Mental Health and Substance Abuse Services

Substance Abuse Day Treatment

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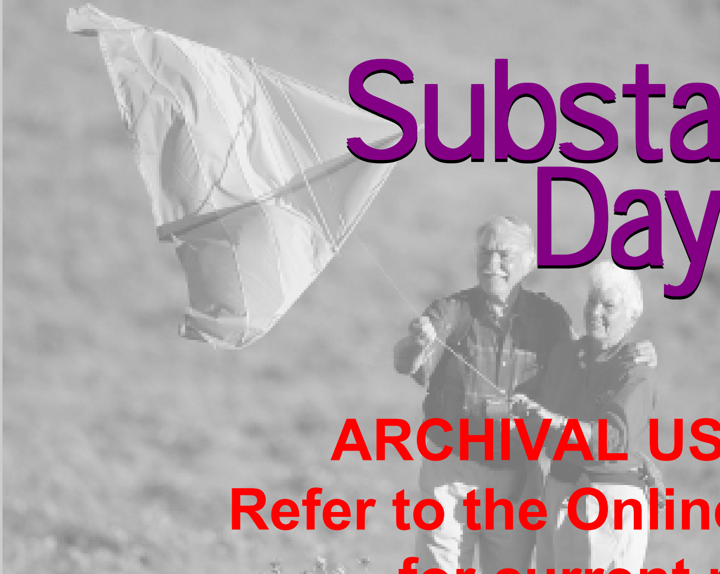

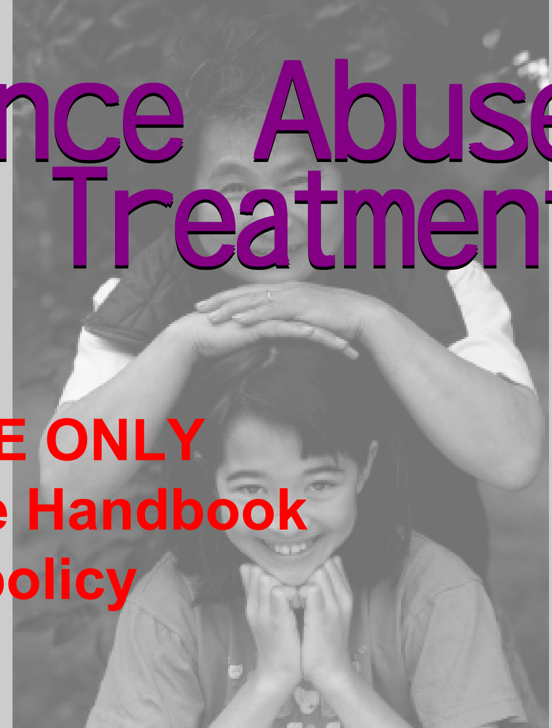

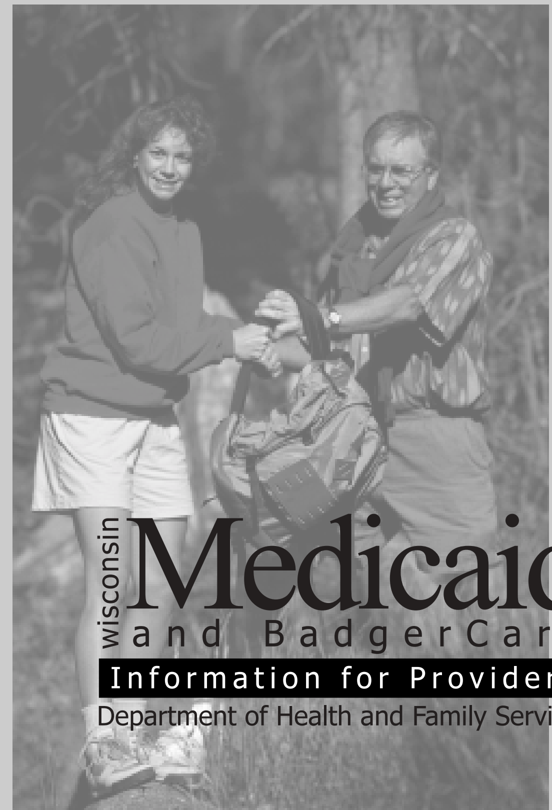

wisconsin Medicaid and BadgerCare

Information for Providers

Department of Health and Family Services

Jim Doyle
Governor

Helene Nelson
Secretary

State of Wisconsin

Department of Health and Family Services

DIVISION OF HEALTH CARE FINANCING
WISCONSIN MEDICAID AND BADGERCARE
PROVIDER SERVICES
6406 BRIDGE ROAD
MADISON WI 53784

Telephone: 800-947-9627
608-221-9883
dhfs.wisconsin.gov/medicaid
dhfs.wisconsin.gov/badgercare

MEMORANDUM

DATE: March 1, 2006

TO: Wisconsin Medicaid-Certified Substance Abuse Day Treatment Providers

FROM: Mark Moody, Administrator
Division of Health Care Financing

SUBJECT: Wisconsin Medicaid Mental Health and Substance Abuse Services Handbook with Substance Abuse Day Treatment section

The Division of Health Care Financing is pleased to provide a copy of two sections of the Mental Health and Substance Abuse Handbook. The General Information section of the handbook articulates current Medicaid policies found in Wisconsin Administrative Code, HFS 101-108, as they apply to mental health and substance abuse services.

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The Substance Abuse Day Treatment Services section incorporates current Medicaid substance abuse policy information into a single reference source. This section replaces Part H, Division IV, the AODA Day Treatment handbook (issued July 1989), and the following service-specific *Wisconsin Medicaid and BadgerCare Updates:*

- The July 2003 *Update* (2003-78), titled "Changes to local codes, paper claims, and prior authorization for substance abuse day treatment services as a result of HIPAA."
- The April 2004 *Update* (2004-34), titled "Medical Record Documentation Requirements for Mental Health and Substance Abuse Services."
- The December 2004 *Update* (2004-88), titled "Coverage of Mental Health and Substance Abuse Services Provided Via Telehealth."
- The January 2005 *Update* (2005-08), titled "Wisconsin Medicaid Accepting Prior Authorization Requests Via the Web for Additional Service Areas."

All-Provider Publications
Providers are reminded to retain their all-provider publications. The revised Mental Health and Substance Abuse Services Handbook sections does *not* replace these publications.

Additional Copies of Publications
The Wisconsin Medicaid Web site, *dhfs.wisconsin.gov/medicaid/,* contains additional information for all Medicaid providers, service-specific information, and electronic versions of the Mental Health and Substance Abuse Services Handbook and the All-Provider Handbook.

Providers who have questions about the information in this handbook may call Provider Services at
(800) 947-9627 or (608) 221-9883.

Contacting Wisconsin Medicaid

Web Site	***dhfs.wisconsin.gov/***
The Web site contains information for providers and recipients about the following: • Program requirements. • Publications. • Forms. • Maximum allowable fee schedules. • Professional relations representatives. • Certification packets.	Available 24 hours a day, seven days a week
Automated Voice Response System	**(800) 947-3544** **(608) 221-4247**
The Automated Voice Response system provides computerized voice responses about the following: • Recipient eligibility. • Prior authorization (PA) status. • Claim status. • Checkwrite information.	Available 24 hours a day, seven days a week
Provider Services	**(800) 947-9627** **(608) 221-9883**
Correspondents assist providers with questions about the following: • Clarification of program requirements. • Recipient eligibility. • Resolving claim denials. • Provider certification.	Available: 8:30 a.m. - 4:30 p.m. (M, W-F) 9:30 a.m. - 4:30 p.m. (T) Available for pharmacy services: 8:30 a.m. - 6:00 p.m. (M, W-F) 9:30 a.m. - 6:00 p.m. (T)
Division of Health Care Financing **Electronic Data Interchange Helpdesk**	**(608) 221-9036** **e-mail: *wiedi@dhfs.state.wi.us***
Correspondents assist providers with *technical* questions about the following: • Electronic transactions. • Companion documents. • Provider Electronic Solutions software.	Available 8:30 a.m. - 4:30 p.m. (M-F)
Web Prior Authorization Technical Helpdesk	**(608) 221-9730**
Correspondents assist providers with Web PA-related *technical* questions about the following: • User registration. • Passwords. • Submission process.	Available 8:30 a.m. - 4:30 p.m. (M-F)
Recipient Services	**(800) 362-3002** **(608) 221-5720**
Correspondents assist recipients, or persons calling on behalf of recipients, with questions about the following: • Recipient eligibility. • General Medicaid information. • Finding Medicaid-certified providers. • Resolving recipient concerns.	Available 7:30 a.m. - 5:00 p.m. (M-F)

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Preface

Wisconsin Medicaid and BadgerCare mental health and substance abuse services publications apply to fee-for-service Medicaid providers. The information in these publications apply to Medicaid and BadgerCare programs for recipients on fee-for-service Medicaid.

Medicaid is a joint federal and state program established in 1965 under Title XIX of the federal Social Security Act. Wisconsin Medicaid is also known as the Medical Assistance Program, WMAP, MA, Title XIX or T19.

BadgerCare extends Medicaid coverage through a Medicaid expansion under Titles XIX and XXI. The goal of BadgerCare is to fill the gap between Medicaid and private insurance without supplanting or "crowding out" private insurance. BadgerCare recipients receive the same health benefits as Medicaid recipients, and their health care is administered through the same delivery system.

Wisconsin Medicaid and BadgerCare are administered by the Department of Health and Family Services (DHFS). Within the DHFS, the Division of Health Care Financing (DHCF) is directly responsible for managing Wisconsin Medicaid and BadgerCare.

Unless otherwise specified, all information contained in this and other Medicaid publications pertains to services provided to recipients who receive care through fee-for-service. Refer to the Managed Care section of the All-Provider Handbook for information about state-contracted managed care organizations.

Substance Abuse Day Treatment Section

The information in the Substance Abuse Day Treatment section of this Mental Health and Substance Abuse Handbook applies to Division of Disability and Elder Services, Bureau of Quality Assurance-certified substance abuse day treatment service programs.

Substance abuse day treatment providers should refer to the All-Provider Handbook, the General Information section of this handbook, and this section to find answers to policy-related questions.

All-Provider Handbook

All Medicaid-certified providers receive a copy of the All-Provider Handbook, which includes the following sections:

- Certification and Ongoing Responsibilities.
- Claims Information.
- Coordination of Benefits.
- Covered and Noncovered Services.
- Informational Resources.
- Managed Care.
- Prior Authorization.
- Recipient Eligibility.

Providers are required to refer to the All-Provider Handbook for more information about these topics.

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Wisconsin Medicaid and BadgerCare Web Sites

Publications (including provider handbooks and *Wisconsin Medicaid and BadgerCare Updates*), maximum allowable fee schedules, telephone numbers, addresses, and more information are available on the following Web sites:

- *dhfs.wisconsin.gov/medicaid/*.
- *dhfs.wisconsin.gov/badgercare/*.

Publications

Medicaid publications apply to both Wisconsin Medicaid and BadgerCare. Publications interpret and implement the laws and regulations that provide the framework for Wisconsin Medicaid and BadgerCare. Medicaid publications provide necessary information about program requirements.

Legal Framework

The following laws and regulations provide the legal framework for Wisconsin Medicaid and BadgerCare:

- Federal Law and Regulation:
  - ✓ Law — United States Social Security Act; Title XIX (42 US Code ss. 1396 and following) and Title XXI.
  - ✓ Regulation — Title 42 CFR Parts 430-498 and Parts 1000-1008 (Public Health).
- Wisconsin Law and Regulation:
  - ✓ Law — Wisconsin Statutes: 49.43-49.499 and 49.665.
  - ✓ Regulation — Wisconsin Administrative Code, Chapters HFS 101-109.

Laws and regulations may be amended or added at any time. Program requirements may not be construed to supersede the provisions of these laws and regulations.

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Provider and Recipient Information

Provider Certification

To be reimbursed for providing substance abuse day treatment services to Medicaid recipients, a provider is first required to be certified by the Department of Health and Family Services (DHFS), Division of Disability and Elder Services (DDES) for substance abuse day treatment under HFS 75.12, Wis. Admin. Code. For information regarding this certification, write to the following address:

Division of Disability and Elder Services
Bureau of Quality Assurance
Program Certification Unit
2917 International Ln Ste 300
Madison WI 53704
(608) 243-2025

Wisconsin Medicaid strongly recommends that providers verify the recipient's current enrollment in an MCO before providing services.

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A provider meeting DHFS, DDES certification may initiate Medicaid substance abuse day treatment provider certification, as outlined in HFS 105.23, Wis. Admin. Code, by doing one of the following:

1. Downloading mental health agency certification materials from the Medicaid Web site.
2. Calling Provider Services at (800) 947-9627 or (608) 221-9883.
3. Writing to the following address:

   Wisconsin Medicaid
   Provider Maintenance
   6406 Bridge Rd
   Madison WI 53784-0006

Refer to Appendix 1 of this section for more information about certification.

Refer to the General Information section of this handbook for more information about provider certification, provider numbers, and provider responsibilities. Refer to the Certification and Ongoing Responsibilities section of the All-Provider Handbook for additional information.

Copayment

Providers are prohibited from collecting copayment from recipients receiving substance abuse day treatment services.

Managed Care Coverage for Day Treatment Services

State-contracted managed care organizations (MCOs) cover substance abuse day treatment services. Recipients enrolled in all state-contracted MCOs must receive substance abuse day treatment services through the MCO. Providers should check with the recipient's MCO for further information on coverage.

Wisconsin Medicaid strongly recommends that providers verify the recipient's current enrollment in an MCO before providing services. Claims submitted to Wisconsin Medicaid for substance abuse day treatment services covered by MCOs will be denied.

Provider/Recipient Information

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Covered Services

The Substance Abuse Day Treatment section of the Mental Health and Substance Abuse Services Handbook contains information for providers of substance abuse day treatment services.

According to HFS 101.03(12m), Wis. Admin. Code, "substance abuse day treatment" means alcohol and other drug abuse treatment services provided by a provider certified under HFS 105.25, Wis. Admin. Code, to a recipient who, in the clinical judgment of a qualified treatment professional, is experiencing a problem with alcohol or other drugs and is willing to receive intensive services of a prescribed duration. These services may include assessment and evaluation, treatment planning, group and individual counseling, recipient education when necessary for effective treatment, and rehabilitative services to ameliorate or remove the disability and restore effective functioning.

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Wisconsin Medicaid reimburses the first three hours of assessment and evaluation per recipient, per provider in a calendar year regarding the need for, and ability to benefit from, substance abuse day treatment.

Program Admission Requirements

For admission to a substance abuse day treatment program, a recipient must be willing to participate; be detoxified from drugs or alcohol; have the ability to function in a semicontrolled, medically supervised environment; have a demonstrated need for structure and intensity of treatment that is not available in outpatient treatment; and be willing to participate in aftercare upon completion of treatment.

Sessions Requirements

A substance abuse day treatment service is a medically monitored, nonresidential substance abuse treatment service that consists of regularly scheduled sessions that may include individual and/or group counseling and case management, provided under the supervision of a physician. Services are provided in a scheduled number of sessions per day and week, with each recipient generally receiving a minimum of 12 hours of counseling per week and/or a minimum of 60 hours within a six-week period of time.

Covered Services

A covered service is a service, item, or supply for which Medicaid reimbursement is available when *all* program requirements are met. For a covered service to meet program requirements, the service must be provided by a qualified Medicaid-certified provider to an eligible recipient. In addition, the service must meet all applicable program requirements, including, but not limited to, medical necessity, prior authorization (PA), claims submission, prescription, and documentation requirements.

The following services are covered under substance abuse day treatment:

- *Assessment.* Wisconsin Medicaid reimburses the first three hours of assessment and evaluation per recipient, per provider in a calendar year regarding the recipient's need for, and ability to benefit from, substance abuse day treatment.
- *Substance abuse day treatment.* Wisconsin Medicaid reimburses for intensive, short-term substance abuse treatment provided in a substance abuse day treatment program certified under HFS 105.25, Wis. Admin. Code, for recipients who need and want day treatment services.

Refer to the Covered and Noncovered Services section of the All-Provider Handbook for more information about covered services, medical necessity, services that are not separately reimbursable, and emergency services.

Services Provided Via Telehealth

Individual substance abuse day treatment services may be provided via Telehealth. Refer to the General Information section of this handbook for information about Telehealth requirements and claims submission.

Reimbursement Limitations

Wisconsin Medicaid does not reimburse the following services or circumstances in accordance with HFS 107.13(3m)(c), Wis. Admin. Code:

- Substance abuse day treatment services in excess of five hours per day are not reimbursable.
- Substance abuse day treatment services may not be billed as psychotherapy, substance abuse outpatient treatment, case management, occupational therapy or any other service modality except substance abuse day treatment.
- Reimbursement for substance abuse day treatment services may not include time devoted to meals, rest periods, transportation, recreation, or entertainment.
- Reimbursement for substance abuse day treatment assessment for a recipient is limited to three hours in a calendar year. Additional assessment hours shall be counted toward the mental health outpatient dollar or hour amount under HFS 107.13(2)(a)6, Wis. Admin. Code, before PA is required or the substance abuse outpatient dollar or hour limit under HFS 107.13(3)(a)4, Wis. Admin. Code, before PA is required.

Noncovered Services

The following services are not covered by Wisconsin Medicaid, in accordance with HFS 107.13(3m)(d), Wis. Admin. Code:

- Collateral interviews and consultations, except as provided in HFS 107.06(4)(d), Wis. Admin. Code.
- Time spent in the substance abuse day treatment setting by affected family members of the recipient.
- Substance abuse day treatment services billed under any other Medicaid service category, including substance abuse outpatient services, psychotherapy, occupational therapy, or case management.
- Substance abuse day treatment services which are primarily recreational or which are provided in non-medically supervised settings. These include, but are not limited to, sports activities, exercise groups, and activities such as crafts, leisure time, social hours, trips to community activities, and tours.
- Services provided to a substance abuse day treatment recipient which are primarily social or educational in nature. Educational sessions are covered as long as these sessions are part of an overall treatment program and include group processing of the information provided.
- Prevention or education programs provided as an outreach service or as case-finding.
- Day treatment provided in the recipient's home.

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Special Circumstances

The following requirements apply specifically to substance abuse day treatment services:

- All substance abuse day treatment services require a physician prescription/ order.
- Wisconsin Medicaid reimburses the provision of services. Documenting the services provided is part of the provision of services.

All substance abuse day treatment services require a physician prescription/order.

Documentation Requirements

Refer to Appendix 14 of this section for documentation requirements for all mental health and substance abuse service providers, including substance abuse day treatment providers. For additional information regarding documentation requirements, refer to the General Information section of this handbook.

Prior Authorization

When assessing recipients who are 18 to 21 years old, providers are to use either the adolescent or adult criteria, depending on the individual recipient's circumstances.

Providers are required to obtain prior authorization (PA) for the substance abuse day treatment services specified in this chapter. Authorization for these services must be received prior to providing the services.

Refer to the General Information section of this handbook for general PA requirements. For more information about general PA forms and attachments and submitting PA requests, refer to the Prior Authorization section of the All-Provider Handbook.

Services Requiring Prior Authorization

Prior authorization is *not* required for the substance abuse assessment, the limit for which is three hours per recipient, per provider in a calendar year.

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Prior authorization *is* required before providing any substance abuse day treatment services to a recipient following the assessment.

Prior Authorization Criteria

Prior authorization criteria for intensity of treatment and severity of illness have been developed for substance abuse day treatment by Wisconsin Medicaid and substance abuse providers. Appendices 6, 7, and 8 of this section contain treatment criteria for substance abuse day treatment services for adults and adolescents.

When assessing recipients who are 18 to 21 years old, providers are to use either the adolescent or adult criteria, depending on the individual recipient's circumstances. Providers are required to refer to the appropriate treatment criteria when requesting PA. The criteria illustrate the factors that will be used in determining whether substance abuse day treatment is considered medically necessary by Wisconsin Medicaid.

Wisconsin Medicaid reviews and adjudicates PA requests on a case-by-case basis. It is therefore essential that adequate, explicit clinical information be provided on each PA request.

Procedures for Obtaining Prior Authorization

Providers are required to submit both the Prior Authorization Request Form (PA/RF), HCF 11018, and the Prior Authorization/Substance Abuse Day Treatment Attachment (PA/SADTA), HCF 11037, for substance abuse day treatment services. The completion instructions and a completed sample PA/RF are located in Appendices 4 and 5 of this section. The PA/RF can be obtained by contacting Provider Services at (800) 947-9627 or (608) 221-9883.

The completion instructions and a copy of the PA/SADTA are located in Appendices 9 and 10 of this section for photocopying and may also be downloaded from the Medicaid Web site.

Backdating Substance Abuse Prior Authorization Requests

In certain cases, it is medically necessary to start a recipient in substance abuse day treatment within a short period of time following the initial assessment or completion of detoxification.

Wisconsin Medicaid allows backdating of substance abuse day treatment PA requests up to five working days prior to the initial date that Wisconsin Medicaid receives the request, as long as backdating procedures are followed.

Refer to the General Information section of this handbook for backdating procedures.

Refer to the Prior Authorization section of the All-Provider Handbook for information on other circumstances affecting PA, such as determination of grant dates and service interruptions.

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Claims Submission

To receive reimbursement, claims and adjustment requests must be received by Wisconsin Medicaid within 365 days of the date of service (DOS). To receive reimbursement for services that are allowed by Medicare, claims and adjustment requests for coinsurance, copayment, and deductible must be received by Wisconsin Medicaid within 365 days of the DOS, or within 90 days of the Medicare processing date, whichever is later.

For more information about exceptions to the claims submission deadline, Medicaid remittance information, adjustment requests, and returning overpayments, refer to the Claims Information section of the All-Provider Handbook.

Healthcare Common Procedure Coding System (HCPCS) codes are required on all substance abuse day treatment claims.

Coordination of Benefits

With few exceptions, Wisconsin Medicaid is the payer of last resort for any Medicaid-covered service. Therefore, the provider is required to make a reasonable effort to exhaust all existing other health insurance sources before submitting claims to Wisconsin Medicaid or to state-contracted managed care organizations.

Refer to the Coordination of Benefits section of the All-Provider Handbook for more information about services that require other health insurance billing, exceptions, claims submission procedures for recipients with other health insurance, and the Other Coverage Discrepancy Report, HCF 1159.

Diagnosis Codes

All diagnoses must be from the *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) coding structure. Claims received without an allowable ICD-9-CM code are denied.

Refer to Appendix 2 of this section for a list of allowable diagnosis code ranges for substance abuse day treatment services.

Procedure Codes

Healthcare Common Procedure Coding System (HCPCS) codes are required on all substance abuse day treatment claims. Claims or adjustments received without a HCPCS code are denied. Refer to Appendix 2 of this section for the allowable procedure code and modifiers.

Place of Service Codes

Allowable place of service codes for substance abuse day treatment are included in Appendix 3 of this section.

837 Health Care Claim: Professional

Providers are encouraged to submit claims electronically since electronic claims submission usually reduces claim errors. Claims for substance abuse day treatment services may be submitted using the 837 Health Care Claim: Professional transaction except when submitting claims that require additional documentation. In these situations, providers are required to submit paper claims.

Refer to the Informational Resources section of the All-Provider Handbook for more information about electronic transactions.

CMS 1500

Paper claims for substance abuse day treatment services must be submitted using the CMS 1500 claim form dated 12/90. Wisconsin Medicaid denies claims for substance abuse day treatment services submitted on any paper claim form other than the CMS 1500.

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Wisconsin Medicaid does not provide the CMS 1500 claim form. The form may be obtained from any federal forms supplier.

Refer to Appendix 11 of this handbook for claim form instructions for substance abuse day treatment services. Appendices 12 and 13 are samples of claims for substance abuse day treatment services.

Reimbursement

Certified substance abuse day treatment providers are reimbursed at the lesser of the provider's usual and customary charge or the maximum allowable fee established by the Department of Health and Family Services. The maximum allowable fee is a comprehensive hourly rate that is paid for any allowable day treatment service regardless of which staff person provided the service or whether the service was a group or individual service.

Hospitals that have certified substance abuse day treatment programs should not include the Medicaid charges associated with the day treatment cost center in the Medicare/ Medicaid Cost Report. Substance abuse day treatment services are not considered hospital outpatient services.

Hospitals that have certified substance abuse day treatment programs should not include the Medicaid charges associated with the day treatment cost center in the Medicare/Medicaid Cost Report.

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Appendix 1
Medicaid Certification Requirements for Substance Abuse Day Treatment Services

This appendix outlines Wisconsin Medicaid certification requirements for substance abuse day treatment service providers. Prior to obtaining Wisconsin Medicaid certification, substance abuse day treatment providers are required to be certified by the Department of Health and Family Services (DHFS), Division of Disability and Elder Services (DDES), Bureau of Quality Assurance (BQA). County/tribal social or human services agencies that request billing-only status do not need to be certified by the DDES.

The following terms are used in the table:

- "Agency Providing the Service" — The agency whose staff actually performs the service.
- "Agency Only Allowed to Bill the Service" — The agency that submits claims to Wisconsin Medicaid for the service. This agency does not perform the service but contracts with a provider to perform the service on the billing agency's behalf. The provider may be a certified program within the billing agency. Only a county/tribal social or human services agency can be a billing agency.

The following table lists required provider numbers and definitions for agencies providing mental health and substance abuse services.

Definitions for Provider Numbers	
Type of Provider Number	**Definition**
Billing/Performing Provider Number	Issued to providers to allow them to identify themselves on claims as either the biller of services or the performer of services.
Billing-Only Provider Number	Issued to county/tribal social or human services agencies to allow them to serve as the biller of services when contracting with a service performer.

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Type of Agency	Certification Requirements				Type of Provider Number Assigned
	Division of Disability and Elder Services/Bureau of Quality Assurance	Wisconsin Medicaid	Specific Certification Section of the Medicaid Mental Health/ Substance Abuse Agency Packet to Be Completed	County/ Tribal Social or Human Services Agency?	
Agency Providing the Service	The agency is required to obtain a Wisconsin DHFS certificate to provide substance abuse day treatment services as authorized under HFS 75.12, Wis. Admin. Code.	The agency is required to do the following: • Have a DDES, BQA certificate on file. • Complete and submit a Mental Health and Substance Abuse Agency Certification Packet.	Substance Abuse Day Treatment	**No**	Day treatment (mental health/ substance abuse) billing/ performing provider number
Agency Only Allowed to Bill the Service	Not required	The agency is required to complete and submit a Mental Health and Substance Abuse Agency Certification Packet to be a billing-only provider for substance abuse day treatment services. An allowable Medicaid performing provider is required to perform the service.	Substance Abuse Day Treatment	**Yes**	Day treatment (mental health/ substance abuse) billing provider number

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Appendix 2
Allowable Procedure Code and Modifiers for Substance Abuse Day Treatment Services

The following table lists the Healthcare Common Procedure Coding System (HCPCS) procedure code and modifiers that substance abuse day treatment providers are required to use when requesting prior authorization and submitting claims.

HCPCS Code	Description	Program Modifier Code	Service Modifier Code	Allowable ICD-9-CM Diagnosis Codes*	Telehealth Services Covered?	Prior Authorization Required?
H2012	Behavioral health day treatment, per hour	**HF** Substance abuse program	None	303.90-303.91 304.00-304.01 304.10-304.11 304.20-304.21 304.30-304.31 304.40-304.41 304.50-304.51 304.60-304.61 304.70-304.71 304.80-304.81 304.90-304.91 305.00-305.01** 305.20-305.21** 305.30-305.31** 305.40-305.41** 305.50-305.51** 305.60-305.61** 305.70-305.71** 305.80-305.81** 305.90-305.91**	For individual services only	Yes
	Behavioral health day treatment, per hour	**HF** Substance abuse program	**U6** Assessment	Diagnosis code required, no restrictions	Yes	No

* ICD-9-CM = *International Classification of Diseases, Ninth Revision, Clinical Modification*. The list of ICD-9-CM diagnosis codes for substance abuse day treatment is inclusive. However, not all Medicaid-covered substance abuse day treatment services are appropriate or allowable for all diagnoses. Wisconsin Medicaid bases approval of services on a valid diagnosis, acceptable substance abuse day treatment practice, and clear documentation of the probable effectiveness of the proposed service.

** An "abuse" diagnosis, as the only and primary diagnosis, is appropriate only for children or adolescents for substance abuse day treatment services.

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Appendix 3
Allowable Place of Service Codes
for Substance Abuse Day Treatment Services

The following table lists allowable place of service (POS) codes that substance abuse day treatment providers may use when submitting prior authorization requests and claims to Wisconsin Medicaid. Substance abuse day treatment services may be provided in the following POS by certified substance abuse day treatment programs only.

Code	Description
05	Indian Health Service Free-Standing Facility
06	Indian Health Service Provider-Based Facility
07	Tribal 638 Free-Standing Facility
08	Tribal 638 Provider-Based Facility
11	Office
22	Outpatient Hospital
50	Federally Qualified Health Center
71	State or Local Public Health Clinic
72	Rural Health Clinic

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Appendix 4
Prior Authorization Request Form (PA/RF) Completion Instructions for Substance Abuse Day Treatment Services

Wisconsin Medicaid requires certain information to enable Medicaid to authorize and pay for medical services provided to eligible recipients.

Recipients are required to give providers full, correct, and truthful information for the submission of correct and complete claims for Medicaid reimbursement. This information should include, but is not limited to, information concerning eligibility status, accurate name, address, and Medicaid identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to Medicaid administration such as determining eligibility of the applicant or processing provider claims for reimbursement. The Prior Authorization Request Form (PA/RF), HCF 11018, is used by Wisconsin Medicaid and is mandatory when requesting PA. Failure to supply the information requested by the form may result in denial of Medicaid payment for the services.

Providers may submit PA requests, along with the Prior Authorization/Substance Abuse Day Treatment Attachment (PA/SADTA), HCF 11037, by fax to Wisconsin Medicaid at (608) 221-8616 or by mail to the following address:

Wisconsin Medicaid
Prior Authorization
Ste 88
6406 Bridge Rd
Madison WI 53784-0088

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The provision of services that are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s).

SECTION I — PROVIDER INFORMATION

Element 1 — Name and Address — Billing Provider
Enter the name and complete address (street, city, state, and zip code) of the billing provider. The name listed in this element must correspond with the Medicaid provider number listed in Element 4. *No other information should be entered in this element, since it also serves as a return mailing label.*

Element 2 — Telephone Number — Billing Provider
Enter the telephone number, including the area code, of the office, clinic, facility, or place of business of the billing provider.

Element 3 — Processing Type
Enter processing type "136." The processing type is a three-digit code used to identify the category of service requested. Prior authorization requests will be returned without adjudication if no processing type is indicated.

Element 4 — Billing Provider's Medicaid Provider Number
Enter the eight-digit Medicaid provider number of the billing provider. The provider number in this element must correspond with the provider name listed in Element 1. The correct suffix for a certified substance abuse day treatment program is "21."

SECTION II — RECIPIENT INFORMATION

Element 5 — Recipient Medicaid ID Number

Enter the recipient's 10-digit Medicaid identification number. Do not enter any other numbers or letters. Use the recipient's Medicaid identification card or the Medicaid Eligibility Verification System (EVS) to obtain the correct identification number.

Element 6 — Date of Birth — Recipient

Enter the recipient's date of birth in MM/DD/YY format (e.g., September 8, 1966, would be 09/08/66).

Element 7 — Address — Recipient

Enter the complete address of the recipient's place of residence, including the street, city, state, and zip code. If the recipient is a resident of a nursing home or other facility, include the name of the nursing home or facility.

Element 8 — Name — Recipient

Enter the recipient's last name, followed by his or her first name and middle initial. Use the EVS to obtain the correct spelling of the recipient's name. If the name or spelling of the name on the Medicaid identification card and the EVS do not match, use the spelling from the EVS.

Element 9 — Sex — Recipient

Enter an "X" in the appropriate box to specify male or female.

SECTION III — DIAGNOSIS / TREATMENT INFORMATION

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for current policy

Element 10 — Diagnosis — Primary Code and Description

Enter the appropriate *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis code and description most relevant to the service requested.

Element 11 — Start Date — SOI (not required)

Element 12 — First Date of Treatment — SOI (not required)

Element 13 — Diagnosis — Secondary Code and Description

Enter the appropriate secondary ICD-9-CM diagnosis code and description relevant to the service requested, if applicable.

Element 14 — Requested Start Date

Enter the requested start date for service(s) in MM/DD/YY format, if a specific start date is requested. If backdating is requested, include the clinical rationale for starting before PA was received. Backdating is not allowed on subsequent PA requests. The maximum backdating allowed is five working days from the date of receipt at Wisconsin Medicaid.

Element 15 — Performing Provider Number (not required)

Element 16 — Procedure Code

Enter the appropriate Healthcare Common Procedure Coding System (HCPCS) procedure code for each service requested.

Element 17 — Modifiers

Enter the modifier(s) corresponding to the procedure code listed, if a modifier is required by Wisconsin Medicaid.

Appendix 4
(Continued)

Element 18 — POS
Enter the appropriate two-digit place of service code designating where the requested service would be provided.

Element 19 — Description of Service
Enter a written description corresponding to the appropriate HCPCS procedure code for each service requested.

Element 20 — QR
Enter the appropriate quantity (e.g., hours) requested for each procedure code listed.

Element 21 — Charge
Enter the 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 the total amount in this element.

Note: The charges indicated on the request form should reflect the provider's usual and customary charge for the service requested. Providers are reimbursed for authorized services according to the provider *Terms of Reimbursement* issued by the Department of Health and Family Services.

Element 22 — Total Charges
Enter the anticipated total charge for this request.

Element 23 — Signature — Requesting Provider
The original signature of the provider requesting this service must appear in this element.

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Element 24 — Date Signed
Enter the month, day, and year the PA/RF was signed (in MM/DD/YY format).

Do not enter any information below the signature of the requesting provider — this space is reserved for Wisconsin Medicaid consultants and analysts.

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Appendix 5
Sample Prior Authorization Request Form (PA/RF) for Substance Abuse Day Treatment Services

DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Health Care Financing
HCF 11018 (Rev. 10/03)

STATE OF WISCONSIN
HFS 106.03(4), Wis. Admin. Code

WISCONSIN MEDICAID
PRIOR AUTHORIZATION REQUEST FORM (PA/RF)

Providers may submit prior authorization (PA) requests by fax to Wisconsin Medicaid at (608) 221-8616; or, providers may send the completed form with attachments to: Wisconsin Medicaid, Prior Authorization, Suite 88, 6406 Bridge Road, Madison, WI 53784-0088. **Instructions:** Type or print clearly. Before completing this form, read your service-specific Prior Authorization Request Form (PA/RF) Completion Instructions.

FOR MEDICAID USE — ICN	AT	Prior Authorization Number

SECTION I — PROVIDER INFORMATION

1. Name and Address — Billing Provider (Street, City, State, Zip Code)	2. Telephone Number — Billing Provider	3. Processing Type
I.M. Provider 1 W. Wilson Anytown, WI 55555	(XXX) XXX-XXXX 4. Billing Provider's Medicaid Provider Number 00000021	136

SECTION II — RECIPIENT INFORMATION

5. Recipient Medicaid ID Number	6. Date of Birth — Recipient (MM/DD/YY)	7. Address — Recipient (Street, City, State, Zip Code)
1234567890	MM/DD/YY	609 Willow Anytown, WI 55555
8. Name — Recipient (Last, First, Middle Initial) Recipient, Im A	9. Sex — Recipient ☒ M ❑ F	

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SECTION III — DIAGNOSIS / TREATMENT INFORMATION

10. Diagnosis — Primary Code and Description	11. Start Date — SOI	12. First Date of Treatment — SOI
303.90 — alcohol dependence		
13. Diagnosis — Secondary Code and Description 305.20 — cannabis abuse	14. Requested Start Date	

15. Performing Provider Number	16. Procedure Code	17. Modifiers 1	2	3	4	18. POS	19. Description of Service	20. QR	21. Charge
	H2012	HF				11	Behavioral health day treatment, per hour	64	XXX.XX

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

22. **Total Charges** XXX.XX

23. **SIGNATURE** — Requesting Provider: I.M. Provider

24. Date Signed: MM/DD/YY

FOR MEDICAID USE Procedure(s) Authorized: Quantity Authorized:

❑ Approved

Grant Date ________ Expiration Date ________

❑ Modified — Reason:

❑ Denied — Reason:

❑ Returned — Reason:

SIGNATURE — Consultant / Analyst ________ Date Signed ________

Appendix

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Appendix 6
Treatment Criteria for Substance Abuse Day Treatment (Adult): Severity of Illness

Severity of Illness: Admission to Treatment Program

Use the information in this appendix to complete the Prior Authorization/Substance Abuse Day Treatment Attachment (PA/SADTA), HCF 11037. Prior authorization criteria for intensity of treatment and severity of illness have been developed for substance abuse day treatment by Wisconsin Medicaid and substance abuse providers. The criteria illustrate the factors that will be used in determining whether substance abuse day treatment is considered medically necessary by Wisconsin Medicaid.

Recipients must have at least *one* indicator from categories 1, 4, 5, and 6 and *two* indicators from categories 2 and 3:

1. Loss of control or relapse crisis (at least one):
   a. At the time of admission, imminent chemical use is likely without close monitoring and structured support.
   b. Recipient has a documented failure to maintain abstinence with a lower level of care.
   c. Relapse would result in grave physical or personal harm to the recipient.
2. Physical conditions or complications (two indicators):
   a. Recipient's physical condition will benefit from substance abuse day treatment.
   b. One of the following:
      - ✓ Recipient's physical condition is stable.
      - ✓ Recipient has physical problems sufficiently severe to trigger addictive behavior and thus requires substance abuse day treatment (e.g., chronic pain creating the urge to seek addictive drugs).
3. Psychiatric conditions or complications (two indicators):
   a. Recipient's psychiatric state will benefit from substance abuse day treatment.
   b. One of the following:
      - ✓ Recipient's psychiatric state is stable.
      - ✓ Recipient has psychological stressors sufficiently severe to result in the use of chemicals if he or she does not receive treatment within the structure of a day treatment program (e.g., depression, unresolved grief, physical or sexual abuse).
4. Recovery environment (at least one):
   a. Recipient's family environment or living situation is stable enough to permit benefit from day treatment.
   b. Family members and/or significant others are unsupportive of recovery goals. Recipient's focus on recovery is enhanced by leaving the home environment during the day, but he or she may return home because there is no active opposition by the family to the recovery effort.
   c. Instability of the recipient's living environment due to substance abuse may be remedied with substance abuse day treatment (e.g., threatened divorce).
5. Life areas impairment (at least one):
   a. Recipient's chemical abuse results in significant behavioral deterioration (e.g., abuse of significant other, dishonesty, criminal charges).
   b. Recipient's chemical abuse results in severe social dysfunction (e.g., breakdown of important personal relationships, financial irresponsibility).
   c. Recipient's chemical abuse results in substantial loss of vocational or educational performance (e.g., significant absenteeism, occupational difficulties, school suspension).
6. Treatment acceptance/resistance (at least one):
   a. Recipient lacks sufficient understanding of the addiction disease process to undertake her or his own recovery and is willing to undergo substance abuse day treatment.
   b. Recipient lacks sufficient personal responsibility for recovery to comply with a treatment program at a lower level of care and is willing to undergo substance abuse day treatment.

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Appendix 7
Treatment Criteria for Substance Abuse Day Treatment Program (Adolescent): Severity of Illness

Severity of Illness: Admission to Treatment Program

Use the information in this appendix to complete the Prior Authorization/Substance Abuse Day Treatment Attachment (PA/SADTA), HCF 11037. Prior authorization criteria for intensity of treatment and severity of illness have been developed for substance abuse day treatment by Wisconsin Medicaid and substance abuse providers. The criteria illustrate the factors that will be used in determining whether substance abuse day treatment is considered medically necessary by Wisconsin Medicaid.

Recipients must have at least *one* indicator from categories 1, 5, and 6 and *two* indicators from category 2; *all* indicators from categories 3 and 4 must be met:

1. Loss of control or relapse crisis (at least one):
   a. At the time of admission, imminent chemical use is likely without close monitoring and structured support.
   b. Recipient has a documented failure to maintain abstinence with a lower level of care.
   c. Relapse would result in grave physical or personal harm to recipient.
2. Physical conditions or complications (two indicators):
   a. Recipient's physical condition will permit benefit from substance abuse day treatment.
   b. One of the following:
      - ✓ Recipient's physical condition is stable.
      - ✓ Recipient has physical problems sufficiently severe to trigger addictive behavior and thus requires substance abuse day treatment (e.g., frequent headaches creating the urge to seek addictive drugs).
3. Psychiatric conditions or complications (all of the following):
   a. Recipient's psychiatric state is stable enough to permit benefit from substance abuse day treatment.
   b. Behaviors, if present, are related to chemical use problems rather than a psychiatric condition (e.g., negativistic behaviors, restlessness, sulkiness, grouchiness, verbal aggression, isolation from family activities).
   c. If changes in moods, feelings, or attitudes are observed, they are related to substance use rather than a separate condition (e.g., feelings of wanting to leave home, not being understood, lacking parental approval, not caring about personal appearance).
   d. Documentation of substance use great enough to damage emotional health.
4. Recovery environment (all of the following):
   a. Recipient's living situation and school environment are stable enough to permit benefit from substance abuse day treatment.
   b. Family conflicts related to the recipient's abuse may be remedied with day treatment (e.g., parents are resentful and angry about drug use).
   c. Other family issues that require attention, if present, can be addressed by the program staff or through appropriate referrals (e.g., conflicts between the parents).
   d. Parents, foster parents, or legal guardians are supportive of recovery goals.
5. Life areas impairment (at least one):
   a. Recipient's substance abuse results in significant behavioral deterioration (e.g., abusive behavior, dishonesty, delinquency, running away).
   b. Recipient's substance abuse results in obvious social dysfunction (e.g., breakdown of important personal relationships, financial irresponsibility, association with delinquent peer group).
   c. Recipient's substance abuse results in substantial loss of vocational or educational performance (e.g., significant absenteeism, school suspension, impaired school performance).

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6. Treatment acceptance/resistance (at least one):
   a. Recipient lacks sufficient understanding of the addiction disease process to undertake his or her own recovery and is willing to undergo substance abuse day treatment.
   b. Recipient lacks sufficient personal responsibility for recovery to comply with a treatment program at a lower level of care and is willing to undergo substance abuse day treatment.

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Appendix 8
Treatment Criteria for Substance Abuse Day Treatment Program (Adult and Adolescent): Intensity of Service

Intensity of Service

Use the information in this appendix to complete the Prior Authorization/Substance Abuse Day Treatment Attachment (PA/SADTA), HCF 11037. Prior authorization criteria for intensity of treatment and severity of illness have been developed for substance abuse day treatment by Wisconsin Medicaid and substance abuse providers. The criteria illustrate the factors that will be used in determining whether substance abuse day treatment is considered medically necessary by Wisconsin Medicaid.

All of the criteria listed in this appendix must be met.

Program Standards

Treatment must take place in a certified substance abuse day treatment program offering a minimum of 60 hours of intensive outpatient services on a short-term basis. For example, a typical substance abuse day treatment program may run for three to five hours per day, three to five days per week, for four to six weeks.

Diagnosis (*Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition*)

1. A physician has stated the recipient currently has a primary diagnosis of one of the following:
   a. 303.90 (alcohol dependence).
   b. 304.00-304.90 (drug dependence).
   In addition, diagnosis codes 305.00 and 305.20-305.90 (alcohol and other drug abuse) are acceptable primary diagnoses for adolescents 18 years and younger.
2. The recipient does not have a primary diagnosis by a physician of 291-292 (substance-induced psychotic disorders), 303.00 (alcohol intoxication), or 317-319 (mental retardation).

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Evaluation and Treatment

1. The PA request must indicate the recipient's history during at least the past 12 months of *all* treatment for substance abuse, including day treatment, other outpatient care, inpatient services, and detoxification, with dates of service. The request also must include a brief narrative on the recipient's previous substance abuse treatment outcomes.
2. If the recipient received any inpatient or day treatment services for substance abuse in the past 12 months, the request must explain why, in the opinion of the professional staff, the requested substance abuse day treatment program is necessary and effective. Such requests will receive intensive scrutiny by the Department of Health and Family Services, according to the following:
   a. Whether substance abuse day treatment is appropriate within the context of previous treatment.
   b. Whether substance abuse day treatment will have a more successful outcome than the previous treatments.
   c. Whether the intensity and design of the substance abuse day treatment program (frequency, duration, and length of sessions) are likely to achieve intended results.
3. The request must document the professional staff's judgment that the recipient has a reasonable potential to improve his or her likelihood of remaining substance free in a less structured environment after completion of substance abuse day treatment.
4. The treatment plan must contain measurable, active treatment goals and objectives. At a minimum, the plan must address goals related to the recipient's selected "Severity of Illness" indicators.
5. The treatment plan must note any special needs of the recipient, such as physical health conditions, secondary psychiatric disorders, learning disabilities, nutritional needs, parenting, leisure time needs, and legal status. The plan

must state how these needs have been assessed and what action has or will be taken to meet these needs in the context of substance abuse day treatment. The request must document that treatment efforts among various providers are coordinated, if the recipient is receiving treatment for other conditions or by other providers.

6. The treatment plan must do the following:
   a. Describe family involvement in treatment planning, if applicable.
   b. Contain a statement that the recipient agrees to maintain abstinence throughout the course of substance abuse day treatment.
   c. Include a plan for continuing care for six to 12 months after completion of substance abuse day treatment.
7. The treatment plan should encourage involvement in ongoing support programs such as self-help groups, if applicable.

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Appendix 9
Prior Authorization/Substance Abuse Day Treatment Attachment (PA/SADTA) Completion Instructions

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(A copy of the Prior Authorization/Substance Abuse Day Treatment Attachment [PA/SADTA] Completion Instructions is located on the following page.)

Appendix

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WISCONSIN MEDICAID
PRIOR AUTHORIZATION / SUBSTANCE ABUSE DAY TREATMENT ATTACHMENT (PA/SADTA) COMPLETION INSTRUCTIONS

Wisconsin Medicaid requires certain information to enable Medicaid to authorize and pay for medical services provided to eligible recipients.

Recipients are required to give providers full, correct, and truthful information for the submission of correct and complete claims for Medicaid reimbursement. This information should include, but is not limited to, information concerning eligibility status, accurate name, address, and Medicaid identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to Medicaid administration such as determining eligibility of the applicant, processing prior authorization (PA) requests, or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of PA or Medicaid payment for the services.

The use of this form is voluntary and providers may develop their own form as long as it includes all the information on this form and is formatted exactly like this form. If necessary, attach additional pages if more space is needed. Refer to the Substance Abuse Day Treatment section of the Mental Health and Substance Abuse Services Handbook for service restrictions and additional documentation requirements. Provide enough information for Wisconsin Medicaid medical consultants to make a reasonable judgment about the case.

Attach the completed Prior Authorization/Substance Abuse Day Treatment Attachment (PA/SADTA), HCF 11037, to the Prior Authorization Request Form (PA/RF), HCF 11018, and physician prescription (if necessary) and send it to Wisconsin Medicaid. Providers may submit PA requests by fax to Wisconsin Medicaid at (608) 221-8616. Providers who wish to submit PA requests by mail may do so by submitting them to the following address:

Wisconsin Medicaid
Prior Authorization
Ste 88
6406 Bridge Rd
Madison WI 53784-0088

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The provision of services that are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s).

SECTION I — RECIPIENT INFORMATION

Element 1 — Name — Recipient (Last, First, Middle Initial)
Enter the recipient's name exactly as it appears on the recipient's Medicaid identification card.

Element 2 — Age — Recipient
Enter the age of the recipient in numerical form (e.g., 16, 21, 60).

Element 3 — Recipient Medicaid Identification Number
Enter the recipient's 10-digit Medicaid identification number exactly as it appears on the recipient's Medicaid identification card.

SECTION II — PROVIDER INFORMATION

Element 4 — Name and Credentials — Requesting / Performing Provider
Enter the name and credentials of the therapist who will be providing treatment/service.

Element 5 — Telephone Number — Requesting / Performing Provider
Enter the performing provider's telephone number, including area code.

Element 6 — Name — Referring / Prescribing Provider
Enter the name of the provider referring/prescribing treatment.

Element 7 — Referring / Prescribing Provider's Medicaid Provider Number
Enter the referring/prescribing provider's eight-digit provider number.

The remaining portions of this attachment are to be used to document the justification for the service requested. **Substance abuse day treatment is not a covered service for recipients who are residents of a nursing home or who are hospital inpatients.**

SECTION III — DOCUMENTATION

Element 8
Describe the length and intensity of treatment requested. Include the anticipated beginning treatment date and estimated substance abuse day treatment discharge date, and attach a copy of treatment design.

Element 9
List the dates of diagnostic evaluations or medical examinations and **specific** diagnostic procedures that were employed.

Element 10
List the codes and descriptions from the most recent *Diagnostic and Statistical Manual of Mental Disorders* (DSM) for the recipient's current primary and secondary diagnosis. Allowable DSM diagnoses are 303.90 (alcohol dependence), 304.00-304.90 (drug dependence), 305.00 (alcohol abuse), or 305.20-305.90 (other drug abuse, excluding caffeine intoxication).

Element 11
Describe the recipient's current clinical problems and relevant clinical history, including substance abuse history. (Give details of dates of abuse, substance[s] abused, amounts used, date of last use, etc.)

Element 12
Indicate whether or not the recipient has received any substance abuse treatment in the past 12 months. If the recipient has received substance abuse treatment within the past 12 months, indicate the date of each treatment episode, the type of service provided, and the treatment outcomes.

Element 13
If the recipient received any inpatient substance abuse care, intensive outpatient substance abuse services, or substance abuse day treatment in the past twelve months, give rationale for appropriateness and medical necessity of the current request. Discuss projected outcome of additional treatment requested.

Element 14
Describe the recipient's severity of illness using the indicators in a-f. Refer to the substance abuse day treatment criteria in the Substance Abuse Day Treatment section of the Mental Health and Substance Abuse Services Handbook.

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Element 15
Discuss the recipient's treatment plan and attach a copy of the plan.

Element 16 — Signature — Recipient or Representative
Signature of the recipient or representative indicates the signer has read the attached request for PA of substance abuse and agrees that it will be sent to Wisconsin Medicaid for review.

Element 17 — Date Signed
Enter the month, day, and year the PA/SADTA was signed by the recipient or the recipient's representative (in MM/DD/YY format).

Element 18 — Relationship (if representative)
Include relationship to recipient (if a representative signs).

Element 19 — Signature — Performing Provider
Enter the signature of the performing provider.

Element 20 — Date Signed
Enter the month, day, and year the PA/SADTA was signed by the performing provider (in MM/DD/YY format).

Element 21 — Discipline of Performing Provider
Enter the discipline of the performing provider.

Element 22 — Signature — Supervising Physician or Psychologist
Enter the signature of the supervising physician or psychologist.

Element 23 — Date Signed
Enter the month, day, and year the PA/SADTA was signed by the supervising physician or psychologist (in MM/DD/YY format).

Element 24 — Supervising Physician or Psychologist's Medicaid Provider Number
Enter the supervising physician or psychologist's Medicaid provider number.

Appendix 10
Prior Authorization/Substance Abuse Day Treatment Attachment (PA/SADTA) (for photocopying)

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for current policy

(A copy of the Prior Authorization/Substance Abuse Day Treatment Attachment [PA/SADTA] is located on the following pages.)

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WISCONSIN MEDICAID
PRIOR AUTHORIZATION / SUBSTANCE ABUSE DAY TREATMENT ATTACHMENT (PA/SADTA)

Providers may submit prior authorization (PA) requests to Wisconsin Medicaid by fax at (608) 221-8616 or by mail to: Wisconsin Medicaid, Prior Authorization, Suite 88, 6406 Bridge Road, Madison, WI 53784-0088. **Instructions:** Type or print clearly. Before completing this form, read the Prior Authorization/Substance Abuse Day Treatment Attachment (PA/SADTA) Completion Instructions, HCF 11037A.

SECTION I — RECIPIENT INFORMATION

1. Name — Recipient (Last, First, Middle Initial)	2. Age — Recipient

3. Recipient Medicaid Identification Number

SECTION II — PROVIDER INFORMATION

4. Name and Credentials — Requesting / Performing Provider

5. Telephone Number — Requesting / Performing Provider	6. Name — Referring / Prescribing Provider

7. Referring / Prescribing Provider's Medicaid Provider Number

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SECTION III — DOCUMENTATION

8. Describe length and intensity of treatment requested.

- Program request is for ______ hours per day,
  ______ days per week,
  for ______ weeks,
  for a total of ______ hours.
- Anticipated beginning treatment date ____.
- Estimated substance abuse day treatment discharge date ______________________________.
- Attach a copy of treatment design, which includes the following:
  a. A schedule of treatment (day, time of day, length of session, and service to be provided during that time).
  b. A brief description of aftercare / continuing care / follow-up component (also include this information in the treatment plan section of this form).

9. List the dates of diagnostic evaluations or medical examinations and **specific** diagnostic procedures that were employed.

Continued

SECTION III — DOCUMENTATION (Continued)

10. List the **current** primary and secondary diagnosis codes and descriptions from the most recent *Diagnostic and Statistical Manual of Mental Disorders* for the recipient's current primary and secondary diagnosis.

11. Describe the recipient's **current** clinical problems and relevant clinical history, including substance abuse history. (Give details of dates of abuse, substance[s] abused, amounts used, date of last use, etc.)

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12. Has the recipient received any substance abuse treatment in the past twelve months? ❑ Yes ❑ No
    If "Yes," provide information on the date of each treatment episode, the type of service provided, and the **treatment outcomes**.

13. Has the recipient received any inpatient substance abuse care, intensive outpatient substance abuse services, or substance abuse day treatment in the past twelve months? ❑ Yes ❑ No
    If "Yes," give rationale for appropriateness and medical necessity of the current request. Discuss projected outcome of additional treatment requested.

Continued

SECTION III — DOCUMENTATION (Continued)

14. Describe the recipient's severity of illness using the following indicators. Individualize all information.

    a. Loss of control / relapse crisis.

    b. Physical conditions or complications.

    c. Psychiatric conditions or complications. (Include psychiatric diagnosis, medications, current psychiatric symptoms.)

    d. Recovery environment.

    e. Life areas impairment. (Specify social / occupational / legal / primary support group.)

    f. Treatment acceptance / resistance.

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15. Treatment Plan

- **Attach** a copy of the recipient's substance abuse day treatment plan (refer to intensity of service guideline in the substance abuse day treatment criteria).
- Describe any special needs of the recipient and indicate how these will be addressed (for example, educational needs, access to treatment facility).

- Describe the recipient's family / personal support system. Indicate how these issues will be addressed in treatment, if applicable. If family members / personal support system are not involved in treatment, explain why not.

Continued

SECTION III — DOCUMENTATION (Continued)

15. Treatment Plan (Continued)

- Briefly describe treatment goals and objectives in specific and measurable terms.

- Describe the expected outcomes of treatment including the plan for continuing care.

I have read the attached request for PA of substance abuse day treatment services and agree that it will be sent to Wisconsin Medicaid for review.

16. SIGNATURE — Recipient or Representative	17. Date Signed

18. Relationship (if representative)

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Attach a photocopy of the physician's current prescription for substance abuse day treatment. (Must be dated within one month of receipt at Wisconsin Medicaid.)

19. SIGNATURE — Performing Provider	20. Date Signed

21. Discipline of Performing Provider

22. SIGNATURE — Supervising Physician or Psychologist	23. Date Signed

24. Supervising Physician or Psychologist's Medicaid Provider Number

Appendix 11
CMS 1500 Claim Form Instructions for Substance Abuse Day Treatment Services

Use the following claim form completion instructions, *not* the claim form's printed descriptions, to avoid denial or inaccurate Medicaid claim payment. Complete all required elements as appropriate. Do not include attachments unless instructed to do so.

Wisconsin Medicaid recipients receive a Medicaid identification card upon being determined eligible for Wisconsin Medicaid. Always verify a recipient's eligibility before providing nonemergency services by using the Medicaid Eligibility Verification System (EVS) to determine if there are any limitations on covered services and to obtain the correct spelling of the recipient's name. Refer to the Informational Resources section of the All-Provider Handbook or the Medicaid Web site for more information about the EVS.

Submit completed paper claims to the following address:

Wisconsin Medicaid
Claims and Adjustments
6406 Bridge Rd
Madison WI 53784-0002

Element 1 — Program Block/Claim Sort Indicator

Enter claim sort indicator "P" in the Medicaid check box for the service billed.

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Element 1a — Insured's I.D. Number

Enter the recipient's 10-digit Medicaid identification number. Do not enter any other numbers or letters. Use the Medicaid identification card or the EVS to obtain the correct identification number.

Element 2 — Patient's Name

Enter the recipient's last name, first name, and middle initial. Use the EVS to obtain the correct spelling of the recipient's name. If the name or spelling of the name on the Medicaid identification card and the EVS do not match, use the spelling from the EVS.

Element 3 — 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) or in MM/DD/YYYY format (e.g., February 3, 1955, would be 02/03/1955). Specify whether the recipient is male or female by placing an "X" in the appropriate box.

Element 4 — Insured's Name (not required)

Element 5 — Patient's Address

Enter the complete address of the recipient's place of residence, if known.

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

Commercial health insurance must be billed prior to submitting claims to Wisconsin Medicaid, unless the service does not require commercial health insurance billing as determined by Wisconsin Medicaid.

If the EVS indicates that the recipient has dental ("DEN") or has no commercial health insurance, leave Element 9 blank.

If the EVS indicates that the recipient has Wausau Health Protection Plan ("HPP"), BlueCross & BlueShield ("BLU"), Wisconsin Physicians Service ("WPS"), Medicare Supplement ("SUP"), TriCare ("CHA"), Vision only ("VIS"), a health maintenance organization ("HMO"), or some other ("OTH") commercial health insurance, *and* the service requires other insurance billing according to the Coordination of Benefits section of the All-Provider Handbook, then one of the following three other insurance (OI) explanation codes *must* be indicated in the *first* box of Element 9. The description is not required, nor is the policyholder, plan name, group number, etc. (Elements 9a, 9b, 9c, and 9d are not required).

Code	Description
OI-P	PAID by commercial health insurance or commercial HMO. In Element 29 of this claim form, indicate the amount paid by commercial health insurance to the provider or to the insured.
OI-D	DENIED by commercial health insurance or commercial HMO 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 was actually billed to the commercial health insurer.
OI-Y	YES, the recipient has commercial health insurance or commercial HMO coverage, but it was not billed for reasons including, but not limited to: ✓ The recipient denied coverage or will not cooperate. ✓ The provider knows the service in question is not covered by the carrier. ✓ The recipient's commercial health insurance failed to respond to initial and follow-up claims. ✓ Benefits are not assignable or cannot get assignment. ✓ Benefits are exhausted.

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Note: The provider may not use OI-D or OI-Y if the recipient is covered by a commercial HMO and the HMO denied payment because an otherwise covered service was not rendered by a designated provider. Services covered by a commercial HMO are not reimbursable by Wisconsin Medicaid except for the copayment and deductible amounts. Providers who receive a capitation payment from the commercial HMO may not submit claims to Wisconsin Medicaid for services that 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

Use the *first* box of this element for Medicare information. (Elements 11a, 11b, 11c, and 11d are not required.) Submit claims to Medicare before submitting claims to Wisconsin Medicaid.

Element 11 should be left blank when one or more of the following statements is true:

- Medicare never covers the procedure in any circumstance.
- Wisconsin Medicaid indicates the recipient does not have any Medicare coverage including Medicare Cost ("MCC") or Medicare + Choice ("MPC") for the service provided. For example, the service is covered by Medicare Part A, but the recipient does not have Medicare Part A.
- Wisconsin Medicaid indicates that the provider is not Medicare enrolled.
- Medicare has allowed the charges. In this case, attach the Explanation of Medicare Benefits, but do not indicate on the claim form the amount Medicare paid.

Appendix 11
(Continued)

If none of the previous statements are true, a Medicare disclaimer code is necessary. The following Medicare disclaimer codes may be used when appropriate.

Code	Description
M-5	Provider is not Medicare certified. This code may be used when providers are identified in Wisconsin Medicaid files as being Medicare certified, but are billing for dates of service (DOS) before or after their Medicare certification effective dates. Use M-5 in the following instances: *For Medicare Part A* (all three criteria must be met): ✓ The provider is identified in Wisconsin Medicaid files as certified for Medicare Part A, but the provider was not certified for the date the service was provided. ✓ The recipient is eligible for Medicare Part A. ✓ The procedure provided is covered by Medicare Part A. *For Medicare Part B* (all three criteria must be met): ✓ The provider is identified in Wisconsin Medicaid files as certified for Medicare Part B, but the provider was not certified for the date the service was provided. ✓ The recipient is eligible for Medicare Part B. ✓ The procedure provided is covered by Medicare Part B.
M-7	Medicare disallowed or denied payment. This code applies when Medicare denies the claim for reasons related to policy (not billing errors), or the recipient's lifetime benefit, spell of illness, or yearly allotment of available benefits is exhausted. Use M-7 in the following instances: *For Medicare Part A* (all three criteria must be met): ✓ The provider is identified in Wisconsin Medicaid files as certified for Medicare Part A. ✓ The recipient is eligible for Medicare Part A. ✓ The service is covered by Medicare Part A but is denied by Medicare Part A due to frequency limitations, diagnosis restrictions, or the service is not payable due to benefits being exhausted. *For Medicare Part B* (all three criteria must be met): ✓ The provider is identified in Wisconsin Medicaid files as certified for Medicare Part B. ✓ The recipient is eligible for Medicare Part B. ✓ The service is covered by Medicare Part B but is denied by Medicare Part B due to frequency limitations, diagnosis restrictions, or the service is not payable due to benefits being exhausted.
M-8	Noncovered Medicare service. This code may be used when Medicare was not billed because the service is not covered in this circumstance. Use M-8 in the following instances: *For Medicare Part A* (all three criteria must be met): ✓ The provider is identified in Wisconsin Medicaid files as certified for Medicare Part A. ✓ The recipient is eligible for Medicare Part A. ✓ The service is usually covered by Medicare Part A but not in this circumstance (e.g., recipient's diagnosis). *For Medicare Part B* (all three criteria must be met): ✓ The provider is identified in Wisconsin Medicaid files as certified for Medicare Part B. ✓ The recipient is eligible for Medicare Part B. ✓ The service is usually covered by Medicare Part B but not in this circumstance (e.g., recipient's diagnosis).

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Elements 12 and 13 — Authorized Person's Signature (not required)

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)

Elements 17 and 17a — Name and I.D. Number of Referring Physician or Other Source

Enter the referring physician's name and six-character Universal Provider Identification Number (UPIN). If the UPIN is not available, enter the eight-digit Medicaid provider number or the license number of the referring physician.

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

Enter the *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis code for each symptom or condition related to the services provided. List the primary diagnosis first. Etiology ("E") and manifestation ("M") codes may not be used as a primary diagnosis. The diagnosis description is not required. Refer to Appendix 2 of this section for a list of diagnosis codes.

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Element 22 — Medicaid Resubmission (not required)

Element 23 — Prior Authorization Number

Enter the seven-digit prior authorization (PA) number from the approved Prior Authorization Request Form (PA/RF), HCF 11018. Services authorized under multiple PA requests must be billed on separate claim forms with their respective PA numbers. Wisconsin Medicaid will only accept one PA number per claim.

Element 24A — Date(s) of Service

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

- When billing for one DOS, enter the date in MM/DD/YY or MM/DD/YYYY format in the "From" field.
- When billing for two, three, or four DOS on the same detail line, enter the first DOS in MM/DD/YY or MM/DD/YYYY format in the "From" field and enter subsequent DOS in the "To" field by listing *only* the date(s) of the month. For example, for DOS on June 1, 8, 15, and 22, 2005, indicate 06/01/05 or 06/01/2005 in the "From" field and indicate 08/15/22 in the "To" field.

It is allowable to enter up to four DOS per line if the following are true:

- All DOS are in the same calendar month.
- All services are billed using the same procedure code and modifier, if applicable.
- All services have the same place of service (POS) code.
- All services were performed by the same provider.
- The same diagnosis is applicable for each service.
- The charge for all services is identical. (Enter the total charge *per detail line* in Element 24F.)
- The number of services performed on each DOS is identical.
- All services have the same HealthCheck or family planning indicator, if applicable.
- All services have the same emergency indicator, if applicable.

Element 24B — Place of Service
Enter the appropriate two-digit POS code for each service. See Appendix 3 for a list of allowable POS codes.

Element 24C — Type of Service (not required)

Element 24D — Procedures, Services, or Supplies
Enter the single most appropriate five-character procedure code. Wisconsin Medicaid denies claims received without an appropriate procedure code.

Modifiers
Enter the appropriate (up to four per procedure code) modifier(s) in the "Modifier" column of Element 24D.

Note: Wisconsin Medicaid has not adopted all national modifiers.

Element 24E — Diagnosis Code
Enter the number (1, 2, 3, or 4) that corresponds to the appropriate ICD-9-CM diagnosis code listed in Element 21.

Element 24F — $ Charges
Enter the total charge for each line item. Providers are required to bill Wisconsin Medicaid their usual and customary charge. The usual and customary charge is the provider's charge for providing the same service to persons not entitled to Medicaid benefits.

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Element 24G — Days or Units
Enter the appropriate number of units for each line item. All day treatment substance abuse services are one-hour procedure codes. When billing for fractions of an hour, indicate units of service in half-hour increments using the standard rules of rounding. Always use a decimal (e.g., 2.0 units).

Minutes Billed	Quantity
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

Element 24H — EPSDT/Family Plan (not required)

Element 24I — EMG (not required)

Element 24J — COB (not required)

Element 24K — Reserved for Local Use

When the billing provider (Element 33) is a county/tribal social or human services agency "biller only" provider, enter the eight-digit individual performing provider number of the contracted agency providing the service. Otherwise, leave this element blank. Any other information entered in this element may cause claim denial.

Element 25 — Federal Tax I.D. Number (not required)

Element 26 — Patient's Account No. (not required)

Optional — Providers may enter up to 20 characters of the patient's internal office account number. This number will appear on the Remittance and Status Report and/or the 835 Health Care Claim Payment/Advice transaction.

Element 27 — Accept Assignment (not required)

Element 28 — Total Charge

Enter the total charges for this claim.

Element 29 — Amount Paid

Enter the actual amount paid by commercial health insurance. (If the dollar amount indicated in Element 29 is greater than zero, "OI-P" must be indicated in Element 9.) If the commercial health insurance denied the claim, enter "000." Do *not* enter Medicare-paid amounts in this field.

Element 30 — Balance Due

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Enter the balance due as determined by subtracting the amount paid in Element 29 from the amount in Element 28.

Element 31 — Signature of Physician or Supplier

The provider or 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 or MM/DD/YYYY format.

Note: The signature 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 Were Rendered (not required)

Element 33 — Physician's, Supplier's Billing Name, Address, ZIP Code, and Phone

Enter the name of the provider submitting the claim and the complete mailing address. The minimum requirement is the provider's name, city, state, and ZIP code. At the bottom of Element 33, enter the billing provider's eight-digit Medicaid provider number.

Appendix 12
Sample CMS 1500 Claim Form for Substance Abuse Day Treatment Services

PICA **HEALTH INSURANCE CLAIM FORM** PICA

CARRIER

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) [P] 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 [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? 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 ____

Refer to the Online Handbook for current policy

PATIENT AND INSURED INFORMATION

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 FROM MM DD YY TO MM DD YY

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

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

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY 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. 303.90
2. ___ . ___
3. ___ . ___
4. ___ . ___

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 1234567

24.	A From MM	DD	YY	To MM	DD	YY	B Place of Service	C Type of Service	D 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	07	05				11		H2012	HF	U6	1	XX XX	1.5				
2	01	12	05				11		H2012	HF		1	XX XX	1.0				
3	01	14	05	21	28		11		H2012	HF		1	XX XX	3.0				
4																		
5																		
6																		

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. Authorized MMDDYY

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
1 W. Williams
Anytown, WI 55555 87654321

PIN# GRP#

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) *PLEASE PRINT OR TYPE* APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

Appendix

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Appendix 13

Sample CMS 1500 Claim Form for Substance Abuse Day Treatment Services, "Biller Only" Providers

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

CARRIER — PATIENT AND INSURED INFORMATION

1. MEDICARE (Medicare #) — MEDICAID (Medicaid #) [P] — 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 [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 ____

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PHYSICIAN OR SUPPLIER INFORMATION

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 FROM MM DD YY TO MM DD YY

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

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

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY 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. 303.90
2. ___ . ___
3. ___ . ___
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	01	07	05				11		H2012	HF U6	1	XX XX	1.5				76543211
2	01	12	05				11		H2012	HF	1	XX XX	1.0				76543211
3	01	14	05	21	28		11		H2012	HF	1	XX XX	3.0				76543211
4																	
5																	
6																	

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. Authorized — MMDDYY

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. County/Tribal Biller-Only
1 W. Williams
Anytown, WI 55555

PIN# — GRP# 87654321

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) — *PLEASE PRINT OR TYPE* — APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

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Appendix 14
Mental Health and Substance Abuse Services Documentation Requirements

Providers are responsible for meeting Medicaid's medical and financial documentation requirements. Refer to HFS 106.02(9)(a), Wis. Admin. Code, for preparation and maintenance documentation requirements and HFS 106.02(9)(c), Wis. Admin. Code, for financial records documentation requirements.

The following are Wisconsin Medicaid's medical record documentation requirements (HFS 106.02[9][b], Wis. Admin. Code) as they apply to all mental health and substance abuse services. In each element, the applicable administrative code language is in parentheses. The provider is required to include the following written documentation in the recipient's medical record, as applicable:

1. Date, department, or office of the provider, as applicable, and provider name and profession.
2. Presenting problem (chief medical complaint or purpose of the service or services).
3. Assessments (clinical findings, studies ordered, and diagnosis or medical impression):
   a. Intake note signed by the therapist (clinical findings).
   b. Information about past treatment, such as where it occurred, for how long, and by whom (clinical findings).
   c. Mental status exam, including mood and affect, thought processes — principally orientation X3, dangerousness to others and self, and behavioral and motor observations. Other information that may be essential depending on presenting symptoms includes thought processes other than orientation X3, attitude, judgment, memory, speech, thought content, perception, intellectual functioning, and general appearance (clinical findings/diagnosis or medical impression).
   d. Biopsychosocial history, which may include, educational or vocational history, developmental history, medical history, significant past events, religious history, substance abuse history, past mental health treatment, criminal and legal history, significant past relationships and prominent influences, behavioral history, financial history, and overall life adjustment (clinical findings).
   e. Psychological, neuropsychological, functional, cognitive, behavioral, and/or developmental testing as indicated (studies ordered).
   f. Current status, including mental status, current living arrangements and social relationships, support system, current activities of daily living, current and recent substance abuse usage, current personal strengths, current vocational and educational status, and current religious attendance (clinical findings).
4. Treatment plans, including treatment goals/objectives, which are expressed in behavioral terms that provide measurable indices of performance, planned intervention, mechanics of intervention (frequency, duration, responsible party[ies]) (disposition, recommendations, and instructions given to the recipient, including any prescriptions and plans of care or treatment provided).
5. Progress notes (therapies or other treatments administered) must provide data relative to accomplishment of the treatment goals in measurable terms. Progress notes also must document significant events that are related to the person's treatment plan and assessments and that contribute to an overall understanding of the person's ongoing level and quality of functioning.

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