disturbance. Services are expected to be required for up to one year.

J. M. Provider, Psychiatrist

22 N. Maple, Anytown
Address

12345678
UPIN/Medical Assistance Provider Number

2/10/92
Date

Department of Health and Social Services
 Division of Community Services
 Office of Mental Health
 March 20, 1992

MODEL PLAN: INTENSIVE IN-HOME PSYCHOTHERAPY OR DAY TREATMENT

Name of Client: Im A. Recipient	Agency Team Developing and Implementing this Plan (include title indicating discipline):
Client Birthdate: 1/12/82	1. I.M. Masters, M.S.W.
Date of Plan: 2/17/92	2. I.M. Bachelor, B.S.
Plan review date: 8/92	3.
Case Manager: I.M. Masters	4.
List family members involved in treatment:	5.
1. M. Recipient, Mother	6.
2.	7.
3.	8.
4.	
5.	
6.	

Problem 1:	Short Term Goal (measurable):
Aggressive Behavior	Reduce fights at home to 3 X wk. (in two months). Identify three things that are frustrating to Im. Identify three healthy ways of expressing these feelings.
Description of Problem:	Long Term Goal (measurable):
Im engages in aggressive acting out behavior at home, in school, and in the community. Fights at home occur about 5 times per week. There has also been property destruction involving Im and his peers.	Reduce fights/acting out to 1 X wk. (six months). Im will consistently find healthy ways to express feelings.
	Plan (include frequency of intervention and team member responsible):
	Meet with Im 1 X wk. to explore frustrations and anger. Identify alternative methods of expressing feelings. Use family meetings to identify how Mother can help. Aide will cue Im during in-home times.
	Measurable Results of Intervention at Time of Plan Review:

Problem 2:	Short Term Goal (measurable);
Mother not able to set limits with Im.	Mother will be able to identify behavioral parenting techniques. She will be able to identify three situations in which limits need to be set and some techniques for responding to these. (2 months.)
Description of the Problem:	Long Term Measurable Goal (measurable):
When Im acts out in the home, Mother yells, sends Im to his room, or drinks. None of these have been effective responses to Im's acting out.	Mother will be able to consistently utilize behavioral techniques which will reduce fights on limits to one time per week (six months).
	Plan (include frequency of intervention and team member(s) responsible):
	Family meetings will be used to identify situations where limit-setting is needed. Team will work with Mother to identify responses. Aide will observe Im and Mother and give feedback in home setting and in role playing. Team will talk with Im about his response to mother's limit-setting.
	Measurable Results of Intervention at Time of Plan Review:

<p>Problem 3:</p>	<p>Short Term Goal (measurable):</p>
<p>Im and Mother do not engage in positive interactions.</p>	<p>Im and Mother will identify 3 positive activities they can be involved in together (one month).</p>
	<p>Long Term Goal (measurable):</p>
	<p>Im and Mother will engage in one positive activity without the other children each week (3 months).</p>
<p>Description of the Problem:</p>	
<p>Due to Mother's drinking and Im's acting out, and the presence of younger siblings, their relationship is characterized by antagonism and isolation from each other. They do not engage in age-appropriate positive activities together.</p>	
<p>Plan (include frequency of intervention and team member(s) responsible):</p>	
	<p>Family meetings will be used to discuss and identify possible activities. Team will help identify barriers to activities occurring and solutions to these. Aide will assist in ensuring that activities occur.</p>
	<p>Use of special play techniques will encourage 1:1 interaction and help team identify barriers to closeness.</p>
	<p>Measurable Results of Intervention at Time of Plan Review:</p>

Problem 4:	Short Term Goal:
Symptoms of ADHD	Assist family to set up evaluation and make sure that evaluation occurs (one month).
	Long Term Goal:
	Initiate chemotherapy. Maintain contact with pediatrician. Give her feedback on effects of medication. Provide feedback to Im and Mother on possible effects of medication.
Description of the Problem:	
Im has difficulty staying on task,	
remaining in his seat, following	Plan (include frequency of intervention and team member(s) responsible):
instructions and completing tasks.	Set up evaluation. Help arrange transportation. Discuss with Im and Mother the reason for the evaluation and implications. Follow-up as needed.
	Measurable Results of Intervention at Time of Plan Review:

Problem 5:	Short Term Goal:
Mother's alcoholism	Identify barriers to remaining in AODA treatment (one month).
	Long Term Goal:
	Mother to attend AA 1 X wk., AODA group 1 X wk. (three months).
Description of Problem:	
Mother has a significant alcohol abuse	
problem which has existed for many	Plan (include frequency of intervention and team member(s) responsible
years. She has had inpatient and	Meet with Mother once per week to discuss her alcohol problem. Review pattern
outpatient treatment, with very	of use/abuse. Identify ambivalence toward treatment. Identify resources and
limited impact on the abuse. Abuse	supports. (This time will not be charged to MA through HealthCheck other
has led to neglect of children and	services.)
out-of-home placement.	
	Measurable Results of Intervention at Time of Plan Review:

MAPB-092-001-Z
October 19, 1992

Program Discharge Criteria:
Im will show increased cooperative behavior at home and school. He will be able to express feelings in healthy ways and will reduce acting out. School performance will improve and he will return to a regular classroom. Mother will be able to use appropriate behavioral limit setting techniques. She will maintain sobriety and involvement in support groups and out-of-home activities. ADHD will be evaluated and appropriate intervention will occur.

J. M. Crocker
Psychiatrist's Signature

MM/DD/YY
Date

MAPB-092-001-Z
 October 19, 1992

Department of Health and Social Services
 Division of Community Services
 Office of Mental Health
 March 20, 1992

STATE OF WISCONSIN

MODEL INTERAGENCY TREATMENT PLAN

Name of Client: Im A. Recipient	Interagency Team Developing and Implementing this Plan (include title indicating discipline):
Client Birthdate: 1/12/82	1. I.M. Masters, MSW (in-home team) <i>S. M. Masters</i>
Client M.A. Number: 1234567890	2. I.M. Bachelor, B.S. (in-home team) <i>J. M. Beckler</i>
Date of this plan: 2/19/92	3. I.M. County, B.S.W. (county social services) <i>J.M. County</i>
Plan review date: 8/92	4. I.M. Teacher (city school) <i>J.M. Teacher</i>
Case Manager: I.M. Masters	5. I.M. Nurse (city health clinic) <i>J.M. Nurse</i>
Parent(s) or Primary Caregiver:	6.
Mother Recipient, Mother	7.
	8.
	9.
	10.
	11.
	12.
	Was parent or primary caregiver present? Yes <input type="checkbox"/>

MAPB-092-001-Z
 October 19, 1992

Please summarize in the spaces provided the element(s) and the methodology to be used by each system to treat this child (school, social services, mental health, health or the juvenile justice system), as applicable. For agencies not involved in treatment, put N/A in box.

<p>Mental Health Agency Response: Mother has very limited parenting skills, and her alcohol abuse has made it difficult for her to show any consistency. Im acts out at home and school and has injured his brother on at least one occasion. Im shows signs of hyperactivity.</p>	<p>Short Term Goal (measurable): Engage family in treatment process. Im's acting out will be reduced to 3 X week in the home. Mother will maintain sobriety. Evaluation for ADHD will be arranged.</p>
<p>and school and has injured his brother on at least one occasion. Im shows signs of hyperactivity.</p>	<p>Long Term Goal (measurable): Im's acting out will be reduced to 1 X week in the home. Im will find healthy ways to express feelings. Mother will maintain sobriety and involved herself in two activities outside the home each week. Mother will understand and utilize behavioral techniques for setting limits.</p>
<p></p>	<p>Plan (include frequency of intervention and team member responsible): In-home team will meet with family one time per week to identify situations which lead to acting out and develop techniques for dealing with them. Parent aide will meet with family two times a week to implement behavioral techniques. Team will encourage Mother in her abstinence and use of support groups and out-of-home activities. Aide will arrange ADHD evaluation. Staff will meet with Im one time each week to teach expression of feelings and anger management.</p>
<p></p>	<p>Measurable Results of Intervention at Time of Plan Review:</p>

Social Services Agency Response:	Short Term Goal (measurable)
Mother's alcohol abuse and treatment needs have led to two foster placements for Im and his	Maintain Im in the home. Monitor safety of children (occurrence of neglect).
siblings. This has lessened Im's trust in his mother and caused significant anxiety for him, likely escalating his acting out behavior.	Long Term Goal (measurable): Maintain children in the home safely.
	Plan (include frequency of intervention and team member responsible):
	In-home team will notify social services if Mother does not follow through with treatment, and social services will pursue long-term placement.
	Measurable Results of Intervention at Time of Plan Review:

<p>School Agency Response:</p> <p>Im's acting out in the school has interfered with his learning and has been disruptive to others. He has been in a special classroom for the current semester. He is unable to attend to a task for 10 minutes.</p>	<p>Short Term Goal (measurable)</p> <p>Im's acting out in school will be limited to 3 X wk. Im will stay on task for 15 minutes at a time at least twice each day.</p>
<p>Long Term Goal (measurable):</p> <p>Im's acting out will be reduced to 2 X per month. Im will stay on task for 20 minutes three times a day. Grades will improve by one level (D to C).</p>	
<p>Plan (include frequency of intervention and team member responsible):</p> <p>Im will remain in special classroom. Im will receive additional 1:1 tutoring. Refer to Families and Schools Together (FAST) program. Social work staff will meet with Im 1 X wk.</p>	
<p>Measurable Results of Intervention at Time of Plan Review:</p>	

Health Agency Response:	Short Term Goal (measurable)
Im shows many of the classic symptoms of ADHD. He is unable to attend to task, he acts out, he doesn't complete activities, he doesn't follow instructions. He has not been formally evaluated nor tried on appropriate medication.	Evaluate for ADHD. Start medication if indicated. Monitor medication effects.
	Long Term Goal (measurable):
	Increased ability to maintain on task, follow instructions, etc. Monitor general health.
	Plan (include frequency of intervention and team member responsible):
	Pediatrician will evaluate ADHD and prescribe medication. In-home team and school will report notable effects of medication to pediatrician. Public health nurse will coordinate yearly HealthCheck screening and follow-up.
	Measurable Results of Intervention at Time of Plan Review:

SERVICES RECOMMENDED BY TREATMENT TEAM:	
1. In-Home Treatment	5.
2. ADHD Evaluation & Follow-Up	6.
3. School Counseling	7.
4.	8.
Program Discharge Criteria:	
Im will show increased cooperative behavior at home, in school, and in the community. Fights at home occur about 5 times per week.	
There has also been property destruction involving Im and his peers.	

Psychiatrist's Signature: L.M. Plowden Date: MM/DD/YY

I (We) have read the foregoing treatment plan and give our consent to my (our) my child receiving the treatment outlined above. I (we) will agree to participate in the treatment intervention outlined above.

Parent(s)' or Primary Caregiver's Signature _____ Date: _____

file = ServiceMATxPlan [E.Green]

	Severe Severe disruption or incapacitation (30)	Moderate Occasional major or frequent disruptions (20)	Mild Significant problems and/or distress (10)	Average No disruption of functioning (0)
(2) Thinking	<p>Extreme distortion 026 of coherent thought and language (may include bizarre play, incoherence, loosening of associations, flight of ideas)...</p> <p>Frequent and/or 022 disruptive delusions or hallucinations/can't distinguish fantasy from reality...</p> <p>Pattern of short 023 term memory loss/disorientation to time or place most of the time...</p> <p>Inability to 024 communicate with others and or marked abnormalities in nonverbal or verbal communication (e.g., echolalia, idiosyncratic language)...</p>	<p>Frequent distortion 026 of thinking (obsessions, mistrust, suspicions</p> <p>Intermittent 027 hallucinations that interfere with normal functioning...</p> <p>Frequent confusion 028 or evidence of short term memory loss...</p> <p>Unable to 029 comprehend consequences of behavior...</p> <p>Evidence of 030 persistent and excessive fantasy (e.g., daydreams, artwork, writing samples) with destructive and/or bizarre themes... delinquent behavior, running away, probation or parole...</p>	<p>Occasional difficulty 032 in communication or behavior due to thought distortions (e.g., obsessions, mistrust, suspicions...</p> <p>May express odd 033 beliefs, excessive fantasy or, if older than eight years old, magical thinking...</p> <p>Eccentric speech 034 e.g., impoverished, digressive, vague)...</p> <p>Unusual 035 perceptual experiences not qualifying as hallucinations...</p>	<p>Thought, as 037 reflected by communication, is not disordered or eccentric...</p>
	EXCEPTION 025	EXCEPTION 031	EXCEPTION 036	EXCEPTION 038
Explanation:				

Could Not Score: 020

	Severe Severe disruption or incapacitation (30)	Moderate Occasional major or frequent disruptions (20)	Mild Significant problems and/or distress (10)	Average No disruption of functioning (0)
(3) Behavior Toward Others/Self 20	Behavior consistently inappropriate or bizarre... 040	Behavior frequently/ typically inappropriate and causing problems for self or others (e.g., promiscuity, fighting, destruction of property)... 046	Quarrelsome or annoying, making life difficult for self or others... 051	Relates satisfactorily to others... 056
	Behavior so disruptive or dangerous that harm to self or others is likely... 041	Predominantly relates to others in an exploitative/manipulative manner (e.g., uses/cons others)... 047	Impulsiveness that is not affected by known consequences (e.g., disregards risk to health or expectations of others)... 052	Not impulsive, shows good judgement in life decisions... 057
	Expelled from family for reasons related to impairment... 042	Relationships frequently fraught with tension or conflict... 048	Withdrawn or tends to be ignored by peers... 053	Is able to establish/sustain a normal range of age-appropriate relationships... 058
	Unable to form/sustain any age-appropriate close relationships... 043	Characteristically poor judgement resulting in serious risk-taking... 049	Difficulty in establishing/sustaining close relationships (e.g., predominantly age-inappropriate relationships; immature behavior leads to routine conflicts)... 054	
	Severe destructiveness toward property (e.g., deliberate fire-setting; serious damage to community/school property)... 044	EXCEPTION 050	EXCEPTION 055	EXCEPTION 059
	EXCEPTION 045			
	Explanation:			

Could Not Score 060

	Severe Severe Disruption or incapacitation (30)	Moderate Occasional major or frequent disruptions (20)	Mild Significant problems and/or distress (10)	Average No disruption of functioning (0)
(4) Moods/ Emotions (Emotions = anxiety, depression, moodiness, fear, worry, irritability, tenseness, panic) 10	Emotional 061 responses incongruous or inappropriate (unreasonable, excessive) most of the time...	Marked changes 065 in moods that are generally intense and abrupt... Symptoms of distress 066 (depressed, sad, fearful or anxious) are pervasive and/or persistent (e.g., disrupts sleep, eating, concentration and/or activities of daily living or symptoms of worthlessness or irritability are pervasive and other symptoms are persistent (e.g., sleep, eating, etc.)	Often worried or 069 sad with some negative effect (e.g., recurrent nightmares)... Disproportionate 070 expression of frustration, irritability or fear... Notable emotional 071 restriction (i.e., has difficulty expressing strong emotions such as fear, hate, love)...	Feels normal distress, 073 but daily life is not disrupted... Considers self 074 a "worthy person"... Can express strong 075 emotions appropriately...
	EXCEPTION 064	EXCEPTION 068	EXCEPTION 072	EXCEPTION 076
	Explanation:			

Could Not Score: 077

	Severe Severe disruption or incapacitation (30)	Moderate Occasional major or frequent disruptions (20)	Mild Significant problems and/or distress (10)	Average No disruption of functioning (0)
	These categories apply to youth of all ages			
(5) Substance Use (Substances = alcohol or drugs)	Lifestyle centers 078 on acquisition and use (e.g., preoccupied with thoughts or urges to use substances)...	Uses in such a way as 084 to interfere with functioning (i.e., job, school, driving) in spite of potential serious consequences...	Infrequent excesses 089 and only without serious consequences...	No use of substances... (093)
	Dependent on 079 continuing use to maintain functioning (e.g., likely to experience withdrawal symptoms)...	Gets into trouble 085 because of usage (e.g., fights with family or friends, in an accident or injured, trouble with teachers, picked up by police, experiencing physical health problems due to use)...	Regular usage 090 (e.g., once a week) but without intoxication or being obviously high...	Has only "dried" themselves not use them... 094
	Failing school 080 or kicked out of school or work related to usage...	High or intoxicated 086 once a week...		Occasional use with no negative consequences... 095
	Frequently intoxicated 081 or high (e.g., more than two times a week)...			
	If youth is 12 or younger, use these additional categories			
	For 12 years or 082 younger, high or intoxicated once or twice a week...	For 12 years 087 or younger, use regularly (once a week) without intoxication and without becoming obviously high...	For 12 years 091 or younger, occasional use with no negative consequences...	
	EXCEPTION 083	EXCEPTION 088	EXCEPTION 092	EXCEPTION 096
	Explanation:			

Could Not Score: 097

TOTAL SCORE
FOR CATEGORIES
1 - 5

50

ADDITIONAL COMMENTS:

CONTINUE ONTO NEXT PAGE

	Severe Severe disruption or incapacitation (30)	Moderate Occasional major or frequent disruptions (20)	Mild Significant problems and/or distress (10)	Average No disruption of functioning (0)
(6) Caregiver Resources: Basic Needs 20	Unable to meet 098 child's needs for food, clothing, housing, transportation, medical attention or safety, such that severe risk to health or welfare is likely--	Frequent 100 problems meeting child's needs for food, housing, clothing, transportation, medical attention, or safety--	Occasional 102 problems meeting child's needs for food, housing, clothing, transportation, medical attention, or safety--	Able to obtain 104 or arrange for adequate meeting of all basic needs--
	EXCEPTION 099	EXCEPTION 101	EXCEPTION 103	EXCEPTION 105
	Explanation:			

Could Not Score 106

	Severe Severe disruption or incapacitation (30)	Moderate Occasional major or frequent disruptions (20)	Mild Significant problems and/or distress (10)	Average No disruption of functioning (0)
(7) Caregiver Resources: Family/ Social Support 20	Sociofamilial setting 107 is potentially dangerous to the child due to lack of family resources required to meet the child's needs/demands-- Gross parental 108 impairment (e.g., psychosis, substance abuse, severe personality disorder, mental retardation)-- Frankly hostile and/or 109 rejecting sociofamilial setting-- Child is subjected to 110 sexual or physical abuse--	Child's developmental 112 needs cannot be adequately met because child's needs/developmental demands exceed family resources-- Marked impairment in 113 parental functioning, related to psychiatric illness, substance use, physical illness, or other impairing condition-- Persistent/severe 114 dysfunctional/discordant familial relationships (characterized by hostility, tension, and/or scapegoating, etc.)-- Family members are 115 insensitive, angry and/or resentful to the child-- Marked lack of 116 parental supervision or consistency in care--	Family not able to 118 provide adequate warmth, security or sensitivity relative to the child's needs. Support from other sources outside the immediate family are unable to compensate for this inadequacy-- Dysfunctional/ 119 discordant familial relationships (characterized by poor problem solving, poor communication, emotional insensitivity, role reversal, etc.). No other supports compensate for this deficit-- Family not able to 120 provide adequate supervision or consistency in care over time relative to the child's needs. No other supports compensate for this deficit--	Family is 122 sufficiently warm, secure, and sensitive to the child's needs-- Parental supervision 123 in consistent and appropriate-- Even though there are 124 temporary problems in providing adequate support to the child, there is compensation from the wider social support system.
	EXCEPTIONAL 111	EXCEPTIONAL 117		
	Explanation:			

Could Not Score: 126

**TOTAL SUB-SCORE
FOR CATEGORIES
6 and 7 ONLY**

40

The Family/Social Support Sub-Scale contains ideas and wording adapted from a measure developed by Setterberg, Shaffer, Williams, and Spitzer.

ATTACHMENT 5

**PRIOR AUTHORIZATION CHILD/ADOLESCENT DAY TREATMENT ATTACHMENT (PA/CADTA)
COMPLETION INSTRUCTIONS**

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 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

GENERAL INSTRUCTIONS

The information contained on this prior authorization child/adolescent day treatment attachment (PA/CADTA) will be used to make a decision about the amount of child/adolescent day treatment which will be approved for Medical Assistance reimbursement. Please complete each section as completely as possible. Where noted in these instructions, you may attach material which you may have in your records.

Initial prior authorization request: Please complete the PA/RF and the entire PA/CADTA and attach all required materials. Please label all attachments (e.g., "Day Treatment-Treatment Plan"). The initial authorization will be for a period of no longer than three months.

First reauthorization: Please complete the PA/RF and page 1 of the PA/CADTA. Attach a copy of the HealthCheck referral form which was included with the initial authorization request. Attach a summary of the treatment to date, and a revised day treatment services treatment plan. Note progress on short- and long-term goals from the original plan. Be explicit in your summary as to the need for continued day treatment services. Authorization will be for a period of no longer than three months.

Second reauthorization: Please complete the PA/RF and page 1 of the PA/CADTA. Attach a copy of the HealthCheck referral form, which was included with the initial authorization request. There should also be an updated multi-agency treatment plan and an updated screening (Achenbach or CAFAS) using the same screening tool used for the initial request. Summarize the treatment since the previous authorization. The need for continued day treatment must be clearly documented. Where no change is noted in the treatment summary, justify the continued use of day treatment or note how changes in the treatment plan address the lack of progress. Specifically address aftercare planning. Authorization will be for a period of no longer than three months.

Subsequent reauthorizations: Please complete the PA/RF and page 1 of the PA/CADTA. Attach a copy of the HealthCheck referral form which was included with the initial authorization request. Attach a summary of the treatment since the previous authorization. Address why recipient has not made transition to aftercare services. Strong justification will be required for day treatment services exceeding nine months per episode of treatment.

Please check the appropriate box at the top of the PA/CADTA to indicate whether this request is an initial, first reauthorization, second reauthorization or subsequent request. Make sure that the appropriate materials are included for the type of request indicated.

Multiple services. When a recipient will require prior authorization for other services concurrent to the day treatment (e.g., in-home treatment), a separate PA/RF must be submitted for those services and the appropriate prior authorization attachment and all required materials must be submitted for that other service. Please indicate on this prior authorization request that services will be coordinated with the other service provider (if the service will be provided by a different agency). These other services must be identified on the multi-agency treatment plan.

SECTION I.

RECIPIENT INFORMATION

Elements 1-4. Enter the recipient's last name, first name, middle initial, and 10-digit Medical Assistance identification 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 (e.g., 21,45,60, etc.).

PROVIDER INFORMATION

Element 6. CERTIFIED DAY TREATMENT PROVIDER NAME

Enter the name of the Medical Assistance certified day treatment program which will be billing for the services.

Element 7. DAY TREATMENT MA PROVIDER NUMBER

Enter the eight-digit Medical Assistance provider number for the day treatment provider. Providers will be assigned a unique provider number for the child/adolescent day treatment program.

Element 8. NAME AND PHONE NUMBER OF CONTACT PERSON

Enter the name and phone number (including area code) of a person who would be able to answer questions about this request.

Element 9. Indicate the date for which you wish services to be first authorized and the end date for the authorization period. See the general instructions for information on the length of authorization that will be generally allowed. If the start date is prior to when this request will be received at EDS, clinical rationale must be provided justifying the need to start treatment prior to getting authorization. Requests may be backdated up to 10 working days on the initial authorization if this is requested and appropriate rationale is provided.

Element 10. Indicate the total number of hours for which you are requesting MA reimbursement for this PA grant period.

SECTION II.

- A. Present or attach a summary of the psychiatric assessment and differential diagnosis. Diagnoses on all five axes of the DSM-III-R are required. The assessment should address the level of reality testing, thought processes, drive control, relational capacity, and defensive functioning. If not conducted by a psychiatrist, a psychiatrist must review and sign the summary and diagnosis. In cases where the only, or primary, diagnosis is a conduct disorder, the request should provide sufficient justification for the appropriateness of day treatment. In those cases where the only, or primary, diagnosis is a psychoactive substance abuse disorder, requests will generally not be approved unless there is sufficient justification for the appropriateness of a mental health day treatment program. Providers may attach copies of an existing assessment if it is no longer than two pages.
- B. Present or attach a summary of the recipient's illness/treatment/medication history. For individuals with significant substance abuse problems, the multi-agency treatment plan should indicate how these will be addressed. Providers may attach copies of illness/treatment/medication histories that are contained in their records if they do not exceed two pages.
- C. Complete the checklist for determining than an individual meets the criteria for severe emotional disturbance. The following information defines the allowable conditions for parts 2 and 3 of the checklist:

For part 2 the individual must have one of the following DSM-III-R diagnoses:

Adult diagnostic categories appropriate for children and adolescents are:

organic mental syndromes and disorders (292.00* - 292.90*, 294.80)
psychoactive substance use disorders (303.90, 304.00 - 304.90*, 305.00, 305.20* - 305.90*) (use codes for abuse only)
schizophrenia (295.1x, 295.2x, 295.3x, 295.6x, 295.9x)
schizoaffective disorders (295.70)
mood disorders (296.2x - 296.70, 300.40, 301.13, 311.00)
somatoform disorders (300.11, 300.70*, 300.81, 307.80)
dissociative disorders (300.12 - 300.15, 300.60)
sexual disorders (302.20 - 302.40, 302.70 - 302.79, 302.81 - 302.84, 302.89, 302.90, 306.51)
intermittent explosive disorder (312.34)
pyromania (312.33)
adjustment disorder (309.00, 309.23 - 309.90)
personality disorders (coded on Axis II: 301.00, 301.20 - 301.50, 301.60 - 301.90)
psychological factors affecting physical condition (316.00 - *and specify physical condition on Axis III*)

Disorders usually first evident in infancy, childhood and adolescence include:

pervasive developmental disorders (coded on Axis II: 299.00, 299.80)
disruptive behavior disorders (312.00, 312.20, 312.90, 313.81, 314.01)
anxiety disorders of childhood or adolescence (309.21, 313.00, 313.21)
eating disorders (307.10, 307.50, 307.51, 307.52, 307.53)
gender identity disorders (302.50, 302.60, 302.85*)
tic disorders (307.20 - 307.23)
reactive attachment disorder of infancy or early childhood (313.89)

For part 3 the symptoms and impairments are defined as follows:

SYMPTOMS

- 1) Psychotic symptoms - serious mental illness (e.g. schizophrenia) characterized by defective or lost contact with reality, often with hallucinations or delusions.
- 2) Suicidality - The individual must have made one attempt within the last three months or have significant ideation about or have a plan for suicide within the past month.
- 3) Violence - The individual must be at risk for causing injury to persons or significant damage to property as a result of emotional disturbance.

FUNCTIONAL IMPAIRMENT (compared with expected developmental level):

- 1) Functioning in self care - Impairment in self care is manifested by a person's consistent inability to take care of personal grooming, hygiene, clothes and meeting of nutritional needs.
 - 2) Functioning in community - Impairment in community function is manifested by a consistent lack of age appropriate behavioral controls, decision-making, judgment and value systems which results in potential involvement or involvement the juvenile justice system.
 - 3) Functioning in social relationships - Impairment of social relationships is manifested by the consistent inability to develop and maintain satisfactory relationships with peers and adults.
 - 4) Functioning in the family - Impairment in family function is manifested by a pattern of significantly disruptive behavior exemplified by repeated and/or unprovoked violence to siblings and/or parents, disregard for safety and welfare of self or others, e.g.- fire setting, serious and chronic destructiveness, inability to conform to reasonable limitations and expectations which may result in removal from the family or its equivalent.
 - 5) Functioning at school/work - impairment in any *one* of the following:
 - a) Impairment in functioning at school is manifested by the inability to pursue educational goals in a normal time frame - e.g. consistently failing grades, repeated truancy, expulsion, property damage or violence toward others; **or**
 - b) meeting the definition of "child with exceptional educational needs" under ch. PI 11 and 115.76(3) Wis. Stats.; **or**
 - c) Impairment at work is the inability to be consistently employed at a self- sustaining level - e.g. inability to conform to work schedule, poor relationships with supervisor and other workers, hostile behavior on the job.
- D. Describe the treatment program which will be provided. Participation in specific groups/activities must be justified by the treatment plan. Attach a summary/description of groups or program components. The

information presented should be adequate for determining that those services for which reimbursement is requested are MA reimbursable (as noted in Section III-D).

- E. If not previously addressed, indicate the rationale for day treatment as opposed to other treatment modalities. Where less intensive outpatient (clinic) services have not been provided, discuss why not. Providers should present this justification in their own words and not assume that the consultants can infer this from other materials presented with the request.
- F. Indicate the expected duration of day treatment. Describe services expected to be rendered following completion of day treatment and transition plans. While providers are expected to indicate their expectations on the initial request, it is critical that plans for terminating day treatment be discussed in any requests for services at and beyond six months of treatment.

SECTION III

The following materials must be attached and labeled:

- A. The prior authorization request form (PA/RF) may be obtained from EDS. The words "**HealthCheck Other Services**" should be written across the top of the form in red ink. Enter procedure code W7081 in element 14 and "Child/Adolescent Day Treatment" in element 18.
- B. A HealthCheck referral must accompany the request. When the request is for a reauthorization the provider should attach a copy of the initial HealthCheck referral. The initial request for this recipient must be received by EDS within six months of the date of the HealthCheck referral.
- C. The multi-agency treatment plan must be developed by representatives from all systems involved with the recipient (school, juvenile justice, social services, etc.). The plan must address the role of each system in the overall treatment and the major goals for each agency involved. Ideally, the plan should be signed by all participants, but to facilitate submission, the provider may document who was involved. Where some agency was not involved in the planning, the provider must document the reason and what attempts were made to include them. The plan should indicate why day treatment services are necessary and desirable. The individual who is coordinating the multi-agency planning should be clearly identified. A psychiatrist must sign either the multi-agency or day treatment plan (please make sure the physician is identified as a psychiatrist). A model multi-agency treatment plan may be obtained by writing to the SED coordinator at:

SED Coordinator
Division of Community Services
Office of Mental Health
P.O. Box 7851
Madison, WI 53707-7851

(608) 266-6838; Fax: (608) 266-0036

If a plan other than the model plan is used, all the information on the model must be included.

- D. The treatment team must complete a treatment plan covering their day treatment services. The plan must contain measurable goals, specific methods, and an expected timeframe for achievement of the goals. The treatment plan must be tailored for the individual recipient.

The plan must clearly identify how specific program components relate to specific treatment goals. The methods allow for a clear determination that the services provided meet criteria for Medical Assistance covered services. Services which are primarily social or recreational in nature, educational services, and mealtimes are not reimbursable.

- E. Providers must complete and attach the results of either the Achenbach Child Behavior Checklist or the Child and Adolescent Functional Assessment Scale. Additional information about these screening instruments can be obtained from the SED Coordinator at the address noted above.
- F. Submit a copy of an AODA assessment where the psychiatric assessment indicates significant AODA problems and AODA related services will be part of the day treatment program. The assessment may be summarized in Section II- A or- B as part of the psychiatric assessment or illness history. If the AODA problems will be addressed by some other agency, this should be indicated in the multi-agency treatment plan.

The request must be signed and dated by the day treatment program director.

ATTACHMENT 6

Check One: initial request first reauthorization
 second authorization subsequent reauthorization

MAIL TO:

EDS
Prior Authorization Unit
Suite 88
6406 Bridge Road
Madison, WI 53784-0088

PA/CADTA

1. Complete this form.
2. Attach PA/RF.
3. Attach all requested information.
4. Attach prescription.
5. Mail to EDS

**PRIOR AUTHORIZATION
CHILD/ADOLESCENT DAY TREATMENT**

Providers should carefully read the attached instructions before completing this form.

SECTION I.

RECIPIENT INFORMATION

(1)	(2)	(3)	(4)	(5)
Patient	Is	A	1234567890	16
Last Name	First Name	MI	Medical Assistance Identification #	Age

PROVIDER INFORMATION

(6)	(7)	(8)
Day Treatment Provider Name	Medical Assistance Provider #	Name and Phone Number of Contact Person
DAY TREATMENT PROVIDER	87654321	I. M. DIRECTOR (xxx) xxx-xxxx

(9) Requested start date and end date for this authorization period (if start date is prior to when request will be received at EDS, please indicate clinical rationale).

2/17/92 - 4/24/92

Please backdate. Is was started in program on 2/17 to coincide with her release from inpatient. Multi-agency meeting held on 2/19.

(10) Number of hours of treatment to be provided over prior authorization grant period. Indicate pattern of treatment, e.g., three hours/day, three days per week for eight weeks.

3 hours - 5 days/wk for 10 weeks = 150 hours

SECTION II.

The following additional information must be provided. If you attach copies of existing records to provide the information requested please limit attachments to two pages for the psychiatric evaluation and illness/treatment history. Highlighting relevant information is helpful. Do not attach M-Team summaries, additional social service reports, court reports, or other similar documents unless directed to do so following initial review of the documentation.

- A. Present a summary of the recipient's psychiatric assessment and differential diagnosis. Diagnoses on all five axes of DSM-III-R are required. If not conducted by a psychiatrist, a psychiatrist must review and sign the summary and diagnoses.

(Summarized from admission statement)

Patient is a 16 year old female who is admitted for her second psychiatric hospitalization in less than six months. Her chief complaints are "I have a drug problem...my life's a mess and I don't know how to fix it". Her admission was precipitated when she was involved in an automobile accident in which she was riding with a drunk driver and she herself was drunk. Although there were no serious injuries the accident seemed to scare Is into some acknowledgement of her substance abuse. She has a history of self-inflicted injury, primarily by cutting on herself.

Summary of Past History

She began outpatient therapy in April of 1991 focusing on her depression, irritability, and mood swings. Little seemed to have been accomplished. Her dysfunctioning became more evident at the start of the school year in September 1991 and resulted in her first hospitalization in October. At this time she was diagnosed with bipolar mood disorder and started on Lithium. She remains on Lithium and Prozac was later added to her regimen. There was some improvement noted during the hospitalization and Is and her family participated in the day treatment program for six weeks following discharge. Despite some improvement in communication and expression of feelings, Patient did not acknowledge substance abuse problems at that time. Following discharge from day treatment in mid-December the family discontinued treatment except that Patient sporadically attended aftercare group.

Patient reports depression dating back to early 1990 with complaints of hopelessness and worthlessness, appetite and sleep disturbance and loss of interest in usual activities. Her grades declined significantly during the following school year and she reported difficulty concentrating which may have been related to her increasing use of drugs during that time. Although Patient admits to occasional drinking as early as age 12, significant usage did not begin until 1990 (see attached substance abuse assessment).

Summary of Family History, Development, Medical

Is lives with her mother and father and a 10 year old brother. The family history is significant for the lack of any outstanding psychopathology. Mother reports a normal development. Patient has no known allergies or medical problems.

Examination Findings

Patient presents as a normally developed female for her age. She did appear very run down and reports that she had been drinking and smoking pot a lot over the past week and not sleeping much. Depression is evident and Patient acknowledges suicidal thinking and planning. (She has considered overdosing on drugs and alcohol.) There was no evidence of hallucinations, delusions, or unusual thinking. Memory is intact. Insight appears limited and is undoubtedly impaired by both her depression and substance abuse.

Impressions

Despite the significant depression and substance abuse, Patient's prognosis is good if her current acknowledgement of her substance abuse can be supported. The family is intact and supportive and is a good asset if they can maintain treatment after the immediate crisis.

(Continued on attached sheet)

**Axis I: Major Depression, recurrent, severe
Alcohol and Cannabis abuse**

Axis II: Deferred

Axis III: None

Axis IV: 2--arguments with parents, difficulty at school

Axis V: GAF at admission--45, highest GAF past year 55 *J.M. Physician*

Plan

Admit for stabilization with suicide precautions. Maintain medication regimen. Individual, group, family therapy. AODA treatment. Plan discharge to day treatment when Patient's suicidal ideation has decreased to the point where she can be trusted not to harm herself and there is stabilization in mood, sleep patterns and eating.

B. Present a summary of the recipient's illness/treatment/medication history and other significant background information. Why do you think day treatment will produce positive change?

Patient relates that her depression started in mid-1990. She began superficial cutting later that year and reported that it decreased her anger and pain. She reports sleep disturbance, nightmares, fatigue, and irritability.

She participated in individual and group outpatient counseling in April, 1991. She reportedly had a difficult time expressing feelings or understanding the connection between her feelings and her behavior. She denied any substance abuse problems at that time.

Patient's functioning deteriorated significantly at the start of the next school year. She was engaged in significant conflict with her parents over rules at home and was missing school frequently. She was expressing a wish to die and refused to sign a No Self Harm contract with her outpatient therapist. She was admitted to inpatient care on October 10, 1991. She was diagnosed with Bipolar Mood Disorder and started on Lithium 300 mg t.i.d. An AODA evaluation (see attached) yielded additional diagnoses of alcohol and cannabis abuse.

At discharge, Patient was admitted to day treatment to provide intensive therapy and support during the transition back to school and home. She attended for six weeks and began to express feelings more appropriately and discuss alternative and safe methods of releasing her emotions. Prozac was added because of continued mood swings and depression. The family participated in treatment and there seemed to be some improvement in communication. However, she continued in denial with regard to substance abuse.

Following discharge from day treatment the family discontinued involvement in therapy. She attended aftercare group sporadically. Despite earlier improvement she quickly regressed into complaints about limits at home and school. Parents reported that she began staying out late at night. She was involved in an automobile accident (she was not the driver) that involved alcohol and Patient was intoxicated at the time. Though she was not charged her parents brought her back to the hospital for intervention. She acknowledged that she felt out of control and was admitted back to inpatient care on February 1, 1992. After two weeks inpatient, during which time her condition was stabilized, she was discharged again to day treatment. Both Patient and the family felt that day treatment was important during the transition back to home and school.

Patient's potential for change seems good now that she has acknowledged her substance abuse. The family also seems to understand the need to continue treatment following Patient's discharge from day treatment.

C. Complete the checklist for determination that an individual meets the criteria for severe emotional disturbance (SED). Criteria for meeting the functional symptoms and impairments are found in the instructions. SED in an individual under the age of 21 requires acute treatment and may lead to institutional care. The disability must be evidenced by 1, 2, 3 and 4 listed below.

1. **The individual must meet all three of the following:**

- a. be under the age of 21, and
- b. have an emotional disability that has persisted for at least 6 months; and
- c. that same disability must be expected to persist for a year or longer.

2. **A condition of severe emotional disturbance as defined by a mental or emotional disturbance listed in the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders, III, Revised (DSM III-R).**

296.33 Major Depression; _____ 305.00 Alcohol Abuse; _____ 305.20 Cannabis Abuse
Primary Diagnosis

3. **Functional Symptoms and Impairments**

The individual must have A. or B.

a. **Symptoms (must have one)**

- 1. Psychotic symptoms
- 2. Suicidality
- 3. Violence

b. **Functional impairments (must have two)**

- 1. Functioning in self care
- 2. Functioning in the community
- 3. Functioning in social relationships
- 4. Functioning in the family
- 5. Functioning at school/work

4. **The individual is receiving services from two or more of the following service systems.**

- Mental Health
- Social Services
- Child Protective Services
- Juvenile Justice
- Special Education

Eligibility Criteria Waived Under Certain Circumstances:

- This individual would otherwise meet the definition of SED, but has not yet received services from more than one system, but would be likely to do so were the intensity of treatment requested not provided. Attach explanation.
- This individual would otherwise meet the definition of SED except that functional impairment has not persisted for six months, but the nature of the acute episode is such that impairment in functioning is likely to be evident without the intensity of treatment requested. Attach explanation.

- D. Describe the treatment program which will be provided. Attach a day treatment program schedule. Summarize the proposed intervention in this section. The treatment plan should specify how program components relate to this specific client's treatment goals.

Patient is to attend day treatment four hours a day, five days per week. Part of this time will not be billed to MA because it is used for educationally related work and recreation. We will use groups led by a psychiatric nurse to work with Is on the identification and expression of feelings (see treatment plan) and groups led by an AODA counselor to improve her understanding of her substance abuse. The family will attend the multiple-family group one time per week and will meet with staff individually once per week to focus on family understanding of both the emotional issues and the substance abuse. These family meetings will be led by our psychologist. A program schedule is attached.

- E. Indicate the rationale for day treatment. Elaborate on this choice where prior outpatient (clinic) treatment is absent or limited. Why does the recipient need this level of intervention at this time?

Patient's quick return to the hospital after her first admission demonstrated the necessity for a more intense aftercare plan. Both Patient and her family understand the need to continue outpatient treatment. Her continued mood swings and rather tentative abstinence argue for a fairly intensive level of treatment for the first two months following discharge. Her history also suggests that she would benefit from a high degree of structure. The plan will be to reduce intervention to weekly group therapy for Patient, weekly to biweekly family therapy and AA, NA, and AI Anon meetings.

- F. Indicate the expected date for termination of day treatment. Describe anticipated service needs following completion of day treatment and transition plan.

Day treatment is expected to terminate on 4/24. Plan is to continue family therapy weekly on an outpatient basis. Is will continue with AA/NA groups. She will also have medication management, as needed.

SECTION III.

Please attach and label the following:

A. The prior authorization request form (PA/RF).

B. One of the following (check which is attached):

- A copy of the signed and dated HealthCheck referral for day treatment from a physician; or
- A copy of the signed and dated HealthCheck referral for day treatment from a provider other than a physician, and a physician's prescription for day treatment, or
- A copy of the signed and dated HealthCheck referral for a psychiatric evaluation/diagnosis if there has not been a differential diagnosis within the past 12 months and a physician's prescription for day treatment, or,
- If there has been a differential diagnosis within the past twelve months, a physician's prescription for day treatment and a copy of the signed and dated HealthCheck referral.

A copy of the HealthCheck referral must be attached to all requests. For reauthorizations, a copy of the original HealthCheck referral must be attached. The initial request for these services must be received by EDS within six months of when the HealthCheck referral was dated.

C. A multi-agency treatment plan.

D. A day treatment services treatment plan.

E. Results of either the Achenbach Child Behavior Checklist or the Child and Adolescent Functional Assessment Scale (CAFAS).

F. An AODA assessment may be included. An AODA assessment must be included if AODA related programming is part of the recipient's treatment program.

Patient reports initial alcohol use around age 12 consisting of drinking at parties when alcohol was available--about one time per month. Marijuana use began about one year later and was also sporadic initially. Prior to her admission to the hospital she reports use of alcohol and/or drugs three to four times per week. Alcohol use is generally limited to beer, about six cans when she is drinking, but she reports occasional use of whiskey. She reports that she loves to smoke pot and would smoke it daily if she could, but her use is limited to how often she can get it. Use of other drugs appears to be fairly limited. She reports trying speed once and using some inhalant, but she reports that she did not like these drugs. She says she uses drugs and alcohol as a way to socialize and feel happy.

She reports blackouts and becoming physically sick on occasion. She reports drinking when she skips school and coming to school drunk or high on a number of occasions. She reports poorer grades and decreased recreational activities (she used to be involved in piano lessons and creative dance, but has dropped these activities) although the relationship between these changes and her substance abuse is not clear. Her activities with friends have become limited to those involving drugs or alcohol and she reports that she is spending more time with people who are heavy users. She seems to see that she often feels worse after use of drugs or alcohol, both physically and emotionally, but minimizes the fact that this does not prevent her from changing her use. She says that she can make choices about avoiding use, but her ability to make consistent healthy choices does not appear to be supported by her drug use history. She reports that she has abstained from use of either drugs or alcohol for periods of up to two weeks.

Patient describes her parents as social drinkers. She identifies an aunt as having been in AODA treatment. She reports that her relationship with her parents has been conflictual over issues of rules at home, when she has to be in, etc. She says she gets along OK with her brother.

A diagnosis of alcohol and cannabis abuse is supported by Is's history of alcohol and marijuana use, her use during school, the decline in school attendance and performance, the decreased recreational activities other than substance use, the presence of blackouts on occasion, and her expressed interest in using marijuana daily if it were available.

I attest to the accuracy of the information on this prior authorization request.

J. M. Director
Signature of Day Treatment Program Director

2/21/92
Date

WMAF Provider Handbook Park A
Issued 01/01/91

A11-085

APPENDIX 32

WMAF HEALTHCHECK/EPSDT REFERRAL FORM

DATE OF SCREENING: 2/14/92

RECIPIENT NAME: Is Patient MA-ID # 1234567890

DATE OF REFERRAL APPOINTMENT: 2/14/92

REASON FOR REFERRAL: Mental Health and General Health Concerns

REFERRED TO: Day Treatment

Provider Name, Address, and/or Specialty

COMMENTS: Just hospitalized for depression/substance abuse. Appears to require follow-up. No other significant findings.

SIGNATURE: J.M. Screener DATE: 2/14/92
Screening Provider

NOTE: This form is acceptable in lieu of the WMAF HealthCheck (EPSDT) Services claim form when it is used as a referral form.

Prescription for Day Treatment

I have examined the following individual and their medical record:

Is Patient
name

609 Willow, Anytown
address

1234567890
medical assistance identification number

I find Is Patient to be appropriate for day treatment for severe emotional disturbance. Services are expected to be required for up to 6 months.

J M. Provider, Psychiatrist

22 N. Maple, Anytown
Address

12345678
UPIN/Medical Assistance Provider Number

2/17/92
Date

Department of Health and Social Services
 Division of Community Services
 Office of Mental Health
 March 20, 1992

STATE OF WISCONSIN

MODEL PLAN: INTENSIVE IN-HOME PSYCHOTHERAPY OR DAY TREATMENT

Name of Client: Is Patient	Agency Team Developing and Implementing this Plan (include title indicating discipline):
Client Birthdate: 7/15/75	1. I.M. Primary, RN (program coordinator)
Date of Plan: 2/19/92	2. I.M. Manager, O.T.
Plan review date: 8/92	3. I.M. Doctor, Ph.D.
Case Manager: I.M. Manager, OT	4. I.M. Artsie, A.T.
List family members involved in treatment:	5.
1. Be Patient, Father	6.
2. Was Patient, Mother	7.
3. Not Patient, Brother	8.
4.	
5.	
6.	

Problem 1:	Short Term Goal (measurable):
Alcohol and Drug Abuse	Abstain from alcohol and drugs. Is will attend day treatment groups and 2 AA/NA/Alateen meetings per week. Is will be able to identify the definition of substance abuse and how it applies to her.
Description of Problem:	Long Term Goal (measurable):
Patient is using alcohol and/or drugs 3-4 times per week, has exhibited decreased school attendance and grades, reports blackouts and potentially dangerous situations related to her substance abuse. She reports a desire to quit but does not demonstrate insight into her addiction.	Continued abstinence from alcohol and drugs (per Is's report and parents description of her behaviors). Acknowledgement of her addiction and understanding of the addiction process. Reintroduction of recreational activities which are non-drug and alcohol related. Plan (include frequency of intervention and team member responsible): Group and individual sessions 5 X wk. with AODA counselor to learn didactics of substance abuse, understand how they apply to her and address other issues related to substance abuse.
	Measurable Results of Intervention at Time of Plan Review:

Problem 2:	Short Term Goal (measurable);
Depression, mood swings, self-mutilation	Discuss feelings in group 3 X wk. Identify three situations which lead to self destructive behavior and three healthy responses.
Description of the Problem:	Long Term Measurable Goal (measurable):
Is has a difficult time identifying and expressing feelings. She acts on feelings, often in destructive ways such as cutting herself and substance use. She has a difficult time initiating interactions with family and friends and has a hard time accepting criticism.	Is will be able to initiate discussions about feelings with parents and therapists. Is will not engage in self destructive behaviors. Is will demonstrate decreased mood swings by self report and parents report.
	Plan (include frequency of intervention and team member(s) responsible):
	Group psychotherapy 5 X wk. with psychiatric nurse/OT; family therapy weekly with Ph.D.; multiple family therapy group weekly with Ph.D. M.D. will monitor psychotropic medications and adjust as needed.
	Measurable Results of Intervention at Time of Plan Review:

<p>Problem 3:</p> <p>Impaired Family Relations</p>	<p>Short Term Goal (measurable):</p> <p>Family will identify three limits that need to exist at home and how to manage them. Parents will understand definition of substance abuse and how it applies to Is.</p>
<p>Description of the Problem:</p> <p>Is's relationship with her parents has been increasingly conflictual over the past two years. Some gains were made during last hospitalization but parents admit to not trusting Is right now. Is has difficulty accepting limits at home and in knowing how to talk about this with parents. Parents do not understand substance abuse/addiction though they are supportive of treatment.</p>	<p>Long Term Goal (measurable):</p> <p>Parents will understand nature of the addiction process and their role in recovery for Is. Family will be able to discuss feelings and argue without resort to destructive communication patterns.</p> <p>Plan (include frequency of intervention and team member(s) responsible):</p> <p>Family therapy weekly; Multiple family group weekly with Ph.D. Is will use other groups and 1:1 time to process feelings about family.</p>
<p>Measurable Results of Intervention at Time of Plan Review:</p>	

Problem 4:	Short Term Goal:
	Long Term Goal:
	Plan (include frequency of intervention and team member(s) responsible):
	Measurable Results of Intervention at Time of Plan Review:

MAPB-092-001-Z
October 19, 1992

Program Discharge Criteria:

Is will be able to identify and express feelings more appropriately. Is will be able to enter into a 'no self harm' contract. Is will have a regular/consistent recovery program. Is and family will show ability to discuss limits and problems and commit themselves to continued outpatient therapy.


Psychiatrist's Signature


Date

MAPB-092-001-Z
 October 19, 1992

DAY TREATMENT PROGRAM

Daily Schedule

Time	Monday	Tuesday	Wednesday	Thursday	Friday
2:00	Check-In ----->				
2:15	Group Therapy	Group Therapy	Group Therapy	Group Therapy	Group Therapy
3:15					
3:45	Break and Homework		Break and Homework		
4:15	O.T. Group	Issues Group	Dinner	Issues Group	O.T. Group
5:00	Wrap-Up			Wrap-Up	
5:45			Family Group		
6:00-8:00					

Shaded areas are times not billed to Medical Assistance.

Department of Health and Social Services
 Division of Community Services
 Office of Mental Health
 March 20, 1992

MODEL INTERAGENCY TREATMENT PLAN

Name of Client: Is Patient	Interagency Team Developing and Implementing this Plan (include title indicating discipline):
Client Birthdate: 7/15/75	1. I.M. Primary, RN (day treatment) <i>J.M. Pruman</i>
Client M.A. Number: 1234567890	2. I.M. Manager, OT (day treatment) <i>S.M. Manager</i>
Date of This Plan: 2/19/92	3. I.M. Doctor, PhD <i>J.M. Doctor</i>
Plan review date: 8/92	4. I.M. Teacher (City School) <i>J.M. Teacher</i>
Case Manager: I.M. Manager	5. I.M. Psychiatrist, M.D. (psychiatrist) <i>S.M. Psychiatrist</i>
Parent(s) or Primary Caregiver:	6.
Be Patient, Father	7.
Was Patient, Mother	8..
	9.
	10.
	11.
	12.
	Was parent or primary caregiver present? Yes No

<p>Mental Health Agency Response:</p>	<p>Short Term Goal (measurable): Is will attend day treatment program and discuss issues in</p>
<p>While Is has made some</p>	<p>group 3 X week. Is will be able to identify three situations which lead to cutting behavior and</p>
<p>progress in expression of feelings and</p>	<p>three healthy responses. Is will be able to identify the definition of substance abuse and relate it</p>
<p>acknowledgement of substance abuse,</p>	<p>to her situation.</p>
<p>she has not shown the ability to</p>	<p>Long Term Goal (measurable): Is will remain abstinent from drugs and alcohol. Is will</p>
<p>function well outside a highly</p>	<p>cease cutting on herself as a response to problems. Is and her family will be able to talk about</p>
<p>structured setting. She appears</p>	<p>feelings and problem solve together. Is will become reinvolved in recreational activities.</p>
<p>unrealistic yet about the severity of</p>	<p></p>
<p>her substance abuse. She needs to</p>	<p>Plan (include frequency of intervention and team member responsible):</p>
<p>develop better communication skills</p>	<p>Attend day treatment 5 days per week. (RN/OT/AODA counselor)</p>
<p>with therapists and family.</p>	<p>Attend 2 AA/NA/or Alateen meetings weekly. (OT will monitor)</p>
<p></p>	<p>Family therapy and multiple family group weekly. (Ph.D.)</p>
<p></p>	<p>Medication Management (M.D.)</p>
<p></p>	<p></p>
<p></p>	<p>Measurable Results of Intervention at Time of Plan Review:</p>
<p></p>	<p></p>
<p></p>	<p></p>
<p></p>	<p></p>

Social Services Agency Response:	Short Term Goal (measurable)

School Agency Response:	Short Term Goal (measurable)
Patient is on a reduced schedule to allow her to attend day treatment and to catch up slowly and not stress her at this time. She is still not attending all classes.	Attend all classes on a daily basis. Seek out staff assistance when she is having problems.

	Severe Severe disruption or incapacitation (30)	Moderate Occasional major or frequent disruptions (20)	Mild Significant problems and/or distress (10)	Average No disruption of functioning (0)
(2) Thinking 10	Extreme distortion of coherent thought and language (may include bizarre play, incoherence, loosening of associations, flight of ideas)... 026	Frequent distortion of thinking (obsessions, mistrust, suspicions) 026	Occasional difficulty in communication or behavior due to thought distortions (e.g., obsessions, mistrust, suspicions)... 032	Thought, as reflected by communication, is not disordered or eccentric... 037
	Frequent and/or disruptive delusions or hallucinations/can't distinguish fantasy from reality... 022	Intermittent hallucinations that interfere with normal functioning... 027	May express odd beliefs, excessive fantasy or, if older than eight years old, magical thinking... 033	
	Pattern of short term memory loss/disorientation to time or place most of the time... 023	Unable to comprehend consequences of behavior... 029	Eccentric speech e.g., impoverished, digressive, vague)... 034	
	Inability to communicate with others and/or marked abnormalities in nonverbal or verbal communication (e.g., echolalia, idiosyncratic language)... 024	Evidence of persistent and excessive fantasy (e.g., daydreams, artwork, writing samples) with destructive and/or bizarre themes... delinquent behavior, running away, probation or parole... 030	Unusual perceptual experiences not qualifying as hallucinations... 035	
EXCEPTION 025	EXCEPTION 031	EXCEPTION 036	EXCEPTION 038	
Explanation:				

Could Not Score: 020

	Severe Severe disruption or incapacitation (30)	Moderate Occasional major or frequent disruptions (20)	Mild Significant problems and/or distress (10)	Average No disruption of functioning (0)
(3) Behavior Toward Others/Self 30	Behavior consistently inappropriate or bizarre... 040	Behavior frequently/ typically inappropriate and causing problems for self or others (e.g., promiscuity, fighting, destruction of property)... 046	Quarrelsome or annoying, making life difficult for self or others... 051	Relates satisfactorily to others... 056
	Behavior so disruptive or dangerous that harm to self or others is likely... 041	Predominantly relates to others in an exploitative/manipulative manner (e.g., uses/cons others)... 047	Impulsiveness that is not affected by known consequences (e.g., disregards risk to health or expectations of others)... 052	Not impulsive, shows good judgement in life decisions... 057
	Expelled from family for reasons related to impairment... 042	Relationships frequently fraught with tension or conflict... 048	Withdrawn or tends to be ignored by peers... 053	Is able to establish/sustain a normal range of age-appropriate relationships... 058
	Unable to form/sustain any age-appropriate close relationships... 043	Characteristically poor judgement resulting in serious risk-taking... 049	Difficulty in establishing/sustaining close relationships (e.g., predominantly age-inappropriate relationships; immature behavior leads to routine conflicts)... 054	
	Severe destructiveness toward property (e.g., deliberate fire-setting; serious damage to community/school property)... 044	EXCEPTION 045	EXCEPTION 050	EXCEPTION 055
Explanation:				

Could Not Score 060

	Severe Severe Disruption or incapacitation (30)	Moderate Occasional major or frequent disruptions (20)	Mild Significant problems and/or distress (10)	Average No disruption of functioning (0)
(4) Moods/ Emotions (Emotions = anxiety, depression, moodiness, fear, worry, irritability, tenseness, panic) 20	Emotional 061 responses incongruous or inappropriate (unreasonable, excessive) most of the time... Fears, phobias, 062 worries, or anxieties result in poor attendance at school (i.e., absent more than present) or marked social withdrawal... Depression is 063 incapacitating at times (e.g., academically, socially) or is accompanied by suicidal intent...	Marked changes 065 in moods that are generally intense and abrupt... Symptoms of distress 066 (depressed, sad, fearful or anxious) are pervasive and/or persistent (e.g., disrupts sleep, eating, concentration and/or activities of daily living or symptoms of worthlessness or irritability are pervasive and other symptoms are persistent (e.g., sleep, eating, etc.) Emotional 067 blunting...	Often worried or 069 sad with some negative effect (e.g., recurrent nightmares)... Disproportionate 070 expression of frustration, irritability or fear... Notable emotional 071 restriction (i.e., has difficulty expressing strong emotions such as fear, hate, love)...	Feels normal distress, 073 but daily life is not disrupted... Considers self 074 a "worthy person"... Can express strong 075 emotions appropriately...
	EXCEPTION 064	EXCEPTION 068	EXCEPTION 072	EXCEPTION 076
	Explanation:			

Could Not Score: 077

•1990 Used with permission from Kay Hodges, Ph.D. (Eastern Michigan University). The CAFAS was modeled after the North Caroline Functional Assessment Scale (NCFAS), which was developed primarily for use with adults. 10/11/90

	Severe Severe disruption or incapacitation (30)	Moderate Occasional major or frequent disruptions (20)	Mild Significant problems and/or distress (10)	Average No disruption of functioning (0)
	These categories apply to youth of all ages			
(5) Substance Use (Substances = alcohol or drugs) 20	Lifestyle centers 078 on acquisition and use (e.g., preoccupied with thoughts or urges to use substances)...	Uses in such a way as 084 to interfere with functioning (i.e., job, school, driving) in spite of potential serious consequences...	Infrequent excesses 089 and only without serious consequences...	No use of substances... 093
	Dependent on 079 continuing use to maintain functioning (e.g., likely to experience withdrawal symptoms)...	Gets into trouble 085 because of usage (e.g., fights with family or friends, in an accident or injured, trouble with teachers, picked up by police, experiencing physical health problems due to use)...	Regular usage 090 (e.g., once a week) but without intoxication or being obviously high...	Has only "dried" themselves not use them... 094
	Failing school 080 or kicked out of school or work related to usage...	High or intoxicated 086 once a week...		Occasional use with no negative consequences... 095
	Frequently intoxicated 081 or high (e.g., more than two times a week)...			
	If youth is 12 or younger, use these additional categories			
	For 12 years or 082 younger, high or intoxicated once or twice a week...	For 12 years 087 or younger, use regularly (once a week) without intoxication and without becoming obviously high...	For 12 years 091 or younger, occasional use with no negative consequences...	
	EXCEPTION 083	EXCEPTION 088	EXCEPTION 092	EXCEPTION 096
	Explanation:			

Could Not Score: 097

TOTAL SCORE
 FOR CATEGORIES
 1 - 5

100

ADDITIONAL COMMENTS:

CONTINUE ONTO NEXT PAGE

	Severe Severe disruption or incapacitation (30)	Moderate Occasional major or frequent disruptions (20)	Mild Significant problems and/or distress (10)	Average No disruption of functioning (0)
(6) Caregiver Resources: Basic Needs	Unable to meet 098 child's needs for food, clothing, housing, transportation, medical attention or safety, such that severe risk to health or welfare is likely--	Frequent 100 problems meeting child's needs for food, housing, clothing, transportation, medical attention, or safety--	Occasional 102 problems meeting child's needs for food, housing, clothing, transportation, medical attention, or safety--	Able to obtain 104 or arrange for adequate meeting of all basic needs--
	EXCEPTION 099	EXCEPTION 101	EXCEPTION 103	EXCEPTION 105
	Explanation:			

Could Not Score 106

(7) Caregiver Resources: Family/ Social Support	Sociofamilial setting 107 is potentially dangerous to the child due to lack of family resources required to meet the child's needs/demands--	Child's developmental 112 needs cannot be adequately met because child's needs/developmental demands exceed family resources--	Family not able to 118 provide adequate warmth, security or sensitivity relative to the child's needs. Support from other sources outside the immediate family are unable to compensate for this inadequacy--	Family is 122 sufficiently warm, secure, and sensitive to the child's needs--
	Gross parental 108 impairment (e.g., psychosis, substance abuse, severe personality disorder, mental retardation)--	Marked impairment in 113 parental functioning, related to psychiatric illness, substance use, physical illness, or other impairing condition--	Dysfunctional/ 119 discordant familial relationships (characterized by poor problem solving, poor communication, emotional insensitivity, role reversal, etc.). No other supports compensate for this deficit--	Parental supervision 123 in consistent and appropriate--
	Frankly hostile and/or 109 rejecting sociofamilial setting--	Persistent/severe 114 dysfunctional/discordant familial relationships (characterized by hostility, tension, and/or scapegoating, etc.)--	Family not able to 120 provide adequate supervision or consistency in care over time relative to the child's needs. No other supports compensate for this deficit--	Even though there are 124 temporary problems in providing adequate support to the child, there is compensation from the wider social support system.
	Child is subjected to 110 sexual or physical abuse--	Family members are 115 insensitive, angry and/or resentful to the child--		
	Marked lack of 116 parental supervision or consistency in care--			
	EXCEPTIONAL 111	EXCEPTIONAL 117		
	Explanation:			

Could Not Score: 126

•1990 Used with permission from Kay Hodges, Ph.D. (Eastern Michigan University). The CAFAS was modeled after the North Carolina Functional Assessment Scale (NCFAS), which was developed primarily for use with adults. 10/11/90

**TOTAL SUB-SCORE
FOR CATEGORIES
6 and 7 ONLY**

0

The Family/Social Support Sub-Scale contains ideas and wording adapted from a measure developed by Setterberg, Shaffer, Williams, and Spitzer.

ATTACHMENT 7
NATIONAL HCFA 1500 CLAIM FORM COMPLETION INSTRUCTIONS
FOR CHILD/ADOLESCENT DAY TREATMENT SERVICES

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

Wisconsin Medical Assistance recipients receive a Medical Assistance identification card upon initial enrollment into the Wisconsin Medical Assistance Program (WMAP) and at the beginning of each month thereafter. Providers should always see this card before rendering services. Please use the information exactly as it appears on the Medical Assistance identification card to complete the patient and insured information.

ELEMENT 1 - Program Block/Claim Sort Indicator

Enter claim sort indicator "P" for the service billed in the Medicaid check box. Claims submitted without this indicator are denied.

ELEMENT 1a - INSURED'S I.D. NUMBER

Enter the recipient's ten-digit Medical Assistance identification number as found on the current Medical Assistance identification card. This element must contain no other numbers, unless the claim is a Medicare crossover claim, in which case the recipient's Medicare number may also be indicated.

ELEMENT 2 - PATIENT'S NAME

Enter the recipient's last name, first name, and middle initial as it appears on the current Medical Assistance identification card.

ELEMENT 3 - PATIENT'S BIRTH DATE, PATIENT'S SEX

Enter the recipient's birth date in MM/DD/YY format (e.g., February 3, 1955, would be 02/03/55) as it appears on the Medical Assistance identification card. Specify if male or female with an "X."

ELEMENT 4 - INSURED'S NAME (not required)

ELEMENT 5 - PATIENT'S ADDRESS

Enter the complete address of the recipient's place of residence.

ELEMENT 6 - PATIENT RELATIONSHIP TO INSURED (not required)

ELEMENT 7 - INSURED'S ADDRESS (not required)

ELEMENT 8 - PATIENT STATUS (not required)

ELEMENT 9 - OTHER INSURED'S NAME

Third-party insurance (commercial insurance coverage) must be billed prior to billing the WMAP, unless the service does not require third-party billing according to Section IX of Part A of the WMAP Provider Handbook.

When "Other Coverage" of the recipient's Medical Assistance identification card indicates HPP, BLU, WPS, CHA, or OTH, one of the following codes **MUST** be indicated in the first box of element 9. The description is not required, nor is the policyholder, plan name, group number, etc. (Elements 9a, 9b, 9c, and 9d are not required.)

Code	Description
OI-P	PAID by other insurance, in whole or in part
OI-D	DENIED by other insurance, benefits exhausted, deductible not reached, noncovered service, etc.
OI-C	Recipient or other party does 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

When "Other Coverage" of the recipient's Medical Assistance identification card indicates "HMO" or "HMP", one of the following disclaimer codes must be indicated, if applicable:

Code	Description
OI-P	PAID by other insurance, in whole or in part
OI-H	DENIED by the HMO or HMP for one of the following reasons: <ul style="list-style-type: none">- noncovered service- applied to deductible or copayment- family planning services (if WPS-HMP only)

Important Note: The provider may not use OI-H if the HMO or HMP denied payment because an otherwise covered service was not rendered by a designated provider.

When the provider has not billed other insurance because the "Other Coverage" of the recipient's Medical Assistance identification card is blank, or the service does not require third-party billing according to Section IX of Part A of the WMAP Provider Handbook, this element may be left blank.

ELEMENT 10 - IS PATIENT'S CONDITION RELATED TO (not required)

ELEMENT 11 - INSURED'S POLICY, GROUP OR FECA NUMBER

This first box of this element is used by the WMAP for Medicare information. (Elements 11a, 11b, 11c, and 11d are not required.) Medicare must be billed prior to billing to the WMAP. When the recipient's Medical Assistance identification card indicates Medicare coverage, but Medicare does not allow any charges, one of the following Medicare disclaimer codes **MUST** be indicated. The description is not required.

<u>Code</u>	<u>Description</u>
M-1	Medicare benefits exhausted
M-5	Provider not Medicare certified
M-6	Recipient not Medicare eligible
M-7	Medicare disallowed (denied) service
M-8	Not a Medicare benefit

If a recipient's Medical Assistance identification card indicates no Medicare coverage, leave this element blank. If Medicare allows an amount on the recipient's claim, attach the Explanation of Medicare Benefit (EOMB) to the claim and leave this element blank. Refer to Appendix 17 of Part A of the WMAP Provider Handbook for further information regarding the submission of this type of claim.

ELEMENTS 12 AND 13 - AUTHORIZED PERSON'S SIGNATURE

(Not required since the provider automatically accepts assignment through Medical Assistance certification.)

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

ELEMENT 15 - IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS (not required)

ELEMENT 16 - DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION (not required)

ELEMENT 17 - NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

When required, enter the referring or prescribing physician's name.

ELEMENT 17a - I.D. NUMBER OF REFERRING PHYSICIAN

Enter the referring provider's eight-digit Medical Assistance provider number if certified by the WMAP. If the referring provider is not WMAP-certified, enter the provider's license number.

ELEMENT 18 - HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (not required)

ELEMENT 19 - RESERVED FOR LOCAL USE

If an unlisted procedure code is billed, providers may describe the procedure in this element. If there is not enough space for the description, or if multiple unlisted procedure codes are being billed, providers must attach documentation to the claim describing the procedure(s). In this instance, providers must indicate "See Attachment" in element 19.

ELEMENT 20 - OUTSIDE LAB (not required)

ELEMENT 21 - DIAGNOSIS OR NATURE OF ILLNESS OR INJURY

The International Classification of Disease (ICD) diagnosis code must be entered for each symptom or condition related to the services provided. Manifestation ("M") codes are not acceptable. List the primary diagnosis first. Etiology ("E") codes may not be used as a primary diagnosis. The diagnosis description is not required.

ELEMENT 22 - MEDICAID RESUBMISSION (not required)

ELEMENT 23 - PRIOR AUTHORIZATION

Enter the seven-digit prior authorization number from the approved prior authorization request form. Services authorized under multiple prior authorizations must be billed on separate claim forms with their respective prior authorization numbers.

ELEMENT 24A - DATE(S) OF SERVICE

Enter the month, day, and year for each procedure using the following guidelines:

- When billing for one date of service, enter the date in MM/DD/YY format in the "From" field.
- When billing for two, three, or four dates of service, enter the first date of service in MM/DD/YY format in the "From" field, and subsequent dates of service in the "To" field by listing only the date(s) of the month (i.e., DD, DD/DD, or DD/DD/DD)

It is allowable to enter up to four dates of service per line if:

- all dates of service are in the same calendar month;
- all services performed are identical;
- all procedures have the same type of service code;
- all procedures have the same place of service code;
- all procedures were performed by the same provider;
- the same diagnosis is applicable for each procedure;
- the charge for all procedures is identical (enter the total charge per detail line in element 24F);
- the number of services performed on each date of service is identical;
- all procedures have same HealthCheck or Family Planning indicator; and
- all procedures have the same emergency indicator.

ELEMENT 24B - PLACE OF SERVICE

Enter one of the following WMAP single-digit place of service codes for each service.

Code	Description
2	Outpatient Hospital
3	Office

ELEMENT 24C - TYPE OF SERVICE CODE

Enter type of service code "9" for each service.

ELEMENT 24D - PROCEDURES, SERVICES, OR SUPPLIES

Enter the five-character procedure code W7081 (Adolescent Day Treatment).

ELEMENT 24E - DIAGNOSIS CODE

When multiple procedures related to different diagnoses are submitted, column E must be used to relate the procedure performed (element 24D) to a specific diagnosis in element 21. Enter the number (1, 2, 3, or 4) which corresponds to the appropriate diagnosis in element 21.

ELEMENT 24F - CHARGES

Enter the total charge for each line.

ELEMENT 24G - DAYS OR UNITS

Enter the total number of services billed for each line. A decimal must be indicated when a fraction of a whole unit is billed. When billing for fractions of an hour, units of service are indicated in one-tenth hour increments, using the following rounding guidelines.

Time (in minutes)	Unit(s) Billed
1-6	.1
7-12	.2
13-18	.3
19-24	.4
25-30	.5
31-36	.6
37-42	.7
43-48	.8
49-54	.9
55-60 (etc.)	1.0

ELEMENT 24H - EPSDT/FAMILY PLANNING

Enter an "H" for each procedure.

ELEMENT 24I - EMG

Enter an "E" for each procedure performed as an emergency, regardless of the place of service.

ELEMENT 24J - COB (not required)

ELEMENT 24K - RESERVED FOR LOCAL USE

When applicable, enter the word "spenddown" and under it, the spenddown amount on the last detail line of element 24K directly above element 30. Refer to Section IX of Part A of the WMAP Provider Handbook for information on recipient spenddown.

ELEMENT 25 - FEDERAL TAX ID NUMBER (not required)

ELEMENT 26 - PATIENT'S ACCOUNT NO.

Optional - provider may enter up to 12 characters of the patient's internal office account number. This number will appear on the EDS Remittance and Status Report.

ELEMENT 27 - ACCEPT ASSIGNMENT

(Not required, provider automatically accepts assignment through Medical Assistance certification.)

ELEMENT 28 - TOTAL CHARGE

Enter the total charges for this claim.

ELEMENT 29 - AMOUNT PAID

Enter the amount paid by other insurance. If the other insurance denied the claim, enter \$0.00. (If a dollar amount is indicated in element 29, "OI-P" must be indicated in element 9.)

ELEMENT 30 - BALANCE DUE

Enter the balance due as determined by subtracting the recipient spenddown amount in element 24K and the amount paid in element 29 from the amount in element 28.

ELEMENT 31 - SIGNATURE OF PHYSICIAN OR SUPPLIER

The provider of the authorized representative must sign in element 31. The month, day, and year the form is signed must also be entered in MM/DD/YY format.

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

ELEMENT 32 - NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (not required)

ELEMENT 33 - PHYSICIAN'S, SUPPLIERS BILLING NAME, ADDRESS, ZIP CODE AND PHONE #

Enter the provider's name (exactly as indicated on the provider's notification of certification letter) and address of the billing provider. At the bottom of element 33, enter the billing provider's eight-digit Medical Assistance provider number.

ATTACHMENT 7
NATIONAL HCFA 1500 CLAIM FORM COMPLETION INSTRUCTIONS
FOR CHILD/ADOLESCENT DAY TREATMENT SERVICES

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

Wisconsin Medical Assistance recipients receive a Medical Assistance identification card upon initial enrollment into the Wisconsin Medical Assistance Program (WMAP) and at the beginning of each month thereafter. Providers should always see this card before rendering services. Please use the information exactly as it appears on the Medical Assistance identification card to complete the patient and insured information.

ELEMENT 1 - Program Block/Claim Sort Indicator

Enter claim sort indicator "P" for the service billed in the Medicaid check box. Claims submitted without this indicator are denied.

ELEMENT 1a - INSURED'S I.D. NUMBER

Enter the recipient's ten-digit Medical Assistance identification number as found on the current Medical Assistance identification card. This element must contain no other numbers, unless the claim is a Medicare crossover claim, in which case the recipient's Medicare number may also be indicated.

ELEMENT 2 - PATIENT'S NAME

Enter the recipient's last name, first name, and middle initial as it appears on the current Medical Assistance identification card.

ELEMENT 3 - PATIENT'S BIRTH DATE, PATIENT'S SEX

Enter the recipient's birth date in MM/DD/YY format (e.g., February 3, 1955, would be 02/03/55) as it appears on the Medical Assistance identification card. Specify if male or female with an "X."

ELEMENT 4 - INSURED'S NAME (not required)

ELEMENT 5 - PATIENT'S ADDRESS

Enter the complete address of the recipient's place of residence.

ELEMENT 6 - PATIENT RELATIONSHIP TO INSURED (not required)

ELEMENT 7 - INSURED'S ADDRESS (not required)

ELEMENT 8 - PATIENT STATUS (not required)

ELEMENT 9 - OTHER INSURED'S NAME

Third-party insurance (commercial insurance coverage) must be billed prior to billing the WMAP, unless the service does not require third-party billing according to Section IX of Part A of the WMAP Provider Handbook.

When "Other Coverage" of the recipient's Medical Assistance identification card indicates HPP, BLU, WPS, CHA, or OTH, one of the following codes **MUST** be indicated in the first box of element 9. The description is not required, nor is the policyholder, plan name, group number, etc. (Elements 9a, 9b, 9c, and 9d are not required.)

Code	Description
OI-P	PAID by other insurance, in whole or in part
OI-D	DENIED by other insurance, benefits exhausted, deductible not reached, noncovered service, etc.
OI-C	Recipient or other party does 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

When "Other Coverage" of the recipient's Medical Assistance identification card indicates "HMO" or "HMP", one of the following disclaimer codes must be indicated, if applicable:

Code	Description
OI-P	PAID by other insurance, in whole or in part
OI-H	DENIED by the HMO or HMP for one of the following reasons: <ul style="list-style-type: none">- noncovered service- applied to deductible or copayment- family planning services (if WPS-HMP only)

Important Note: The provider may not use OI-H if the HMO or HMP denied payment because an otherwise covered service was not rendered by a designated provider.

When the provider has not billed other insurance because the "Other Coverage" of the recipient's Medical Assistance identification card is blank, or the service does not require third-party billing according to Section IX of Part A of the WMAP Provider Handbook, this element may be left blank.

ELEMENT 10 - IS PATIENT'S CONDITION RELATED TO (not required)

ELEMENT 11 - INSURED'S POLICY, GROUP OR FECA NUMBER

This first box of this element is used by the WMAP for Medicare information. (Elements 11a, 11b, 11c, and 11d are not required.) Medicare must be billed prior to billing to the WMAP. When the recipient's Medical Assistance identification card indicates Medicare coverage, but Medicare does not allow any charges, one of the following Medicare disclaimer codes **MUST** be indicated. The description is not required.

<u>Code</u>	<u>Description</u>
M-1	Medicare benefits exhausted
M-5	Provider not Medicare certified
M-6	Recipient not Medicare eligible
M-7	Medicare disallowed (denied) service
M-8	Not a Medicare benefit

If a recipient's Medical Assistance identification card indicates no Medicare coverage, leave this element blank. If Medicare allows an amount on the recipient's claim, attach the Explanation of Medicare Benefit (EOMB) to the claim and leave this element blank. Refer to Appendix 17 of Part A of the WMAP Provider Handbook for further information regarding the submission of this type of claim.

ELEMENTS 12 AND 13 - AUTHORIZED PERSON'S SIGNATURE

(Not required since the provider automatically accepts assignment through Medical Assistance certification.)

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

ELEMENT 15 - IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS (not required)

ELEMENT 16 - DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION (not required)

ELEMENT 17 - NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

When required, enter the referring or prescribing physician's name.

ELEMENT 17a - I.D. NUMBER OF REFERRING PHYSICIAN

Enter the referring provider's eight-digit Medical Assistance provider number if certified by the WMAP. If the referring provider is not WMAP-certified, enter the provider's license number.

ELEMENT 18 - HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (not required)

ELEMENT 19 - RESERVED FOR LOCAL USE

If an unlisted procedure code is billed, providers may describe the procedure in this element. If there is not enough space for the description, or if multiple unlisted procedure codes are being billed, providers must attach documentation to the claim describing the procedure(s). In this instance, providers must indicate "See Attachment" in element 19.

ELEMENT 20 - OUTSIDE LAB (not required)

ELEMENT 21 - DIAGNOSIS OR NATURE OF ILLNESS OR INJURY

The International Classification of Disease (ICD) diagnosis code must be entered for each symptom or condition related to the services provided. Manifestation ("M") codes are not acceptable. List the primary diagnosis first. Etiology ("E") codes may not be used as a primary diagnosis. The diagnosis description is not required.

ELEMENT 22 - MEDICAID RESUBMISSION (not required)

ELEMENT 23 - PRIOR AUTHORIZATION

Enter the seven-digit prior authorization number from the approved prior authorization request form. Services authorized under multiple prior authorizations must be billed on separate claim forms with their respective prior authorization numbers.

ELEMENT 24A - DATE(S) OF SERVICE

Enter the month, day, and year for each procedure using the following guidelines:

- When billing for one date of service, enter the date in MM/DD/YY format in the "From" field.
- When billing for two, three, or four dates of service, enter the first date of service in MM/DD/YY format in the "From" field, and subsequent dates of service in the "To" field by listing only the date(s) of the month (i.e., DD, DD/DD, or DD/DD/DD)

It is allowable to enter up to four dates of service per line if:

- all dates of service are in the same calendar month;
- all services performed are identical;
- all procedures have the same type of service code;
- all procedures have the same place of service code;
- all procedures were performed by the same provider;
- the same diagnosis is applicable for each procedure;
- the charge for all procedures is identical (enter the total charge per detail line in element 24F);
- the number of services performed on each date of service is identical;
- all procedures have same HealthCheck or Family Planning indicator; and
- all procedures have the same emergency indicator.

ELEMENT 24B - PLACE OF SERVICE

Enter one of the following WMAP single-digit place of service codes for each service.

Code	Description
2	Outpatient Hospital
3	Office

ELEMENT 24C - TYPE OF SERVICE CODE

Enter type of service code "9" for each service.

ELEMENT 24D - PROCEDURES, SERVICES, OR SUPPLIES

Enter the five-character procedure code W7081 (Adolescent Day Treatment).

ELEMENT 24E - DIAGNOSIS CODE

When multiple procedures related to different diagnoses are submitted, column E must be used to relate the procedure performed (element 24D) to a specific diagnosis in element 21. Enter the number (1, 2, 3, or 4) which corresponds to the appropriate diagnosis in element 21.

ELEMENT 24F - CHARGES

Enter the total charge for each line.

ELEMENT 24G - DAYS OR UNITS

Enter the total number of services billed for each line. A decimal must be indicated when a fraction of a whole unit is billed. When billing for fractions of an hour, units of service are indicated in one-tenth hour increments, using the following rounding guidelines.

Time (in minutes)	Unit(s) Billed
1-6	.1
7-12	.2
13-18	.3
19-24	.4
25-30	.5
31-36	.6
37-42	.7
43-48	.8
49-54	.9
55-60 (etc.)	1.0

ELEMENT 24H - EPSDT/FAMILY PLANNING

Enter an "H" for each procedure.

ELEMENT 24I - EMG

Enter an "E" for each procedure performed as an emergency, regardless of the place of service.

ELEMENT 24J - COB (not required)

ELEMENT 24K - RESERVED FOR LOCAL USE

When applicable, enter the word "spenddown" and under it, the spenddown amount on the last detail line of element 24K directly above element 30. Refer to Section IX of Part A of the WMAP Provider Handbook for information on recipient spenddown.

ELEMENT 25 - FEDERAL TAX ID NUMBER (not required)

ELEMENT 26 - PATIENT'S ACCOUNT NO.

Optional - provider may enter up to 12 characters of the patient's internal office account number. This number will appear on the EDS Remittance and Status Report.

ELEMENT 27 - ACCEPT ASSIGNMENT

(Not required, provider automatically accepts assignment through Medical Assistance certification.)

ELEMENT 28 - TOTAL CHARGE

Enter the total charges for this claim.

ELEMENT 29 - AMOUNT PAID

Enter the amount paid by other insurance. If the other insurance denied the claim, enter \$0.00. (If a dollar amount is indicated in element 29, "OI-P" must be indicated in element 9.)

ELEMENT 30 - BALANCE DUE

Enter the balance due as determined by subtracting the recipient spenddown amount in element 24K and the amount paid in element 29 from the amount in element 28.

ELEMENT 31 - SIGNATURE OF PHYSICIAN OR SUPPLIER

The provider of the authorized representative must sign in element 31. The month, day, and year the form is signed must also be entered in MM/DD/YY format.

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

ELEMENT 32 - NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (not required)

ELEMENT 33 - PHYSICIAN'S, SUPPLIERS BILLING NAME, ADDRESS, ZIP CODE AND PHONE #

Enter the provider's name (exactly as indicated on the provider's notification of certification letter) and address of the billing provider. At the bottom of element 33, enter the billing provider's eight-digit Medical Assistance provider number.

ATTACHMENT 8a

HEALTH INSURANCE CLAIM FORM

1 MEDICARE MEDICAID CHAMPUS CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER (Medicare #) (Medicaid #) (Sponsor's SSN) (VA File #) (SSN or ID) (SSN) (ID)		1a INSURED'S ID NUMBER 1234567890
2 PATIENT'S NAME (Last Name First Name Middle Initial) Recipient, Im A		3 PATIENT'S BIRTH DATE MM DD YY SEX 01 12 82 M <input checked="" type="checkbox"/> F <input type="checkbox"/>
5 PATIENT'S ADDRESS (No Street) 609 Willow		7 INSURED'S ADDRESS (No Street)
CITY Anytown	STATE WI	8 PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/> Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>
ZIP CODE 55555	TELEPHONE (Include Area Code) (XXX) XXX-XXXX	ZIP CODE ()
9 OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10 IS PATIENT'S CONDITION RELATED TO
a OTHER INSURED'S POLICY OR GROUP NUMBER	b OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>	a EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO
c EMPLOYER'S NAME OR SCHOOL NAME	d INSURANCE PLAN NAME OR PROGRAM NAME	b AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input type="checkbox"/> NO
12 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____		c OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO
14 DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY		15 IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY
17 NAME OF REFERRING PHYSICIAN OR OTHER SOURCE I.M. Referring MD		17a ID NUMBER OF REFERRING PHYSICIAN 12345678
19 RESERVED FOR LOCAL USE		16 DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY
21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE)		18 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY
1 313 81		20 OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO
2 1		22 MEDICAID RESUBMISSION CODE ORIGINAL REF NO
3 1		23 PRIOR AUTHORIZATION NUMBER 1234567
4 1		24
5 1		25 FEDERAL TAX ID NUMBER SSN EIN 26 PATIENT'S ACCOUNT NO 27 ACCEPT ASSIGNMENT? (For gov't claims, see back) YES <input type="checkbox"/> NO <input type="checkbox"/>
6 1		28 TOTAL CHARGE \$ XXX XX 29 AMOUNT PAID \$ 30 BALANCE DUE \$ XXX XX
31 SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) I.M. Authorized MDDYY		32 NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)
SIGNED _____ DATE _____		33 PHYSICIAN'S SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # In-Home Treatment Provider I W. Williams Anytown, WI 55555 PIN# _____ GRP# 87654321

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8 86)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (U2) (12-90)
FORM OWCP-1500 FORM RRB-1500

ATTACHMENT 8b

HEALTH INSURANCE CLAIM FORM

1 MEDICARE <input type="checkbox"/> (Medicare #) <input type="checkbox"/> MEDICAID <input type="checkbox"/> (Medicaid #) <input type="checkbox"/> CHAMPUS <input type="checkbox"/> (Sponsor's SSN) <input type="checkbox"/> CHAMPVA <input type="checkbox"/> (VA File #) <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA BLK LUNG (SSN) <input type="checkbox"/> OTHER (ID) <input type="checkbox"/>	1a INSURED'S ID NUMBER (FOR PROGRAM IN ITEM 1) 1234567890
2 PATIENT'S NAME (Last Name, First Name, Middle Initial) Recipient, Im A	3 PATIENT'S BIRTH DATE MM DD YY 01 12 82 M <input checked="" type="checkbox"/> F <input type="checkbox"/>
4 INSURED'S NAME (Last Name, First Name, Middle Initial)	5 PATIENT'S ADDRESS (No., Street) 609 Willow
6 PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	7 INSURED'S ADDRESS (No., Street)
8 PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>	9 OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)
9a OTHER INSURED'S POLICY OR GROUP NUMBER	9b OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>
9c EMPLOYER'S NAME OR SCHOOL NAME	9d INSURANCE PLAN NAME OR PROGRAM NAME
10 IS PATIENT'S CONDITION RELATED TO: a EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO b AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input type="checkbox"/> NO c OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	11 INSURED'S POLICY GROUP OR FECA NUMBER
12 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____	13 INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____ DATE _____
14 DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY	15 IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY
17 NAME OF REFERRING PHYSICIAN OR OTHER SOURCE I.M. Referring MD	17a ID NUMBER OF REFERRING PHYSICIAN 12345678
19 RESERVED FOR LOCAL USE	20 OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO
21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE) 1 1313 . 81	22 MEDICAID RESUBMISSION CODE ORIGINAL REF NO
23 PRIOR AUTHORIZATION NUMBER 1234567	24
25 FEDERAL TAX ID NUMBER SSN EIN	26 PATIENT'S ACCOUNT NO 1234JED
27 ACCEPT ASSIGNMENT? (For gov. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO	28 TOTAL CHARGE \$ XXX XX
29 AMOUNT PAID \$	30 BALANCE DUE \$ XXX XX
31 SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) I.M. Authorized MDDYY SIGNED _____ DATE _____	32 NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (if other than home or office)
33 PHYSICIAN'S SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # In-Home Treatment Provider I W. Williams Anytown, WI 55555 PIN# _____ GRP# 87654321	24

CARRIER
PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION

ATTACHMENT 8c

HEALTH INSURANCE CLAIM FORM

1 MEDICARE <input type="checkbox"/> (Medicare #) <input type="checkbox"/> MEDICAID <input type="checkbox"/> (Medicaid #) <input type="checkbox"/> CHAMPUS <input type="checkbox"/> (Sponsor's SSN) <input type="checkbox"/> CHAMPVA <input type="checkbox"/> (VA File #) <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID) <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> (SSN) <input type="checkbox"/> OTHER <input type="checkbox"/> (ID) <input type="checkbox"/>				1a INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) 1234567890					
2 PATIENT'S NAME (Last Name, First Name, Middle Initial) Patient, Is A.				3 PATIENT'S BIRTH DATE 07 15 75 M <input type="checkbox"/> F <input checked="" type="checkbox"/>		4 INSURED'S NAME (Last Name, First Name, Middle Initial)			
5 PATIENT'S ADDRESS (No., Street) 609 Willow				6 PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7 INSURED'S ADDRESS (No., Street)			
CITY Anytown		STATE WI		8 PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>		CITY		STATE	
ZIP CODE 55555		TELEPHONE (Include Area Code) (XXX) XXX-XXXX		Employed <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Student <input type="checkbox"/>		ZIP CODE		TELEPHONE (INCLUDE AREA CODE)	
9 OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)				10 IS PATIENT'S CONDITION RELATED TO		11 INSURED'S POLICY GROUP OR FECA NUMBER			
a OTHER INSURED'S POLICY OR GROUP NUMBER		a EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO		a INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>		b EMPLOYER'S NAME OR SCHOOL NAME		c INSURANCE PLAN NAME OR PROGRAM NAME	
b OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>		b AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input type="checkbox"/> NO		c OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		d IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO # yes, return to and complete item 9 a-d		13 INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below	
c EMPLOYER'S NAME OR SCHOOL NAME		d INSURANCE PLAN NAME OR PROGRAM NAME		10d. RESERVED FOR LOCAL USE		SIGNED		SIGNED	
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.									
12 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.				DATE		16 DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY			
14 DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY				15 IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY		18 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY			
17 NAME OF REFERRING PHYSICIAN OR OTHER SOURCE I.M. Referring MD				17a I.D. NUMBER OF REFERRING PHYSICIAN 12345678		20 OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO			
19 RESERVED FOR LOCAL USE				21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1 296 33 3 305 20 2 305 00 4		22 MEDICAID RESUBMISSION CODE ORIGINAL REF NO			
23 PRIOR AUTHORIZATION NUMBER 1234567				24 A DATE(S) OF SERVICE From MM DD YY To MM DD YY B Place of Service C Type of Service D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) (CPT HCPCS MODIFIER) E DIAGNOSIS CODE F \$ CHARGES G DAYS (EPSDT) OR Family Plan H I EMG J COB K RESERVED FOR LOCAL USE		25 FEDERAL TAX I.D. NUMBER SSN EIN 26 PATIENT'S ACCOUNT NO 27 ACCEPT ASSIGNMENT? (For gov. claims see back) <input type="checkbox"/> YES <input type="checkbox"/> NO 28 TOTAL CHARGE \$ 495 00 29 AMOUNT PAID \$ 30 BALANCE DUE \$ 495 00			
31 SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof) I.M. Authorized MMDDYY DATE				32 NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)		33 PHYSICIAN'S SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # Day Treatment Provider 1 W. Williams Anytown, WI 55555 PIN# GRP# 87654321			

CARRIER
PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8-86)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (U2) (12-90)
FORM OWCP-1500 FORM RRB-1500