PART H, DIVISION II

MENTAL HEALTH AND ALCOHOL AND OTHER DRUG ABUSE SERVICE PROVIDERS: 51.42 BOARD OWNED-AND-OPERATED CLINICS

PART H, DIVISION II
MENTAL HEALTH AND ALCOHOL AND OTHER DRUG ABUSE SERVICES
TRANSMITTAL LOG

This log is designed as a convenient record sheet for recording receipt of handbook updates. Each update to Part H, Division II, of the handbook is numbered sequentially. This sequential numbering system alerts the provider to any updates not received. Providers must delete old pages and insert new pages as instructed. Use of this log helps eliminate errors and ensures an up-to-date handbook.

If a provider is missing a transmittal, please request it by transmittal number. For example, if the last transmittal number on your log is 2H-3 and you receive 2H-5, you are missing 2H-4. If a provider is missing a transmittal, copies of complete provider handbooks may be purchased by completing the form included in Appendix 36 of Part A of the WMAP Provider Handbook.

Transmittal Number	Initials	Issue Date
2H-1		03/92
2H-2		06/92
2H-3		11/92
2H-4		08/94

Transmittal Number	Initials	Issue Date

MENTAL HEALTH AND ALCOHOL AND OTHER DRUG ABUSE SERVICES
INTRODUCTION

The Wisconsin Medical Assistance Program (WMAP) is governed by a set of regulations known as the Wisconsin Administrative Code, Rules of Health and Social Services, Chapters HSS 101-108, and by state and federal law. These regulations are interpreted for provider use in two parts of the WMAP Provider Handbook. The two parts of the handbook are designed to be used in conjunction with each other and with the Wisconsin Administrative Code.

Part A of the WMAP Provider Handbook includes general policy guidelines, regulations, and billing information applicable to all types of providers certified in the WMAP. The service specific part of the handbook includes information on provider eligibility criteria, covered services, reimbursement methodology, and billing instructions. Each provider is sent a copy of the Part A and appropriate service specific part of the handbook at the time of certification.

Additional copies of provider handbooks may be purchased by completing the order form in Appendix 36 of Part A of the WMAP Provider Handbook.

When requesting a handbook, be sure to indicate the type(s) of service provided (e.g., physician, chiropractic, dental) and document number.

It is important that both the provider of service and the provider's billing personnel read all materials prior to initiating services to ensure a thorough understanding of WMAP policy and billing procedures.

NOTE: For a complete source of WMAP regulations and policies, the provider is referred to the Wisconsin Administrative Code, Chapters HSS 101-108. In the event of any conflict in meaning between HSS 101-108 and the handbook, the meaning of the Wisconsin Administrative Code will hold. Providers may purchase HSS 101-108 from Document Sales at the address indicated in Appendix 3 of Part A of the WMAP Provider Handbook.

Providers should also be aware of other documents, including state and federal laws and regulations, relating to the WMAP:

- Chapter 49.43 - 49.497, Wisconsin Statutes.
- Title XIX of the Social Security Act and its enabling regulations, Title 42 - Public Health, Parts 430-456.

A list of common terms and their abbreviations appears in Appendix 30 of Part A of the WMAP Provider Handbook and also in the Wisconsin Administrative Code, Chapter HSS 101.

MENTAL HEALTH AND ALCOHOL AND OTHER DRUG ABUSE SERVICES
TABLE OF CONTENTS

MENTAL HEALTH AND ALCOHOL AND OTHER DRUG ABUSE SERVICES
TABLE OF CONTENTS
(continued)

A. TYPE OF HANDBOOK

Part H, Division II, Mental Health and Alcohol and Other Drug Abuse (AODA) Services: 51.42 Board Owned-and-Operated Clinics, is the service-specific portion of the Wisconsin Medical Assistance Provider Handbook. Part H, Division II, includes information for providers regarding provider eligibility criteria, recipient eligibility criteria, covered services, prior authorization procedures, and billing instructions. Part H, Division II is intended to be used in conjunction with Part A of the Wisconsin Medical Assistance Provider Handbook which includes general policy guidelines, regulations, and billing information applicable to all types of providers certified in the Wisconsin Medical Assistance Program (WMAP).

The information in Part H, Division II of the handbook applies only to providers who are certified as 51.42 Board owned and operated outpatient psychotherapy or AODA clinics.

Hospitals providing mental health and AODA services through a hospital outpatient mental health or AODA clinic are subject to the policies and prior authorization procedures outlined in this handbook. However, the billing information does not apply to hospitals since they use a different claim form. As specified in HSS 107.08(3)(b)2. Wis. Admin. Code, outpatient services performed outside the hospital facility may not be reimbursed as hospital outpatient services. Therefore, clinics which are owned and operated by hospitals, but which are not located at the site of the hospital, must be separately certified as outpatient psychotherapy clinics. These clinics are subject to all policies in this handbook. These clinics must bill services on the HCFA 1500 claim form.

Since HSS 105, Wis. Admin. Code, contains distinct certification requirements for separate programs, agencies providing other types of mental health programs (e.g. day treatment, Community Support Programs) are required to obtain separate WMAP certification for each of these programs. Providers may contact EDS for certification materials. Refer to Appendix 2 of Part A of the WMAP Provider Handbook for information on how to contact EDS. Separate DCS certification is required for each type of mental health program.

Providers who are also certified to provide other WMAP covered mental health/AODA services should refer to the appropriate service-specific handbooks for information on those services. Part H, Division I, is for use by non-51.42 Board-Operated Clinics providing mental health and AODA services. Part H, Division III, is for Mental Health Day Treatment providers. Part H, Division IV, is for AODA Day Treatment providers. Part H, Division V is for Community Support Program (CSP) providers.

Please note that the qualifications, definitions and procedures for psychotherapy differ from AODA treatment and are separately described throughout this handbook.

B. PROVIDER INFORMATION

Eligibility for Certification of Psychotherapy Providers

In order to be certified as a WMAP psychotherapy provider, one of the following requirements must be met:

A 51.42 Board Owned-and-Operated psychotherapy clinic must be certified by the Division of Community Services (DCS) of the Department of Health and Social Services (DHSS) as meeting the outpatient psychotherapy clinic standards under HSS 61.91 to 61.98, Wis. Admin. Code. Staff providing services which are billed to the WMAP must meet the following criteria but do not need to be individually certified by the WMAP:

A psychiatrist must be a licensed physician under ch. 448, Wis. Stats., who has completed a residency in psychiatry.

B. PROVIDER INFORMATION (continued)

A psychologist must be licensed under ch. 455, Wis. Stats., and be listed or eligible to be listed in the National Register of Health Service Providers in Psychology. A psychologist licensed under ch. 455, Wis. Stats., with the academic credential of a doctoral degree who is not eligible for listing in the National Register, is considered a master's level provider.

A master's degree psychotherapist must be employed by the clinic and must meet the requirements listed in HSS 61.96 (1)(b) or (2), and HSS 61.96(3), Wis. Admin. Code.

Important Note: All psychotherapists at 51.42 Board-operated clinics who provide services to recipients who are dually eligible for Medical Assistance and Medicare must be individually certified by the WMAP in order for reimbursement to occur.

Eligibility for Certification of AODA Treatment Providers
In order to be certified as a WMAP AODA treatment provider, a 51.42 Board Owned-and-Operated AODA Clinic must be certified by DCS as meeting the outpatient treatment program standards under HSS 61.59, Wis. Admin. Code.

Staff providing services which are billed to the WMAP must meet the following criteria but need not be individually certified:

A physician must be licensed under ch. 448, Wis. Stats.

A psychologist must be licensed under ch. 455, Wis. Stats., and be listed or eligible to be listed in the National Register of Health Service Providers in Psychology. A psychologist licensed under ch. 455, Wis. Stats., with the academic credential of a doctoral degree who is not eligible for listing in the National Register is considered a master's level provider.

A master's degree psychotherapist must be employed by the clinic and meet the requirements listed in HSS 61.96(1)(b) or (2), and HSS 61.96 (3), Wis. Admin. Code.

An alcohol and/or drug counselor must be employed by the clinic and must be certified by the Wisconsin Alcoholism Counselor Certification Board. An alcohol and/or drug counselor who is not certified by the Wisconsin Alcoholism Counselor Certification Board but has a development plan on file does not meet this requirement.

Certification as Psychotherapy and AODA Treatment Providers
Providers are encouraged to apply for certification materials through EDS prior to the time of their DCS certification site visit in order to ensure the earliest possible certification effective date.

A 51.42 Board Owned-and-Operated clinic meeting the eligibility requirements for psychotherapy or AODA treatment that wishes to be certified as a WMAP psychotherapy or AODA clinic must contact:

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

The clinic is required to submit a copy of the approval letter from the DCS of the DHSS to verify that it has been certified to provide psychotherapy and/or AODA services in Wisconsin.

Scope of Service
The policies in Part H, Division II, govern services provided within the scope of practice as defined HSS 107.13 (2) and (3), Wis. Admin. Code. Covered services and related limitations are listed in Section II of this handbook.

B. PROVIDER INFORMATION (continued)

Reimbursement

Mental health and AODA providers in non-Board operated clinics are reimbursed for most services at the lesser of the provider's usual and customary charge or the maximum allowable fee established by the DHSS. However, reimbursement rates for some services provided by 51.42 Board Owned-and-Operated clinics are provider-specific. Information about current rates established for 51.42 Board Owned-and-Operated clinics may be obtained by writing to:

Mental Health/AODA Policy Analyst
Bureau of Health Care Financing
1 West Wilson Street
Post Office Box 309
Madison, WI 53701-0309

Providers are required to bill the WMAP their usual and customary charge for services provided, that charge being the amount charged by the provider for the same service when provided to private-pay patients. For providers using a sliding fee scale for specific services, the usual and customary charge is the median of the individual provider's charge for the service when provided to non-Medical Assistance patients. Further information on billing is found in Section IV of this handbook.

Master's degree psychotherapists and AODA counselors are non-billing performing providers and may not be directly reimbursed for services they provide. Reimbursement for services performed by these providers may be made only to the certified clinic which employs them. Refer to Section IV-F of this handbook for billing instructions.

Provider Responsibilities

Specific responsibilities as a provider under the WMAP are stated in Section IV of Part A of the WMAP Provider Handbook. This section should be referenced for detailed information regarding fair treatment of the recipient, maintenance of records, recipient requests for noncovered services, services rendered to a recipient during periods of retroactive eligibility, grounds for provider sanctions, and additional state and federal requirements.

C. RECIPIENT INFORMATION

Eligibility For Medical Assistance

Recipients meeting eligibility criteria for the WMAP are issued Medical Assistance identification cards. The identification cards include the recipient's name, date of birth, 10-digit Medical Assistance identification number, medical status code, and when applicable, an indicator of health insurance coverage, managed care program coverage, and Medicare coverage.

Medical Assistance identification cards are sent to recipients monthly. All Medical Assistance identification cards are valid only through the end of the month for which they are issued. It is important that the provider or the designated agent check a recipient's Medical Assistance identification card prior to providing service to determine if the recipient is currently eligible and if there are any limitations to the recipient's coverage.

Section V of Part A of the WMAP Provider Handbook provides detailed information regarding eligibility for the WMAP, Medical Assistance identification cards, temporary cards, restricted cards, and how to verify eligibility. Review Section V of Part A carefully before services are rendered. A sample Medical Assistance identification card may be found in Appendix 7 of Part A of the WMAP Provider Handbook.

C. **RECIPIENT INFORMATION** (continued)

Medical Status

Medical Assistance recipients are classified into one of several eligibility categories, including qualified Medicare beneficiary-only (QMB-only). These categories allow for a differentiation of benefit coverage.

Additional information regarding medical categories may be found in Section V of Part A of the WMAP Provider Handbook.

Copayment

Except as noted below, all recipients are responsible for paying part of the costs involved in obtaining mental health and AODA services. The procedure codes and their applicable copayment amounts may be found in Appendix 15 of this handbook.

Providers are reminded of the following copayment exemptions:

- Emergency services
- Services provided to nursing home residents
- Services provided to recipients under 18 years of age
- Services provided to a pregnant woman if the services are related to the pregnancy
- Services covered by WMAP-contracted managed care programs to enrollees of the WMAP-contracted managed care program

Copayment must be collected from the recipient by the provider of service. Applicable copayment amounts are automatically deducted by EDS from payments allowed by the WMAP. Do not reduce the billed amount of the claim by the amount of recipient copayment. Refer to Section IV of Part A of the WMAP Provider Handbook for further information on copayment.

Managed Care Program Coverage

WMAP recipients enrolled in WMAP-contracted managed care programs receive a yellow Medical Assistance identification card. This card has a six-character code in the "Other Coverage" column designating the recipient's managed care program. These codes are defined in Appendices 20, 21, and 22 of Part A of the WMAP Provider Handbook.

Providers must always check the recipient's current Medical Assistance identification card for managed care program coverage before providing services. Claims submitted to EDS for services covered by WMAP-contracted managed care programs are denied.

WMAP-contracted managed care programs are required to cover all WMAP-covered mental health and AODA services. Further, managed care programs must guarantee that all Medical Assistance recipients enrolled in WMAP-contracted managed care programs have access to all medically necessary outpatient mental health and AODA services. No limit may be placed on the number of hours of outpatient treatment which the managed care program provides or reimburses when it is determined that treatment for mental or nervous disorders, alcohol or drug abuse is medically necessary. Managed care programs may not establish any monetary limit or limit on the number of days of inpatient hospital treatment when it is determined that this treatment is medically necessary. Managed care programs may establish their own authorization procedures.

C. RECIPIENT INFORMATION (continued)

For recipients enrolled in a WMAP-contracted managed care program, all conditions of reimbursement and prior authorization for mental health and AODA services are established by the contract between the managed care programs and certified providers.

Additional information regarding managed care program noncovered services, emergency services, disenrollment and hospitalizations is included in Section IX of Part A of the WMAP Provider Handbook.

Recipient Eligibility for Mental Health and Alcohol and other Drug Abuse Services
As specified in HSS 107.03(15), Wis. Admin. Code, the following recipients are not eligible for services through the WMAP:

1. an individual who is currently in jail or a correctional facility; and

2. an individual 21 to 64 years of age who is a resident of an institution for mental disease (IMD), unless the recipient is 21 years of age, was a resident of the IMD immediately prior to turning 21 and has been continuously a resident since then, unless the individual is on convalescent leave. (If these conditions are met, treatment may be provided up to the recipient's 22nd birthday.) "Convalescent leave" means a resident's temporary release from an IMD to

   residency in a community setting, not more frequently than once a year and beginning on the fourth day after release. The trial period of residence in the community must last at least four days but no longer than 30 days, or until the recipient is permanently discharged from the IMD, whichever occurs first.

Any WMAP payments made on these claims must be returned to the WMAP. Medicare claims for coinsurance/deductible are not reimbursable by the WMAP for recipients in an IMD.

A. INTRODUCTION

Covered services are those described in the HSS 107.13 (2) and 107.13(3), Wis. Admin. Code, when delivered by providers certified in accordance with HSS 105.22 (for psychotherapy providers) and HSS 105.23 (for Alcohol and Other Drug Abuse [AODA] providers), Wis. Admin. Code. Please refer to Appendix 3 of this handbook for a complete list of allowable procedure codes for mental health and AODA services, along with information on which psychotherapy and AODA providers may bill each procedure code, limitations which apply to the procedure codes, and allowable diagnoses.

B. COVERED PSYCHOTHERAPY SERVICES

Requirements for Psychotherapy Services

Recordkeeping and General Requirements

The following record keeping and general requirements are outlined in HSS 61.97. (11) - (15) Wis. Admin. Code.

An initial assessment must be performed by staff to establish a diagnosis on which a preliminary treatment plan is based, which shall include but is not limited to:

- the recipient's presenting problems with the onset and course of symptoms, past treatment response, and current manifestation of the presenting problems;
- preliminary diagnosis; and
- personal and medical history.

A treatment plan must be developed with the recipient upon completion of the diagnosis and evaluation.

Progress notes must be written in the recipient's clinical record. The notes shall contain status and activity information about the recipient that relates to the treatment plan. Progress notes are to be completed and signed by the therapist performing the therapy session.

A discharge summary containing a synopsis of treatment given, progress and reasons for discharge shall be written in the recipient's clinical record when services are terminated.

All recipient clinical information received by the provider shall be kept in the recipient's clinical record. The following requirements must be met:

- recipient records must be stored in a safe and secure manner;
- policy must be developed to determine the disposition of recipient clinical records in the event of closing;
- a written policy governing the disposal of recipient clinical records must be developed;
- recipient clinical records must be kept at least five years;
- upon termination of a staff member, the recipient clinical records for which he or she is responsible must remain in the custody of the clinic where the recipient was receiving services unless the recipient requests, in writing, that the records be transferred; and
- upon written request of the recipient, the provider must transfer the clinical information required for further treatment as determined by the supervising physician or psychologist.

B. COVERED PSYCHOTHERAPY SERVICES (continued)

Based on reviews of recipient records, the WMAP believes that recordkeeping can be enhanced by the following good practices:

- including information in the assessment on previous treatment history and outcome, making sure the assessment materials support the diagnosis made, and updating assessment materials as new information becomes available;
- including both short-term and long-term measurable goals in the treatment plan; and
- including information in the discharge summary on the provider's response to non-compliance, including efforts to engage the recipient in treatment, when this was a factor in discontinuing treatment. Also, identify how a return to treatment might be most easily handled.

Refer to Section IV of Part A of the WMAP Provider Handbook for further information regarding recordkeeping.

Outpatient psychotherapy services are a covered benefit when provided under the following conditions:

- treatment is provided in accordance with the definition of psychotherapy;

  Psychotherapy is defined in HSS 101.03(145) Wis. Admin. Code, as "the treatment of an individual who is mentally ill or has medically significant emotional or social dysfunctions by a psychotherapy provider. The treatment is a planned and structured program based on information from a differential diagnostic examination and directed at the accomplishment of specified goals. The treatment goals may include removing, modifying, or retarding existing symptoms, mediating disturbed patterns of behavior, and promoting positive personal growth and development by enhancing the ability to adapt and cope with internal and external stresses."

- a differential diagnostic examination is performed by a certified psychotherapy provider. A physician's prescription is not required to perform the examination. Any WMAP certified psychotherapy provider may perform the differential diagnostic examination;

  A differential diagnostic examination is defined in HSS 101.03(42), Wis. Admin. Code, as "an examination and assessment of a recipient's emotional and social functioning which includes one or more of the following: neurological studies, psychological tests and psycho-social assessments."

- before the actual provision of psychotherapy services, a physician (this need not be a psychiatrist) prescribes the therapy in writing. Prescriptions must include the length of time that services are expected to be required. The length of time may be up to one year. New prescriptions are required after one year; and

- the provider who performs psychotherapy meets the requirements of a psychotherapy provider as described in Section I-B of this handbook and engages in face-to-face contact with the recipient for at least 5/6 of the time for which reimbursement is claimed.

B. **COVERED PSYCHOTHERAPY SERVICES** (continued)

Psychiatric Evaluation and Diagnostic Testing

Up to six hours of face-to-face psychiatric evaluation or diagnostic testing during a two year period may be provided without prior authorization. Time spent scoring and interpreting diagnostic tests and writing up the results of the evaluation are allowable parts of diagnostic testing. These six hours do not count towards the 15 hours or $500 prior authorization threshold for psychotherapy/AODA services. Evaluation and testing services provided to a recipient by any certified psychotherapy provider count toward the two year evaluation threshold.

Services by a psychiatrist or psychologist provided at the inpatient hospital setting and separately billed as a professional service are not subject to prior authorization.

When evaluation services by any combination of psychotherapy providers exceed six hours in a two-year period, the provider may seek prior authorization for the evaluation. Psychiatric evaluation and diagnostic testing in excess of six hours in a two-year period must be prior authorized to be paid as a psychiatric evaluation. Refer to Section III of this handbook for information on requesting prior authorization for psychiatric evaluation and testing.

Psychiatric evaluations in excess of six hours in a two year period that do not have prior authorization are denied and may be rebilled as limitation exceeded psychotherapy, or if the limit was exceeded because the services were provided by more than one provider, backdating of the prior authorization request may be allowed. Refer to Section III-G of this handbook for information on backdating prior authorization requests. Psychiatric evaluations and diagnostic testing services are not subject to a diagnosis restriction and do not require a referring/prescribing provider.

Allowable psychiatric evaluations and diagnostic testing services include:

- the initial differential diagnostic examination;
- assessments necessitated by changes in the individual's behavior, environment, physical or psychological condition which are required to determine whether changes need to be made in the recipient's treatment plan;
- assessments or evaluations which are performed with the recipient as a part of supervisory oversight;
- time spent in face-to-face contact with a recipient as part of a consultation requested by the primary psychotherapy provider;
- psychiatric evaluations which are required pursuant to legal proceedings to determine an individual's mental competency, if the recipient is not incarcerated at the time of the evaluation;
- evaluations or assessments which are performed on children or adolescents pursuant to legal proceedings to determine the necessity for out-of-home placement; and
- court appearances to defend against commitment.

Neuropsychological testing is considered a neurological service and is not subject to the policy described in this handbook. Procedure codes for neuropsychological testing may be billed by WMAP-certified physicians or psychologists.

B. COVERED PSYCHOTHERAPY SERVICES (continued)

Evaluation techniques and instruments are to include those which are accepted as the standard of practice (e.g., psychological testing instruments should be listed in the latest edition of the Mental Measurements Handbook). The provider must have training in the use of the particular instrument being employed.

Limitation-Exceeded Psychotherapy

Limitation-exceeded psychotherapy is used to bill allowable psychiatric evaluation and diagnostic testing services when any combination of providers has exceeded the six hour per two-year limit when evaluation services have not been prior authorized. The limitation-exceeded psychotherapy procedure codes, like psychiatric evaluations, are not subject to a diagnosis restriction and do not require a referring/prescribing provider. However, they do count toward the 15 hour/$500 yearly prior authorization threshold for psychotherapy/AODA services and are denied if this threshold has been exceeded and the provider does not have prior authorization. Refer to Section III of this handbook for information on requesting prior authorization for evaluations and diagnostic testing.

Services by a psychiatrist or psychologist provided at the inpatient hospital setting and separately billed as a professional service are not subject to prior authorization.

Individual Psychotherapy

Individual psychotherapy is covered when it meets the requirements for psychotherapy services above. Specialized forms of individual treatment, such as narcosynthesis, hypnotherapy, medical psychoanalysis, and biofeedback, should be performed by providers who have specific training and experience in the use of these techniques. Providers should refer to Appendix 3 of this handbook for information on who may bill for these procedures and limitations that may apply. Only one provider may bill for a particular treatment session.

Family Psychotherapy

Family psychotherapy is covered for the recipient, the recipient's immediate family member(s), and the recipient's significant others. Immediate family members include parents, foster parents, spouse, children, or foster children. The recipient who is the identified mental health client must be present in order for the session to be billed as family psychotherapy. Such a session may involve more than one recipient, but only one provider may bill for one recipient for a particular treatment session. No more than two providers may bill for the same family psychotherapy session.

Family psychotherapy without the recipient present is also covered for members of the recipient's immediate family as defined in the previous paragraph and must be billed under the procedure code for "Family Medical Psychotherapy (without recipient present)."

Group Psychotherapy

Group psychotherapy is defined as a session in which more than one but not more than ten individuals (they do not all need to be Medical Assistance recipients) receive psychotherapy services together from one or two providers. No more than two providers may be reimbursed for the same session, and they may not claim reimbursement for the same recipients in the group.

Group psychotherapy is considered a hospital service when provided to an inpatient and may not be separately billed as a professional service by any professional discipline. The recipient who is the identified mental health client must be present in the group in order for the session to be billed.

B. COVERED PSYCHOTHERAPY SERVICES (continued)

Emergency Psychotherapy

Emergency psychotherapy may be performed by a provider for a recipient even if the required prescription for treatment or prior authorization has not been obtained prior to the provision of care when the provider has reason to believe that the recipient is an immediate threat to him/herself or others. A prescription for the emergency treatment must be obtained within 48 hours of the time the emergency treatment was provided, excluding weekends and holidays. Emergency psychotherapy requires prior authorization before payment is made if the recipient has exceeded the 15 hour/ $500 limit for services in a calendar year. Refer to Section III of this handbook for information on requesting prior authorization.

Psychotherapy Medication Management (Medication Check)

Psychotherapy medication management is a covered service when provided by a physician or a registered nurse. Psychotherapy medication management includes the prescription, directions on the use of, and review of medication, with no more than minimal psychotherapy. When physicians or registered nurses provide chemotherapy management, they may also administer the medication.

Psychotherapy medication management is considered a hospital service when provided to hospital inpatients and may not be separately billed as a professional service.

C. COVERED AODA TREATMENT SERVICES

Requirements for AODA Treatment Services

Recordkeeping and General Requirements

The following recordkeeping requirements are taken from HSS 61 52(5)-(12), Wis. Admin. Code.

There shall be a case record for each recipient and contact register for all service inquiries.

The case recordkeeping format shall provide for consistency, facilitate information retrieval, and shall include the following:

1. Consent for treatment forms signed by the recipient.
2. Acknowledgement of program policies and procedures which is signed and dated by the recipient.
3. Reports from referring sources.
4. Results of all examinations, tests, and other assessment information.
   An assessment shall be done by members of the clinical staff and shall be clearly explained to the recipient and to the recipient's family, when appropriate, and must include the following:
   - identification of the alcohol or drug abused, frequency and duration of use, method of administration and relationship to the recipient's dysfunction; and
   - available information on the recipient's family, legal, social, vocational, and educational history.
5. Treatment plans
   Based on the assessment made of the recipient's needs, a written treatment plan shall be developed and recorded in the recipient's case record.

   A preliminary treatment plan shall be developed as soon as possible, but not later than five working days after the recipient's admission.

C. COVERED AODA TREATMENT SERVICES (continued)

Treatment may begin before completion of the plan.

The plan shall be developed with the recipient, and the recipient's participation in the development of treatment goals shall be documented.

The plan shall specify the services needed to meet the recipient's needs and attain the agreed upon goals.

The goals shall be developed with both short and long range expectations and written in measurable terms.

The plan shall describe criteria to be met for termination of treatment.

6. Medication records which shall allow for ongoing monitoring of all medications administered and the detection of adverse drug reactions. All medication orders in the recipient case record shall specify the name of the medication, dose, route of administration, frequency of administration, person administrating, and name of the physician who prescribed the medication.

7. Multidisciplinary case conference and consultation notes
Recipient progress and current status in meeting the goals set in the plan shall be reviewed by the recipient's treatment staff at regularly scheduled case conferences.

The date and results of the review and any changes in the treatment plan shall be written into the recipient's record.

The participants in the case conference shall be recorded in the case record.

8. Correspondence including all letters and dated notations of telephone conversations relevant to the recipient's treatment.

9. Consent for disclosure of information release forms.

10. Progress notes
Progress notes shall be regularly entered into the recipient's case record.

Progress notes shall include the following:

- chronological documentation of treatment given to the recipient which shall be directly related to the treatment plan;
- documentation of the recipient's response to and the outcome of treatment; and
- progress notes shall be dated and signed by the person making the entry.

11. Record of services provided which shall include summaries sufficiently detailed so that the person not familiar with the program may identify the types of services the recipient has received.

12. Discharge documentation
A discharge summary shall be entered in the recipient's case record within one week after termination of treatment.

The discharge summary shall include:

- a description of the reasons for discharge;

C. COVERED AODA TREATMENT SERVICES (continued)

- the recipient's treatment status and condition at discharge;
- a final evaluation of the recipient's progress towards the goals set forth in the treatment plan; and
- a plan developed, in conjunction with the recipient, regarding care after discharge and follow-up.

Based on reviews of recipient records, the WMAP believes that recordkeeping can be enhanced by the following good practices:

- including information in the assessment on previous treatment history and outcome, making sure the assessment materials support the diagnosis made, and updating assessment materials as new information becomes available, and
- including information in the discharge summary on the provider's response to non-compliance, including efforts to engage the recipient in treatment, when this was a factor in discontinuing treatment. Also, identify how a return to treatment might be most easily handled.

Refer to Section IV of Part A of the WMAP Provider Handbook for further information regarding recordkeeping.

Outpatient AODA treatment services are a covered benefit when provided under the following conditions:

1. the treatment services are in accordance with the definition of AODA treatment. AODA treatment services are defined in HSS 101.03(13), Wis. Admin. Code, as alcohol and other drug abuse treatment services provided by a certified provider to assist alcoholics and drug abusers and persons affected by problems related to the abuse of alcohol or drugs. Examples of AODA treatment services are client evaluation, orientation and motivation, treatment planning, consultation and referral, client education, individual counseling, group counseling and crisis intervention;

2. before the enrollment in an AODA treatment program, the recipient must receive a complete medical evaluation by a physician. The medical evaluation must be performed within 60 days prior to the first date of AODA services. The evaluation should include diagnosis, summary of present medical findings, medical history, and explicit recommendations and prescription by the physician for participation in the alcohol or drug abuse treatment program;

   This medical evaluation is not a differential diagnostic evaluation. Differential diagnostic evaluations are psychiatric evaluations. A medical evaluation is required to determine the recipient's medical conditions which may have a bearing on the suitability of the person for AODA treatment. The medical evaluation does not count toward the 15 hour/$500 psychotherapy prior authorization threshold or toward the six hour per 2 year limit on psychiatric evaluation.

3. the supervising physician or psychologist develops a treatment plan which relates to behavior and personality changes being sought and to the expected outcome of treatment; and

C. COVERED AODA TREATMENT SERVICES (continued)

4. the provider who performs alcohol and other drug abuse treatment meets the requirements of an AODA treatment provider as described in Section I-B of this handbook and engages in face-to-face contact with the recipient for at least 5/6 of the time for which reimbursement is claimed under the WMAP Program.

Individual AODA Therapy
Individual AODA therapy is a covered service when it meets the criteria listed in the section on "Requirements for AODA Treatment Services." Providers should refer to Appendix 3 of this handbook for information on who may bill for this service and limitations that may apply. Only one provider may bill for the same treatment session.

Family AODA Therapy
Family AODA therapy is covered for the recipient, the immediate member (or members) of the recipient's family, and the recipient's significant others. Immediate family members include parents, foster parents, spouse, children, or foster children. Such a session may involve more than one recipient, but only one provider may bill for one recipient for the same treatment session. No more than two providers may bill for the same family AODA psychotherapy session.

Group AODA Therapy
Group AODA therapy is defined as a session in which more than one but not more than ten individuals (they do not all need to be WMAP recipients) receive AODA therapy services together from one or two providers. No more than two providers may be reimbursed for the same session, and they may not claim reimbursement for the same recipients in the group.

Treatment of Affected Family Members
Treatment of recipients who are affected family members or significant others of individuals with alcohol and other drug abuse problems is covered as an AODA treatment service when the affected recipient has very recently been involved with

an active alcohol or drug abuser and has active treatment issues with the addicted individual regardless of whether the addicted person is still abusing alcohol or drugs, or is in treatment or recovery. The affected family member receiving treatment services must have an allowable ICD-9-cm diagnosis, as listed in Appendix 3 of this handbook. The affected family member may receive individual, group, or family therapy, and the appropriate AODA procedure code should be billed. Refer to Appendix 3 of this handbook for a list of allowable procedure codes.

If the affected individual requires treatment for the effects of his/her relationship with an addicted individual, but no longer are actively involved with that person, the treatment is considered psychotherapy and must meet the requirements listed in Section II-B of this handbook.

AODA Intensive Outpatient Treatment
The WMAP covers AODA intensive outpatient treatment as a 51.42 Board clinic service. Intensive outpatient service consists of a combination of individual, group, and family therapy offered for 4-16 hours per week for 4-16 weeks. Most of this service requires prior authorization. Refer to Section III-B and Appendices 9, 10 and 11 of this handbook for further information on requesting prior authorization for these services.

D. SERVICES PROVIDED TO RECIPIENTS DIAGNOSED AS MENTALLY RETARDED

Psychotherapy or AODA treatment services are not covered for individuals whose primary or only diagnosis is mental retardation (ICD-9-CM diagnosis 317-319). However, the WMAP recognizes that these individuals may have valid mental health or AODA problems distinct from the mental retardation. For purposes of coverage as a WMAP psychotherapy or AODA treatment service, the mental health or AODA diagnosis is considered primary in these situations. In addition to having an allowable ICD-9-CM diagnosis for the procedure billed, the recipient must be able to benefit from the particular treatment provided in order for the service to be reimbursable by the WMAP.

E. HEALTHCHECK "OTHER SERVICES"

The WMAP considers requests for medically necessary mental health/AODA services which are not specifically listed as covered services, or which are listed in this section as noncovered services, when the following conditions are met:

1. the provider verifies that a comprehensive HealthCheck screening has been performed;
2. the service is allowed under the Social Security Act as a "medical service";
3. the service is medically necessary and reasonable to correct or ameliorate a condition or defect which is discovered during a HealthCheck screening;
4. the service is noncovered under the current WMAP state plan; and
5. a service currently covered by the WMAP is not appropriate to treat the identified condition.

All requests for HealthCheck "Other Services" are subject to prior authorization. Refer to Section III-B of this handbook for information on requesting prior authorization.

F. REVIEW OF PSYCHIATRIC AND AODA INPATIENT STAYS

This handbook must be followed by physicians in private practice. Admitting physicians and hospitals are responsible for meeting the requirements in this section.

Prior to elective/urgent admissions and after emergency admissions, the following inpatient hospital stays must be reviewed by the Wisconsin Peer Review Organization (WIPRO):

- all AODA admissions;
- all elective psychiatric admissions; and
- all psychiatric admissions to inpatient hospital programs for individuals under age 21 in an IMD.

This review is used to evaluate the medical necessity of inpatient treatment for WMAP payment purposes. WIPRO makes final determinations of medical necessity of admissions that are "suspect" based on a retrospective review of the recipient's medical record. All psychiatric and AODA hospitalizations are subject to retrospective review by WIPRO based on selection criteria established by the WMAP. Providers should contact WIPRO directly at 1-800-833-7247, if there are questions about this review process. Refer to Appendix 21 of this handbook for additional information on the review process.

G. NONCOVERED SERVICES AND RELATED LIMITATIONS

As specified in HSS 107.13(2)(d), Wis. Admin. Code, the following services are not WMAP-covered outpatient psychotherapy clinic services:

- collateral interviews with persons other than the recipient's immediate family (parents, spouse and children, or for children in foster care, foster parents) and consultations, except as provided in HSS 107.06 (4)(c), Wis. Admin. Code;

G. NONCOVERED SERVICES AND RELATED LIMITATIONS (continued)

- psychotherapy for persons with the primary diagnosis of mental retardation, except when they experience psychological problems that necessitate psychotherapeutic intervention;
- psychotherapy provided in a recipient's home;
- self-referrals ("self-referral" means that a provider refers a recipient to an agency in which the provider has a direct financial interest, or to himself or herself acting as a practitioner in private practice, and
- court appearances except when necessary to defend against commitment.

As specified in HSS 107.13 (3)(d), Wis. Admin. Code, the following services are not WMAP-covered AODA clinic services:

- collateral interviews and consultations with persons other than the recipient's immediate family, except as provided in HSS 107.06 (4)(c), Wis. Admin. Code;
- court appearances except when necessary to defend against commitment; and
- detoxification provided in a social setting, as described in HSS 61.58, Wis. Admin. Code.

As specified in HSS 107.03, Wis. Admin. Code, the following services are not WMAP-covered services:

- psychiatric examinations and evaluations ordered by the court, following the conviction of a crime, pursuant to s. 972.15, Wis. Stats;
- services to a recipient who is an inmate of a public institution or services to a person 21 to 64 years of age who is a resident of an institution for mental diseases (IMD), unless the recipient is 21 years of age, was a resident of the IMD immediately prior to turning 21 and has been continuously a resident since then, unless the recipient is on convalescent leave from an IMD; and
- consultations between or among providers. Direct recipient contact for the purpose of performing an evaluation that forms the basis of a consultation is covered as noted in Section II-C of this handbook.

As specified in HSS 107.13(1)(f), Wis. Admin. Code, the following services are not WMAP-covered outpatient psychotherapy or AODA professional services when provided to hospital inpatients:

- services provided to a hospital inpatient by a master's level psychotherapist or AODA counselor are not separately reimbursable as mental health/AODA professional services when billed by an outpatient psychotherapy clinic; and
- group therapy and medication management are not separately reimbursable as professional mental health or AODA services when provided to a hospital inpatient.

As specified in HSS 107.13(2)(c), Wis. Admin. Code, outpatient psychotherapy services are not reimbursed if the recipient is receiving WMAP-covered community support program (CSP) services.

A. GENERAL REQUIREMENTS

Prior authorization procedures are designed to safeguard against unnecessary utilization of care, to promote the most effective and appropriate use of available services, and to assist in cost containment. Providers are required to seek prior authorization for certain specified services before delivery of that service, unless the service is provided on an emergency basis. Payment is not made for services provided either prior to the grant date or after the expiration date indicated on the approved prior authorization request form. If the provider renders a service which requires prior authorization without first obtaining authorization, the provider is responsible for the cost of the service.

Under normal circumstances, to receive reimbursement from the Wisconsin Medical Assistance Program (WMAP), prior authorization must be obtained before services are performed. However, in the case of provider or recipient retroactive eligibility, or the provision of a service requiring prior authorization which was performed on an emergency basis, retroactive prior authorization may be obtained. Refer to Section III-G of this handbook and Section VIII of Part A of the WMAP Provider handbook for additional information on retroactive prior authorization.

B. SERVICES REQUIRING PRIOR AUTHORIZATION

Psychiatric Evaluations and Diagnostic Testing

Psychiatric evaluations and diagnostic testing are limited to six hours per recipient in a two year period. Evaluation services by any combination of psychotherapy providers count toward this limit. Psychiatric evaluations and diagnostic testing in excess of six hours in a two year period, which are billed as limitation-exceeded psychotherapy, are also subject to the 15 hour or $500 threshold beyond which prior authorization is required. Therefore, providers require prior authorization for these services when they exceed these limits or when a series of testing alone may exceed the six hour limit. Services by a psychiatrist or psychologist provided at the inpatient hospital setting and separately billed as a professional service are not subject to prior authorization.

Providers requesting prior authorization for psychiatric evaluation and testing services must use the Prior Authorization Request Form (PA/RF) and Prior Authorization Evaluation and Testing Attachment (PA/ETA). Refer to Appendices 4 and 5c of this handbook for a sample PA/RF and completion instructions, to Appendices 12 and 13 of this handbook for a sample PA/ETA and completion instructions, and to Appendix 14 of this handbook for a summary of prior authorization guidelines.

Psychotherapy and AODA Treatment Services

Prior authorization is required for most mental health and Alcohol and Other Drug Abuse (AODA) treatment services after a recipient has accumulated 15 hours or $500 (whichever comes first) in allowed services in any calendar year. Appendix 3 of this handbook indicates outpatient psychotherapy services which accumulate toward this limit and which require prior authorization when services exceed 15 hours or $500 of allowed charges to an individual recipient in a calendar year. Outpatient hospital services for mental health or AODA treatment also accumulate towards this threshold. Services by a psychiatrist or psychologist provided at the inpatient hospital setting and separately billed as a professional service are not subject to prior authorization.

The allowed dollar amount is calculated based upon the lesser of the billed amount or the maximum allowable fee for the service as established by the WMAP. Services reimbursed by any health insurance payer count toward this limit. Reimbursement to any outpatient psychotherapy or AODA provider is included when calculating the 15 hours or $500 of allowed service for each individual.

B. SERVICES REQUIRING PRIOR AUTHORIZATION (continued)

Providers requesting prior authorization for psychotherapy services must use the PA/RF and the Prior Authorization/Psychotherapy Attachment (PA/PSYA). Refer to Appendices 4 and 5a of this handbook for a sample PA/RF and completion instructions, to Appendices 6 and 7 of this handbook for a sample PA/PSYA and completion instructions, and to Appendix 8 of this handbook for a summary of prior authorization guidelines.

Providers requesting prior authorization for AODA treatment services must use the PA/RF and the Prior Authorization/AODA Attachment (PA/AA). Refer to Appendices 4 and 5b of this handbook for a sample PA/RF and completion instructions, to Appendices 9 and 10 of this handbook for a sample PA/AA and completion instructions, and to Appendix 11 of this handbook for a summary of prior authorization guidelines.

Emergency Psychotherapy

Although emergency psychotherapy may be provided without first obtaining prior authorization, as described in Section II-B of this handbook, claims for emergency psychotherapy require prior authorization before payment is made if the 15 hour/$500 limit for services in a calendar year has been exceeded. Claims submitted for emergency psychotherapy services which exceed the prior authorization threshold and which do not indicate a valid prior authorization number are denied. Providers should use the standard psychotherapy prior authorization request forms (refer to Appendices 5 and 7 of this handbook) to receive a prior authorization number for emergency services which have been provided. Up to eight hours of emergency psychotherapy in a two-week period may be authorized. The prior authorization request must be received by EDS within two weeks of performance of emergency psychotherapy, must request backdating, and must justify the need for emergency treatment.

Concurrent Mental Health/AODA Prior Authorizations

Prior authorization is normally only granted to one provider at a given time. However, concurrent prior authorizations may be approved for separate providers providing mental health and AODA services. Concurrent prior authorization requests must meet the following requirements:

- The prior authorization requests must clearly indicate that each provider is aware of the services being provided by the other, and that these services are being coordinated.
- Justification must be given for having services provided by separate providers.
- The overall intensity of service must be within the range ordinarily approved for outpatient mental health/AODA (e.g., intensive AODA outpatient treatment is generally not approved concurrently with one to two hours of family psychotherapy per week, but one 2-hour AODA group therapy session plus one 1-hour individual psychotherapy session may be approved).

Concurrent Outpatient Mental Health and Medical Day Treatment Services

Outpatient psychotherapy or AODA therapy may be provided concurrently with medical day treatment services which are considered medically necessary and appropriate when the following conditions are met:

1. the recipient's diagnosis is appropriate for both services (refer to the guidelines used to process prior authorization requests);
2. there is documentation that the providers are communicating with each other about the recipient's needs, the treatment is coordinated, and the outpatient and day treatment services augment one another; and

B. SERVICES REQUIRING PRIOR AUTHORIZATION (continued)

3. when one of the following statements is true:

   a. there is a pre-existing relationship between the recipient and the outpatient provider;

   b. the recipient has appropriate day treatment needs, but the recipient also has a need for specialized intervention which the day treatment staff is not trained to provide; or

   c. the recipient is transitioning from day treatment to outpatient services.

The day treatment provider is required to request prior authorization for any day treatment services requested for a recipient who is also receiving outpatient services.

In general, a recipient who is able to benefit from outpatient services does not require as high a level of day treatment services and the consultant may modify the hours requested based on clinical judgement.

HealthCheck "Other Services"

All requests for services under the HealthCheck "Other Services" benefit require prior authorization. Providers should submit a PA/RF indicating the description of the service (but leaving blank the section requesting the procedure code, as one is assigned by EDS) and the number of hours of service requested. To expedite processing of the request, write "HealthCheck Other Services" or "HOS" in red ink at the top of the PA/RF. The provider must submit documentation that the recipient received a comprehensive HealthCheck screening in the past year. A physician's prescription for the particular treatment service is required. Additional information documenting the recipient's need for the service and the appropriateness of the service being delivered must be supplied by the provider.

C. WHEN TO REQUEST PRIOR AUTHORIZATION

Because a provider may have no way of knowing whether or not a recipient has received services from another provider and has, therefore, reached the prior authorization threshold, providers are encouraged to request prior authorization as soon as possible when providing psychotherapy or AODA services. Because the WMAP ordinarily grants prior authorization to only one psychotherapy/AODA provider at a time, making the prior authorization request helps protect the provider against potential denial of services.

Any part of the 15 hours or $500 of services which may be reimbursed without prior authorization that is not used, remains available for use by the recipient for the remainder of the calendar year.

Providers are advised that prior authorization does not guarantee payment. Provider eligibility and recipient eligibility on the date of service, as well as all other WMAP requirements must be met prior to payment of the claim.

Non-billing performing providers (master's degree psychotherapists or AODA counselors) requesting prior authorization must indicate the group or clinic provider name and number as the billing provider on the Prior Authorization Request Form (PA/RF).

D. PRIOR AUTHORIZATION CRITERIA

Appendices 8, 11, and 14 of this handbook summarize the criteria which are used to process prior authorization requests for psychotherapy, AODA, and psychiatric evaluations and testing. A copy of the complete guidelines used to process prior authorization requests may be obtained by writing to:

D. PRIOR AUTHORIZATION CRITERIA (continued)

Mental Health/AODA Policy Analyst
Bureau of Health Care Financing, Room 250
Division of Health
Post Office Box 309
Madison, WI 53701

Prior authorization requests may be returned to providers for additional information when the initial request does not contain adequate information to process the prior authorization request. Returned requests are not denials. Providers are responsible for providing adequate, updated, information to allow the mental health/AODA consultants to determine the appropriateness of the service being requested. The additional information must be added to the returned request and resubmitted to EDS. Do not complete a new PA/RF.

E. PROCEDURES FOR OBTAINING PRIOR AUTHORIZATION

Section VIII of Part A of the WMAP Provider Handbook identifies procedures for obtaining prior authorization including emergency situations, appeal procedures, supporting materials, retroactive authorization, recipient loss of eligibility midway in treatment, and prior authorization for out-of-state providers.

The appropriate prior authorization request forms and attachments along with their completion and submittal instructions are given in Appendices 4, 5, 6, 7, 9, 10, 12 and 13 of this handbook.

Completed prior authorization request forms must be submitted to:

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

Prior authorization request forms may be obtained by submitting a written request to:

EDS
Attn: Claim Reorder Department
6406 Bridge Road
Madison, WI 53784-0003

Please specify the prior authorization form requested and the number of forms desired. Reorder forms are included in the mailing of each request for forms. Do not request forms by telephone.

F. SERVICE INTERRUPTIONS

If a provider is unable to utilize all prior authorized services during the prior authorization grant period due to unforeseeable interruptions in service (e.g., recipient illness or vacation), the provider may request an extension of the grant period. The provider should write a letter indicating the change requested and the reason and attach it to a copy of the PA/RF and send these to the EDS Prior Authorization Unit. Gaps in service exceeding one month require special justification.

If a recipient transfers to another mental health or AODA provider before the expiration of a prior authorization period, the provider should notify the EDS Prior Authorization Unit of the exact date care is terminated so that a new prior authorization may be granted.

G. GRANT DATES AND BACKDATING FOR PRIOR AUTHORIZATIONS

Determination of Grant Dates

The prior authorization grant date (i.e., the first date of service which may be reimbursed under the authorization), is the date the prior authorization request is reviewed by the WMAP mental health consultant, or the date the request is first received by EDS if this date is deemed appropriate for continuity of care reasons by the WMAP mental health consultant. See Section VIII of Part A of the WMAP Provider Handbook.

Procedures for Backdating Prior Authorization Requests

Backdating of prior authorization requests up to two weeks prior to the date the prior authorization request is received at EDS may be allowed at the discretion of the WMAP mental health consultant. The provider must request backdating and must indicate the clinical rationale for the request on the prior authorization attachment or in a narrative submitted with the prior authorization request.

Backdating for Services by Multiple Providers Exceeding the Prior Authorization Threshold

Providers may request backdating of prior authorizations to cover services which are denied because they exceeded the prior authorization threshold. In these cases, authorization may be granted for services provided more than two weeks prior to the receipt of the prior authorization request at EDS. Requests for backdating prior authorization are considered if the following conditions are met:

- More than one provider must have provided service during the period for which backdating is requested;
- The provider must document an inability to obtain information from the recipient or other provider which would have allowed the provider to determine that prior authorization would have been required.

A. COORDINATION OF BENEFITS

The Wisconsin Medical Assistance Program (WMAP) is the payer of last resort for any WMAP-covered service. If the recipient is covered under health insurance (including Medicare), the WMAP reimburses that portion of the allowable cost remaining after all other health insurance sources have been exhausted. Refer to Section IX of Part A of the WMAP Provider Handbook for more detailed information on services requiring health insurance billing, exceptions, and the "Other Coverage Discrepancy Report."

Psychotherapy and AODA services provided to a recipient which have been paid for by another health insurance payer count toward the yearly 15 hour/$500 threshold beyond which prior authorization is required.

B. MEDICARE/ MEDICAL ASSISTANCE DUAL ENTITLEMENT

Recipients covered under both Medicare and Medical Assistance are referred to as dual-entitlees. Claims for Medicare-covered services provided to dual-entitlees must be billed to Medicare prior to billing Medical Assistance.

If the recipient has Medicare, but Medicare benefits are not available (e.g., Medicare benefits exhausted), a Medicare disclaimer code must be indicated on the claim, as indicated in the claim form instructions in Appendix 1 of this handbook.

C. MEDICARE QMB-ONLY

Qualified Medicare Beneficiary only (QMB-only) recipients are only eligible for WMAP payment of the coinsurance and the deductibles for Medicare-covered services. Since Medicare does cover some psychotherapy/AODA services, claims submitted for QMB-only recipients for Medicare-allowed services may be reimbursed.

D. BILLED AMOUNTS

Providers must bill the WMAP their usual and customary charge for services provided, that charge being the amount charged by the provider for the same service when provided to private-pay patients. For providers using a sliding fee scale for specific services, usual and customary means the median of the individual provider's charge for the service when provided to non-Medical Assistance patients. Providers may not discriminate against Medical Assistance recipients by charging a higher fee for the service than is charged to a private-pay patient.

The billed amount should not be reduced by the amount of recipient copayment. The applicable copayment amount is automatically deducted from the payment allowed by the WMAP.

Providers should refer to Appendix 1 of this handbook for complete billing instructions.

E. CLAIM SUBMISSION

Paperless Claim Submission

As an alternative to submission of paper claims, EDS is able to process claims submitted on magnetic tape (tape-to-tape) or through telephone transmission via modem. Claims submitted electronically have the same legal requirements as claims submitted on paper and are subjected to the same processing requirements as paper claims. Providers submitting electronically may usually reduce their claim submission errors. For additional information on paperless claim submission, complete the form found in Appendix 20 of this handbook or contact the Electronic Media Claims (EMC) Department at:

EDS
Attn: EMC Department
6406 Bridge Road
Madison, WI 53784-0009
(608) 221-4746

E. CLAIM SUBMISSION (continued)

Paper Claim Submission

Claims for psychotherapy and AODA services must be submitted using the National HCFA 1500 claim form. Sample claim forms and completion instructions may be found in Appendices 1 and 2 of this handbook.

Claims for psychotherapy and AODA services submitted on any other paper form than the HCFA 1500 claim form are denied.

The HCFA 1500 claim form is not provided by the WMAP or EDS. It may be obtained from a number of forms suppliers.

One such source is:

State Medical Society Services
Post Office Box 1109
Madison, WI 53701
(608) 257-6781 (Madison Area)
1-800-362-9080 (Toll-Free)

Completed claims submitted for payment must be mailed to the following address:

EDS
6406 Bridge Road
Madison, WI 53784-0002

Submission of Claims

All claims for services rendered to eligible WMAP recipients must be received by EDS within 365 days from the date the service was rendered. Claims for coinsurance and deductible for services rendered to recipients covered by both Medicare and Medical Assistance must be received by EDS within 365 days from the date of service, *or* within 90 days from the Medicare EOMB date, whichever is later. (Refer to Section IX of Part A of the WMAP Provider Handbook for exceptions to the 90-day extension.) This policy applies to all initial claim submissions, resubmissions, and adjustment requests.

Exceptions to the claim submission deadline and requirements for submission to Late Billing Appeals may be found in Section IX of Part A of the WMAP Provider Handbook.

F. TYPES OF PROVIDERS

Billing Providers

Psychotherapy clinics, psychiatrists, psychologists, AODA clinics and physicians are issued billing performing provider numbers which may be used to independently bill the WMAP. All claims must indicate the billing performing provider name and number on the HCFA 1500 claim form. Services performed by the billing performing provider may be billed by:

- Indicating the billing performing provider name and number in element 33 of the HCFA 1500 claim form (in which case all payment is made directly to the billing performing provider.)

NOTE: Staff providing services in a 51.42 Board Owned-and-Operated psychotherapy or AODA clinic which are billed to the WMAP must meet the certification criteria in Section I-B of this handbook but do not need to be individually certified by the WMAP.

F. TYPES OF PROVIDERS (continued)

Non-Billing Providers (Master's Degree Psychotherapists or AODA Counselors)
Master's degree psychotherapists and AODA counselors are issued non-billing performing provider numbers which may not be used to independently bill the WMAP. All claims must be billed under the group or clinic provider name and number. Services performed by the non-billing performing provider may be billed by:

- Indicating the group or clinic provider name and number in element 33 of the HCFA 1500 claim form (in which case all payment is made directly to the group or clinic provider number.)

NOTE: Staff providing services in a 51.42 Board Owned-and Operated psychotherapy or AODA clinic which are billed to the WMAP must meet the certification criteria in Section I-B of this handbook but do not need to be individually certified by the WMAP.

G. DIAGNOSIS CODES

All diagnoses listed on the HCFA 1500 claim form must be from the International Classification of Diseases, 9th Edition, Clinical Modifications (ICD-9-CM) coding structure. An allowable diagnosis code must be indicated for each procedure performed. Refer to Appendix 3 of this handbook for allowable diagnoses for specific procedure codes.

Claims received without the appropriate ICD-9-CM code are denied.

The complete ICD-9-CM code book may be ordered by writing to the address listed in Appendix 3 of Part A of the WMAP Provider Handbook.

Providers should note the following diagnosis code restrictions:

- Codes with an "E" prefix must not be used as the primary or sole diagnosis on a claim submitted to the WMAP.
- Codes with an "M" prefix are not acceptable on a claim submitted to the WMAP.

Providers should note that the Prior Authorization Request Form (PA/RF) also requires ICD-9 diagnosis codes, but the prior authorization attachment forms request the most recent version of DSM diagnosis code.

H. PROCEDURE CODES

HCFA Common Procedure Coding System (HCPCS) codes are required on all psychotherapy and AODA claims. Claims or adjustments received without HCPCS codes are denied. Allowable HCPCS codes for psychotherapy and AODA services are included in Appendix 3 of this handbook.

I. PSYCHOTHERAPY MEDICATION MANAGEMENT (MEDICATION CHECK)

Up to 30 minutes of psychotherapy medication management may be billed per date of service and up to one hour per calendar month.

J. FOLLOW-UP TO CLAIM SUBMISSION

It is the responsibility of the provider to initiate follow-up procedures on claims submitted to EDS. Processed claims appear on the Remittance and Status Report either as paid, pending, or denied. Providers are advised that EDS takes no further action on a denied claim until the information is corrected and the claim is resubmitted for processing. If a claim was paid incorrectly, the provider is responsible for submitting an adjustment request form to EDS. Section X of Part A of the WMAP Provider Handbook includes detailed information regarding:

- the Remittance and Status Report;

J. FOLLOW-UP TO CLAIM SUBMISSION (continued)

- adjustments to paid claims;
- return of overpayments;
- duplicate payments;
- denied claims; and
- Good Faith claims filing procedures.

MENTAL HEALTH AND ALCOHOL AND OTHER DRUG ABUSE SERVICES
APPENDICES

MENTAL HEALTH AND ALCOHOL AND OTHER DRUG ABUSE SERVICES
APPENDICES
(continued)

Page #

APPENDIX 1
NATIONAL HCFA 1500 CLAIM FORM COMPLETION INSTRUCTIONS FOR 51.42 BOARD OPERATED PSYCHOTHERAPY/ ALCOHOL AND OTHER DRUG ABUSE SERVICES
(For Claims Received on or after January 4, 1993)

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 "M" 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
Health insurance must be billed prior to billing the WMAP, unless the service does not require health insurance billing according to Appendix 18a of Part A of the WMAP Provider Handbook.

- When the provider has not billed health insurance because the "Other Coverage" of the recipient's Medical Assistance identification card is blank, the service does not require health insurance billing according to Appendix 18a of Part A of the WMAP Provider Handbook, or the recipient's Medical Assistance identification card indicates "DEN" only, this element must be left blank.

- When "Other Coverage" of the recipient's Medical Assistance identification card indicates HPP, BLU, WPS, CHA, or OTH, and the service requires health insurance billing according to Appendix 18a of Part A of the WMAP Provider Handbook, 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 in part by health insurance. The amount paid by health insurance to the provider or the insured is indicated on the claim.

  OI-D DENIED by health insurance following submission of a correct and complete claim, or payment was applied towards the coinsurance and deductible. DO NOT use this code unless the claim in question was actually billed to the private insurer.

  OI-Y YES, card indicates other coverage but it was not billed for reasons including, but not limited to:

  - the recipient denies coverage or will not cooperate;
  - the provider knows the service in question is noncovered by the carrier;
  - health insurance failed to respond to initial and follow-up claim; or
  - benefits not assignable or cannot get an assignment.

- 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 HMO or HMP. The amount paid is indicated on the claim.

  OI-H HMO or HMP does not cover this service or the billed amount does not exceed the coinsurance or deductible amount.

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. Services covered by an HMO or HMP are not reimbursable by the WMAP except for the copayment and deductible amounts. Providers who receive a capitation payment from the HMO may not bill the WMAP for services which are included in the capitation payment.

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.

Code Description

M-1 Medicare benefits exhausted. This disclaimer code may be used by hospitals, nursing homes, and home health agencies when Medicare has made payment up to the lifetime limits of its coverage.

M-5 Provider not Medicare certified for the benefits provided.

M-6 Recipient not Medicare eligible.

M-7 Medicare disallowed (denied) payment. Medicare claim cannot be corrected and resubmitted.

M-8 Medicare was not billed because Medicare never covers this service.

If Medicare is not billed because the recipient's Medical Assistance identification card indicated no Medicare coverage, this element must be left blank.

If Medicare allows an amount on the recipient's claim, the Explanation of Medicare Benefit (EOMB) must be attached to the claim and this element must be left blank. Do not enter Medicare paid amounts on the claim form. Refer to Appendix 17 of Part A of the WMAP Provider Handbook for further information regarding the submission of claims for dual entitlees.

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. For psychotherapy/AODA services, the prescribing physician's name is required for all services except evaluation (W8931-W8933) and limitation exceeded psychotherapy (W8987). If a psychiatrist is the referring or prescribing provider and the performing provider, the psychiatrist's name must be entered in this element.

ELEMENT 17a - I.D. NUMBER OF REFERRING PHYSICIAN
When required, enter the referring provider's six-character UPIN number. If the UPIN number is not available, enter the WMAP provider number or license number of the referring provider.

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

ELEMENT 19 - RESERVED FOR LOCAL USE (not required)

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. The primary diagnosis must be entered first and must be one of the allowable diagnosis codes for psychotherapy and AODA services found in Appendix 3 of this handbook. The diagnosis description is not required.

A manifestation ("M") code is not an acceptable diagnosis code. Etiology ("E") codes may not be used as a primary diagnosis.

ELEMENT 22 - MEDICAID RESUBMISSION (not required)

ELEMENT 23 - PRIOR AUTHORIZATION
Enter the seven-digit prior authorization number from the approved prior authorization request form. Do not attach a copy of the prior authorization to the claim. 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.
- All procedures have the same emergency indicator.

ELEMENT 24B - PLACE OF SERVICE
Enter the appropriate WMAP single-digit place of service code for each service. Refer to Appendix 16 of this handbook for a list of allowable place of service codes.

ELEMENT 24C - TYPE OF SERVICE CODE
Enter the appropriate single-digit type of service code. Refer to Appendix 16 of this handbook for a list of allowable type of service codes.

ELEMENT 24D - PROCEDURES, SERVICES, OR SUPPLIES
Enter the appropriate five-character procedure code. Refer to Appendix 3 of this handbook for the list of allowable procedure codes.

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 on each line item. A decimal must be indicated when a fraction of a whole unit is billed.

For all 51.42 board operated psychotherapy/AODA services, except chemotherapy management (W8937 or W8938), one unit equals one hour. However, services should be billed in tenths of an hour, based on six-minute increments.

For chemotherapy management, one unit equals 15 minutes. Providers may round to the nearest whole unit (up to two units per date of service) or bill fractions of a unit.

Refer to Appendix 17 of this handbook for rounding guidelines to be used when submitting claims.

ELEMENT 24H - EPSDT/FAMILY PLANNING
Enter an "H" for each procedure that was performed as the result of to a HealthCheck (EPSDT) referral. Otherwise, leave this element blank.

ELEMENT 24I - EMG
Enter an "E" for each procedure performed as an emergency, regardless of the place of service. Otherwise, leave this element blank.

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. Any other information entered in this element may cause claim denial.

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
If the services were provided to a recipient in a nursing home (place of service 7 or 8), indicate the nursing home's eight-digit Medical Assistance provider number.

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.

APPENDIX 2a

51.42 BOARD PSYCHOTHERAPY SERVICES

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

1 MEDICARE (Medicare #) | MEDICAID M (Medicaid #) | CHAMPUS (Sponsor's SSN) | CHAMPVA (VA File #) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. 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: MM DD YY | SEX M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 609 Willow

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street):

CITY: Anytown | STATE: WI

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ] | Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

CITY | STATE

ZIP CODE: 55555 | TELEPHONE (Include Area Code): (XXX) XXX-XXXX

ZIP CODE | TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): OI-P

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: M-1

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) [ ] YES [ ] NO

a. INSURED'S DATE OF BIRTH MM DD YY | SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY | SEX M [ ] F [ ]

b. AUTO ACCIDENT? [ ] YES [ ] NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? [ ] YES [ ] NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [ ] YES [ ] NO *If yes*, return to and complete item 9 a-d.

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.

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 _____

14. DATE OF CURRENT: MM DD YY ◀ ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: I.M.Referring

17a. I.D. NUMBER OF REFERRING PHYSICIAN: 12345678

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? [ ] YES [ ] NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE): 296.35

1. ____ 3. ____

2. ____ 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 OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 02 20 92	27	3	1	W8928		1	XX XX	2.0				
2 03 01 92		3	1	W8938		1	XX XX	1.0				
3												
4												
5												
6												spenddown XX.XX

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [ ]

26. PATIENT'S ACCOUNT NO.: 1234JED

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [ ] YES [ ] NO

28. TOTAL CHARGE: $ XXX XX

29. AMOUNT PAID: $ XX XX

30. BALANCE DUE: $ XX 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.Provider MM/DD/YY

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 #

I.M.Billing
100 W. Williams
Anytown, WI 55555

PIN# GRP# 87654321

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) **PLEASE PRINT OR TYPE** FORM HCFA-1500 (U2) (12-90) FORM OWCP-1500 FORM RRB-1500

APPENDIX 2b
51.42 BOARD AODA SERVICES

PICA — **HEALTH INSURANCE CLAIM FORM** — PICA

CARRIER

PATIENT AND INSURED INFORMATION

1 MEDICARE (Medicare #) MEDICAID (Medicaid #) M CHAMPUS (Sponsor's SSN) CHAMPVA (VA File #) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)		1a. INSURED'S I.D. 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; SEX M X F	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street): 609 Willow	6. PATIENT RELATIONSHIP TO INSURED: Self Spouse Child Other	7. INSURED'S ADDRESS (No., Street)
CITY: Anytown; STATE: WI	8. PATIENT STATUS: Single Married Other; Employed Full-Time Student Part-Time Student	CITY; STATE
ZIP CODE: 55555; TELEPHONE (Include Area Code): (XXX) XXX-XXXX		ZIP CODE; TELEPHONE (INCLUDE AREA CODE): ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): OI-P	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER: M-8
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO	a. INSURED'S DATE OF BIRTH MM DD YY; SEX M F
b. OTHER INSURED'S DATE OF BIRTH MM DD YY; SEX M F	b. AUTO ACCIDENT? YES NO; PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, return to and complete item 9 a-d.
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. 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 _____
14. DATE OF CURRENT MM DD YY; ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: I.M.Referring	17a. I.D. NUMBER OF REFERRING PHYSICIAN: 12345678	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? YES NO; $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. 303.91 2. 3. 4.		22. MEDICAID RESUBMISSION CODE; ORIGINAL REF. NO 23. PRIOR AUTHORIZATION NUMBER: 1234567

PHYSICIAN OR SUPPLIER INFORMATION

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 OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 01 14 92 21 28	3	1	W8975		1	XXX XX	3.0				
2 01 14 92	3	1	W8979		1	XX XX	3.0				
3											
4											
5											
6											spenddown XX.XX

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
	1234JED		$ XXX XX	$ XX XX	$ 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.)	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 #
I.M.Provider MM/DD/YY SIGNED DATE		I.M.Billing 100 W. Williams Anytown, WI 55555 PIN# GRP# 87654321

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) **PLEASE PRINT OR TYPE** FORM HCFA-1500 (U2) (12-90) FORM OWCP-1500 FORM RRB-1500

APPENDIX 3
WMAP ALLOWABLE PROCEDURE CODES FOR 51.42 BOARD PROVIDERS

The following table lists the HCPCS procedure codes and descriptions to be used for billing mental health and AODA services, who may bill the codes, what limitations apply, and their allowable diagnoses. The only allowable type of service is TOS 1.

Proc. Code	Description	Who May Provide Service	Limitations**	Allowable Diagnoses
W8927	Individual/Family Psychotherapy	Ph.D.	PA	290-316
W8928	Individual/Family Psychotherapy	M.S.	PA, ***	290-316
W8930	Individual/Family Psychotherapy	M.D.*	PA	290-316
W8931	Psychiatric Evaluation	Ph.D.	6 hrs./2 yrs.	All
W8932	Psychiatric Evaluation	M.S.	6 hrs./2 yrs, ***	All
W8933	Psychiatric Evaluation	M.D.*	6 hrs./2 yrs.	All
W8934	Group Psychotherapy	Ph.D.	PA, ***	290-316
W8935	Group Psychotherapy	M.S.	PA, ***	290-316
W8936	Group Psychotherapy	M.D.*	PA, ***	290-316
W8937	Psychotherapy Medication Management (Medication Check) (15 minutes)	R.N.	30 min./day 4/month,***	290-316
W8938	Psychotherapy Medication Management (Medication Check) (15 minutes)	M.D.	2/day 4/month,***	290-316
W8972	Individual/Family AODA	Ph.D.	PA	290-316

* Physician must be a psychiatrist in order to bill this code.

** Codes with the "PA" limitation accumulate toward the 15 hours/$500 yearly threshold per recipient beyond which prior authorization is required.

*** POS 1 (inpatient hospital) is NOT an allowable Place of Service.

NOTE: Prior authorization is not required for services provided at the inpatient hospital setting (POS 1).

Proc. Code	Description	Who May Provide Service	Limitations**	Allowable Diagnoses
W8973	Individual/Family AODA	M.S.	PA, ***	290-316
W8974	Individual/Family AODA	M.D.	PA	290-316
W8975	Individual/Family AODA	A.C.	PA, ***	290-316
W8976	Group AODA	Ph.D.	PA, ***	290-316
W8977	Group AODA	M.S.	PA, ***	290-316
W8978	Group AODA	M.D.	PA, ***	290-316
W8979	Group AODA	A.C.	PA, ***	290-316
W8987	Limitation-Exceeded Psychotherapy/AODA Evaluation	M.D.,* Ph.D., M.S.	PA	All

* Physician must be a psychiatrist in order to bill this code.

** Codes with the "PA" limitation accumulate toward the 15 hours/$500 yearly threshold per recipient beyond which prior authorization is required.

*** POS 1 (inpatient hospital) is NOT an allowable Place of Service.

NOTE: Prior authorization is not required for services provided at the inpatient hospital setting (POS 1).

APPENDIX 4
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.

126 - Psychotherapy
128 - AODA Services

ELEMENT 2 - RECIPIENT'S MEDICAL ASSISTANCE IDENTIFICATION NUMBER
Enter the 10-digit Medical Assistance recipient identification number as found on the recipient's Medical Assistance identification card.

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

ELEMENT 4 - RECIPIENT'S ADDRESS
Enter the address of the recipient's place of residence; the street, city, state, and zip code must be included. If the recipient is a resident of a nursing home or other facility, also include the name of the nursing home or facility.

ELEMENT 5 - RECIPIENT'S DATE OF BIRTH
Enter the recipient's date of birth in MM/DD/YY format (e.g., June 8, 1941, would be 06/08/41), as it appears on the recipient's Medical Assistance identification card.

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

ELEMENT 7 - BILLING PROVIDER'S NAME, ADDRESS AND ZIP CODE
Enter the name and complete address (street, city, state, and zip code) of the billing provider. No other information should be entered in this element since it also serves as a return mailing label. Non-billing performing providers (master's degree psychotherapists or AODA counselors) must indicate the clinic name and number as the billing provider.

ELEMENT 8 - BILLING PROVIDER'S TELEPHONE NUMBER
Enter the telephone number, including the area code, of the office, clinic, facility, or place of business of the billing provider. Non-billing performing providers (master's degree psychotherapists or AODA counselors) must indicate the clinic telephone number.

ELEMENT 9 - BILLING PROVIDER'S MEDICAL ASSISTANCE PROVIDER NUMBER
Enter the eight-digit Medical Assistance provider number of the billing provider. Non-billing performing providers (master's degree psychotherapists or AODA counselors) must indicate the eight-digit Medical Assistance provider number of the clinic.

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 International Classification of Disease, 9th Edition, Clinical Modification (ICD-9-CM) diagnosis code and description additionally descriptive of the recipient's clinical condition. A diagnosis code is not required on prior authorization requests for psychiatric evaluation or diagnostic tests.

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 HCPCS procedure code for each service requested in this element.

ELEMENT 15 - MODIFIER (not required)

ELEMENT 16 - PLACE OF SERVICE
Enter the appropriate single-digit place of service code designating where the requested service would be performed. Refer to Appendix 16 of this handbook for a list of allowable place of service codes.

ELEMENT 17 - TYPE OF SERVICE
Enter the appropriate type of service code for each service requested. Refer to Appendix 16 of this handbook for a list of allowable type of service codes.

ELEMENT 18 - DESCRIPTION OF SERVICE
Enter a written description corresponding to the appropriate HCPCS procedure code for each service requested.

ELEMENT 19 - QUANTITY OF SERVICE REQUESTED
Enter the number of hours requested for each service.

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 Terms of Provider Reimbursement issued by the Department of Health and Social Services.

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 eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment is not made for services initiated prior to approval or after authorization expiration. Reimbursement is in accordance with Wisconsin Medical Assistance Program payment methodology and Policy. If the recipient is enrolled in a WMAP-contracted managed care program at the time a prior authorized service is provided, WMAP reimbursement is allowed only if the service is not covered by the managed care program.

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 RESERVED FOR THE WISCONSIN MEDICAL ASSISTANCE PROGRAM CONSULTANT(S) AND ANALYST(S).

APPENDIX 5A

PRIOR AUTHORIZATION REQUEST FORM (PA/RF)

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

PRIOR AUTHORIZATION REQUEST FORM
PA/RF (DO NOT WRITE IN THIS SPACE)
ICN #
A.T. #
P.A. # 1234567

1 PROCESSING TYPE: 126

2 RECIPIENT'S MEDICAL ASSISTANCE ID NUMBER: 1234567890

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

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

5 DATE OF BIRTH: MM/DD/YY

6 SEX: M [ ] F [X]

8 BILLING PROVIDER TELEPHONE NUMBER: (XXX) XXX-XXXX

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

9 BILLING PROVIDER NO.: 87654321

10 DX: PRIMARY: 296.35 - Major Depressive Disorder

11 DX: SECONDARY: 309.00 - Adjustment Disorder

12 START DATE OF SOI: N/A

13 FIRST DATE RX: N/A

14 PROCEDURE CODE	15 MOD	16 POS	17 TOS	18 DESCRIPTION OF SERVICE	19 QR	20 CHARGES
W8928		3	1	Individual/Family Psychotherapy	19	XXX.XX
					TOTAL CHARGE	21 XXX.XX

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

23 MM/DD/YY (DATE) 24 I.M. Provider (REQUESTING PROVIDER SIGNATURE)

(DO NOT WRITE IN THIS SPACE)

AUTHORIZATION:

[ ] APPROVED — GRANT DATE — EXPIRATION DATE — PROCEDURE(S) AUTHORIZED — QUANTITY AUTHORIZED

[ ] MODIFIED — REASON:

[ ] DENIED — REASON:

[ ] RETURN — REASON:

DATE — CONSULTANT/ANALYST SIGNATURE

PA12118KJF/HB3

APPENDIX 5B

PRIOR AUTHORIZATION REQUEST FORM (PA/RF)

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

PRIOR AUTHORIZATION REQUEST FORM
PA/RF (DO NOT WRITE IN THIS SPACE)
ICN #
A.T. #
P.A. # 1234567

1 PROCESSING TYPE: 128

2 RECIPIENT'S MEDICAL ASSISTANCE ID NUMBER: 1234567890

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

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

5 DATE OF BIRTH: MM/DD/YY

6 SEX: M [X] F [ ]

8 BILLING PROVIDER TELEPHONE NUMBER: (XXX) XXX-XXXX

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

9 BILLING PROVIDER NO.: 87654321

10 DX: PRIMARY: 303.91 - Alcohol Dependent

11 DX: SECONDARY: 296.2 - Depressive Disorder

12 START DATE OF SOI: N/A

13 FIRST DATE RX: N/A

14 PROCEDURE CODE	15 MOD	16 POS	17 TOS	18 DESCRIPTION OF SERVICE	19 QR	20 CHARGES
W8979		3	1	Group AODA	60	XXX.XX
W8975		3	1	Individual/Family AODA	4	XXX.XX
					TOTAL CHARGE	21 XXX.XX

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

23 MM/DD/YY (DATE)

24 I.M. Provider (REQUESTING PROVIDER SIGNATURE)

(DO NOT WRITE IN THIS SPACE)

AUTHORIZATION:

[ ] APPROVED — GRANT DATE — EXPIRATION DATE — PROCEDURE(S) AUTHORIZED — QUANTITY AUTHORIZED

[ ] MODIFIED — REASON:

[ ] DENIED — REASON:

[ ] RETURN — REASON:

DATE

CONSULTANT/ANALYST SIGNATURE

PA12118KJF/HB3

APPENDIX 5C

PRIOR AUTHORIZATION REQUEST FORM (PA/RF)

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

PRIOR AUTHORIZATION REQUEST FORM
PA/RF (DO NOT WRITE IN THIS SPACE)
ICN #
A.T. #
P.A. # 0123456

1 PROCESSING TYPE: 126

2 RECIPIENT'S MEDICAL ASSISTANCE ID NUMBER: 1234567890

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

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

5 DATE OF BIRTH: MM/DD/YY

6 SEX: M [ ] F [X]

8 BILLING PROVIDER TELEPHONE NUMBER: (XXX) XXX-XXXX

7 BILLING PROVIDER NAME, ADDRESS, ZIP CODE:
Board Owned-and-Operated Outpatient Psychotherapy Clinic
2 East Williams
Anytown, WI XXXXX

9 BILLING PROVIDER NO.: 12345678

10 DX: PRIMARY

11 DX: SECONDARY

12 START DATE OF SOI: N/A

13 FIRST DATE RX: N/A

14 PROCEDURE CODE	15 MOD	16 POS	17 TOS	18 DESCRIPTION OF SERVICE	19 QR	20 CHARGES
W8931		3	1	Psych Evaluation of Hospital Records	2 hrs.	XX.XX
					TOTAL CHARGE	21 XX.XX

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

23 MM/DD/YY (DATE) 24 I.M. Provider (REQUESTING PROVIDER SIGNATURE)

(DO NOT WRITE IN THIS SPACE)

AUTHORIZATION:

[ ] APPROVED — GRANT DATE — EXPIRATION DATE — PROCEDURE(S) AUTHORIZED — QUANTITY AUTHORIZED

[ ] MODIFIED — REASON:

[ ] DENIED — REASON:

[ ] RETURN — REASON:

DATE — CONSULTANT/ANALYST SIGNATURE

PA12118KJF/HB3

APPENDIX 6
PRIOR AUTHORIZATION PSYCHOTHERAPY ATTACHMENT (PA/PSYA) 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:

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

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

GENERAL INSTRUCTIONS:

The information contained on this prior authorization psychotherapy attachment is used to make a decision about the amount and type of psychotherapy which is approved for continued Medical Assistance reimbursement. Please complete each section as completely as possible and include any material which you believe is of help in understanding the necessity for the services you are requesting. Where noted in these instructions, you may substitute material which you may have in your records for the information requested on the form.

When submitting the first prior authorization request for a particular individual, please fill out page one and two. For continuing authorization on the same individual, it is not necessary to rewrite page one, unless new information has caused you to change any of the information on this page (e.g., a different diagnosis, belief that intellectual functioning is in fact significantly below average). When there has been no change in the page one information, please submit a photocopy of this page along with your updated page two. Medical consultants reviewing the prior authorization request have before them a file containing the previous requests; therefore, updates and progress need to reflect changes only from the information contained on the previous request.

Prior authorization for psychotherapy is not granted when another provider already has a prior authorization in place for psychotherapy services to the same recipient. In these cases, the recipient must request that the previous provider notify EDS that they have discontinued treatment with the recipient. The new provider must complete both page one and two for the initial prior authorization request.

RECIPIENT INFORMATION:

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

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

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

ELEMENT 4 - RECIPIENT'S MEDICAL ASSISTANCE IDENTIFICATION NUMBER
Enter the recipient's 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., 45, 60, 21, etc.).

PROVIDER INFORMATION:

ELEMENT 6 - PERFORMING PROVIDER NAME AND CREDENTIALS
Enter the name and credentials of the therapist who will be providing treatment (e.g., I.M. Provider, M.D. or I.M. Provider Ph.D.).

ELEMENT 7 - PERFORMING PROVIDER'S MEDICAL ASSISTANCE NUMBER
Enter the eight-digit Medical Assistance provider number of the performing provider. (Not required for 51.42 Board-operated clinics.)

ELEMENT 8 - PERFORMING PROVIDER'S TELEPHONE NUMBER
Enter the telephone number, including area code, of the performing provider.

ELEMENT 9 - SUPERVISING PROVIDER'S NAME
Enter the name of the physician or psychologist who is supervising the treatment if the performing provider is a master's level therapist.

ELEMENT 10 - SUPERVISING PROVIDER'S MEDICAL ASSISTANCE NUMBER
Enter the eight-digit Medical Assistance provider number of the physician or psychologist who is supervising the treatment if the performing provider is a master's level therapist. (Not required for 51.42 Board-operated clinics.)

ELEMENT 11 - PRESCRIBING PROVIDER'S NAME
Enter the name of the physician who wrote the prescription for psychotherapy.

ELEMENT 12 - PRESCRIBING PROVIDER'S MEDICAL ASSISTANCE NUMBER
Enter the eight-digit Medical Assistance provider number of the physician who wrote the prescription for psychotherapy. If the physician is not WMAP-certified, enter the physician's name.

DOCUMENTATION:

A. DIAGNOSIS: Enter the diagnosis codes and descriptions from the most recent version of DSM. Axis IV and V are optional, but are strongly encouraged when a provider is requesting a continuing authorization for a recipient.

B. DATE TREATMENT BEGAN: Date of first treatment by this provider.

C. DIAGNOSED BY: Indicate the procedure(s) used to make the diagnosis.

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

E. RESULTS OF CONSULTATION: Summarize the results of this consultation or attach a copy of the consultant's report.

F. PRESENTING SYMPTOMS: Enter the presenting symptoms and indicate their degree of severity. This information may also be provided as part of an intake summary which you may attach to this request form.

G&H. INTELLECTUAL FUNCTIONING: Indicate whether intellectual functioning is significantly below average (e.g., I.Q. below 80). If "yes," indicate the IQ or intellectual functioning level.

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

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

K. PRESENT MENTAL STATUS/SYMPTOMATOLOGY: Indicate the recipient's current mental status and symptoms. For continuing authorization requests, indicate the progress that has been made since the beginning of treatment or since the previous authorization. This information may be supplied in the form of an intake summary or a treatment summary as long as the summary presents a crystallization of the progress to date. It is

not acceptable to send progress notes which do not summarize the progress to date.

L. UPDATED HISTORICAL DATA: For continuing requests, indicate any new information about the recipient's history which may be relevant to a determination of the need for continued treatment.

M. TREATMENT MODALITIES: Indicate the treatment modalities to be used.

N. NUMBER OF MINUTES PER SESSION: Indicate the length of session for each modality.

O&P. FREQUENCY OF REQUESTED SESSIONS AND TOTAL NUMBER OF SESSIONS YOU ARE REQUESTING: If you are requesting sessions more than once a week, please indicate the need for this. If you anticipate a series of treatment which is not regular (e.g., frequent sessions for a few weeks, with treatment tapering off thereafter), indicate the total number of hours of treatment you are requesting, the time period over which you are requesting the treatment, and the expected pattern of treatment. The total hours must match the quantity(ies) indicated on the PA/RF.

EXAMPLE: 15 hours of treatment is requested over a 12-week period. The recipient attends a one and one-half hour group every other week (6 groups for a total of 9 hours). There are individual sessions of one hour weekly for four weeks, and every other week for the next four weeks (6 individual sessions for a total of 6 hours).

Q. PSYCHOACTIVE MEDICATION: Indicate all the medications the recipient is taking which may be affecting the symptoms you are treating. Indicate whether a medication review has been done in the past three months.

R. RATIONALE FOR FURTHER TREATMENT: Indicate the symptoms or problems in functioning that require further treatment. If recipient has not progressed in treatment thus far, indicate reasons for believing that continued treatment is of help.

S. GOALS/OBJECTIVES OF TREATMENT: A treatment plan may be attached in response to this item.

T. STEPS TO TERMINATION: Indicate how you are preparing the recipient for termination. When available, indicate a planned date of termination.

U. FAMILY MEMBERS: If an individual provider is seeing more than one family member in individual psychotherapy, this requires adequate justification.

RECIPIENT AUTHORIZATION: Signature indicates the signer has read the form. Signature is optional.

* *

In addition to the above information, we need the following to process your prior authorization request:

1. The performing provider(s) signature on the PA/PSYA. Read the Prior Authorization Statement before dating and signing the attachment.

2. The supervising provider's signature is required only if the performing provider is not a physician or psychologist.

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

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

APPENDIX 7

PRIOR AUTHORIZATION PSYCHOTHERAPY ATTACHMENT (PA/PSYA)

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

PA/PSYA

PRIOR AUTHORIZATION PSYCHOTHERAPY ATTACHMENT

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

RECIPIENT INFORMATION

(1) Last Name	(2) First Name	(3) MI	(4) Medical Assistance Identification Number	(5) Age
RECIPIENT	IM	A	1234567890	26

PROVIDER INFORMATION

(6) Performing Provider Name	(7) Performing Provider #	(8) Performing Provider's Telephone Number	Discipline (circle one)
I.M. PERFORMING		XXX-XXX-XXXX	MSW (MS) MD PHD DO PSYCH Other:

(9) Supervising Provider's Name	(10) Supervising Provider's Number	(11) Prescribing Provider's Name	(12) Prescribing Provider's Number
I.M. SUPERVISING		I. M. PRESCRIBING	12345678

A. Diagnosis: DSM-III-R Axis I: a)major depression, recurrent, in partial remission 296.35
b) Adjustment disorder with depressed mood. 309.00
Axis II: Rule out Historonic Personality disorder.
Axis III: Seizure disorder.
Axis IV: 1 2 3 (4) 5 6 7 8 9 0 (optional)
Axis V: (past year) 50 (optional) Highest GAF past year: 75

B. Date Treatment Began: 09/18/90 with this provider.

C. Diagnosed By: X Clinical Exam __ Psychological Testing X Other (specify): MAST Hookings Symptom Checklist 90.

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

E. Result(s) of Consultation: Medication & assessed for ability to progress in psychotherapy which was seen as positive.

F. Presenting Symptoms: Insomnia, anergy: suicidal ideation, history of 1 attempt 2 yrs ago, much guilt and self reproach.
Severity: __ Mild X Moderate __ Severe

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

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

I. Historical Data. Give relevant social and school history including development (if under 18), treatment history, past mental status, diagnosis(es), etc. (attach additional sheets if necessary): Im is from a step-family home with the step-father being "alcoholic." She was 14 years old when her step-brother committed suicide. Reported history of physical & sexual abuse in family of origin. Long history of depressed mood. Diagnosed as having major depression 1 yr ago when hospitalized at Anytown Hospital in Anytown, WI (12/03/89-12/31/89). No further treatment history. Seeking out help at this time due to husband being accused of abusing her 3 children. At time of hospitalization, reported being very suicidal & having some auditory hallucinations. Denies AODA usage. Currently well-groomed, pleasant, no signs of psychomotor retardation. Thought and speech intact. Very tearful. Admits to suicidal thoughts; no plans. Oriented in all spheres. (See attached intake summary sheet for additional history.)

APPENDIX 7 (Continued)

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

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

L. Updated/historical data (family dynamics, living situation, etc.):
Client is considering divorce. Still separated at this time. Client's 3 children live with her and this has increased stress. We will begin to see her with children on an as needed basis.

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

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

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

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

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

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

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

S. Goals/objectives of treatment:
1. Continue to support & monitor mood; promote a positive self-image.
2. Continue to help in dealing with stress thru teaching cognitive as well as relaxation techniques for stress management.
3. Increase self-awareness of own past abuse and it's realtionship to current reality.
4. Begin to help with parenting skills.

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

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

J. M. Performing, MS		J. M. Supervising	MM/DD/YY
Signature of Performing Provider	Recipient Signature (optional)	Signature of Supervising Provider	Date

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

APPENDIX 8
SUMMARY OF OUTPATIENT PSYCHOTHERAPY PRIOR AUTHORIZATION GUIDELINES (FOR USE WITH THE PRIOR AUTHORIZATION PSYCHOTHERAPY ATTACHMENT: PA/PSYA)

Authorization for outpatient psychotherapy is granted for individuals with an appropriate DSM diagnosis, where the documentation provided supports the treatment requested. Normative authorization is for up to one 60-minute individual session per week and/or one 60-120 minute group session per week for significantly functionally disabling symptoms. Authorization usually spans a period of 13 weeks, but where therapy is non-intensive (one to two sessions per month) authorization may be for a longer period. Authorization may also be granted for a specified number of hours over the time span requested which may be used at the provider's discretion (e.g., 20 hours over a 13 week period).

Where the recipient is clearly a suicidal or homicidal risk, up to one session per day may be authorized for a short period of time. Emergency psychotherapy may be performed without prior authorization for up to eight hours in a two week period when the provider has reason to believe that harm to the recipient or others may be imminent. Authorization is conditional upon the provider expeditiously seeking authorization (within two weeks of the completion of the emergency service) and justifying the need for the emergency psychotherapy.

The following DSM diagnostic categories are generally not expected to yield to psychotherapeutic treatment alone and require extensive justification.

- mental retardation (317-319) cannot be approved if this is the primary or only diagnosis
- organic mental disorders/dementia (290.0-290.4, 310-310.9)
- alcohol related disorders (291-291.9, 303-303.9, 305.0) and drug related disorders (292.0-292.9, 304.0-304.9, 305.2-305.9): requests in these categories must demonstrate that psychotherapeutic intervention alone has a reasonable probability of remediating the disease which is diagnosed as indicated by history, previous response to treatment, etc.
- schizophrenia/delusional (paranoid) disorders and psychotic disorders not elsewhere classified (295.1-295.9, 297.3, 297.10, 298.8, 298.9). Requests in this category must demonstrate an understanding of the importance of supportive psychotherapy, community support services, family intervention and medication management.
- other disorders which experience has demonstrated are refractory to psychotherapy (e.g., some personality disorders [301]), are transitory or self-limiting (e.g., adjustment disorders [309]), or in which psychotherapy is considered to be controversial.

Other Considerations:

- emphasis on family treatment is favored where conditions affect more than one family member and family issues are involved.
- requests for extension of authorization must include information updated within the past authorization period in all specific clinical areas of the prior authorization request form. Requests returned for more information do not constitute a denial of services. Providers are responsible for sending adequate, updated information to allow processing of the prior authorization request.
- therapy by two or more providers simultaneously is ordinarily not allowed.

APPENDIX 9

INSTRUCTIONS FOR THE COMPLETION OF THE PRIOR AUTHORIZATION AODA ATTACHMENT (PA/AA)

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:

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

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

RECIPIENT INFORMATION:

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

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

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

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

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

PROVIDER INFORMATION:

ELEMENT 6 - PERFORMING PROVIDER'S NAME AND CREDENTIALS
Enter the name and credentials of the therapist who will be providing treatment.

ELEMENT 7 - PERFORMING PROVIDER'S MEDICAL ASSISTANCE PROVIDER NUMBER
Enter the eight-digit Medical Assistance provider number of the performing provider. (Not required for providers in 51.42 Board-operated clinics.)

ELEMENT 8 - PERFORMING PROVIDER'S TELEPHONE NUMBER
Enter the telephone number, including area code, of the performing provider.

ELEMENT 9 - REFERRING/PRESCRIBING PROVIDER'S NAME
Enter the eight-digit Medical Assistance provider number of the provider referring/prescribing treatment. If the provider is not WMAP-certified, enter the provider's name.

ELEMENT 10 - REFERRING/PRESCRIBING PROVIDER'S NUMBER
Enter the eight-digit Medical Assistance provider number of the referring/prescribing provider, if available.

* *

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

- PART A - Designate the type of treatment requested (i.e., primary intensive outpatient treatment; aftercare/follow-up service or affected family member/co-dependency treatment). Identify the types of sessions, duration and schedule. The total hours must match the quantity(ies) indicated on the PA/RF.

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

- PART B - Complete elements 1-10.

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

1. Attach a copy of the signed and dated prescription for AODA services. The initial presentation must be dated and signed within three months of receipt by EDS. Subsequent prescriptions must be dated within twelve months of receipt by EDS.

   NOTE: **If a physician will be the performing provider, a prescription need not be attached.**

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

3. The recipient's signature is optional.

4. The attachment must be dated and signed by the provider requesting/providing the service.

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

APPENDIX 10

PRIOR AUTHORIZATION AODA SERVICES ATTACHMENT (PA/AA)

Mail To:

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

PA/AA

PRIOR AUTHORIZATION
AODA SERVICES ATTACHMENT

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

RECIPIENT INFORMATION

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

PROVIDER INFORMATION

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

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

PART A **TYPE OF TREATMENT REQUESTED:**

☒ **PRIMARY INTENSIVE OUTPATIENT TREATMENT**

- ☒ Individual ☒ Group ☒ Family
- Number of minutes per session: 60 Individual 180 Group 60 Family
- Sessions will be: ☐ Twice/month ☐ Once/week ☐ Once/month ☒ Other (specify) 5X/WK
- Requesting 16 hrs/week, for 4 weeks
- Anticipated beginning treatment date 01/03/91
- Estimated intensive treatment termination date 02/01/91
- Attach a copy of treatment design, which includes the following:
  (a) Schedule of treatment (day, time of day, length of session and service to be provided during that time)
  (b) Description of aftercare/follow-up component

Group 3 HR/day, 5 days/week
Ind. 2-1 HR sessions
Family 2-1 HR sessions

☐ **AFTERCARE/FOLLOWUP SERVICE**

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

☐ AFFECTED FAMILY MEMBER/CO-DEPENDENCY TREATMENT

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

PART B

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

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

   12/15/90

3. Specify diagnostic procedures employed:

   12/21/90 - INTAKE ALCOHOLISM CHECKLIST & CLINICAL INTERVIEW.

303.91 ALCOHOL DEPENDENCE-CONTINUOUS AS MANIFESTED BY MALADAPTIVE PATTERN OF USE FOR 3 YEARS, BLACKOUTS, LOSS OF CONTROL, LEGAL AND FAMILY PROBLEMS ASSOCIATED WITH DRINKING.

296.2 MAJOR DEPRESSIVE DISORDER

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

CLIENT HAS DECIDED TO RECEIVE TREATMENT AND COMMITTED HIMSELF TO ABSTINENCE FROM ALL MIND/MOOD ALTERING CHEMICALS. CLIENT HAS HAD A PATTERNED USE WHICH INCLUDED DRINKING 4-5X/WK CONSUMING 6-18 BEERS PER DRINKING BOUT. CLIENT REPORTS BEING INTOXICATED AT LEAST 1X WEEK. CLIENT BEGAN TRYING TO CONTROL HIS DRINKING ABOUT 2 YEARS AGO AFTER BEING ARRESTED FOR DRUNK DRIVING. SINCE THAT TIME HE HAS RECEIVED ONE OTHER DWI CONVICTION. CLIENT REPORTS GUILT AND SHAME ABOUT HIS BEHAVIOR. HE REPORTS PERIODS OF VIOLENCE WHILE INTOXICATED WHICH OCCURED IN HIS FAMILY. IN ADDITION, CLIENT REPORTS A POSITIVE GENETIC HISTORY FOR ALCOHOLISM, CLAIMING THAT HIS FATHER IS ALCOHOLIC.

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

CLIENT LIVES WITH HIS FAMILY. HIS WIFE REPORTS SHE HAS BEEN CONCERNED ABOUT HIS DRINKING FOR 6 YEARS AND HAS ONLY RECENTLY REPORTED HER CONCERN TO HER SPOUSE. THE CHILDREN IN THE FAMILY CONSISTS OF A 13 Y/O SON AND A 10 Y/O DAUGHTER. THE 13 Y/O WAS VERY QUIET DURING THE FAMILY ASSESSMENT AND DENIED ANY CONCERN ABOUT HIS DAD'S DRINKING. THE DAUGHTER WAS ABLE TO EXPRESS HER WORRY AND ATTEMPTS TO DISCONTINUE HER DAD'S DRINKING. (i.e. HIDING HIS BEER). THE FAMILY AGREED TO ATTEND OUR EDUCATIONAL NIGHT AND ALSO AGREED TO PERIODIC FAMILY SESSIONS. THEY DECIDED AT THIS TIME NOT TO BE INVOLVED WITH MORE INTENSIVE TREATMENT.

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

1) CLIENT WILL LEARN BASIC INFORMATION ON ALCOHOLISM.
2) CLIENT WILL BE ABLE TO SHARE HIS DRINKING HISTORY TO GROUP BY THE 2ND WEEK.
3) CLIENT WILL VERBALIZE & IDENTIFY SELF AS ALCOHOLIC.
4) CLIENT WILL CONTINUE ABSTINENCE FROM ALCOHOL.
5) CLIENT WILL DEVELOP A SELF-HELP PROGRAM.
6) CLIENT WILL VERBALIZE IN HIS FAMILY HIS OWN HISTORY WITH ALCOHOL.
7) CLIENT WILL BEGIN TO IDENTIFY & EXPRESS FEELINGS.
8) CLIENT WILL OBTAIN A SPONSOR BY TERMINATION DATE.

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

CLIENT WILL CONTINUE TO DEVELOP AND MAINTAIN A SOBER LIFESTYLE. CLIENT WILL ALSO PARTICIPATE IN OUR 12 WEEK AFTERCARE PROGRAM. CLIENT WILL RETURN TO GAINFUL EMPLOYMENT.

Recipient Authorization

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

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

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

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

10. O. M. Performing — Signature of Performing Provider
Alcohol and Drug Counselor — Discipline of Performing Provider

I.M. SUPERVISING — Name of Supervising Provider
87654321 — Provider Number of Supervising Provider

I. M. Supervising — Signature of Supervising Provider
MM/DD/YY — Date

PA04180L_JF/HB3

APPENDIX 11
SUMMARY OF OUTPATIENT AODA AND AODA INTENSIVE OUTPATIENT TREATMENT PRIOR AUTHORIZATION GUIDELINES (FOR USE WITH THE AODA SERVICES ATTACHMENT: PA/AA)

Severity of Illness Indicators

Outpatient AODA and AODA intensive outpatient treatment may be authorized for individuals with a DSM diagnosis of alcohol dependence (303.9), drug dependency (304.0-304.9), or alcohol or other drug abuse (305.0, or 305.2-305.9) when they meet the severity of illness criteria. Among the criteria for adults are:

- the recipient's family environment or living situation is stable enough to permit benefit from outpatient treatment and family members or significant others are supportive of the recipient's recovery goals (or recipient is able to find alternative sources of support).

- the recipient's psychological state is stable enough to permit benefit from treatment or those psychological difficulties that are present are most closely related to the recipient's chemical abuse rather than to another psychological condition.

- the recipient's chemical abuse results in behavioral deterioration, damaged social functioning, or loss of vocational or educational performance.

- the recipient admits an alcohol/drug problem, recognizes the adverse impact the abuse is having on his/her life, and shows sufficient personal responsibility to comply with treatment and is willing to do so.

For adolescents, additional criteria include:

- school environment is stable enough to permit benefit from outpatient treatment.

- family issues may be addressed by program staff or through appropriate referrals.

All recipients must demonstrate:

- a history of recent chemical abuse, the ability to maintain short-term abstinence goals or the potential for relapse which could result in physical or personal harm.

- their physical condition is sufficiently stable to permit benefit from treatment.

Additional Documentation

The provider must document the recipient's AODA treatment history, if any, including outcomes, for the 12 months preceding the request. The treatment plan must contain measurable active treatment goals and objectives and must note any special needs of the recipient. Requests returned for more information do not constitute a denial of service. The provider is responsible for sending adequate, updated information to allow processing of the prior authorization request.

Normative Authorization for Outpatient AODA

Authorization for adults is generally for no more than one to two therapy contacts per week totalling one to three hours. Group therapy is considered the modality of choice. For adolescents not more than two to three contacts per week totalling three to five hours are authorized. Group and family therapy are the modalities of choice. Individual therapy sessions of 60 minutes are considered if documentation is provided to support such a request. Authorization is generally granted for a three month period. Where therapy is non-intensive, authorization may be for up to a six month period.

Additional Instructions for Requests for AODA Intensive Outpatient Treatment

The severity of illness criteria for recipients for whom intensive outpatient treatment is requested needs to justify the more intensive treatment. It is assumed that the program design is appropriate for achieving the intended results.

The treatment plan should reflect the following:

- Indication of the family's involvement in the treatment plan.

- The concept of abstinence from alcohol and drugs.

- Involvement in self-help groups for on-going support.

- A plan for aftercare for 6-12 months following intensive outpatient treatment.

Normative Authorization for AODA Intensive Outpatient Treatment
Services are authorized for 4-16 hours a week for 4-16 weeks (e.g., up to 64 hours over an appropriate period of time; 16 hours a week for 4 weeks). A copy of the program design should be submitted along with the request in order that the consultant may determine that the program elements (individual, group, family sessions) are appropriate to the needs of the recipient.

Intensive treatment is generally not authorized if the recipient participated in the same or a similar program in the past 12 months.

If the recipient is receiving other treatment (such as psychotherapy or day treatment for the mentally ill) at the same time as AODA intensive outpatient treatment, this should be indicated. The request should justify the need for such services and indicate how they are coordinated. However, a recipient may not be in AODA intensive outpatient service and intensive mental health day treatment (more than 10 hours per week) concurrently.

Services to Affected Family Members
Services to individuals who have a problem resulting from their relationship to an individual who has been an active alcohol or drug abuser may be reimbursed as AODA services if the individual has an allowable ICD-9-CM diagnosis (as noted in Appendix 3 of this handbook), and their involvement with the alcohol or drug abuser has been very recent. These services may be provided by a certified AODA counselor. Normative authorization is for weekly group, individual, or family therapy.

Services to affected family members who have not recently been involved with an alcohol or other drug abuser are considered psychotherapy services and are subject to the requirements for psychotherapy services.

APPENDIX 12

INSTRUCTIONS FOR THE COMPLETION OF THE PRIOR AUTHORIZATION EVALUATION AND TESTING ATTACHMENT (PA/ETA)

****

The information contained on the Prior Authorization Evaluation and Testing (PA/ETA) Attachment will be used to make a decision about the amount and type of evaluation and testing which will be approved for Medical Assistance reimbursement. Please complete each section as completely as possible and include any material which you believe will be of help in understanding the necessity for the services you are requesting. Where noted in these instructions, you may substitute material which you may have in your records for the information requested on the form. The timely determination of authorization is significantly enhanced by the completeness and quality of the documentation submitted. Complete this attachment form, attach it to the Prior Authorization Request Form (PA/RF) and submit to the following address:

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

When the provider performing the evaluation or testing services will also be providing psychotherapy services or when the psychotherapy provider is employed by the same agency as the person providing the evaluation or testing, and both will be billed by that agency, the prior authorization psychotherapy attachment (PA/PSYA) must be submitted along with the PA/ETA. One PA/RF may be used indicating the appropriate procedure codes for all requested services. This will simplify future billing by having all services under one prior authorization number which may then be billed on the same claim form.

However, if the evaluation or testing is being performed by a provider whose services are not being billed by the same agency, then separate PA/RFs must be submitted with the appropriate attachments. In these cases, a separate prior authorization number is assigned for the evaluation or testing services and the psychotherapy services, and the services will need to be billed on separate claim forms.

Questions regarding the completion of the PA/RF and/or the PA/ETA may be addressed to EDS' Telephone/Written Correspondence Unit.

RECIPIENT INFORMATION

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

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

ELEMENT 3 - RECIPIENT'S MIDDLE INITIAL
Enter the recipient's middle initial exactly as it appears on the recipient's Medical Assistance Identification card.

ELEMENT 4 - RECIPIENT'S MEDICAL ASSISTANCE IDENTIFICATION NUMBER
Enter the recipient's 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 - PERFORMING PROVIDER NAME
Enter the name of the therapist who will be performing the evaluation or testing.

ELEMENT 7 - PERFORMING PROVIDER NUMBER
Enter the eight-digit Medical Assistance provider number of the performing provider. (Not required for providers in 51.42 Board-operated clinics.)

ELEMENT 8 - PERFORMING PROVIDER TELEPHONE NUMBER
Enter the telephone number, including area code, of the performing provider.

ELEMENT 9 - PERFORMING PROVIDER CREDENTIALS
Indicate the credentials of the performing provider.

DOCUMENTATION

A. TYPE OF EVALUATION/TESTING AND RATIONALE

Document the type of evaluation being requested and why it is needed. For instance, the evaluation may be a competency examination or it may be necessitated by the need to confirm a diagnosis. If the recipient was referred for evaluation, indicate who made the referral and why. Indicate how the results of the evaluation or testing will be used. Indicate how the recipient will benefit (e.g., indicate if the evaluation might be used to place the recipient in a less restrictive setting, or to obtain guardianship which would be in the recipient's best interests). **Providers requesting retroactive authorization must document the emergency situation or the court order that justifies such a request and indicate the initial date of service.**

B. TECHNIQUES OR INSTRUMENTS TO BE USED

Indicate the specific tests, instruments or procedures which will be used to conduct the testing or evaluation. These tests, instruments or procedures must be those accepted as standard of practice for the psychiatrist/psychologist (e.g., proposed psychological testing instruments should be listed in the latest edition of the Mental Measurements Handbook).

C. OTHER EVALUATIONS

The provider needs to indicate what other evaluations or testing they are aware of that have been done on the recipient in the past two years and why the current request is not duplicative. Where possible attach copies of the evaluations or tests or summaries of their results.

A physician's prescription is not required for evaluation and testing services.

APPENDIX 13

PRIOR AUTHORIZATION EVALUATION AND TESTING ATTACHMENT

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

PA/ETA

PRIOR AUTHORIZATION EVALUATION AND TESTING ATTACHMENT

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

RECIPIENT INFORMATION

(1) Last Name	(2) First Name	(3) MI	(4) Medical Assistance Identification #	(5) Age
Recipient	Im	A	1234567890	72

PROVIDER INFORMATION

(6) Performing Provider Name	(7) Performing Provider #	(8) Performing Provider Telephone #	(9) Discipline (circle one)
I.M. Provider		(XXX)XXX-XXXX	M.D. (Ph.D.) Other:

A. Indicate the type of evaluation being requested and why this evaluation is needed (if this was a referral, indicate who made the referral). Be specific as to how the recipient will benefit from this evaluation.

An in-depth clinical evalutation is requested which may include appropriate psychological tests to determine recipient's competency and need for guardianship. Four months ago the patient suffered her second CVA (stroke) and presents with both confusion and depression. It is necessary to determine the extent of her cognitive impairment in order to determine whether guardianship should be recommended to the court. The recipient will benefit by having appropriate oversight and protection if her competence to act in her own behalf is found to be impaired (especially in medical decisions, which presently is most problematic since she wants to leave the nursing home but cannot give herself the twice daily insulin shots).

(continued on opposite side)

B. Indicate the techniques or instruments that will be used to conduct the evaluation.

An in-depth clinical interview will be the initial step in this evaluation. If the results are unclear, further psychological testing would be done as is appropriate, possibly to include the Hooper V.O.T., Bender, WAIS, aphasia screening, etc.

C. Indicate other evaluations which you are aware of that have been conducted on this recipient in the past two years. Indicate why requested evaluation does not duplicate earlier evaluations.

Eighteen months ago the patient had an in-depth evalutaion to determine the reasons for lack of compliance to her diabetic diet. It was determined that she mourned the loss of functioning in her left leg and arm because of her stroke two years ago. With the focus being a situational/adaptional one, she underwent three months of brief psychotherapy since, despite her age, testing showed her to be a good treatment candidate. Therapy was moderately successful as she religiously stuck to her diet following therapy.

J. M. Performing, Ph.D. MM/DD/YY

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

APPENDIX 14
SUMMARY OF PRIOR AUTHORIZATION GUIDELINES FOR THE PRIOR AUTHORIZATION EVALUATION AND TESTING ATTACHMENT (PA/ETA)

Prior authorization for evaluation and testing is targeted for necessary testing and evaluation subsequent to a differential diagnostic examination. These situations include:

- A significant change in a recipient's clinical status, which requires evaluation in order to ascertain the need for a change in the treatment plan.
- New information appears during treatment (e.g., abuse) which requires more in-depth assessment.
- A change, or potential change, in the recipient's environment (parental separation, possible need for more restrictive placement) for which evaluation is needed to plan intervention.
- Assessment is ordered by the court (e.g., for competency hearing).

Except in extraordinary circumstances, authorization is only granted to psychiatrists and psychologists.

In requesting authorization the provider must:

- Clearly document the need for the evaluation and its potential benefit to the recipient.
- Indicate the specific techniques and instruments which are used in the evaluation. These techniques must conform to usual standards of practice.
- Document other evaluations the provider is aware of which have been performed during the previous two years and demonstrate that the requested evaluation is not duplicative of these.

Requests may be returned to the provider if the information submitted does not allow processing of the prior authorization request. Returned requests are not denials. Providers should attempt to provide all the information requested on the attachment form (PA/ETA).

When all conditions are met, authorization is generally granted for the requested number of hours as long as this time corresponds with the usual and customary time to conduct such evaluations. Providers are reimbursed according to the rates of reimbursement which apply to their provider type and specialty for the evaluation procedure code being billed. Providers are allowed one month to complete evaluations unless they specifically request a longer period of time and document the rationale for this.

Evaluations which are court-ordered following a criminal conviction are not covered WMAP services.

APPENDIX 1S
COPAYMENT SCHEDULE FOR PSYCHOTHERAPY AND AODA SERVICES

Psychotherapy/AODA Services
Outpatient psychotherapy/AODA services in excess of 15 hours or $500.00 of accumulated services per recipient, per calendar year, are exempt from copayment. Services to hospital inpatients (place of service 1) are exempt from recipient copayment.

Individual/Family Psychotherapy	W8927-W8928, W8930	$2.00 per 60 minutes
Evaluation	W8931-W8933	$1.00 per 60 minutes
Evaluation - Limit Exceeded	W8987	$2.00 per 60 minutes
Group AODA Therapy	W8976-W8979	$ .50 per 60 min./recipient
Group Medical Psychotherapy	W8934-W8936	$ .50 per 60 minutes/recipient
Individual/Family AODA Therapy	W8972-W8975	$2.00 per 60 minutes/recipient
Chemotherapy Management - RN/MD (Medication Checks)	W8937-W8938	$0.00

APPENDIX 16

WMAP ALLOWABLE PLACE OF SERVICE (POS) AND TYPE OF SERVICE (TOS) CODES FOR 51.42 BOARD-OPERATED CLINICS

ALLOWABLE PLACE OF SERVICE (POS) CODES

POS	Description
1	Inpatient Hospital*
2	Outpatient Hospital
3	Office
4	Home **
7	Nursing Home
8	Skilled Nursing Facility
0	Other (school only except that medication checks are allowed in school and Community Based Residential Facility [CBRF])

* Neither group therapy nor services provided to a hospital inpatient by masters level psychotherapists or AODA counselors are separately reimbursable as an outpatient professional service.

** POS 4 (home) is allowable only for recipients under 21 years of age when the service is prior authorized as a HealthCheck "Other Service."

ALLOWABLE TYPE OF SERVICE (TOS) CODES

TOS	Description
1	Medical Services (all 51.42 Board services)

APPENDIX 17
ROUNDING GUIDELINES

The following chart illustrates the rules of rounding and gives the appropriate billing unit for all services except chemotherapy management and electroconvulsive therapy:

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	1.0
etc.	

The following chart illustrates the rules of rounding and gives the appropriate billing unit for chemotherapy management:

Time (in Minutes)	Unit(s) Billed
1 - 3	0.2
4 - 6	0.4
7 - 9	0.6
10 - 12	0.8
13 - 15	1.0
16 - 18	1.2
19 - 21	1.4
22 - 24	1.6
25 - 27	1.8
28 - 30	2.0
etc.	

APPENDIX 18
BILLING HINTS FOR MENTAL HEALTH SERVICES BILLED ON THE HCFA 1500 CLAIM FORM

Use this chart and Appendix 19 (sample HCFA 1500 claim form) to better understand EOB messages you may receive. The second column indicates the EOB message, the place in the handbook to find clarifying information, and the claim form element that triggered the message.

EOB	Message, Resource, and Related Claim Form Element
29	Recipient's Last Name does not match number. MA Card or other eligibility source - Refer to Part A, Section I for more information. Element 2
614	Recipient's First Name does not match number. MA Card or other eligibility source - Refer to Part A, Section I for more information. Element 2
281	Recipient MA number incorrect. MA Card or other eligibility source - Refer to Part A, Section I for more information. Element 1a
229	Claim indicator is missing or incorrect. Refer to Appendix 1 of this handbook Element 1
10	Recipient eligible for Medicare. Bill Medicare first. (Surgical Procedures) Refer to Part A, Appendix 17 Medicare allowed charges - attach Medicare EOMB Medicare denied charges - Element 11 - use M-code and do not attach Medicare EOMB.
273	Resubmit MA covered services Denied by Medicare. Refer to Part A, Appendix 17 Element 11 - use M-code and do not attach Medicare EOMB
278	MA files show recipient has other health insurance. Refer to Part A, Appendix 18 - Bill denied services on separate claim from paid services to maximize benefits. Elements 9 & 29
014	A discrepancy was noted between the other insurance indicator and the amount paid on your claim. Refer to Appendix 1 of this handbook Elements 9 & 29
192	Prior Authorization required for this service. Refer to Section III of this handbook Element 23
424	Billing Provider Name/Number missing, mismatched, or invalid Refer to Section IV-F of this handbook Element 33
425	Performing Provider Name/Number missing, mismatched, or invalid Refer to Section IV-F of this handbook Element 24K

177 Place of Service invalid or not payable
Refer to Appendix 16 of this handbook
Element 24B

388 Procedure code is incorrect (not on EDS file)
Refer to Appendix 3 of this handbook
Element 24D

116 Procedure not a benefit on date of service
Refer to Appendix 3 of this handbook
Elements 24A & 24D

247 Procedure code obsolete for date of service
Refer to Appendix 3 of this handbook
Elements 24A & 24D

172 Recipient is not Eligible for date of service
MA Card or other eligibility source - Refer to Part A, Section I for more information.
Element 24A

171 Claim/Adjustment received after 12 months from date of service
Refer to Part A, Section IX for more information.
Element 24A

100 Claim previously /partially paid on (claim number and R & S date)
Refer to Part A, Appendix 27 for more information.
Adjustment Request Form

91 Referring/Prescribing Physician required
Elements 17 & 17A

218 Prior Authorization required for service(s) exceeding psych/AODA/AODA Day Treatment guidelines
Refer to Section III of this handbook
Element 23

183 Provider not authorized to perform procedure code &/or type of service code
Refer to Appendix 3 & 16 of this handbook
Elements 24C, 24D, 24K, & 33

477 Billing provider indicated on claim not allowable as billing provider
Refer to Section IV-F of this handbook
Element 33

84 Signature and/or Date is missing
Element 31

NOTE: WMAP HCFA 1500 Claim Form Completion Instructions are found in Appendix 1 of this handbook.

APPENDIX 19
BILLING HINTS FOR MENTAL HEALTH SERVICES
SAMPLE CLAIM FORM

229

HEALTH INSURANCE CLAIM FORM

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE (Medicare #) / MEDICAID (Medicaid #) / CHAMPUS (Sponsor's SSN) / CHAMPVA (VA File #) / GROUP HEALTH PLAN (SSN or ID) / FECA BLK LUNG (SSN) / OTHER (ID)	1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)
	281
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) 29, 614	3. PATIENT'S BIRTH DATE MM DD YY / SEX M F	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED Self / Spouse / Child / Other	7. INSURED'S ADDRESS (No., Street)
CITY / STATE	8. PATIENT STATUS Single / Married / Other Employed / Full-Time Student / Part-Time Student	CITY / STATE
ZIP CODE / TELEPHONE (Include Area Code) ( )		ZIP CODE / TELEPHONE (INCLUDE AREA CODE) ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 278, 014	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER 10, 273
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES / NO	a. INSURED'S DATE OF BIRTH MM DD YY / SEX M F
b. OTHER INSURED'S DATE OF BIRTH MM DD YY / SEX M F	b. AUTO ACCIDENT? PLACE (State) YES / NO	b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES / NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES / NO *If yes*, return to and complete item 9 a-d.
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 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 _____
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	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM / MM DD YY TO
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE 91	17a. I.D. NUMBER OF REFERRING PHYSICIAN 91	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM / MM DD YY TO
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? YES / NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1 ____ 3 ____ 2 ____ 4 ____		22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER 192, 218

PHYSICIAN OR SUPPLIER INFORMATION

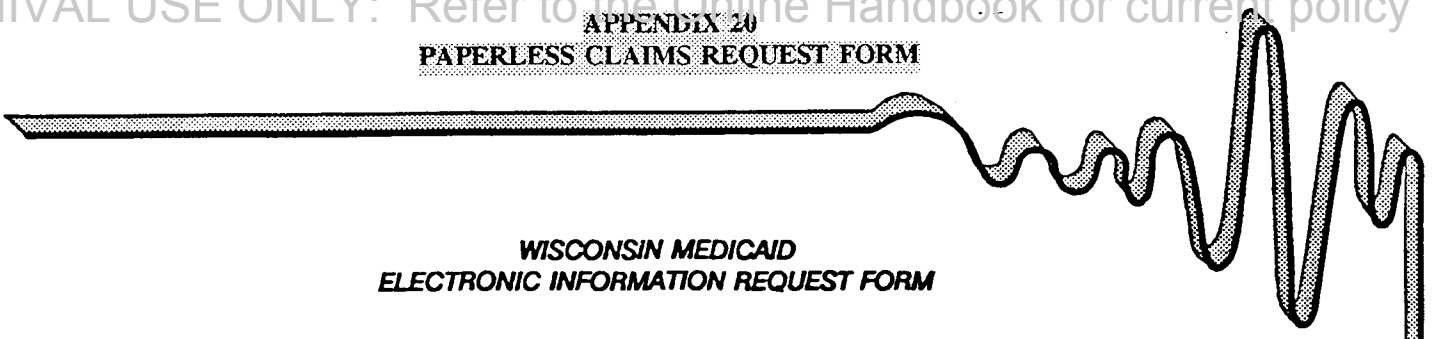
24 A. DATE(S) OF SERVICE From MM DD YY / To MM DD YY	B. Place of Service	C. Type of Service	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS / MODIFIER	E. DIAGNOSIS CODE	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. EMG	J. COB	K. RESERVED FOR LOCAL USE
1 116	177	183	388							425
2 247			116							183
3 172			247							
4 171			183							
5										
6										

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES / NO	28. TOTAL CHARGE $	29. AMOUNT PAID $ 278 014	30. BALANCE DUE $

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.) 84 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 # 424, 183, 477 PIN# / GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) **PLEASE PRINT OR TYPE** FORM HCFA-1500 (12-90) FORM OWCP-1500 FORM RRB-1500

APPENDIX 20
PAPERLESS CLAIMS REQUEST FORM



WISCONSIN MEDICAID
ELECTRONIC INFORMATION REQUEST FORM

The Wisconsin Medical Assistance Program offers many different methods for submitting your Medicaid claims electronically. All of this information is available for downloading from the EDS bulletin board system (EDS-EPIX). By downloading you will be able to obtain this information within minutes at your convenience. Please refer to the back of this page for the "Quick Guide to Obtaining Medicaid Electronic Claim Information" to assist you with the downloading process.

_____ *ECS (Electronic Claim Submission) EDS supplies free software that runs on a stand alone IBM compatible computer and uses a hayes compatible modem. The electronic record layouts are also available to create your own data files containing WMAP claim information.*
_____ *3 1/2" diskette* _____ *5 1/4" diskette*

_____ *3780 Protocol 3780 protocol is an IBM communication protocol that enables mini or mainframe computers to send claim data files to EDS.*

_____ *Magnetic Tape Providers with the capability to create their claim information on tape can submit those tapes to EDS. EDS also provides Remittance Advice information on magnetic tape.*

_____ *MicroECS MicroECS allows providers to send their data files to EDS using most basic telecommunication packages at a line speed up to 9600 bps.*

_____ *Reformatter The Reformatter is software designed for EDS that enables providers to enjoy the benefits of electronic billing without making costly changes to their existing billing system. Instead of printing claims on paper, claims are printed to a data file on a personal computer and transmitted to EDS. EDS reformats the data into the required electronic record format and brings the claims into the WMAP processing system.*

_____ *Please send me additional information on EDS' bulletin board system (EDS-EPIX).*

If you are unable to download and would like information on electronic claim submission, please check off the above method(s) you are interested in and complete the following:

NAME: _____ *PROVIDER NUMBER:* _____

ADDRESS: _____ *TYPE OF SERVICE:* _____

_____ *CONTACT PERSON:* _____

_____ *PHONE NUMBER:* _____

Please return to:

EDS
6406 Bridge Rd
Madison, WI 53784-0009
(608)221-4746

This is a quick guide to retrieving and installing EDS' Electronic Claim Submission software using *EDS-EPIX*.

1. If you wish to obtain EDS Software, create a subdirectory on your hard drive for your Electronic Claim Submission software called "EDS". At the DOS command prompt type:

   C: <Enter>
   CD\ <Enter>
   MD EDS <Enter>

2. Set up your communication software to dial *EDS-EPIX*. You may need to program your software to dial with the following settings:

Phone Number:	(608) 221-8824	**Stop Bits:**	1
Baud Rate:	9600 (maximum)	**Duplex:**	Full
Parity:	None	**Protocol:**	XMODEM (recommended)
Data Bits:	8	**Terminal Emulation:**	ANSI

3. Dial into *EDS-EPIX*. When you go through this initial logon, we recommend you select Xmodem/CRC as your default protocol.

4. Select option "F" (File Directories) from the main menu and then view the "ECS Software and Manuals for New Users" or the "Record Layout and Manual Updates" directory. Choose the name of the file you need to download. If you need help deciding which file you need, go back to the main menu and view Bulletin #2 or 3 for more information. When you have chosen a file, write down the file name (you will need it to download).

5. Select option "D" (Download a File) from the main menu, and type the file name you chose in step 4. Next, follow the download instructions in the user manual for your communications software package. This basically involves telling your communications software package that you wish to "Receive a File", choosing a transfer protocol, and specifying the name and directory path of the file. If you fail to specify the directory path with the file name, the file will be downloaded into the default download directory for your communications software.

6. When you have downloaded your file, select "G" (Goodbye) to end your *EDS-EPIX* session, quit your communication software, and return to DOS.

7. Go to the subdirectory you specified in your path and look for your download file. It should be listed when you list the directory.

8. If the download file is in the directory, you will need to decompress the file. At the DOS command prompt type the name of the download file without the ".EXE" extension. For example, for dental software, at the DOS command prompt type:

   DENTAL <Enter>

9. This will extract your software and manual(s).

10. The files ending in .DOC are your manuals. This manual is an ASCII DOS text file. To print this document, use the DOS Print command:

    PRINT *FILENAME*.DOC <Enter>

    The document will be printed on the print device you specify.

APPENDIX 21
WISCONSIN PEER REVIEW ORGANIZATION (WIPRO) REVIEW PROCESS

Admission Review
WIPRO must be notified of the following admissions by the admitting/attending physician or the hospital:

- all AODA admissions to general hospitals or IMDs;
- all elective psychiatric admissions to general hospitals or IMDs; and
- all urgent/emergent admissions to IMDs for recipients under 21 years of age.

At the time the physician or hospital contacts WIPRO, a WIPRO nurse reviewer determines whether the admission is subject to these review procedures and, if so, gathers information over the telephone regarding the patient's medical condition. The WIPRO reviewer uses WMAP psychiatric/AODA criteria to determine whether, on the basis of information provided, the admission appears to be medically necessary. If the reviewer determines that the admission might be "suspect" (i.e., not medically necessary):

1. the reviewer informs the provider that the admission is suspect.
2. WIPRO "flags" the case for retrospective review.

A determination that the medical necessity of the admission might be suspect, for WMAP payment purposes, is made if the admission does not meet the criteria for admission, or if there is not adequate information to determine whether the criteria are met. A decision to recoup WMAP payments for the hospitalization is not made until there has been a review of the recipient's medical record, the recipient has been discharged from the hospital, and a denial determination has been made by a WIPRO physician advisor. Complete medical record documentation is essential for WIPRO in determining the medical necessity of the admission and hospitalization. Physicians must be certain that the patient's record continually and adequately documents the recipient's condition and need for inpatient care.

A control number is issued by WIPRO when notified at the time of admission for all psychiatric and AODA admissions subject to this review. Claims for admissions subject to this review process which do not have a control number are denied.

Retrospective Review
WIPRO also conducts retrospective reviews on targeted psychiatric and AODA admissions. Cases found suspect on admission review are targeted for retrospective review. However, retrospective reviews are not limited to those admissions which must be reported to WIPRO. For instance, urgent/emergent psychiatric admissions which have short lengths of stay or are transfers may also be subject to retrospective review.

If a case is selected for retrospective review, WIPRO requests the recipient's medical record from the hospital. If upon retrospective review, WIPRO determines that the admission or any portion of the inpatient stay was not medically necessary for WMAP purposes, WIPRO informs the hospital, physician, and the WMAP of their final determination.

Special Cases

1. Border status hospitals and court-ordered admissions are subject to WIPRO review process.
2. Dual entitlees (Medicare/Medical Assistance) are subject to WIPRO review process after the recipient's psychiatric benefits under Medicare are exhausted.
3. Cases in which an application for WMAP eligibility is submitted at the time of admission or at any point during an inpatient stay are subject to this review process. If the recipient is determined eligible for WMAP coverage after admission, the hospital must notify WIPRO of the hospitalization prior to submitting the claim so that WIPRO may assign a control number. This type of situation includes separate case eligibility determinations for children admitted to specialty hospitals and recipient retroactive eligibility.

Exempted Cases

1. Recipients in WMAP-contracted managed care programs are exempted from WIPRO review. Managed care programs have their own procedures relative to mental health and AODA services and should be contacted prior to admission for elective services, and within 72 hours after admission for emergency care.

2. Out-of-state hospitals (excluding border status hospitals) are exempted from WIPRO review. Except for emergency care, such stays are subject to prior authorization.

Questions About the Pre-Admission Review (PAR)

All questions about the review of PAR should be directed to WIPRO at 1-800-833-7247 or (608) 274-3832.

Please do not contact EDS with questions regarding this review process