Physical Therapy, Occupational Therapy, and Speech and Language Pathology Services

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Refer to the Online Handbook for current policy

wisconsin Medicaid and BadgerCare
Information for Providers
Department of Health and Family Services

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

This Physical Therapy, Occupational Therapy, and Speech and Language Pathology Services Handbook is issued to all Medicaid-certified physical therapy (PT), occupational therapy (OT), and speech and language pathology (SLP) providers. The information in this handbook applies to Medicaid and BadgerCare.

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, and 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 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 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 on a fee-for-service basis. Refer to the Managed Care section of the All-Provider Handbook for information about state-contracted managed care organizations.

Handbook Organization

This Physical Therapy, Occupational Therapy, and Speech and Language Pathology Services Handbook consists of the following chapters:

- Certification and Ongoing Responsibilities.
- Provider Communication.
- Documentation Requirements.
- Services and Requirements.
- Codes.
- Prior Authorization.
- Requesting Extension of Therapy, Maintenance Therapy, or Services That Always Require Prior Authorization.
- Requesting Spell of Illness.
- Extension of Therapy vs. Spell of Illness.
- Requesting Services for Birth to 3 Participants.
- Requesting Amendments.
- Claims.
- Reimbursement.

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 information about these topics.

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.

Certification and Ongoing Responsibilities

Physical therapists, PTAs, occupational therapists, COTAs, and speech-language pathologists offering services addressed in this handbook are required to be licensed through the Wisconsin Department of Regulation and Licensing (DR&L).

Program requirements in this handbook pertain to the following:

- Physical therapists.
- Physical therapist assistants (PTAs).
- Physical therapy (PT) aides.
- Occupational therapists.
- Certified occupational therapy assistants (COTAs).
- Speech-language pathologists.
- Speech and language pathology (SLP) provider assistants.
- Physical therapy, occupational therapy (OT), and SLP students.
- Therapy groups, therapy clinics, and speech and hearing clinics.
- Rehabilitation agencies.
- Outpatient hospitals offering PT, OT, and SLP services.
- Physical therapy, OT, and SLP providers offering off-site hospital services.
- Physical therapy, OT, and SLP providers offering services in a nursing home.

Physical therapists, PTAs, occupational therapists, COTAs, and speech-language pathologists offering services addressed in this handbook are required to be licensed through the Wisconsin Department of Regulation and Licensing (DR&L). Temporary licensure through the DR&L is sufficient but is subject to the terms of the DR&L. Program requirements may not be construed to supersede the provisions for registration or licensure under s. 448, or 459.24., Wis. Stats. Refer to the DR&L Web site at *drl.wi.gov/* for more information about registration and licensure requirements.

Physical therapists, PTAs, occupational therapists, COTAs, and speech-language pathologists who are granted border status are exempt from the Wisconsin licensure requirement. However, these providers are required to be licensed by the appropriate agency in the state they practice. Refer to HFS 105.48, Wis. Admin. Code, for more information about border status.

Refer to Appendix 1 of this handbook for more information about certification requirements and provider numbers for PT, OT, and SLP providers.

Wisconsin Medicaid requires providers offering *outpatient* hospital PT, OT, and SLP services who are employed by, or under contract to, hospitals to meet all Medicaid certification requirements but does not require them to be individually certified by Wisconsin Medicaid. The hospital is required to maintain records showing that its individual providers meet Medicaid requirements.

Wisconsin Medicaid requires providers offering *off-site* hospital PT, OT, and SLP services who are employed by, or under contract to, hospitals to be individually certified by Wisconsin Medicaid.

Wisconsin Medicaid requires PT, OT, and SLP providers employed by, or under contract to, nursing homes to be individually certified by Wisconsin Medicaid.

Other Facilities

Other facilities may provide PT, OT, and SLP services by employing or contracting with individuals, groups, or agencies.

Information contained in this handbook does not apply to the following:

- Inpatient hospital PT, OT, and SLP services. Refer to hospital services publications for information about these services.
- Physical therapy, OT, and SLP services provided through the school-based services (SBS) benefit. Refer to SBS publications for information about these services.
- Physical therapy, OT, and SLP services provided by a home health agency. Refer to home health services publications for information about these services.
- Mental health and substance abuse services provided by an OT provider. Refer to mental health publications for information about these services.
- Community support program (CSP) services provided by an OT provider. Refer to CSP publications for information about these services.

Responsibilities

The following laws and regulations provide the legal framework for the program requirements in this handbook:

- Section 15, Wis. Stats., gives general powers to examining boards that license PT, OT, and SLP providers.
- Section 227, Wis. Stats., gives an agency the authority to promulgate rules.
- Section 448, Wis. Stats., outlines the qualifications for licensure or certification of PT or OT providers.
- Section 459, Wis. Stats., outlines the qualifications for licensure of SLP providers.
- Section 448, Wis. Stats., and Ch. PT, Wis. Admin. Code, define the scope of practice for PT providers.
- Section 448, Wis. Stats., and Ch. OT, Wis. Admin. Code, define the scope of practice for OT providers.
- Section 459, Wis. Stats., and Ch. HAS, Wis. Admin. Code, define the scope of practice for SLP providers.

To participate in Wisconsin Medicaid, providers are required to be certified by Wisconsin Medicaid as described in HFS 105, Wis. Admin. Code. Medicaid-certified providers have responsibilities that include, but are not limited to, the following:

- Providing the same level and quality of care to Medicaid recipients as private-pay patients.
- Billing only for services that were actually provided.
- Complying with all state and federal laws related to Wisconsin Medicaid.
- Obtaining prior authorization for certain services, when applicable.
- Notifying recipients in advance if a service is not Medicaid covered.
- Maintaining accurate medical and billing records.
- Allowing a recipient access to his or her records.
- Monitoring contracted staff.
- Accepting Medicaid reimbursement as payment in full for covered services.
- Keeping provider information (e.g., address, business name, business ownership) current.
- Responding to Medicaid recertification notifications.
- Safeguarding recipient confidentiality.
- Verifying recipient eligibility.
- Keeping up-to-date with changes in program requirements as published in Medicaid publications.

Providers are required to refer to the All-Provider Handbook for more information on these and other topics. Providers should also refer to the Certification and Ongoing Responsibilities section of the All-Provider Handbook for information about certification, provider rights, and recertification.

To participate in Wisconsin Medicaid, providers are required to be certified by Wisconsin Medicaid as described in HFS 105, Wis. Admin. Code.

Supervision Requirements

When supervision requirements are met, Medicaid reimbursement is available for services provided by assistants, students, or aides who are qualified to provide the service. Refer to Appendix 2 of this handbook for supervision requirements and services that may be provided by assistants, students, and aides.

When supervision requirements are met, Medicaid reimbursement is available for services provided by assistants, students, or aides who are qualified to provide the service.

Declaration of Supervision

Physical therapist assistants, COTAs and SLP provider assistants are required to complete the Declaration of Supervision for Nonbilling Providers form, HCF 1182, for changes in physical address or supervising therapist. The completion instructions and form are located in Appendices 3 and 4 of this handbook for photocopying and may also be downloaded and printed from the Medicaid Web site.

Supervision Waiver

Physical therapists and occupational therapists who wish to use assistants under general supervision may receive a waiver granting an alternative to Wisconsin Medicaid's current supervision requirements for PTAs and COTAs. The waiver must be requested when a provider wishes to use assistants under general supervision as allowed by the supervision requirements of the Wisconsin DR&L. Each billing provider should complete the Request for Waiver of Physical Therapist Assistant and Occupational Therapy Assistant Supervision Requirements form, HCF 1149, only once. Providers should retain copies of these forms for certification and audit purposes.

The form is located in Appendix 5 of this handbook for photocopying and may also be downloaded and printed from the Medicaid Web site.

The waiver is automatically granted when Wisconsin Medicaid acknowledges receipt of the form and is effective until the direct, immediate, on-premises supervision requirement is revised through a change to Wisconsin Administrative Code.

Durable Medical Equipment and Disposable Medical Supplies

Medicaid-certified PT, OT, and SLP providers do not need separate certification to dispense certain durable medical equipment (DME) and disposable medical supplies (DMS). Refer to DME and DMS publications for more information.

Provider Communication

School-Based Services providers are required to cooperate with PT, OT, and SLP providers who request copies of the child's Individualized Education Plan (IEP) or components of the IEP team evaluation.

Medicaid physical therapy (PT), occupational therapy (OT), and speech and language pathology (SLP) providers are required to communicate with other providers as frequently as necessary to do the following:

- Avoid duplication of services.
- Ensure service coordination.
- Facilitate continuity of care.

Other providers include, but are not limited to, the following:

- County Birth to 3 (B-3) programs.
- Community mental health agencies.
- Home care agencies.
- In-home autism providers.
- Local health departments.
- Medicaid HMOs.
- Medical equipment vendors.
- Physician clinics.
- Rehabilitation agencies.
- School-Based Services (SBS) providers.
- Therapists.
- Tribal health agencies.

Providers are required to document their communication with other providers in the recipient's medical record.

Providers should refer to the Certification and Ongoing Responsibilities section of the All-Provider Handbook for information about safeguarding recipient confidentiality.

Coordination with School-Based Services Providers

A recipient who receives SBS may also receive PT, OT, and SLP services that are not included in the Medicaid SBS benefit.

Physical therapy, OT, and SLP providers are required to coordinate evaluations and services with SBS providers. Physical therapy, OT, and SLP providers along with SBS providers are required to communicate with each other at least once a year. School-Based Services providers are required to cooperate with PT, OT, and SLP providers who request copies of the child's Individualized Education Plan (IEP) or components of the IEP team evaluation.

Coordination with County Birth to 3 Programs

Per HFS 90.07(3)(b), Wis. Admin. Code, PT, OT, and SLP providers are required to refer children who may be eligible for B-3 services to the appropriate county B-3 program within two working days of identification.

When a B-3 program is involved with a child (either for eligibility determination or service delivery), PT, OT, and SLP providers are required to cooperate with B-3 service coordination.

Refer to Appendix 38 of this handbook for general information about the B-3 Program.

Therapy Services for Children Brochure

A brochure titled "Medicaid Therapy Services for Children," PHC 1794, is available for families with children who are eligible for Medicaid PT, OT, and SLP services. The question-and-answer format of the brochure covers a variety of topics including how to access PT, OT, and SLP services for children and the PA process. This brochure does not address services provided through the SBS benefit. The brochure is located in Appendix 6 of this handbook for photocopying and may also be downloaded and printed from the Medicaid Web site.

Guide to Obtaining Augmentative Communication Devices and Accessories

A booklet titled "A Guide to Obtaining Augmentative Communication Devices and Accessories Through Wisconsin Medicaid," PHC 11065, is available for recipients and their families. The booklet covers a variety of topics including devices that are covered by Wisconsin Medicaid and the PA process. The booklet is located in Appendix 7 of this handbook for photocopying and may also be downloaded and printed from the Medicaid Web site.

Directory of Used Medical Equipment

A directory of established community agencies and organizations throughout Wisconsin that accept used medical equipment is available for recipients and their families. When a recipient has equipment that is no longer needed, he or she may donate the used equipment. Refer to the Recipient section of the Medicaid Web site for the directory.

A booklet titled "A Guide to Obtaining Augmentative Communication Devices and Accessories Through Wisconsin Medicaid," PHC 11065, is available for recipients and their families.

Documentation Requirements

To receive reimbursement for PT, OT, and SLP services, Wisconsin Medicaid requires a prescription.

As stated in HFS 106.02(9), Wis. Admin. Code, providers are required to prepare and maintain truthful, accurate, complete, legible, and concise medical documentation and financial records. Providers should refer to the Certification and Ongoing Responsibilities section of the All-Provider Handbook for general information about documentation requirements.

To be reimbursed by Wisconsin Medicaid, all physical therapy (PT), occupational therapy (OT), and speech and language pathology (SLP) services must be documented in the recipient's medical record. Documentation requirements include, but are not limited to, the following:

- The physician's prescription for PT, OT, and SLP services.
- The written report of the recipient's evaluation.
- The recipient's plan of care (POC).
- A written entry for each date a PT, OT, or SLP service is provided.
- A discharge plan, including any applicable home exercise programs and maintenance plans.

Prescriptions

To receive reimbursement for PT, OT, and SLP services, Wisconsin Medicaid requires a prescription. The prescription must be signed and dated by a physician and included in the recipient's medical record. The prescription is valid for one year or until a new POC is required.

Evaluations

Physical therapy, OT, or SLP providers are required to include a written report of the recipient's evaluation in the recipient's medical record. The evaluation report must be signed and dated and include the following:

- Assessment of the recipient's condition and recommendations for therapy intervention.
- Baseline measurements that establish a performance or ability level using units of objective measurement that can be consistently applied when reporting subsequent status of the recipient's progress.
- Chronological history of treatment provided for the diagnosis.
- Diagnosis(es) with date(s) of onset, current medical status, and functional status of the recipient.
- List of other PT, OT, and SLP service providers who are currently treating the recipient to the extent known by the evaluating PT, OT, or SLP provider.
- Previous level of function and change in medical status since previous prior authorization requests if performing a re-evaluation.
- Reason for the referral.
- Test charts or forms used in the evaluation.
- Underlying conditions or impairments to be treated.

Plan of Care

Physical therapy, OT, or SLP providers are required to establish a written POC for all recipients before providing services. The POC must be promptly signed and dated by the

prescribing physician and included in the recipient's medical record. The POC must include the following:

- Diagnoses.
- Amount, frequency, duration, and specific PT, OT, or SLP services.
- Reports of current status that support the POC.
- Measurable objectives.
- Anticipated short-term and long-term functional goals, which must be outcome based, appropriate for the diagnoses or presenting problems, and related to the specific PT, OT, and SLP services.
- A reasonable estimate of when the goals will be achieved.
- Communication and coordination with other providers. Such documentation includes the following:
  - ✓ Date(s) of communication.
  - ✓ Person(s) contacted.
  - ✓ A brief summary of the PT, OT, and SLP services provided by the other providers.
  - ✓ The unique and specific contribution of this PT, OT, or SLP provider given other PT, OT, and SLP providers' contributions.

At least every 90 days, or earlier if necessary, both of the following must occur:

- Physical therapy, OT, and SLP providers are required to do one of the following:
  - ✓ Develop a new POC.
  - ✓ Review and update the POC.
- Physicians are required to sign and date the POC with each review.

Daily Entries

Physical therapy, OT, and SLP providers are required to write a note in the recipient's medical record for every date of service (DOS). In the event of a provider audit, auditors will review any or all of the provider and recipient records that support reimbursement for services provided on a specific DOS. Records limited to checklists with attendance, procedure codes, and units of time are insufficient to meet this requirement. Daily entries must include the following:

- Date of service.
- Duration of the PT, OT, or SLP session.
- Specific treatment activities/interventions provided and the corresponding procedure codes.
- Problem(s) treated.
- Objective measurement of the recipient's response to the services provided during the treatment session.
- Signatures and credentials of the performing provider and, when necessary, the appropriate supervising therapist.

If a PT, OT, or SLP session does not occur as scheduled, the provider is required to indicate the reason the session did not occur.

Physical therapy, OT, and SLP providers are required to write a note in the recipient's medical record for every date of service (DOS).

Services and Requirements

To receive Medicaid reimbursement for a covered service, all Medicaid requirements must be met.

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.

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, services that do not meet program requirements, noncovered services, and situations when it is permissible to collect payment from recipients for noncovered services.

Covered physical therapy (PT), occupational therapy (OT), and speech and language pathology (SLP) services are identified by the procedure codes listed in Appendices 8, 9, and 10 of this handbook.

To receive Medicaid reimbursement for a covered service, all Medicaid requirements must be met. For PT, OT, and SLP services, the following statements must be true:

- Professional skills of a PT, OT, or SLP provider are required to meet the recipient's therapy treatment needs.
- Services are cost-effective when compared with other services that meet the recipient's needs.
- Services are established in a written plan of care (POC) before they are provided.
- Services are medically necessary as defined under HFS 101.03(96m), Wis. Admin. Code.
- Services are performed by a qualified provider and supervision requirements are met.
- Services are prescribed by a physician.
- Services are prior authorized by Wisconsin Medicaid, when applicable.

Initial Spell of Illness

Up to 35 dates of service (DOS) are allowed for each therapy discipline the first time a recipient requires PT, OT, or SLP services in his or her lifetime. This is called the recipient's *initial* spell of illness (SOI). The recipient's initial SOI does not require PA. However, some services always require PA, even when they are provided during a recipient's initial SOI. (Refer to the Requesting Extension of Therapy, Maintenance Therapy, and Services That Always Require Prior Authorization chapter of this handbook for information about services that always require PA.)

The initial SOI begins with the first day of evaluation or treatment and ends when the services are no longer required or after the 35 DOS, whichever comes first. The 35 DOS include any treatment days covered by other health insurance sources or any treatment days provided by another provider in any setting. If after 35 DOS a recipient's condition requires additional PT, OT, or SLP services, PA is required.

To receive Medicaid reimbursement, PT, OT, and SLP services provided within the initial 35 treatment days must meet the same medical necessity requirements as PT, OT, and SLP services that require PA.

Daily Limitations

For procedure codes that specify the unit of time, Wisconsin Medicaid does not reimburse PT, OT, and SLP providers beyond 90 minutes per day unless additional time is requested and

approved through an adjustment request to an allowed claim. Services provided beyond this daily limit generally exceed the medically necessary, reasonable, and appropriate duration of PT, OT, and SLP services.

In addition, the same modality may not be reimbursed as a PT service and an OT service on the same DOS for the same recipient.

Many PT, OT, and SLP services may be provided only a limited number of times per day. Refer to Appendices 8, 9, and 10 of this handbook for daily service limitations as they correspond to PT, OT, and SLP procedure codes.

Duplicate Services

Duplicate services may not be reimbursed by Wisconsin Medicaid. Wisconsin Medicaid may deny payment when another provider has a valid PA for duplicate PT, OT, or SLP services or when prior payment for duplicate services has been made to another provider.

To avoid potential claim denials resulting from duplicate services, providers are encouraged to request PA when they are unsure whether the recipient has received, or is currently receiving, PT, OT, or SLP services from another provider.

Evaluations

Evaluations are not reimbursed by Wisconsin Medicaid when any of the following are true:

- A screening is sufficient.
- Professional skills of a PT, OT, or SLP provider are not required to perform the evaluation.
- The evaluation is completed solely because of a change in one of the following:
  - ✓ The recipient's other health insurance coverage.
  - ✓ The PT, OT, or SLP provider's employment status (e.g., business ownership).
- The evaluation is not medically necessary (e.g., an evaluation performed for the purpose of vocational training).
- The PT, OT, or SLP provider reports a change in the recipient's status, but the POC is not updated to reflect this change.

Group Therapy

Group therapy may be reimbursed by Wisconsin Medicaid for OT and SLP services, but not for PT services.

A group setting for OT may consist of either of the following:

- Up to six patients supervised by one Medicaid-certified occupational therapist.
- Six to 12 patients supervised by two qualified OT staff members, one of whom is a Medicaid-certified occupational therapist.

A group setting for SLP may consist of up to four Medicaid recipients. Speech and language pathology group therapy is limited to the areas of expressive language, hearing or auditory training, or receptive language.

Many PT, OT, and SLP services may be provided only a limited number of times per day.

Natural Environments

Federal regulations require that providers deliver all Birth to 3 (B-3) services in the child's natural environment to the maximum extent possible. Birth to 3 services may be provided in a setting other than a natural environment only when outcomes cannot be satisfactorily achieved in the child's natural environment. Refer to Appendix 38 of this handbook for more information about natural environments and the B-3 Program.

Durable Medical Equipment and Disposable Medical Supplies

Certain durable medical equipment (DME) and disposable medical supplies (DMS) may be provided by PT, OT, and SLP providers. As with all Medicaid-covered services, DME and DMS must meet all program requirements, including medical necessity, to be reimbursed by Wisconsin Medicaid. All DME and DMS must be prescribed by a physician. In addition, they must be cost-effective and appropriate for use in the recipient's place of residence. Most DME and some DMS require PA.

HealthCheck services consist of a comprehensive health screening of Medicaid recipients under 21 years of age.

Most DMS used when providing a service are considered part of the provider's overhead cost and are not separately reimbursable. For example, Wisconsin Medicaid does not cover gloves used during PT, OT, and SLP sessions.

Refer to the DME and DMS indices on the Medicaid Web site for DME and DMS that may be provided by PT, OT, and SLP providers. Refer to DME and DMS publications for more information about DME, DMS, and Specialized Transmission Approval Technology-Prior Authorization.

HealthCheck "Other Services"

HealthCheck services consist of a comprehensive health screening of Medicaid recipients under 21 years of age. On occasion, a HealthCheck screening may identify the need for health care services that are not otherwise covered or that exceed Medicaid limitations. These services are called HealthCheck "Other Services." Federal law requires that these services be reimbursed by Wisconsin Medicaid through HealthCheck "Other Services" if they are medically necessary and prior authorized. The purpose of HealthCheck "Other Services" is to assure that medically necessary services are available to recipients under 21 years of age.

Refer to the Covered and Noncovered Services section of the All-Provider Handbook for more information about HealthCheck "Other Services" including, but not limited to, requirements that must be met for a service to be reimbursed through HealthCheck "Other Services."

Services Not Separately Reimbursable

Only face-to-face time for PT, OT, and SLP services may be reimbursed by Wisconsin Medicaid. Non-face-to-face time is considered part of the provider's overhead cost and is not separately reimbursable. This includes, but is not limited to, the following:

- Communicating with other professionals, staff, or caregivers.
- Reviewing records, scoring evaluation tests, or writing reports.
- Travel time and expenses related to delivery of services, including services provided in a B-3 participant's natural environment.

Reimbursement Not Available

Wisconsin Medicaid may deny or recoup payment for covered services that fail to meet program requirements. Medicaid reimbursement is also not available for noncovered services.

The following are not reimbursable as PT, OT, or SLP services:

- Group PT.
- Group SLP for services other than expressive language, hearing auditory training, or receptive language.
- Facilitated communication.
- Auditory integration training.

- Services provided for the general good and welfare of recipients, including the following:
  - ✓ General exercises to promote overall fitness and flexibility.
  - ✓ Activities to provide diversion or general motivation.
- Crafts and other supplies used in OT services for inpatients in an institutional program.
- Formal educational services in academic and vocational subjects.
- Foot orthoses or orthopedic or corrective shoes for the following conditions:
  - ✓ Flattened arches, regardless of the underlying pathology.
  - ✓ Incomplete dislocation or subluxation metatarsalgia with no associated deformities.
  - ✓ Arthritis with no associated deformities.
  - ✓ Hypoallergenic conditions.
- Durable medical equipment that are not primarily medical in nature, including the following:
  - ✓ Air conditioners and air purifiers.
  - ✓ Auditory or listening music programs.
  - ✓ Baby or infant exercise saucers.
  - ✓ Ceiling lifts.
  - ✓ Cleaning and disinfectant supplies.
  - ✓ Cold air humidifiers.
  - ✓ Computers.
  - ✓ Copy machines.
  - ✓ Dehumidifiers.
  - ✓ Educational learning computer programs.
  - ✓ Electric page turners.
  - ✓ Emergency alert contact systems or services.
  - ✓ Exercise and fitness equipment (stationary bicycles, treadmills, pulleys, weights, exercise therapy mats, rowing machines, physioballs, therapy putty, or therapy bands).
  - ✓ Extended warranty.
  - ✓ Fax machine.
  - ✓ Home and environmental modifications (electronic or mechanical devices to control lighting, appliances, etc.).
  - ✓ Homemaking equipment (microwaves, food carts, cutting boards, or other adaptive equipment for cooking, cleaning, etc.).
  - ✓ Hydrocollator equipment or other devices for heat or cold, including hot and cold packs.
  - ✓ Hypoallergenic items including bedding.
  - ✓ Intercom monitors.
  - ✓ Laptop computers.
  - ✓ Lights, horns, flags, or signs for mobility bases.
  - ✓ Pacemaker monitors.
  - ✓ Playground and recreation equipment (swings, jungle gyms, tunnels, parachutes, obstacle courses, tricycles, or other adapted or specialized toys).
  - ✓ Power door openers.
  - ✓ Reading machines.
  - ✓ Restraints.
  - ✓ Ring walkers.
  - ✓ Safety equipment (gait belts, harnesses, vests, alarm systems, wanderguard, medical alert bracelets or other types of monitoring equipment, or fences).
  - ✓ Service animals.
  - ✓ Telephone modems.
  - ✓ Telephones, cellular phones, and speaker phones.
  - ✓ Van or vehicle modifications.
  - ✓ Video games.
  - ✓ Durable medical equipment that are not generally accepted by the medical profession as being therapeutically effective. These items include heat and massage foam cushion pads.

Codes

Procedure Codes

Covered physical therapy (PT), occupational therapy (OT), and speech and language pathology (SLP) services are identified by allowable *Current Procedural Terminology* and Healthcare Common Procedure Coding System procedure codes and are listed in Appendices 8, 9, and 10 of this handbook. Allowable PT, OT, and SLP procedure codes for Birth to 3 services are located in Appendices 11, 12, and 13 of this handbook.

Physical therapy, OT, and SLP services must be provided in an allowable place of service (POS).

Unit of Service

Some procedure code descriptions do not specify a unit of time. When an amount of time is not specified, the entire service, for each date of service, equals one unit. For example, descriptions for 94667 (for PT and OT services) and 92612 (for SLP services) do not specify the duration of the service; therefore, one unit indicates the complete service.

Some procedure code descriptions specify a unit of time. When an amount of time is specified, that amount of time equals one unit. For example, the description for 97032 (for PT and OT services) indicates "each 15 minutes"; therefore, 15 minutes are equal to one unit. The description for 92607 (for SLP services) indicates "first hour"; therefore, one hour is equal to one unit.

In addition, part of a unit may be indicated by using a number with a decimal point. For example, in the case of 97140, 7.5 minutes are equal to .5 units. In the case of 92607, 30 minutes are equal to .5 units. (As with Medicare, *SLP* providers may not submit a claim for services provided for less than eight minutes.)

Modifiers

Allowable modifiers for PT, OT, and SLP services are listed in Appendix 14 of this handbook.

Place of Service Codes

Physical therapy, OT, and SLP services must be provided in an allowable place of service (POS). Refer to Appendix 15 of this handbook for allowable POS codes for PT, OT, and SLP services.

Diagnosis Codes

All diagnosis codes indicated on claims and prior authorization (PA) requests submitted to Wisconsin Medicaid must be from the *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) coding structure. Etiology ("E") and manifestation ("M") codes may not be used as a primary diagnosis.

Providers are responsible for keeping current with diagnosis code changes. Claims and PA requests received without an allowable ICD-9-CM diagnosis code are denied.

Prior Authorization

Prior authorization requests for PT, OT, and SLP services must be received by Wisconsin Medicaid within two weeks of performing the initial evaluation.

Prior authorization (PA) is required for certain services before they are provided. Wisconsin Medicaid does not reimburse providers for services provided either before the grant date or after the expiration date indicated on the approved Prior Authorization Request Form (PA/RF), HCF 11018. If the provider delivers a service either before the grant date or after the expiration date of an approved PA, or provides a service that requires PA without obtaining PA, the provider is responsible for the cost of the service. In these situations, providers may not collect payment from the recipient. Providers should refer to HFS 107.02(3), Wis. Admin. Code, for more information about Medicaid PA requirements.

Prior authorization does not guarantee payment. To receive Medicaid reimbursement, provider and recipient eligibility on the date of service, as well as all other Medicaid requirements, must be met.

For more information about general PA requirements, obtaining PA forms, submitting PA requests, and PA decisions, refer to the Prior Authorization section of the All-Provider Handbook.

Wisconsin Medicaid requires PA for the following:

- Physical therapy (PT), occupational therapy (OT), and speech and language pathology (SLP) services provided subsequent to the recipient's initial spell of illness (SOI).
- Physical therapy, OT, and SLP services that require PA starting with the first day of treatment. (Refer to the Requesting Extension of Therapy, Maintenance Therapy, and Services That Always Require Prior Authorization chapter of this handbook for information about services that always require PA.)

To avoid potential claim denials, providers are encouraged to request PA when they are unsure whether the recipient has received, or is currently receiving, PT, OT, or SLP services from another provider.

Prior authorization requests for PT, OT, and SLP services must be received by Wisconsin Medicaid within two weeks of performing the initial evaluation. This allows the PA request to be backdated to the date the evaluation was performed.

Prior Authorization Forms and Attachments

When PA is required, a PA/RF must be submitted with the appropriate attachment to Wisconsin Medicaid. Refer to Appendix 25 of this handbook for PA/RF completion instructions. Refer to Appendices 26, 27, and 28 for sample PA/RFs for PT, OT, and SLP services.

Physical therapy, OT, and SLP providers have the following choices for PA attachments:

- The Prior Authorization/Therapy Attachment (PA/TA), HCF 11008.
- The Prior Authorization/Spell of Illness Attachment (PA/SOIA), HCF 11039.
- The Prior Authorization/Birth to 3 Therapy Attachment (PA/B3), HCF 11011.

Medical Necessity

Wisconsin Medicaid relies on its definition of medically necessary, as stated in HFS 101.03(96m), Wis. Admin. Code, to determine whether a particular service may be reimbursed by Wisconsin Medicaid. Medical necessity for PT, OT, and SLP services is focused on intervention activities that are designed to produce specific outcomes.

Wisconsin Medicaid uses the PA process to determine whether the standards of medical necessity are met and to assure that appropriate PT, OT, and SLP services are provided to Medicaid recipients. Medicaid consultants evaluate PA requests for PT, OT, and SLP services on a case-specific basis. A PA request may be approved only if the documentation submitted in the PA request establishes that the standards of medical necessity, in addition to all other program requirements, are met. Refer to Appendix 16 of this handbook for examples of how the standards of medical necessity are evaluated on PA requests.

Common reasons for finding a "lack of medical necessity" include the following:

- Baseline performance is not documented in terms of the recipient's current functional abilities and limitations.
- Clinical information is not provided in sufficient detail to suggest that both of the following are true:
  - ✓ Treatment goals are reasonable given the current age and health status of the recipient.
  - ✓ Attainment of treatment goals would result in predictable functional improvement to the recipient.
- Documentation fails to support that the professional skills of a PT, OT, or SLP provider are required to meet the recipient's functional needs and therapy treatment needs.
- The recipient has failed to make progress toward the targeted goals and objectives in a reasonable time period, and the PT, OT, or SLP provider has not modified the treatment plan or objectives in spite of the anticipated outcomes not being achieved.

Relationship of Medical Necessity to Clinical Practice Principles

Physical therapy, OT, or SLP services reimbursed by Wisconsin Medicaid reflect the following principles of clinical practice:

- An intervention plan should not be based solely on the presence of a medical diagnosis.
- Frequency or duration of treatment is determined by rate of change as a result of therapy, rather than level of severity.[1]
- Decisions about direct service intervention are contingent on timely monitoring of patient or client response and progress made toward achieving the anticipated goals and expected outcomes.[2]
- The need for the service has been determined in collaboration with the primary caregivers and others working together on behalf of the individual.
- Families or caregivers affect the priorities for intervention through their direct and proactive participation in the therapeutic process and should be encouraged to participate in all treatment decisions.
- Intervention is unlikely to promote lasting functional improvements if the only opportunity to develop new skills occurs during sessions with the therapist.
- Therapeutic intervention strategies include an educational focus and home program that enables the family or caregiver and eventually the individual to facilitate and reinforce long-term gains.

Wisconsin Medicaid uses the PA process to determine whether the standards of medical necessity are met and to assure that appropriate PT, OT, and SLP services are provided to Medicaid recipients.

Flexibility of Approved Services

Wisconsin Medicaid allows flexible use of approved, medically necessary PT, OT, and SLP sessions so a provider may meet a recipient's needs.

Wisconsin Medicaid may approve a specific number of PT, OT, and SLP sessions that can be used flexibly. For example, rather than being restricted to providing PT, OT, and SLP services once a week for 10 weeks as

approved on a PA request, a provider and recipient may change the frequency of the sessions over the 10-week period. Therefore, PT, OT, and SLP services could be provided once a week for the first four weeks and twice a week *every other* week for the next six weeks.

The number of PT, OT, and SLP sessions used may not exceed the approved quantity and must be used between the PA grant and expiration dates.

Wisconsin Medicaid allows providers to request coordination of grant and expiration dates for the same recipient for multiple therapy disciplines.

Plan of Care Must Reflect Flexibility of Approved Services

Wisconsin Medicaid requires that the frequency and duration of PT, OT, and SLP services be written in the recipient's plan of care (POC) under HFS 107.16, 107.17, and 107.18, Wis. Admin. Code. To use the sessions flexibly, PT, OT, and SLP providers are required to have a physician's prescription that allows PT, OT, and SLP services to be used flexibly.

Note: Flexibility applies to all sessions approved on PAs including extension of therapy, maintenance therapy and SOI.

Duration of Approved Services

Prior authorization requests for PT, OT, and SLP services must meet the criteria of medically necessary under HFS 101.03(96m), Wis. Admin. Code.

In addition, the duration and frequency on a PA request should accurately reflect the POC.

If the PA request meets the criteria of medically necessary and the duration and frequency accurately reflect the POC, Wisconsin Medicaid should allow the following duration and number of sessions for PT, OT, and SLP services provided to individuals with *ongoing* treatment needs:

- Up to three sessions per week, for a duration of up to 26 weeks (maximum of 78 sessions).
- One or less than one therapy session per week, for a duration of up to 52 weeks (maximum of 52 sessions).

Duration applies for extension of therapy and maintenance therapy PAs but not SOI.

Coordinating Multiple Prior Authorization Requests

Wisconsin Medicaid allows providers to request coordination of grant and expiration dates for the same recipient for multiple therapy disciplines. The intent of this provision is to increase coordinated planning by PT, OT, and SLP providers and enable recipients and their families to benefit from a coordinated service delivery plan. Providers can facilitate this process by consulting with other PT, OT, and SLP providers. Wisconsin Medicaid will respond to coordination requests when possible. Providers should request the same grant and expiration dates on each PA request and note that it is for coordination of care purposes.

When initiating PA coordination, providers may need to request shorter duration periods to synchronize the PA requests.

[1] American Occupational Therapy Association.

[2] Guide to Physical Therapist Practice, 2001 American Physical Therapy Association, p. 38 and 46.

Requesting Extension of Therapy, Maintenance Therapy, and Services That Always Require Prior Authorization

Physical therapy (PT), occupational therapy (OT), and speech and language pathology (SLP) providers should use the Prior Authorization/Therapy Attachment (PA/TA), HCF 11008, when requesting the following:

- Extension of therapy services.
- Maintenance therapy services.
- Services that require PA starting with the first day of treatment.

No single factor, such as diagnosis or age of the recipient, will result in automatic approval or denial of a PA request for extension of therapy services, maintenance therapy services, or services that always require PA.

The completion instructions and PA/TA are located in Appendices 29 and 30 of this handbook for photocopying and may also be downloaded and printed from the Medicaid Web site.

Approval Criteria

Comprehensive information about the recipient helps to establish the functional potential of the recipient and forms the basis for determining whether the recipient will benefit from the requested services. No single factor, such as diagnosis or age of the recipient, will result in automatic approval or denial of a PA request for extension of therapy services, maintenance therapy services, or services that always require PA.

It is essential that documentation is complete, accurate, and specific to the recipient's current condition and needs. Providers are required to submit the following when submitting the PA/TA:

- A written report of the recipient's evaluation. Refer to the Documentation Requirements chapter of this handbook for information about evaluation reports.
- An individualized plan of care (POC) if not documented on the PA/TA. Refer to the Documentation Requirements chapter of this handbook for more information about the POC.
- A copy of the Individualized Family Service Plan (IFSP) if the recipient is a Birth to 3 participant and the services are being requested with the PA/TA.* Refer to the Requesting Services for Birth to 3 Participants chapter of this handbook for information about submitting the IFSP with the PA/TA.
- A copy of the Individualized Education Plan (IEP) if the recipient is a school-age child.*
- A copy of the Interdisciplinary Program Plan (IPP) if the recipient is in a residential or day facility for the developmentally disabled.* The IPP must document coordination and integration of the active treatment and medical care plan of the recipient.

* Only one team member needs to submit the IFSP, IEP, or IPP with a PA request. The team should discuss who will submit the IFSP, IEP, or IPP. The other providers should reference the PA request that was submitted with the IFSP, IEP, or IPP by indicating the PA number and the date the PA was submitted. The team member designated to submit the IFSP, IEP, or IPP should receive an additional copy from the coordinator. If the recipient does not have an IFSP, IEP, or IPP, the provider is required to indicate the reason these documents do not exist.

Refer to Appendix 17 of this handbook for additional approval criteria for extension of therapy services, maintenance therapy services, and services that always require PA.

Extension of Therapy

Prior authorization is required to extend PT, OT, and SLP services subsequent to the recipient's initial spell of illness. As specified in HFS 107.16(3)(e), 107.17(3)(e), and 107.18(3)(e), Wis. Admin. Code, a PA request to extend therapy services (i.e., continuation of therapy services) will *not* be approved in any of the following circumstances:

- The recipient shows no progress toward meeting or maintaining established and measurable treatment goals over a six-month period, or the recipient shows no ability within six months to carry over abilities gained from treatment in a facility to the recipient's home.
- The recipient's chronological or developmental age, lifestyle, or home situation indicates the stated goals are not appropriate for the recipient or serve no functional or maintenance purpose.
- The recipient has achieved independence in daily activities or can be supervised and assisted by restorative nursing personnel, active treatment staff, activity or recreation staff, caregivers, or family.
- The evaluation indicates the recipient's abilities are functional for the recipient's present lifestyle.
- The recipient shows no motivation, interest, or desire to participate in a PT, OT, or SLP program.
- Other therapies or services being provided are sufficient to meet the recipient's treatment needs.
- The procedures requested are not medical in nature or are not covered services. Inappropriate diagnoses for PT, OT, and SLP services and procedures of questionable medical necessity may not receive departmental authorization, depending upon the individual circumstances.

Maintenance Therapy

Prior authorization is required for maintenance therapy services. Prior authorization requests for maintenance therapy services may be approved when the following apply:

- Specialized knowledge and judgment of a PT, OT, or SLP provider are required to establish and monitor the therapy program.
- The recipient's functional abilities cannot be maintained without PT, OT, or SLP services.
- Treatment allows the recipient to achieve or maintain a specific level of functional independence.

When evaluating a PA request for maintenance therapy services, Wisconsin Medicaid evaluates the recipient's diagnoses, history, functional status, cognitive abilities, and the chronic or progressive nature of the identified diagnosis impairments or disabilities. In addition, consideration is given to the following:

- Caregivers involved with the recipient.
- Exercises prescribed in the home exercise program/preventive maintenance plan (HEP/PMP).
- Level of caregiver assistance required to execute the HEP/PMP.
- Professional skills and expertise the PT, OT, or SLP provider brings to the maintenance program.
- Recipient's residence (e.g., private residence, group home).
- Specific functional outcomes of the HEP/PMP.
- Treatment goals and anticipated outcomes of the requested services.

Direct Maintenance

Wisconsin Medicaid evaluates a PA request for direct maintenance therapy services when

P Prior authorization is required to extend PT, OT, and SLP services subsequent to the recipient's initial spell of illness.

one or more of the following conditions are met:

- Nursing personnel cannot handle the recipient safely and effectively due to the severity or complexity of the recipient's condition.
- Professional knowledge and judgment of a PT, OT, or SLP provider are required to establish and monitor the therapy maintenance program, including the following:
  - ✓ Designing the program as well as monitoring the recipient's functional abilities.
  - ✓ Performing the initial evaluation.
  - ✓ Performing any necessary re-evaluations.
  - ✓ Providing instruction for nursing personnel, family, caregiver, or recipient.
- The POC and the recipient's condition require continual adjustment of therapeutic input and/or constant use of therapeutic principles.

The frequency requested for maintenance therapy services should be based on the predictability of change in the recipient's status or condition.

Direct maintenance therapy services provided one time per week or less in isolation from an established HEP/PMP are generally not considered effective maintenance of the recipient's functional abilities. For maintenance therapy services to be effective, the recipient should also be involved in a routine HEP/PMP.

Routine HEP/PMPs can be performed with the assistance of a caregiver or by the recipient. Routine HEP/PMPs can influence the recipient's functional abilities on a consistent basis and are considered more effective than PT, OT, or SLP sessions provided one time per week or less.

Monitoring Maintenance

Monitoring maintenance therapy services is most often approved when the professional skills of a PT, OT, or SLP provider are needed to monitor or modify an HEP/PMP that is carried out by the recipient's caregivers.

In these situations, it is expected that the recipient's medical condition or functional abilities change often enough to warrant re-evaluation and modification of the HEP/PMP. The frequency requested for maintenance therapy services should be based on the predictability of change in the recipient's status or condition. Subsequently, an assessment to modify an HEP/PMP needs to be justified in a PA request by a change in the recipient's medical condition, living situation, adaptive equipment needs, functional abilities, and/or caregiver status.

Approved maintenance therapy services may also involve the process of teaching a routine HEP/PMP to a caregiver to assure follow-through and understanding of the HEP/PMP techniques. The requested frequency should reflect the need for intervention and teaching from a PT, OT, or SLP provider.

Discontinuing Maintenance

When there is an established HEP/PMP and the recipient's response to treatment is predictable, the following examples of HEP/PMPs may not require the professional skills and expertise of a PT, OT, or SLP provider after the initial treatment and instruction:

- Active-assisted, active, and resisted exercises.
- Activities of daily living.
- Ambulation when level of assistance and/or assistive device has been determined.
- Aquatic exercises.
- Chest PT.
- Cognitive skills — orientation, attention span, problem solving, conceptualization, integration of learning.
- Coping skills.
- Exercises to promote overall fitness.
- Expressive language.
- Fluency (e.g., stuttering).
- Hot/cold treatments.
- Independent living skills.
- Language structure, content, or functions.
- Massage.
- Memory sequencing.

- Play activities that stimulate development/ strength/range of motion/coordination.
- Positioning.
- Range of motion exercises.
- Rote, drill activities.
- Sensory integration.
- Standing table.
- Strengthening exercises.
- Stretching exercises.
- Unattended electrical stimulation.
- Voice quality.

The professional skills and expertise of a PT, OT, or SLP provider may be required to execute the recipient's maintenance therapy services if there is documentation that the nursing personnel or caregivers routinely performed the HEP/PMP as prescribed, but the outcome was affected by one or more of the following:

- Complicating factors related to the recipient's diagnosis.
- Risk to the recipient's health or safety as identified by the PT, OT, or SLP provider's reassessment of the HEP/PMP.
- Unforeseeable problems associated with the recipient's functional abilities being maintained by other caregivers.

In these situations it may be necessary for a period of brief, intensive treatment (if the recipient's status has regressed) prior to resuming a maintenance program. These situations may require a new PA request.

Services That Always Require Prior Authorization

The following PT, OT, and SLP services require PA starting with the first day of treatment:

- Aural rehabilitation following cochlear implants.
- Cotreatment.
- Dual treatment.
- HealthCheck "Other Services."
- Services identified by unlisted procedure codes.
- Treatment of decubitus ulcers.
- Treatment for conditions resulting from mental retardation.

Cotreatment

Cotreatment (interdisciplinary treatment) always requires PA. Cotreatment is simultaneous treatment by two providers of different therapy disciplines during the same time period. Cotreatment may be authorized when the treatment approach is medically necessary to optimize the recipient's benefit from therapy.

If cotreatment is approved, two providers of different therapy disciplines can be reimbursed by Wisconsin Medicaid for the same time period.

Each of the providers involved in cotreatment is required to complete a separate PA request; the requests must be submitted at the same time. Providers may either mail the PA requests in the same envelope or fax them at the same time. The Prior Authorization Request Forms (PA/RFs), HCF 11018, may be submitted via the Web if both PA requests are mailed together or faxed at the same time.

Each provider's PA request for cotreatment must include the following:

- A specific request for cotreatment.
- Documentation verifying the following:
  - ✓ Individual treatment from a single PT, OT, or SLP provider does not provide maximum benefit to the recipient.
  - ✓ Services of two different therapy disciplines, *simultaneously* performed, are required to treat the recipient.
- Identification of the other provider and therapy discipline.

When cotreatment is approved, "cotreatment is approved" will be written on the bottom of the PA request.

If cotreatment is approved, two providers of different therapy disciplines can be reimbursed by Wisconsin Medicaid for the same time period. For example, if a recipient is treated by an OT provider and an SLP provider from 1:00 to 2:00, both providers could receive Medicaid

reimbursement for one hour. However, if cotreatment is *not* approved, both the OT provider and the SLP provider would not receive reimbursement for one hour. Instead, each provider could receive reimbursement for 30 minutes.

Dual Treatment

Dual treatment (intradisciplinary treatment) always requires PA. Dual treatment is treatment by two or more providers of the same therapy discipline from different agencies or organizations. Each of the providers involved in dual treatment is required to complete a separate PA request; the requests must be submitted at the same time. Providers may either mail the PA requests in the same envelope or fax them at the same time. The PA/RFs may be submitted via the Web if both PA requests are mailed together or faxed at the same time.

Treatment of decubitus ulcers using electrical stimulation always requires PA.

Each provider's PA request for dual treatment must include the following:

- A specific request for dual treatment.
- Identification of the other provider.
- Procedures for coordination of the treatment plans.
- Specific days of the week each provider will provide services.
- The specific and unique contribution of each PT, OT, or SLP provider.

Unlisted Procedure Codes

Services identified by unlisted procedure codes always require PA. Unlisted procedure codes include 97039 for PT services, 97139 for PT and OT services, and 92700 for SLP services. A PA request with one of these procedure codes should include an explanation of why no other procedure code accurately reflects the service being requested.

Decubitus Ulcers

Treatment of decubitus ulcers using electrical stimulation always requires PA. When requesting PA for electrical stimulation of decubitus ulcers, the service should be requested as a manual electrical stimulation procedure. Wisconsin Medicaid reimburses only for the face-to-face time that the PT provider is in attendance.

A PA request for electrical stimulation of decubitus ulcers must include documentation of the following:

- The character, size, etc., of the pressure sore.
- The need for additional time for dressing changes.
- Weekly measurements.
- Weekly percentage change in size or healing.

Prior authorization for continuing electrical stimulation treatment is considered only when there has been interval formation of granulation tissue or a 25 percent reduction in area has occurred within 45 treatment days. When this rapid improvement has not occurred within 45 days, a PA request for continuing electrical stimulation treatment must include documentation of nursing protocols, positioning recommendations, and dietary recommendations.

Requesting Spell of Illness

After the initial SOI, any new disease, injury, medical condition, or increased severity of a pre-existing medical condition that requires PT, OT, or SLP services is called a *subsequent* SOI.

Physical therapy (PT), occupational therapy (OT), and speech and language pathology (SLP) providers should submit the Prior Authorization/Spell of Illness Attachment (PA/SOIA), HCF 11039, when requesting approval for SOI.

The completion instructions and PA/SOIA are located in Appendices 31 and 32 of this handbook for photocopying and may also be downloaded and printed from the Medicaid Web site.

After the initial SOI, any new disease, injury, medical condition, or increased severity of a pre-existing medical condition that requires PT, OT, or SLP services is called a *subsequent* SOI. A subsequent SOI always requires PA.

When submitting the PA/SOIA, providers are required to provide the appropriate primary *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis code or the appropriate ICD-9-CM surgical procedure code and answer "yes" or "no" to seven statements about the recipient's diagnosis or condition. The answers to these statements are used to determine if the SOI request will be approved. If the PA request is approved, Wisconsin Medicaid uses the combination of the ICD-9-CM code and the answers to these statements to assign the maximum allowable treatment days for the SOI.

A PA request for an SOI may be approved if all of the following are true:

- The recipient has incurred a demonstrated functional loss of ability to perform daily living skills within the past six weeks, and there is measurable evidence to support this.
- There is a reasonable expectation that the recipient will return to his or her previous level of function by the end of this SOI or sooner.
- Only one of statements "A" through "F" from Element 11 of the PA/SOIA would be marked "yes." If the recipient's condition could be categorized by more than one of statements "A" through "F," providers should choose the statement that best describes the reason for the SOI. Examples of situations covered in statements "A" through "F" are provided on the back of the PA/SOIA.

  Note: Statement "D" does not apply to PT services. Statements "C," "D," and "F" do not apply to SLP services.

If these conditions are not met, Wisconsin Medicaid will return the PA request and instruct the provider to use the Prior Authorization/Therapy Attachment (PA/TA), HCF 11008.

Maximum Allowable Treatment Days

An SOI begins with the first day of evaluation or treatment and ends when the services are no longer required or after the allowable treatment days have been used, whichever comes first. The allowable treatment days include any treatment days covered by other health insurance sources or any treatment days provided by another provider in any setting.

The maximum allowable treatment days that may be granted for each ICD-9-CM code have been determined separately for each therapy discipline. There are two charts for each therapy discipline. Refer to Appendices 19 and 20 of this handbook for PT services, Appendices 21 and 22 of this handbook for OT services, and Appendices 23 and 24 of this

handbook for SLP services. The two charts for each therapy discipline contain the same information, but are organized differently. Appendices 19, 21, and 23 of this handbook are organized alphabetically by the ICD-9-CM code description. Appendices 20, 22, and 24 of this handbook are organized by statements "A" through "F" of the PA/SOIA. Providers should use the appendix that best suits their needs. Instructions for reading each chart are included at the top of the appendix. Providers should use the appendices to determine the allowable combinations of ICD-9-CM codes and statements for SOI approval.

Only the ICD-9-CM codes that are listed in the appendices are available for SOI approval. If the ICD-9-CM code is not listed for the appropriate therapy discipline, the PT, OT, or SLP provider should submit the PA/TA.

Unused Treatment Days

Unused treatment days from one SOI cannot be carried over into a new SOI. When a new, approved SOI occurs during an existing SOI, the current SOI ends, and a new one begins.

Only the ICD-9-CM codes that are listed in the appendices are available for SOI approval.

Extension of Therapy vs. Spell of Illness

Wisconsin Medicaid will *not* approve a request for SOI when extension of therapy services is necessary.

Physical therapy (PT), occupational therapy (OT), and speech and language pathology (SLP) providers may always choose to request extension of therapy services instead of spell of illness (SOI). For example, a provider may request extension of therapy services instead of SOI when treating an acute onset of a condition, such as a stroke. However, Wisconsin Medicaid will *not* approve a request for SOI when extension of therapy services is necessary.

Physical therapy, OT, and SLP providers are *required* to request extension of therapy services (instead of SOI) when any of the following are true:

- The onset of the recipient's condition occurred more than six weeks prior to the request for SOI.
- The combination of the *International Classification of Diseases, Ninth Revision, Clinical Modification* code for the PT, OT, or SLP services and the true statement from the Prior Authorization/ Spell of Illness Attachment, HCF 11039, does not allow for SOI approval.
- The recipient's need for PT, OT, or SLP services has exceeded the maximum allowable treatment days for that SOI.
- The recipient's condition does not qualify for an SOI. (Certain conditions never qualify for an SOI, such as mental retardation.)

Physical therapy, OT, and SLP providers are *encouraged* to request extension of therapy services (instead of SOI) when either of the following are true:

- The provider is unsure if the recipient has received, or is currently receiving, PT, OT, or SLP services from another provider for the current SOI.
- The recipient's need for PT, OT, or SLP services is expected to exceed the maximum allowable treatment days for that SOI.

Refer to Appendix 18 of this handbook to determine which PA attachment is best suited for the services being requested.

Requesting Services for Birth to 3 Participants

An approved PA is granted up to the recipient's third birthday.

Physical therapy (PT), occupational therapy (OT), and speech and language pathology (SLP) providers should submit the Prior Authorization/Birth to 3 Therapy Attachment (PA/B3), HCF 11011, for Birth to 3 (B-3) services.

The PA/B3 is located in Appendix 33 of this handbook for photocopying and may also be downloaded and printed from the Medicaid Web site.

Providers receive a real-time decision for approved B-3 services requested via the Web. Providers should refer to the Medicaid Web site for more information about Web submission.

Wisconsin Medicaid requires PT, OT, and SLP providers to submit a PA request only once per child, per therapy discipline, per billing provider for recipients who participate in the B-3 Program. An approved PA is granted up to the recipient's third birthday.

Birth to 3 services must be provided by Medicaid PT, OT, and SLP providers who are employed by, or under agreement with, a B-3 agency to provide B-3 services. In addition, the B-3 services must be one or both of the following:

- Provided in conjunction with the B-3 initial evaluation and assessment in accordance with HFS 90, Wis. Admin. Code, even if the evaluation and assessment determines the child is not eligible for B-3 services.
- Identified in the recipient's Individualized Family Service Plan (IFSP) and performed at the same frequency, intensity, and duration listed in the IFSP. Wisconsin Medicaid will not reimburse the provider beyond the frequency and duration specified in the prescription or the physician-signed plan of care.

Providers may submit the PA/B3 in either of the following situations:

- At any time once an evaluation or a PT, OT, or SLP service has been initiated through the B-3 Program.
- Two to four weeks before the child's initial 35 treatment days per discipline have been used.

Situations That Do Not Qualify for Birth to 3

Providers may not use the PA B-3 process for any of the following:

- Children who are not being evaluated as part of an initial B-3 assessment or who are not participating in the B-3 Program. (Some children are not eligible for the B-3 Program. One example would be a child without developmental delays who needs therapy to recover from an accident or injury, such as a broken arm. Providers are required to indicate the reason the child is not a B-3 participant.)
- Services provided by Medicaid PT, OT, or SLP providers who are not employed by, or under agreement with, a B-3 agency to provide B-3 services.
- Services not identified in the IFSP.
- Procedure codes not listed in Appendices 11, 12, and 13 of this handbook.
- Cotreatment services.

For situations that do not meet the criteria for the PA B-3 process, providers are required to submit the Prior Authorization/Therapy Attachment (PA/TA), HCF 11008, or the Prior Authorization/Spell of Illness Attachment (PA/SOIA), HCF 11039. Providers should refer to the Requesting Extension of Therapy, Maintenance Therapy, or Services That Always Require Prior Authorization chapter and the Requesting Spell of Illness chapter of this handbook for information about submitting the PA/TA or PA/SOIA.

Providers are required to include the following components of the IFSP when submitting the PA/TA for B-3 participants:

- The child's health history and current medical status, including results of hearing and vision screening.
- A summary of the child's development in the following five areas:
  - ✓ Cognitive skills.
  - ✓ Physical development (fine and gross motor skills).
  - ✓ Communication skills.
  - ✓ Social or emotional development.
  - ✓ Adaptive development (including self-help skills).
- Concerns, priorities, and resources as identified by the family and other team members.
- Functional outcomes (including the follow-through plans for the child's family and any outcome evaluation criteria).
- Summary of services.

In accordance with HFS 90, Wis. Admin. Code, the IFSP describes the outcomes, strategies, supports, and services appropriate to meet the child's and family's needs. The IFSP does not establish medical necessity.

After the IFSP has been submitted once, only the sections of the IFSP that change significantly need to be submitted to Wisconsin Medicaid. This typically includes the following:

- The annual update on developmental status.
- Changes in desired outcomes that may be developed at either six-month or annual reviews.

After the IFSP has been submitted once, only the sections of the IFSP that change significantly need to be submitted to Wisconsin Medicaid.

Requesting Amendments

Providers may request an amendment to a current approved or modified prior authorization (PA) request to change any of the following:

- The frequency of treatment.
- The grant and expiration date(s).
- The request for cotreatment.
- The specific treatment code(s).

Prior authorization expiration dates may be amended up to one month beyond the original expiration date if the additional services are medically necessary and physical therapy (PT), occupational therapy (OT), or speech and language pathology (SLP) services will be discontinued after this brief extension of services.

If the need for PT, OT, or SLP services is expected to continue for longer than one month beyond the expiration date, submission of a new PA request is required.

Providers are required to submit a new PA request (instead of requesting an amendment) if the recipient's medical condition changes significantly and requires a new plan of care (POC).

Providers are required to submit a new PA request (instead of requesting an amendment) if the recipient's medical condition changes significantly and requires a new plan of care (POC).

The request to amend the Prior Authorization Request Form (PA/RF), HCF 11018, should include the following:

- A copy of the original PA/RF.
- A Prior Authorization Amendment Request form, HCF 11042. (Refer to the Prior Authorization section of the All-Provider Handbook for more information about this form.)
- The specific, requested changes to the PA/RF.
- Documentation justifying the requested changes. This may include the POC, a new written report of the recipient's evaluation, treatment goals, etc.

Approval Criteria

Wisconsin Medicaid may approve an amendment request if the following are true:

- Documentation establishes that the amendment request is medically necessary.
- The request is received by the date of the requested change.

Reasons for Denial

Wisconsin Medicaid may deny an amendment request for reasons including, but not limited to, the following:

- The request is not medically necessary.
- The request is solely for the convenience of the recipient, the recipient's family, or the provider.
- The request is not received before the date of the requested change.
- The PA expired prior to receipt of the amendment request.
- The recipient's medical condition changes significantly, requiring a new POC.
- The request is to allow for a vacation, missed appointments, illness, or a leave of absence by the provider.

Claims

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.

When the performing provider is an individual therapist, the billing provider number of the therapist must be indicated on the claim.

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.

When submitting crossover claims (i.e., automatic crossover claims and provider-submitted crossover claims) for outpatient hospital physical therapy (PT), occupational therapy (OT), and speech and language pathology (SLP) services, providers should follow Medicare's procedures.

837 Health Care Claim: Professional

Providers are encouraged to submit claims electronically since electronic claims submission usually reduces claim errors. Claims for PT, OT, and SLP services may be submitted using the 837 Health Care Claim: Professional (837P) transaction, except when submitting a claim that requires 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 submitting electronic transactions.

CMS 1500

Paper claims for PT, OT, and SLP services must be submitted using the CMS 1500 claim form dated 12/90. Wisconsin Medicaid denies claims for PT, OT, and SLP services submitted on any paper claim form other than the CMS 1500.

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

Refer to Appendix 34 of this handbook for claim form instructions for PT, OT, and SLP services. Appendices 35, 36, and 37 of this handbook are samples of claims for PT, OT, and SLP services.

Provider Numbers

Individual Providers

When the performing provider is an individual therapist, the billing provider number of the therapist must be indicated on the claim. A performing provider number should not be indicated.

When the performing provider is supervised by an individual therapist, the billing provider number of the supervising therapist must be indicated on the claim. If the performing provider is a physical therapist assistant (PTA), certified occupational therapy assistant (COTA), or SLP provider assistant, the performing provider of the assistant must be indicated.

Groups, Clinics, and Nursing Homes

When the performing provider is employed by, or under contract to, a therapy group, therapy clinic, speech and hearing clinic, or nursing home, the billing provider number of the group,

clinic, or nursing home must be indicated on the claim. A performing provider number must be indicated.

Rehabilitation Agencies

When the performing provider is employed by, or under contract to, a rehabilitation agency, the billing provider number of the rehabilitation agency must be indicated on the claim. A performing provider number should not be indicated.

Hospitals

When the performing provider is employed by, or under contract to, a hospital and offering *outpatient* hospital PT, OT, or SLP services, the billing provider number of the hospital must be indicated on the claim. A performing provider number should not be indicated.

When the performing provider is employed by, or under contract to, a hospital and offering *off-site* hospital PT, OT, or SLP services, the billing provider number of the therapist must be indicated on the claim. A performing provider number should not be indicated.

When the performing provider is supervised by a therapist who is employed by, or under contract to, a hospital and offering *off-site* hospital PT, OT, or SLP services, the billing provider number of the supervising therapist must be indicated on the claim. If the performing provider is a PTA, COTA, or SLP provider assistant, the performing provider number of the assistant must be indicated.

Referring Provider

Claims for PT, OT, and SLP services require the referring physician's name and Universal Provider Identification Number.

Evaluations

Claims for evaluations and re-evaluations may be submitted only upon completion regardless of the number of days needed to complete the evaluation.

Services Provided Beyond Daily Limits

When a PT, OT, or SLP service, which is indicated by a procedure code that specifies the unit of time, is provided beyond 90 minutes per day, the provider should submit a claim for the actual duration of the service provided. After the claim is reimbursed, an Adjustment/ Reconsideration Request form, HCF 13046, must be submitted with documentation verifying that the duration of the service was medically necessary. The adjustment request must be submitted on paper because a national standard for electronic claim attachments has not been established at this time. Refer to the Claims Information section of the All-Provider Handbook for general information about submitting paper adjustment requests.

When the performing provider is employed by, or under contract to, a rehabilitation agency, the billing provider number of the rehabilitation agency must be indicated on the claim.

Unlisted Procedure Codes

Claims for services identified by unlisted procedure codes must be submitted on paper because a national standard for electronic claim attachments has not been established at this time. To receive reimbursement for a service identified by an unlisted procedure code, a description of the service must be indicated in Element 19 of the paper claim. If Element 19 does not provide enough space for the description, or if a provider is billing multiple unlisted procedure codes, documentation may be attached to the claim. In this instance, the provider should indicate "see attachment" in Element 19.

Multiple Services During One Session

Multiple procedure codes may be prior authorized in anticipation of the required services. However, only the procedure codes that reflect the services actually provided on that DOS may be indicated on the claim. Claims found to be in conflict with this program requirement will be recouped.

Submitting Claims for Birth to 3 Services

Multiple procedure codes may be prior authorized in anticipation of the required services. However, only the procedure codes that reflect the services actually provided on that DOS may be indicated on the claim.

Federal regulations allow a Birth to 3 (B-3) participant's parents or guardians to refuse consent to bill their commercial health insurance (34 CFR Part 303) if it would result in a cost to the family, such as:

- Reaching the lifetime limit on a policy.
- An increase in premiums, copayments, or deductibles.

Birth to 3 agencies may reimburse the commercial health insurance liability when both of the following occur:

- The Medicaid recipient participates in the B-3 Program and is receiving B-3 services.
- The parents or guardians do not allow their Medicaid provider or Medicaid HMO to bill their commercial health insurance first.

Refer to Appendix 39 of this handbook for procedures to follow when the B-3 agency reimburses the commercial health insurance liability.

When a child's parents or guardians give consent to billing their commercial health insurance (or when the child has no commercial health insurance coverage), federal and state regulations require the provider to submit claims in the following order:

1. Bill the commercial health insurance with the informed, written consent of the child's parents or guardians if applicable.
2. Submit claims to Wisconsin Medicaid.
3. Bill the county B-3 agency (according to the agency's requirements) if Wisconsin Medicaid does not cover the services.

Reimbursement

Maximum Allowable Fees

The maximum allowable fee is the maximum amount that Wisconsin Medicaid will pay a provider for a service. Maximum allowable fee schedules that contain reimbursement rates for physical therapy (PT), occupational therapy (OT), or speech and language pathology (SLP) services may be obtained from one of the following sources:

Enhanced reimbursement will be reflected as a cash payout on Medicaid remittance information.

- An electronic version on the Medicaid Web site.
- A paper copy, which may be purchased by doing either of the following:
  - ✓ Calling Provider Services at (800) 947-9627 or (608) 221-9883 for the cost of the fee schedule.
  - ✓ Writing to the following address:

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

Maximum allowable fees for services provided through a rehabilitation agency vary among agencies. Agencies may obtain their agency-specific fee schedule by contacting Provider Services.

Hospitals may obtain maximum allowable fees for outpatient hospital PT, OT, and SLP services by referring to outpatient hospital publications.

Reimbursement Methods

Physical therapy, OT, and SLP services are reimbursed at the lesser of the billed amount or the maximum allowable fee. However, PT and OT services provided by physical therapist assistants and certified occupational therapy assistants working under general supervision (after a supervision waiver is obtained) are reimbursed at the lesser of the billed amount or 90 percent of the maximum allowable fee.

Natural Environment Enhanced Reimbursement

Physical therapy, OT, and SLP providers receive an enhanced reimbursement from Wisconsin Medicaid when certain PT, OT, and SLP services are provided in the natural environment of a recipient who participates in the Birth to 3 Program. The enhanced reimbursement applies on a per child, per date of service, per therapy discipline basis.

Wisconsin Medicaid sends PT, OT, and SLP providers their natural environment enhanced reimbursement as a quarterly lump sum payment. Enhanced reimbursement will be reflected as a cash payout on Medicaid remittance information. Detailed information about the cash payout will not appear on remittance information; providers will receive a separate report with detailed information about the cash payout.

Copayment

Wisconsin Medicaid requires providers to collect copayment from recipients for certain services. Providers are required to make a reasonable attempt to collect the copayment unless the provider determines that the cost of collecting the copayment exceeds the amount to be collected.

Certain groups of recipients, including recipients under 18 years old and recipients in nursing homes, and certain Medicaid-covered services are exempt from copayments. Refer to the Recipient Eligibility section of the All-Provider Handbook for more information about exemptions and other information about copayments.

Copayment amounts for PT, OT, and SLP services are determined per procedure code and correspond to the maximum allowable fee for the procedure code. Providers should refer to the Recipient Eligibility section of the All-Provider Handbook and to their maximum allowable fees to determine copayment amounts.

Annual Copayment Maximum

Wisconsin Medicaid does not deduct copayment after the first 30 hours or $1,500 of reimbursement for PT, OT, or SLP services per calendar year, per recipient. Wisconsin Medicaid calculates copayment limits separately for each therapy discipline.

The copayment maximum applies to each recipient, regardless of the number of providers. For example, if a recipient receives PT services from more than one provider, the copayment maximum may be reached sooner than an individual provider's records indicate.

When a recipient has met the copayment maximum, Wisconsin Medicaid does not deduct any copayment from the reimbursement to the provider. If the provider collects copayment beyond the copayment maximum, the provider is required to return or credit the recipient for the extra amount.

If the provider collects copayment beyond the copayment maximum, the provider is required to return or credit the recipient for the extra amount.

Appendix

ARCHIVAL USE ONLY
Refer to the Online Handbook
for current policy

Appendix 1

Certification Requirements and Reimbursement Information for Physical Therapy, Occupational Therapy, and Speech and Language Pathology Providers

	Certification Requirements	Reimbursement	Provider Numbers
Physical Therapists	Physical therapists may become Medicaid certified if they are licensed under s. 448, Wis. Stats., and Ch. PT 1, Wis. Admin. Code.	Wisconsin Medicaid directly reimburses physical therapists for covered physical therapy (PT) services when all program requirements are met.	Wisconsin Medicaid assigns physical therapists a billing performing provider number. The billing performing provider number can be used as a billing number and a performing provider number. It allows physical therapists to do the following: • Request prior authorization (PA) and submit claims. • Request PA and submit claims for the services of physical therapist assistants (PTAs), PT students, and PT aides who are supervised by the physical therapist.
Physical Therapist Assistants	Physical therapist assistants may become Medicaid certified if they are licensed under s. 448, Wis. Stats., and Ch. PT 5, Wis. Admin. Code.	Wisconsin Medicaid does not directly reimburse PTAs. When all program requirements are met, covered PT services provided by PTAs may be reimbursed under the supervising therapist's, therapy clinic's, therapy group's, rehabilitation agency's, hospital's, or nursing home's billing number.	Wisconsin Medicaid assigns PTAs a nonbilling performing provider number. The nonbilling performing provider number can be used as a performing provider number but not as a billing number. The nonbilling provider number does not allow PTAs to request PA, submit claims, or receive reimbursement.
Physical Therapy Aides*	Wisconsin Medicaid does not certify PT aides. A PT aide is an individual who provides delegated PT services and is trained in a manner appropriate to his or her job duties.	Wisconsin Medicaid does not directly reimburse PT aides. When all program requirements are met, covered PT services delegated to and provided by PT aides may be reimbursed under either of the following: • The supervising therapist's, rehabilitation agency's, or hospital's (for outpatient services) billing number. • The supervising therapist's performing provider number *and* the therapy group's, therapy clinic's, hospital's (for off-site services), or nursing home's billing number.	Wisconsin Medicaid does not assign a performing provider number or a billing number to PT aides.
Occupational Therapists	Occupational therapists may become Medicaid certified if they are licensed under s. 448, Wis. Stats., and Ch. OT 2, Wis. Admin. Code.	Wisconsin Medicaid directly reimburses occupational therapists for covered occupational therapy (OT) services when all program requirements are met.	Wisconsin Medicaid assigns occupational therapists a billing performing provider number. The billing performing provider number can be used as a billing number and a performing provider number. It allows occupational therapists to do the following: • Request PA and submit claims. • Request PA and submit claims for the services of certified occupational therapy assistants (COTAs) and OT students who are supervised by the physical therapist.

*Medicaid reimbursement is not available for services provided by OT or SLP aides.

Appendix 1 (Continued)

	Certification Requirements	Reimbursement	Provider Numbers
Certified Occupational Therapy Assistants	Occupational therapy assistants may become Medicaid certified if they are licensed under s. 448, Wis. Stats., and Ch. OT 2, Wis. Admin. Code.	Wisconsin Medicaid does not directly reimburse COTAs. When all program requirements are met, covered OT services provided by COTAs may be reimbursed under the supervising therapist's, therapy clinic's, therapy group's, rehabilitation agency's, hospital's, or nursing home's billing number.	Wisconsin Medicaid assigns COTAs a nonbilling performing provider number. The nonbilling performing provider number can be used as a performing provider number but not as a billing number. The nonbilling provider number does not allow COTAs to request PA, submit claims, or receive reimbursement.
Speech-Language Pathologists	Speech-language pathologists may become Medicaid certified if they are licensed under s. 459, Wis. Stats., and Ch. HAS, Wis. Admin. Code. They may also become Medicaid certified if any of the following are true: • They are certified by the American Speech-Language-Hearing Association (ASHA). • They have completed the education and work experience necessary for ASHA certification. • They have completed the education and are in the process of completing the work experience necessary for ASHA certification.	Wisconsin Medicaid directly reimburses speech-language pathologists for covered speech and language pathology (SLP) services when all program requirements are met.	Wisconsin Medicaid assigns speech-language pathologists a billing performing provider number. The billing performing provider number can be used as a billing number and a performing provider number. It allows speech-language pathologists to do the following: • Request PA and submit claims. • Request PA and submit claims for the services of SLP provider assistants and SLP students who are supervised by the speech-language pathologist.
SLP Provider Assistants	Individuals with a Bachelor's degree (B.A. or B.S.) in SLP may become Medicaid certified as SLP nonbilling performing providers. These individuals are referred to as SLP provider assistants.	Wisconsin Medicaid does not directly reimburse SLP provider assistants. When all program requirements are met, covered SLP services provided by SLP provider assistants may be reimbursed under the supervising therapist's, speech and hearing clinic's, therapy group's, rehabilitation agency's, hospital's, or nursing home's billing number.	Wisconsin Medicaid assigns SLP provider assistants a nonbilling performing provider number. The nonbilling performing provider number can be used as a performing provider number but not as a billing number. The nonbilling provider number does not allow SLP provider assistants to request PA, submit claims, or receive reimbursement.
PT, OT, and SLP Students	Wisconsin Medicaid does not certify PT, OT, and SLP students. A PT, OT, or SLP student is an individual who is providing services during a practicum.	Wisconsin Medicaid does not directly reimburse PT, OT, or SLP students. When all program requirements are met, covered services provided by PT, OT, and SLP students may be reimbursed under either of the following: • The supervising therapist's, rehabilitation agency's, or hospital's (for outpatient services) billing number. • The supervising therapist's performing provider number *and* the therapy group's, therapy clinic's, speech and hearing clinic's, hospital's (for off-site services), or nursing home's billing number.	Wisconsin Medicaid does not assign a performing provider number or a billing number to PT, OT, or SLP students.

	Certification Requirements	Reimbursement	Provider Numbers
Therapy Groups, Therapy Clinics, or Speech and Hearing Clinics	Therapy groups that provide two or more types of therapy (e.g., PT and OT or PT, OT, and SLP) may become Medicaid certified as a therapy group. Therapy clinics that provide one type of therapy (e.g., PT or OT) may become Medicaid certified as a therapy clinic. Speech and hearing clinics may become Medicaid certified if they are accredited by the ASHA. Wisconsin Medicaid requires providers employed by, or under contract to, groups and clinics to be individually certified by Wisconsin Medicaid.	Wisconsin Medicaid directly reimburses groups or clinics for covered PT, OT, and SLP services when all program requirements are met.	Wisconsin Medicaid assigns groups and clinics a group billing number that requires individual performing provider numbers. Wisconsin Medicaid assigns an individual performing provider number to each Medicaid-certified provider within the group or clinic. The group billing number used with an individual performing provider number allows groups or clinics to do the following: • Request PA and submit claims. • Receive one reimbursement and one Remittance and Status (R/S) Report and 835 Health Care Claim Payment Advice (835) transaction for services performed by individual providers within the group or clinic.
Rehabilitation Agencies	Rehabilitation agencies must be certified by Medicare to obtain Medicaid certification. Wisconsin Medicaid requires providers employed by, or under contract to, rehabilitation agencies to meet all Medicaid certification requirements, but does not require them to be individually certified by Wisconsin Medicaid. The rehabilitation agency is required to maintain records showing that its individual providers meet Medicaid requirements. Medicaid therapy group providers considering conversion to the Medicaid rehabilitation agency provider type should contact Provider Services at (800) 947-9627 or (608) 221-9883 for more information. For information about Medicare certification, providers should contact the Division of Disability and Elder Services at the following address: Bureau of Quality Assurance Division of Disability and Elder Services PO Box 2969 Madison WI 53701-2969	Wisconsin Medicaid directly reimburses rehabilitation agencies for covered PT, OT, and SLP services when all program requirements are met.	Wisconsin Medicaid assigns rehabilitation agencies a group billing number that does *not* require a separate performing provider number. Wisconsin Medicaid does not assign an individual performing provider number to each provider within the rehabilitation agency. The group billing number can be used as a billing number and a performing provider number. It allows rehabilitation agencies to do the following: • Request PA and submit claims. • Receive one reimbursement and one R/S Report and 835 transaction for services performed by individual providers within the agency.

Appendix 2

Allowable Services and Supervision Requirements for Assistants, Students, and Aides

When supervision requirements are met, Medicaid reimbursement is available for services provided by assistants, students, or aides who are qualified to provide the service. Refer to the following table for allowable services and supervision requirements for physical therapist assistants (PTAs), certified occupational therapy assistants (COTAs), speech and language pathology (SLP) provider assistants, physical therapy (PT) students, occupational therapy (OT) students, SLP students, and PT aides. The following definitions apply to the supervision requirements:

- Direct, immediate, on-premises supervision is defined as face-to-face contact between the supervisor and the person being supervised, as necessary, with the supervisor physically present in the same building when the service is being performed by the person being supervised.
- General supervision is defined as direct, on-premises contact between the supervisor, the person being supervised, and the recipient at least once every two weeks. Between direct contacts, the supervisor is required to maintain indirect, off-premises contact (by telephone, written reports, and group conferences) with the person being supervised.
- Direct, immediate, one-to-one supervision is defined as one-to-one supervision with face-to-face contact between the person being supervised and the supervisor during each PT, OT, or SLP session with the person being supervised assisting the supervisor.

	Allowable Services	Supervision Requirements
PTAs	Certain PT services, such as evaluations, may not be reimbursed by Wisconsin Medicaid when provided by PTAs. Refer to Appendix 8 of this handbook to determine which services may be provided by PTAs.	Physical therapist assistants must be under the direct, immediate, on-premises supervision of a Medicaid-certified physical therapist who is responsible for recipient care. However, if a supervision waiver is obtained, PTAs may provide services under the general supervision of a Medicaid-certified physical therapist.
COTAs	Certain OT services, such as evaluations, may not be reimbursed by Wisconsin Medicaid when provided by COTAs. Refer to Appendix 9 of this handbook to determine which services may be provided by COTAs.	For some services (i.e., activities of daily living skills), COTAs are required to be under the general supervision of a Medicaid-certified occupational therapist who is responsible for recipient care. The following circumstances must apply: • The COTA is providing services that are for the purpose of providing activities of daily living skills. • The supervising therapist visits the recipient on a bi-weekly basis or after every five contacts between the COTA and the recipient, whichever is greater. • The COTA and supervising therapist meet to discuss treatment of the recipient after every five contacts between the COTA and the recipient. For all other services, COTAs must be under the direct, immediate, on-premises supervision of a Medicaid-certified occupational therapist who is responsible for recipient care. However, if a supervision waiver is obtained, COTAs may provide these services under general supervision.

	Allowable Services	Supervision Requirements
SLP Provider Assistants	Evaluations (92506, 92597, 92607, 92608, and 92610) may not be reimbursed by Wisconsin Medicaid when provided by SLP provider assistants. All other SLP services may be reimbursed by Wisconsin Medicaid when provided by SLP provider assistants.	Speech and language pathology provider assistants must be under the direct, immediate, on-premises supervision of an American Speech-Language-Hearing Association (ASHA)-certified and Medicaid-certified speech-language pathologist who is responsible for recipient care.
PT, OT, and SLP Students	All PT, OT, and SLP services, including evaluations, may be reimbursed by Wisconsin Medicaid when provided by students during their practicum.	Physical therapy and OT students must be under the direct, immediate, on-premises supervision of a Medicaid-certified physical therapist or occupational therapist who is responsible for recipient care. Speech and language pathology students must be under the direct, immediate, on-premises supervision of an ASHA-certified and Medicaid-certified speech-language pathologist who is responsible for recipient care.
PT Aides	The following PT services may be reimbursed by Wisconsin Medicaid when provided by PT aides who are trained in a manner appropriate to their job duties: • Assisting with the use of equipment and performing simple modalities once the recipient's program has been established, and the recipient's response to the equipment is highly predictable. • Performing simple activities required to assist in the performance or conclusion of treatment (such as transferring a recipient to or from a mat). • Providing protective assistance during exercise, activities of daily living skills, and ambulation activities related to the development of strength and refinement of activity. Clinical services that exceed a PT aide's competence, education, training, and experience are not reimbursable by Wisconsin Medicaid.	Physical therapy aides must be under the direct, immediate, one-to-one supervision of a Medicaid-certified physical therapist who is responsible for recipient care. The therapist-to-aide ratio must be 1:1, except as noted. Wisconsin Medicaid may exempt a facility from this supervision requirement if it determines that direct, immediate, one-to-one supervision is not required for specific assignments that PT aides are performing. For example, facilities providing significant amounts of hydrotherapy may be eligible for a supervision exemption for PT aides who fill or clean tubs. If an exemption is granted, Wisconsin Medicaid will indicate the specific services for which the exemption is granted and set an appropriate supervision ratio for these services.

Appendix 3
Declaration of Supervision for Nonbilling Providers Instructions

(A copy of the Declaration of Supervision for Nonbilling Providers Instructions is located on the following pages.)

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WISCONSIN MEDICAID
DECLARATION OF SUPERVISION FOR NONBILLING PROVIDERS INSTRUCTIONS

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

Personally identifiable information about Medicaid providers is used for purposes directly related to Medicaid administration such as determining the certification of providers or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of Medicaid payment for those services.

INSTRUCTIONS
Nonbilling providers receive nonbilling provider numbers. The numbers cannot be used independently to bill Wisconsin Medicaid. The following nonbilling providers are required to complete the Declaration of Supervision for Nonbilling Providers form, HCF 1182, for changes in physical address and all supervisor changes:

- Occupational Therapy Assistants.
- Physical Therapist Assistants.
- Physician Assistants.
- Speech Therapists, Bachelor of arts (BA) level.

The nonbilling provider(s) who has changed his or her work address or supervisor should complete Section I. The nonbilling provider's supervisor should complete Section II.

SECTION I — PROVIDER INFORMATION

Name and Credentials — Nonbilling Provider
Enter the nonbilling provider's first name, middle initial, and last name. Also include whether the nonbilling provider is an occupational therapy assistant, physical therapist assistant, physician assistant, or speech therapist, BA level.

Wisconsin Medicaid Provider Number
Enter the nonbilling provider's eight-digit Medicaid identification number. Do not enter any other numbers or letters.

Address — Nonbilling Provider
Enter the nonbilling provider's complete physical work address (street, city, state, and zip code). A post office (P.O.) box number alone is not acceptable.

Telephone Number — Nonbilling Provider
Enter the nonbilling provider's telephone number, including the area code, of the office, clinic, facility, or place of business.

Provider Reimbursement Statement
In the space labeled "Name — Provider," write the complete name of the nonbilling provider. In the space labeled "Name — Clinic or Supervisor" write the name of the clinic or supervisor where Wisconsin Medicaid will send reimbursement.

Signature — Nonbilling Provider
The signature of the nonbilling provider is required here. Signature stamps and electronic signatures are not acceptable.

Date Signed
Enter the month, day, and year (in MM/DD/YYYY format) this form was completed and signed. This is a required field.

SECTION II — SUPERVISOR INFORMATION

Name — Supervisor
Enter the supervisor's first name, middle initial, and last name.

Wisconsin Medicaid Provider Number
Enter the supervisor's eight-digit Medicaid identification number, if applicable. Do not enter any other numbers or letters.

IRS Number — Employer
Enter the nine-digit federal tax identification number (Internal Revenue Service [IRS] number) of the supervisor's employer.

Address — Supervisor
Enter the supervisor's complete physical work address (street, city, state, and zip code).

Telephone Number — Supervisor
Enter the supervisor's telephone number, including the area code, of the office, clinic, facility, or place of business.

Supervisor Reimbursement Statement
In the space labeled "Name — Supervisor," write the complete name of the nonbilling provider's supervisor. In the space labeled "Name — Provider," write the complete name of the nonbilling provider. In the space labeled "Supervisor's Effective Starting Date," enter the month, day, and year (in MM/DD/YYYY format) when this person began supervising the nonbilling provider's work.

Signature — Supervisor
The signature of the supervisor must appear here. Signature stamps and electronic signatures are not allowed.

Date Signed
Enter the month, day, and year (in MM/DD/YYYY format) this form was completed and signed.

Appendix 4

Declaration of Supervision for Nonbilling Providers Form (for photocopying)

(A copy of the Declaration of Supervision for Nonbilling Providers form is located on the following page.)

DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Health Care Financing
HCF 1182 (Rev. 09/02)

STATE OF WISCONSIN
HFS 105.02(1), Wis. Admin. Code

WISCONSIN MEDICAID
DECLARATION OF SUPERVISION FOR NONBILLING PROVIDERS

SECTION I — NONBILLING PROVIDER INFORMATION	
Name and Credentials — Nonbilling Provider	Wisconsin Medicaid Provider Number
Address — Nonbilling Provider	Telephone Number — Nonbilling Provider

I, _____, direct Wisconsin Medicaid to make checks payable to
(Name — Provider)

_____ for all claims payments for services performed by me
(Name — Clinic or Supervisor)

under Wisconsin Medicaid since Wisconsin Medicaid cannot reimburse me.

I understand that this payment arrangement will continue in effect until Wisconsin Medicaid receives a new Declaration of Supervision for Nonbilling Providers form from me. When my supervisor, employer, or work address changes, I will immediately send this completed form to Wisconsin Medicaid.

SIGNATURE — Nonbilling Provider (required)	Date Signed (required)

SECTION II — SUPERVISOR INFORMATION		
Name — Supervisor	Wisconsin Medicaid Provider Number	Internal Revenue Service (IRS) Number — Employer
Address — Supervisor		Telephone Number — Supervisor

I, _____, am supervising the work of _____.
(Name — Supervisor) (Name — Provider)

I began supervising the previously listed nonbilling provider on _____. I hereby acknowledge and
(Supervisor's Effective Starting Date)
agree to the above payment arrangement.

I understand that if my name is indicated in Section I above, Wisconsin Medicaid payment for services provided by the nonbilling provider will be payable to me directly and will be reported under the IRS number written above. If I discontinue supervision of the nonbilling provider, I understand that I must notify Wisconsin Medicaid at the address at the bottom of this page.

SIGNATURE — Supervisor	Date Signed

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

For more information, contact Provider Services at (800) 947-9627 or (608) 221-9883.

Appendix 5

Request for Waiver of Physical Therapist Assistant and Occupational Therapy Assistant Supervision Requirements Form (for photocopying)

(A copy of the Request for Waiver of Physical Therapist Assistant and Occupational Therapy Assistant Supervision Requirements form is located on the following page.)

WISCONSIN MEDICAID

REQUEST FOR WAIVER OF PHYSICAL THERAPIST ASSISTANT AND OCCUPATIONAL THERAPY ASSISTANT SUPERVISION REQUIREMENTS

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

Personally identifiable information about Medicaid providers is used for purposes directly related to Medicaid administration such as determining the certification of providers or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of Medicaid payment for the services.

Completion of this form is mandatory to receive a waiver of Wisconsin Medicaid's supervision requirements for therapy/therapist assistants as specified in HFS 105.27(2), 107.16(1), and 107.17(1), Wis. Admin. Code.

Instructions: Type or print clearly.

Name — Billing Provider	Telephone Number — Billing Provider
Address — Billing Provider (Street, City, State, Zip Code)	Billing Provider's Wisconsin Medicaid Provider Number

I request a waiver under HFS 106.13, Wis. Admin. Code, for services provided on and after August 1, 2000, for the following requirement:

- ❑ A Medicaid-certified physical therapist assistant under the direct, immediate, on-premises supervision of a physical therapist (HFS 107.16[1], Wis. Admin. Code).
- ❑ A certified occupational therapy assistant under the direct, immediate, on-premises supervision of a certified occupational therapist (HFS 107.17[1], Wis. Admin. Code).

Under this waiver, I understand that I am required to do the following:

- Continue to meet the Department of Regulation and Licensing (DR&L) standards for supervision of assistants who provide services to Medicaid recipients.
- Document this supervision by countersigning all entries in medical records, in accordance with HFS 106.02, Wis. Admin. Code.
- Maintain appropriate records regarding supervision, in compliance with DR&L requirements and with HFS 106.02, Wis. Admin. Code.

I understand that this waiver is automatically granted when Wisconsin Medicaid acknowledges receipt of this form. The waiver is effective until the direct, immediate, on-premises supervision requirement is revised through a change in the Wisconsin Administrative Code.

SIGNATURE — Provider	Date Signed

Send completed form to:

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

Retain a copy of this form for your records.

Appendix 6
Medicaid Therapy Services for Children

(A copy of the Medicaid Therapy Services for Children brochure is located on the following pages.)

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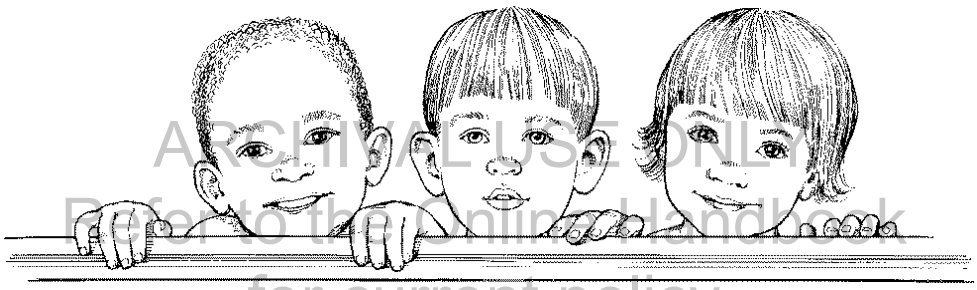
Medicaid Therapy Services for Children



English – For help to translate or understand this, please call (800) 362-3002 (TTY).

Spanish – Si necesita ayuda para traducir o entender este texto, por favor llame al teléfono (800) 362-3002 (TTY).

Russian – Если вам не всё понятно в этом документе, позвоните по телефону (800) 362-3002 (TTY).

Hmong – Yog xav tau kev pab txhais cov ntaub ntawv no kom koj totaub, hu rau (800) 362-3002 (TTY).

Medicaid Therapy Services for Children

The information in this brochure is for children in the BadgerCare and Wisconsin Medicaid programs. The term "Wisconsin Medicaid" will be used to represent both programs.

Contact your county/tribal social or human services agency or your local W-2 agency for more information on applying for Wisconsin Medicaid, BadgerCare, or Healthy Start. ■

This brochure is for recipients and their families considering occupational therapy, physical therapy, and/or speech and language therapy services provided in the community with coverage by Wisconsin Medicaid. Wisconsin Medicaid covers medically necessary services that meet state and federal guidelines. ■

This brochure does not address therapy services provided by schools or Medicaid HMOs.

What is Medicaid?

Medicaid is a joint federal/state program formed in 1965 under Title XIX of the Social Security Act. Wisconsin Medicaid pays for medical services for people with disabilities, people 65 years and older, children and their caretakers, and pregnant women who meet the program's financial requirements and are enrolled in the program.

Wisconsin Medicaid is also known as the Medical Assistance Program, MA, Title XIX, or T19.

What is BadgerCare?

BadgerCare extends Medicaid coverage to uninsured children and parents with incomes at or below 185 percent of the Federal Poverty Level and who meet other program requirements. The goal of BadgerCare is to fill the gap between Wisconsin Medicaid and private insurance without "crowding out" private insurance.

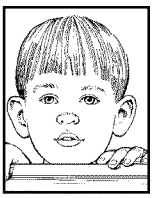
What are the Katie Beckett, Healthy Start, and SSI programs?

Katie Beckett, Healthy Start, and Supplemental Security Income (SSI) are special eligibility programs that allow certain individuals to become eligible for Wisconsin Medicaid.

Who can provide therapy services to my child?

Your child can get therapy services from any licensed therapist. If you want Wisconsin Medicaid to pay for therapy services, the therapist must be Medicaid certified. You should ask your child's therapist if he or she is Medicaid certified before your child receives services. Medicaid-certified therapists can practice:

- Individually.
- In therapy clinics and rehabilitation agencies.
- In hospitals and nursing homes.
- In home health agencies.



How do I get therapy services for my child?

Whom do I contact?

If your child needs therapy services, contact your child's doctor. Your child's doctor needs to write a prescription for therapy services. Your child's doctor is able to refer you to a *Medicaid-certified* occupational therapist, physical therapist, or speech-language therapist.

The therapist will then assess your child to see if therapy may help him or her.

When do you need a prior authorization request for therapy services?

If the therapist thinks your child needs therapy, the therapist will complete and send a prior authorization request to Wisconsin Medicaid. There is a separate prior authorization process for children enrolled in the Birth to 3 Program.

What does the prior authorization request include?

The prior authorization request for children who are older than age 3 or not enrolled in the Birth to 3 Program includes:

- The therapy evaluation of your child by the therapist.
- The therapy plan of care.
- The Individualized Education Program (IEP), if applicable.

The prior authorization request for children under age 3 who are enrolled in the Birth to 3 Program includes an affidavit signed by the provider indicating that he or she will follow the rules and regulations of Wisconsin Medicaid. For more information about the Birth to 3 Program, contact your county Birth to 3 Program or call (800) 642-STEP (7837).

Plan of Care

A therapy plan of care includes goals of the therapy treatment, how the treatment will be delivered, how long the therapy will last, and how often treatments will be provided. The plan of care must be reviewed and signed by the doctor prescribing therapy. You and your family are encouraged to participate in the development of the plan of care.

For children older than age 3, the plan of care will include the school IEP and team reports, if available. For more information on a school IEP, contact your local school district.

Prior Authorization Process

After the prior authorization materials are ready, the therapist will send them to Wisconsin Medicaid. You have the right, and are encouraged, to review the prior authorization request before it is sent to Wisconsin Medicaid. The prior authorization request is being submitted on your child's behalf.

A Medicaid therapy consultant reviews each request to make sure it meets Wisconsin Medicaid requirements. In some cases, the prior authorization request is returned to your child's requesting therapist for more information. When a prior authorization decision is delayed because more information is needed, your therapist is expected to notify you of the reason for the delay.

When all of the needed information is sent in, the Medicaid therapy consultant approves, modifies, or denies the request. The approval includes the number of therapy sessions and the start and end dates of the approval. Before the end date of the current prior authorization, your child's therapist should submit a new prior authorization request if services need to be continued.

If the prior authorization request is modified or denied, you will receive a letter telling you the reasons for the decision and your right to appeal that decision. You are encouraged to always review the prior authorization decision with the requesting therapist. There is an optional line on the prior authorization request for you to sign to indicate that you have read it and agree.

Remember, you have the right to:

- Review the prior authorization request before it is sent to Wisconsin Medicaid.
- Review the prior authorization decision.
- Know the start and end dates of the prior authorization.

Frequently Asked Questions

What is looked at for approval of a prior authorization request?

Prior authorization requests are reviewed on an individual basis. If the requested services do not meet the Medicaid requirements, they are denied. Some of the factors taken into consideration are:

- The medical necessity of the service.
- The appropriateness of the service.
- The cost of the service.
- The frequency of the service.
- The quality and timeliness of the service.
- The extent to which less expensive alternative services are available.
- The utilization practices of the providers and recipients.
- The limitations imposed by federal and state statutes, rules, regulations, or interpretation, including Medicare or private-insurance guidelines.

Some of the reasons that a prior authorization request for therapy might not be approved are:

- The skills of a therapist are not needed to perform the activity with the child.
- Another provider or caregiver is working on the same activity.
- No functional progress is documented as a result of therapy.
- The services are experimental.
- The needs of the child can be met without therapy.

What can I do if Wisconsin Medicaid modifies or denies a prior authorization request?

If the prior authorization request is denied or modified, you will receive a letter. You may wish to discuss the decision with your child's therapy provider to understand the reasons for Wisconsin Medicaid's decision. You may also want to make sure that the agency or the individual provider sent in all the necessary information. If more information is needed, your child's provider may contact Wisconsin Medicaid to determine if additional information should be submitted at this time.

The letter will also give you information about how to appeal the decision and request a fair hearing before an administrative hearing officer.

If a prior authorization request was denied or modified, will future prior authorization requests also be denied or modified?

Not necessarily. If your child's condition or situation changes, a new prior authorization request for therapy services with current information may be submitted.

If my child receives therapy or special education services through his or her school, may my child receive additional therapy services outside the school through Wisconsin Medicaid?

Each case is reviewed on an individual basis. Wisconsin Medicaid approves requests that meet Medicaid regulations and guidelines. Wisconsin Medicaid does not base approval or denial of prior authorization requests on whether the school seeks payment through the Medicaid school-based services (SBS) benefit. Medicaid consultants do not review SBS billing information.

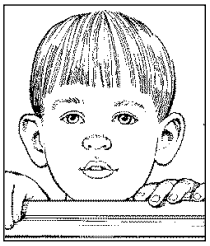
When making a decision on a prior authorization request, Wisconsin Medicaid considers the medical necessity of services and other criteria including (but not limited to) whether the service is appropriate, cost-effective, and not duplicative of other services. As part of the prior authorization process, therapists submit each child's IEP with their prior authorization request. Medicaid therapy consultants review the prior authorization request and IEP in addition to all other required materials and records to determine if a child is receiving other services that meet the child's needs.

What if I have other health insurance?

You will be expected to see therapists and other health care providers who accept your child's other health insurance as well as Wisconsin Medicaid. This is because your child's other health insurance will be billed first, before Wisconsin Medicaid. This is not always true for Birth to 3 services. You should talk to your child's therapist or Birth to 3 coordinator for more information about billing other health insurance.

What if I or my children are enrolled in a Medicaid HMO?

You should contact your Medicaid HMO for more information on how to receive therapy services from your HMO's providers.



If you have more questions about Medicaid occupational therapy, physical therapy, or speech and language therapy, please call Recipient Services at (800) 362-3002.

Department of Health and Family Services
Division of Health Care Financing
PHC 1794 (Rev. 06/05)

Appendix 7

A Guide to Obtaining Augmentative Communication Devices and Accessories Through Wisconsin Medicaid

(A copy of A Guide to Obtaining Augmentative Communication Devices and Accessories Through Wisconsin Medicaid is located on the following pages.)

The following instructions describe how to assemble "A Guide to Obtaining Augmentative Communication Devices and Accessories Through Wisconsin Medicaid" as a booklet:

1. Print all six pages of the PDF document. (One PDF page will contain two booklet pages.)

2. Photocopy each even page of the PDF document onto the back of the preceding odd page as follows:
   - Booklet pages 2 and 11 will be on the reverse side of the title page and the Important names and resources page.
   - Booklet pages 4 and 9 will be on the reverse side of pages 3 and 10.
   - Booklet pages 6 and 7 will be on the reverse side of pages 5 and 8.

   Be sure to reverse the orientation of the page that is being copied so that the pages do not appear upside down when the booklet is assembled.

3. Assemble the pages as follows from bottom to top:
   - Pages 2 and 11 facing up.
   - Pages 4 and 9 facing up.
   - Pages 6 and 7 facing up.

4. Fold all pages in half to create the booklet. Make sure that all pages are in numerical order. Staple the booklet along the crease.

Important names and resources

Speech-Language Pathologist _____

Telephone Number _____

E-mail Address _____

❑ Report Completed

Durable Medical Equipment Provider _____

_____

Telephone Number _____

E-mail Address _____

❑ Documentation Completed

Physician _____

Telephone Number _____

E-mail Address _____

❑ Prescription Obtained

Other _____

Telephone Number _____

E-mail Address _____

❑ Report Completed

Other _____

Telephone Number _____

E-mail Address _____

❑ Report Completed

A Guide to Obtaining Augmentative Communication Devices and Accessories Through Wisconsin Medicaid

Department of Health and Family Services
Division of Health Care Financing
PHC 11065 (04/04)

About this booklet ...

This booklet is intended for Medicaid and BadgerCare recipients, their caregivers, and providers considering augmentative communication devices, accessories, and services. Wisconsin Medicaid covers medically necessary equipment and services that meet state and federal guidelines.

Information in this brochure is for recipients in BadgerCare and Wisconsin Medicaid. The term "Wisconsin Medicaid" will be used in this booklet to represent both programs.

This booklet does not address services or equipment provided by Medicaid HMOs or the School-Based Services Benefit.

Checklist for obtaining Augmentative Communication Devices through Wisconsin Medicaid

- ❑ The recipient must be Medicaid eligible. Contact the local county / tribal social or human services department or your local W-2 agency for more information on applying for Wisconsin Medicaid, BadgerCare, or Healthy Start.
- ❑ An augmentative communication assessment must be obtained.
- ❑ A physician's prescription for the rental or purchase of the specific augmentative communication device and accessories is needed.
- ❑ A four- to eight-week rental of the device is recommended. In order for Wisconsin Medicaid to reimburse providers for a rental of an augmentative communication device, providers are required to submit a prior authorization request to Wisconsin Medicaid prior to the rental. Wisconsin Medicaid may approve a prior authorization for up to eight weeks for a rental.
- ❑ A Medicaid-certified provider submits *all* documentation for the prior authorization request to Wisconsin Medicaid.

If you have more questions about Medicaid funding of augmentative communication devices call Recipient Services at 1-800-362-3002 or 1-608-221-5720.

Q What should a recipient do if the device is no longer needed?

A Medical equipment that is purchased for recipients by Wisconsin Medicaid becomes the property of the recipient. When the recipient no longer needs the equipment and does not anticipate any future need for the medical equipment, he or she may choose to donate the used equipment.

Wisconsin Medicaid has established a convenient listing of the locations that accept used medical equipment. This information can be found on the Medicaid Web site at *dhfs.wisconsin.gov/medicaid/*. Click on the "Recipients" link at the top of the page, then click on the "Contacts / Help" link to the left. The directory can be found under the heading, "Directory of used medical equipment."

This information is also available to recipients by calling Recipient Services at 1-800-362-3002 or 1-608-221-5720 and to providers by calling Provider Services at 1-800-947-9627 or 1-608-221-9883.

Q What is an augmentative communication device?

A An augmentative communication device is durable medical equipment which is used to assist a recipient who has difficulty speaking.

Q What augmentative communication devices, accessories, and services are covered by Wisconsin Medicaid?

A The following augmentative communication devices, accessories, and services are covered by Wisconsin Medicaid:

- The rental and purchase of medically necessary speech-generating devices.
- Speech-generating software programs.
- Mounting systems.
- Carrying cases.
- Repair of recipient-owned speech-generating devices.

Q What makes an augmentative communication device medically necessary?

A All services funded by Wisconsin Medicaid must be medically necessary. The recipient must have a condition that severely limits his or her ability to talk. It must be demonstrated that the device chosen for

rental or purchase will significantly improve the recipient's ability to communicate and make his or her thoughts and needs known. The recipient must be able to use the device effectively.

Q What products, accessories, and services are not covered by Wisconsin Medicaid?

A The following products, accessories, and services are not covered by Wisconsin Medicaid:

- Extended warranties.
- Fax machines.
- Laptop computers.
- Non-speech-generating software programs.
- Printers.
- Repair of rented speech-generating devices.
- Sales tax.
- Shipping and handling.
- Video games.

Q What is needed to request augmentative communication devices and accessories through Wisconsin Medicaid?

A A prior authorization (see description on page 6) is required for the purchase or rental of an augmentative communication device and/or accessories through Wisconsin Medicaid. The prior authorization process includes the following:

- Verify the recipient is Medicaid eligible.

Q How often will Wisconsin Medicaid approve the purchase of a new augmentative communication device for a recipient?

A Wisconsin Medicaid considers each recipient's situation separately. There is no established time period that an augmentative communication device is expected to last. Wisconsin Medicaid monitors the purchase of augmentative communication devices as a part of the prior authorization process.

Q What if a recipient has other insurance?

A The durable medical equipment provider will bill the recipient's other health insurance before billing Wisconsin Medicaid.

Q What if a recipient is enrolled in a Medicaid HMO?

A Contact your Medicaid HMO directly for more information on how to receive an augmentative communication device through a Medicaid HMO.

Q What can a recipient do if Wisconsin Medicaid modifies or denies a prior authorization request?

A If the prior authorization request is denied or modified, the recipient will receive a letter from Wisconsin Medicaid. The letter will provide information about how the recipient can appeal the decision and request a fair hearing before an administrative law judge.

The speech-language pathologist and recipient may want to discuss the decision to make sure that all of the required information was sent. If more information is needed, the durable medical equipment provider may contact Wisconsin Medicaid to determine if additional information should be submitted.

Q Is a trial period to rent and try out the augmentative communication device required by Wisconsin Medicaid?

A No, a trial period is not required, but it is strongly recommended. A trial period allows a recipient and his or her caregivers to use the device for several weeks and see if it will meet the recipient's daily needs. Wisconsin Medicaid may approve the rental of a device for up to eight weeks.

- Complete an augmentative communication assessment (see description on page 6) documenting the medical necessity for the augmentative communication device and accessories.
- Obtain a physician's prescription for the rental or purchase of the specific augmentative communication device and accessories chosen.
- Contact a Medicaid-certified provider who will submit the prior authorization and receive payment for the equipment.

  One way to find a Medicaid-certified provider is to contact the manufacturer of the chosen augmentative communication device and ask for their Medicaid-certified provider in Wisconsin. Or, contact a local medical equipment and supplies dealer.
- Rent the chosen augmentative communication device and accessories to try out, if necessary. In order for Wisconsin Medicaid to reimburse providers for a rental of an augmentative communication device, providers are required to submit a prior authorization request to Wisconsin Medicaid. Wisconsin Medicaid may approve a prior authorization for up to an eight-week rental period.
- Submit a prior authorization request to Wisconsin Medicaid for the purchase of an augmentative communication device and accessories. The Medicaid-certified provider is responsible for submitting all documentation included in a prior authorization request.

Q What is prior authorization?

A Some services require approval from Wisconsin Medicaid before they are covered. This is called "Prior Authorization."

A Medicaid-certified provider requests prior authorization from Wisconsin Medicaid. Wisconsin Medicaid must approve the service before the individual receives the service.

Recipients and/or their caregivers have the right, and are encouraged, to review the prior authorization request before it is sent to Wisconsin Medicaid.

A Medicaid consultant will review the request to make sure it meets Wisconsin Medicaid requirements. After all the required information is sent in, the Medicaid consultant either approves, modifies, or denies the request.

Q What is included in the augmentative communication assessment?

A This assessment is completed by a speech-language pathologist. The assessment includes the recipient's medical diagnosis and communication diagnosis, provides a description of how the recipient currently communicates, and indicates how an augmentative communication device will improve communication. The report also includes the current baseline of the recipient's:

- Receptive language skills.
- Expressive language skills.
- Cognitive abilites.
- Ability to initiate communication.
- Ability to remember signs or pictures, attach meaning to them, and use them to communicate.
- Attention to task.
- Speed and accuracy of processing information.
- Description of the rental period, if applicable.

The assessment should include a discussion regarding which equipment was considered and why, and why the equipment being requested was chosen over other available options. Justification should be provided that the recommended equipment represents the least costly option that meets the recipient's functional communication needs.

The report also needs to include a statement of where the device will be used and the person who will be responsible for programming the device.

An occupational therapist or physical therapist may provide recommendations for positioning, mounting, and access of the equipment.

Q Can a letter of support be submitted with the prior authorization request?

A Yes. Additional documentation supporting the recipient's need for the augmentative device would be beneficial to a prior authorization request, but is not required. Sometimes letters from parents, family members, teachers, or caregivers may be helpful in documenting how the device has aided the recipient.

Any supporting documentation *must* be submitted with the prior authorization request and should not be mailed separately.

Appendix 8

Allowable Procedure Codes for Physical Therapy Services

Evaluations			
Procedure Code	**Description**	**Limit Per Day**	**Service May Be Provided by a Physical Therapist Assistant**
97001	Physical therapy evaluation [15 minutes]	Not applicable	No
97002	Physical therapy re-evaluation [15 minutes]	2 per day	No

Modalities			
Procedure Code	**Description**	**Limit Per Day**	**Service May Be Provided by a Physical Therapist Assistant**
G0281	Electrical stimulation, (unattended), to one or more areas, for chronic stage iii and stage iv pressure ulcers, arterial ulcers, diabetic ulcers, and venous stasis ulcers not demonstrating measurable signs of healing after 30 days of conventional care, as part of a therapy plan of care	1 per day	Yes
G0282	Electrical stimulation, (unattended), to one or more areas, for wound care other than described in G0281	1 per day	Yes
G0283	Electrical stimulation (unattended), to one or more areas for indication(s) other than wound care, as part of a therapy plan of care	1 per day	Yes
90901	Biofeedback training by any modality [15 minutes]	Not applicable	Yes
97012	Application of a modality to one or more areas; traction, mechanical	1 per day	Yes
97016	vasopneumatic devices	1 per day	Yes
97018	paraffin bath	1 per day	Yes
97020	microwave	1 per day	Yes
97022	whirlpool	1 per day	Yes
97024	diathermy	1 per day	Yes
97026	infrared	1 per day	Yes
97028	ultraviolet	1 per day	Yes

Appendix 8
(Continued)

Modalities (Continued)			
Procedure Code	**Description**	**Limit Per Day**	**Service May Be Provided by a Physical Therapist Assistant**
97032	Application of a modality to one or more areas; electrical stimulation (manual), each 15 minutes	Not applicable	Yes
97033	iontophoresis, each 15 minutes	Not applicable	Yes
97034	contrast baths, each 15 minutes	Not applicable	Yes
97035	ultrasound, each 15 minutes	Not applicable	Yes
97036	Hubbard tank, each 15 minutes	Not applicable	Yes
97039	Unlisted modality (specify type and time if constant attendance)	1 per day	Yes

Therapeutic Procedures			
Procedure Code	**Description**	**Limit Per Day**	**Service May Be Provided by a Physical Therapist Assistant**
97110	Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility	Not applicable	Yes
97112	neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities	Not applicable	Yes
97113	Aquatic therapy with therapeutic exercises	Not applicable	Yes
97116	gait training (includes stair climbing)	Not applicable	Yes
97124	massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion)	Not applicable	Yes
97139	Unlisted therapeutic procedure (specify)	Not applicable	Yes
97140	Manual therapy techniques (eg, mobilization/manipulation, manual lymphatic drainage, manual traction), one or more regions, each 15 minutes	Not applicable	When appropriate*
97520	Prosthetic training, upper and/or lower extremities, each 15 minutes	Not applicable	Yes
97530	Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes	Not applicable	Yes

Appendix 8
(Continued)

Therapeutic Procedures (Continued)			
Procedure Code	**Description**	**Limit Per Day**	**Service May Be Provided by a Physical Therapist Assistant**
97533	Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one-on-one) patient contact by the provider, each 15 minutes	Not applicable	Yes
97535	Self-care/home management training (eg, activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact by provider, each 15 minutes	Not applicable	Yes
97542	Wheelchair management/propulsion training, each 15 minutes	Not applicable	Yes
97597	Removal of devitalized tissue from wound(s), selective debridement, without anesthesia (eg, high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps), with or without topical application(s), wound assessment, and instruction(s) for ongoing care, may include use of a whirlpool, per session; total wound(s) surface area less than or equal to 20 square centimeters	1 per day	No
97598	total wound(s) surface area greater than 20 square centimeters	1 per day	No

Other Procedures			
Procedure Code	**Description**	**Limit Per Day**	**Service May Be Provided by a Physical Therapist Assistant**
93797	Physician services for outpatient cardiac rehabilitation; without continuous ECG monitoring (per session)	1 per day	No
93798	with continuous ECG monitoring (per session)	1 per day	No
94667	Manipulation chest wall, such as cupping, percussing, and vibration to facilitate lung function; initial demonstration and/or evaluation	1 per day	No
94668	subsequent	1 per day	No

*When provided by physical therapist assistants, Medicaid reimbursement is not available for myofascial release/soft tissue mobilization for one or more regions or joint mobilization for one or more areas (peripheral or spinal).

Notes: Procedure codes for many physical therapy (PT) services are defined as 15 minutes. One unit of these codes = 15 minutes. If less than 15 minutes is used, bill in decimals. For example, 7.5 minutes = .5 units.

All other procedure codes for PT services do not have a time increment indicated in their description. For these procedure codes, a quantity of "1" indicates a complete service.

Appendix 9

Allowable Procedure Codes for Occupational Therapy Services

Evaluations			
Procedure Code	**Description**	**Limit Per Day**	**Service May Be Provided by a Certified Occupational Therapy Assistant**
97003	Occupational therapy evaluation [15 minutes]	Not applicable	No
97004	Occupational therapy re-evaluation [15 minutes]	2 per day	No

Therapeutic Procedures			
Procedure Code	**Description**	**Limit Per Day**	**Service May Be Provided by a Certified Occupational Therapy Assistant**
97110	Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility	Not applicable	Yes
97112	neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities	Not applicable	Yes
97124	massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion)	Not applicable	Yes
97139	Unlisted therapeutic procedure (specify)	Not applicable	Yes
97140	Manual therapy techniques (eg, mobilization/manipulation, manual lymphatic drainage, manual traction), one or more regions, each 15 minutes	Not applicable	When appropriate*
97150	Therapeutic procedure(s), group (2 or more individuals) [each 15 minutes]	Not applicable	Yes
97520	Prosthetic training, upper and/or lower extremities, each 15 minutes	Not applicable	Yes
97530	Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes	Not applicable	Yes
97532	Development of cognitive skills to improve attention, memory, problem solving (includes compensatory training), direct (one-on-one) patient contact by the provider, each 15 minutes	Not applicable	Yes

Therapeutic Procedures (Continued)			
Procedure Code	**Description**	**Limit Per Day**	**Service May Be Provided by a Certified Occupational Therapy Assistant**
97533	Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one-on-one) patient contact by the provider, each 15 minutes	Not applicable	Yes
97535	Self-care/home management training (eg, activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact by provider, each 15 minutes	Not applicable	Yes
97542	Wheelchair management/propulsion training, each 15 minutes	Not applicable	Yes
97597	Removal of devitalized tissue from wound(s), selective debridement, without anesthesia (eg, high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps), with or without topical application(s), wound assessment, and instruction(s) for ongoing care, may include use of a whirlpool, per session; total wound(s) surface area less than or equal to 20 square centimeters	1 per day	No
97598	total wound(s) surface area greater than 20 square centimeters	1 per day	No

Modalities			
Procedure Code	**Description**	**Limit Per Day**	**Service May Be Provided by a Certified Occupational Therapy Assistant**
90901	Biofeedback training by any modality [15 minutes]	Not applicable	Yes
97016	Application of modality to one or more areas; vasopneumatic devices	1 per day	Yes
97018	paraffin bath	1 per day	Yes
97022	whirlpool	1 per day	Yes
97032	Application of a modality to one or more areas; electrical stimulation (manual), each 15 minutes	Not applicable	Yes
97033	iontophoresis, each 15 minutes	Not applicable	Yes
97034	contrast baths, each 15 minutes	Not applicable	Yes
97035	ultrasound, each 15 minutes	Not applicable	Yes

* When provided by certified occupational therapy assistants, Medicaid reimbursement is not available for myofascial release/soft tissue mobilization for one or more regions or joint mobilization for one or more areas (peripheral or spinal).

Notes: Procedure codes for many occupational therapy (OT) services are defined as 15 minutes. One unit of these codes = 15 minutes. If less than 15 minutes is used, bill in decimals. For example, 7.5 minutes = .5 units.

All other procedure codes for OT services do not have a time increment indicated in their description. For these procedure codes, a quantity of "1" indicates a complete service.

Appendix 10

Allowable Procedure Codes for Speech and Language Pathology Services

Procedure Code	Description	Billing Limitations	Additional Conditions
31575	Laryngoscopy, flexible fiberoptic; diagnostic		Use this code if speech-language pathologist actually inserts a laryngoscope. Do not use this code if the speech-language pathologist is providing an analysis and does not insert the laryngoscope; instead, use code 92506 or 92610, as appropriate. For treatment, use 92507 or 92526, as appropriate. This service is to be performed according to the American Speech-Language-Hearing Association (ASHA) Code of Ethics and ASHA Training Guidelines for Laryngeal Videoendoscopy/Stroboscopy.
31579	Laryngoscopy, flexible or rigid fiberoptic, with stroboscopy		Use this code if speech-language pathologist actually inserts a laryngoscope. Do not use this code if the speech-language pathologist is providing an analysis and does not insert the laryngoscope; instead, use code 92506 or 92610 as appropriate. This service is to be performed according to the ASHA Code of Ethics and ASHA Training Guidelines for Laryngeal Videoendoscopy/Stroboscopy.
92506	Evaluation of speech, language, voice, communication, auditory processing, and/or aural rehabilitation status	Cannot use on the same date of service (DOS) as 96105 or 92510.	This code is also used for re-evaluation.
92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder (includes aural rehabilitation); individual	Cannot use on the same DOS as 92510.	This code should be used for therapy services that address communication/cognitive impairments and voice prosthetics. If treatment focus is aural rehabilitation as a result of a cochlear implant, submit a prior authorization request using the Prior Authorization/Therapy Attachment (PA/TA), HCF 11008, to request code 92510.
92508	group, two or more individuals		Group is limited to two to four individuals.
92510	Aural rehabilitation following cochlear implant (includes evaluation of aural rehabilitation status and hearing, therapeutic services) with or without speech processor programming	Cannot use on the same DOS as 92506 or 92507.	Prior authorization is always required. Use this procedure code for evaluation and treatment.
92511	Nasopharyngoscopy with endoscope (separate procedure)		Use this code if speech-language pathologist actually inserts an endoscope. Do not use this code if the speech-language pathologist is providing an analysis and does not insert the scope; instead, use code 92506 or 92610 as appropriate. Use this code for evaluation of dysphagia or assessment of velopharyngeal insufficiency or incompetence. This service is to be performed according to the ASHA Code of Ethics and ASHA Training Guidelines for Laryngeal Videoendoscopy/Stroboscopy.

Appendix 10
(Continued)

Procedure Code	Description	Billing Limitations	Additional Conditions
92512	Nasal function studies (eg, rhinomanometry)		Use this code if completing aerodynamic studies, oral pressure/nasal airflow, flow/flow studies, or pressure/pressure studies.
92520	Laryngeal function studies		Use this code for laryngeal air flow studies, subglottic air pressure studies, acoustic analysis, EGG (electroglottography) laryngeal resistance.
92526	Treatment of swallowing dysfunction and/or oral function for feeding		The recipient must have an identified physiological swallowing and/or feeding problem. This is to be documented using professional standards of practice such as identifying oral phase, esophageal phase or pharyngeal phase dysphagia, baseline of current swallowing and feeding skills not limited to signs of aspiration, an oral mechanism exam, report of how nutrition is met, current diet restrictions, compensation strategies used, and level of assistance needed.
92597	Evaluation for use and/or fitting of voice prosthetic device to supplement oral speech	Cannot use on the same DOS as 96105.	This code describes the services to evaluate a patient for the use of a voice prosthetic device (e.g., electrolarynx, tracheostomy-speaking valve). Evaluation of picture communication books, manual picture boards, sign language, the Picture Exchange Communication System, picture cards, gestures, etc., are not included in the reimbursement for this code. Instead, use code 92506.
92607*	Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; first hour	Cannot use on the same DOS as 96105.	This code describes the services to evaluate a patient to specify the speech-generating device recommended to meet the patient's needs and capacity. This can also be used for re-evaluations. Evaluation of picture communication books, manual picture boards, sign language, the Picture Exchange Communication System, picture cards, gestures, etc., are not included in the reimbursement for this code. Instead, use code 92506.
92608**	each additional 30 minutes (List separately in addition to code for primary procedure)	This code can only be billed in conjunction with 92607.	A maximum of 90 minutes is allowable. The maximum allowable number of units for this service is one unit of 92607 and one unit of 92608.
92609	Therapeutic services for the use of speech-generating device, including programming and modification		This code describes the face-to-face services delivered to the patient to adapt the device to the patient and train him or her in its use.
92610	Evaluation of oral and pharyngeal swallowing function		

Appendix 10
(Continued)

Procedure Code	Description	Billing Limitations	Additional Conditions
92611	Motion fluoroscopic evaluation of swallowing function by cine or video recording		Accompanying a recipient to a swallow study is not reimbursable. This code involves participation and interpretation of results from the dynamic observation of the patient swallowing materials of various consistencies. It is observed fluoroscopically and typically recorded on video. The evaluation involves using the information to assess the patient's swallowing function and developing a treatment.
92612	Flexible fiberoptic endoscopic evaluation of swallowing by cine or video recording;		
92614	Flexible fiberoptic endoscopic evaluation, laryngeal sensory testing by cine or video recording;	Only allowable when used in conjunction with 92612.	
92700	Unlisted otorhinolaryngological service or procedure		Prior authorization is always required to use this code. Use this code when no other *Current Procedural Terminology* code description appropriately describes the evaluation or treatment.
96105***	Assessment of aphasia (includes assessment of expressive and receptive speech and language function, language comprehension, speech production ability, reading, spelling, writing, eg, by Boston Diagnostic Aphasia Examination) with interpretation and report, per hour	Cannot use on the same DOS as 92506, 92597, 92607, or 92608.	

* The procedure code description defines this code as one hour. One unit of this code = 1 hour. If less than one hour is used, bill in decimals to the nearest quarter hour. For example, 45 minutes = .75 units and 30 minutes = .5 units. If more than one hour of service is provided, up to one unit of code 92608 can be used in combination with this code.

** The procedure code description defines this code as 30 minutes. One unit of this code = 30 minutes. If less than 30 minutes is used, bill in decimals to the nearest quarter hour. For example, 15 minutes = .5 units.

*** The procedure code description defines this code as one hour. One unit of this code = 1 hour. A maximum of 90 minutes or 1.5 units is allowable. If less or more than one hour is used, bill in decimals to the nearest quarter hour. For example, 45 minutes = .75 units and 30 minutes = .5 units.

Notes: All codes listed in this chart, if billed with an applicable place of service code, are eligible for natural environment enhanced reimbursement.

As with Medicare, providers may not submit claims for services for less than eight minutes.

Most procedure codes for speech and language pathology services do not have a time increment indicated in their description. Except as noted above, a quantity of "1" indicates a complete service. The daily service limitation for these codes is one.

Appendix 11

Allowable Physical Therapy Procedure Codes for Birth to 3 Services

Procedure Code*	Description
97001	Physical therapy evaluation
97002	Physical therapy re-evaluation
97110	Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility
97112	neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities
97113	aquatic therapy with therapeutic exercises
97116	gait training (includes stair climbing)
97140	Manual therapy techniques (eg, mobilization/manipulation, manual lymphatic drainage, manual traction), one or more regions, each 15 minutes
97530	Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes
97533	Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one-on-one) patient contact by the provider, each 15 minutes
97535	Self-care/home management training (eg, activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact by the provider, each 15 minutes

*All codes listed in this chart, if billed with an applicable place of service code, are eligible for natural environment enhanced reimbursement.

Appendix 12

Allowable Occupational Therapy Procedure Codes for Birth to 3 Services

Procedure Code*	Description
97003	Occupational therapy evaluation
97004	Occupational therapy re-evaluation
97110	Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility
97112	neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities
97140	Manual therapy techniques (eg, mobilization/manipulation, manual lymphatic drainage, manual traction), one or more regions, each 15 minutes
97150	Therapeutic procedure(s), group (2 or more individuals) (Report 97150 for each member of the group) (Group therapy procedures involve constant attendance of the physician or therapist, but by definition do not require one-on-one patient contact by the physician or therapist)
97530	Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes
97532	Development of cognitive skills to improve attention, memory, problem solving, (includes compensatory training), direct (one-on-one) patient contact by the provider, each 15 minutes
97533	Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one-on-one) patient contact by the provider, each 15 minutes
97535	Self-care/home management training (eg, activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devises/adaptive equipment) direct one-on-one contact by provider, each 15 minutes

*All codes listed in this chart, if billed with an applicable place of service code, are eligible for natural environment enhanced reimbursement.

Appendix 13

Allowable Speech and Language Pathology Procedure Codes for Birth to 3 Services

Procedure Code	Description	Billing Limitations	Additional Conditions
92506	Evaluation of speech, language, voice, communication, auditory processing, and/or aural rehabilitation status	Cannot use on the same date of service (DOS) as 92510 or 96105.	This code is also used for re-evaluation.
92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder (includes aural rehabilitation); individual	Cannot use on the same DOS as 92510.	Therapy addressing communication/cognitive impairments and voice prosthetics should use this code. If treatment focus is aural rehabilitation as a result of a cochlear implant, submit a prior authorization request using the Prior Authorization/Therapy Attachment (PA/TA), HCF 11008, to request code 92510.
92508	group, two or more individuals		Group is limited to two to four individuals.
92526	Treatment of swallowing dysfunction and/or oral function for feeding		The recipient must have an identified physiological swallowing and/or feeding problem. This is to be documented using professional standards of practice such as identifying oral phase, esophageal phase or pharyngeal phase dysphagia, baseline of current swallowing and feeding skills not limited to signs of aspiration, an oral mechanism exam, report of how nutrition is met, current diet restrictions, compensation strategies used, and level of assistance needed.
92597	Evaluation for use and/or fitting of voice prosthetic device to supplement oral speech	Cannot use on the same DOS as 96105.	This code describes the services to evaluate a patient for the use of a voice prosthetic device (e.g., electrolarynx, tracheostomy-speaking valve). Evaluation of picture communication books, manual picture boards, sign language, the Picture Exchange Communication System, picture cards, gestures, etc., are not included in the reimbursement for this code. Instead, use code 92506.

Procedure Code	Description	Billing Limitations	Additional Conditions
92607*	Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; first hour	Cannot use on the same DOS as 96105.	This code describes the services to evaluate a patient to specify the speech-generating device recommended to meet the patient's needs and capacity. This can also be used for re-evaluations. Evaluation of picture communication books, manual picture boards, sign language, the Picture Exchange Communication System, picture cards, gestures, etc., are not included in the reimbursement for this code. Instead, use code 92506.
92608**	each additional 30 minutes	This code can only be billed in conjunction with 92607.	A maximum of 90 minutes is allowable. The maximum allowable number of units for this service is one unit of 92607 and one unit of 92608.
92609	Therapeutic services for the use of speech-generating device, including programming and modification		This code describes the face-to-face services delivered to the patient to adapt the device to the patient and train him or her in its use.
92610	Evaluation of oral and pharyngeal swallowing function		

* The procedure code description defines this code as one hour. One unit of this code = 1 hour. If less than one hour is used, bill in decimals to the nearest quarter hour. For example, 45 minutes = .75 units and 30 minutes = .5 units. If more than one hour of service is provided, up to one unit of code 92608 can be used in combination with this code.

** The procedure code description defines this code as 30 minutes. One unit of this code = 30 minutes. If less than 30 minutes is used, bill in decimals to the nearest quarter hour. For example, 15 minutes = .5 units.

Notes: All codes listed in this chart, if billed with an applicable place of service code, are eligible for natural environment enhanced reimbursement. As with Medicare, providers may not submit a claim for services for less than eight minutes.

Most procedure codes for speech and language pathology services do not have a time increment indicated in their description. Except as noted above, a quantity of "1" indicates a complete service. The daily service limitation for these codes is one.

Appendix 14

Allowable Modifiers for Physical Therapy, Occupational Therapy, and Speech and Language Pathology Services

Therapy Discipline	Modifier	Description	Notes
Occupational therapy (OT)	GO	Services delivered [personally by an occupational therapist or] under an outpatient occupational therapy plan of care	
Physical therapy (PT)	GP	Services delivered [personally by physical therapist or] under an outpatient physical therapy plan of care	
PT and OT	TF	Intermediate level of care	"TF" should be indicated when submitting claims for services provided by physical therapist assistants or certified occupational therapy assistants under general supervision. "TF" should not be indicated on prior authorization (PA) requests.
PT, OT, and speech and language pathology	TL	Early intervention/Individualized Family Services Plan (IFSP)	"TL" should be indicated when submitting claims for Birth to 3 (B-3) services provided in the natural environment of a B-3 participant. "TL" should not be indicated on PA requests.

Appendix 15

Allowable Place of Service Codes for Physical Therapy, Occupational Therapy, and Speech and Language Pathology Services

Place of Service Code	Description
04*	Homeless Shelter
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
12*	Home
15	Mobile Unit
20	Urgent Care Facility
21	Inpatient Hospital
22	Outpatient Hospital
31	Skilled Nursing Facility
32	Nursing Facility
33	Custodial Care Facility
34	Hospice
50	Federally Qualified Health Center
54	Intermediate Care Facility/Mentally Retarded
71	State or Local Public Health Clinic
72	Rural Health Clinic
99*	Other Place of Service

* Place of service codes "04," "12," and "99" are eligible for the natural environment enhanced reimbursement when providing services to recipients who participate in the Birth to 3 Program.

Appendix 16

Examples of Standards of Medical Necessity As Evaluated on Prior Authorization Requests

The following information and case examples are offered to illustrate how the standards of medical necessity, as defined in HFS 101.03(96m), Wis. Admin. Code, are applied when prior authorization (PA) requests for physical therapy (PT), occupational therapy (OT), or speech and language pathology (SLP) services are reviewed by Wisconsin Medicaid.

HFS 101.03(96m), Wis. Admin. Code, "medically necessary" means a medical service under ch. 107 that is:

(a) Required to prevent, identify or treat a recipient's illness, injury or disability; and

Example 1: Many individuals having the same diagnosis may have certain characteristics in common; however, the physical expression and functional severity of their conditions can vary greatly. As a result, documentation in the PA request must include a medical diagnosis as well as a problem statement (treatment diagnosis) related to the medical diagnosis that identifies the specific treatment needs of the individual.

For example, physical therapy is requested for a four-year-old child with spastic diplegic cerebral palsy and a gross motor age equivalency of 44-48 months. A plan of care (POC) to address "continued development of age-appropriate mobility skills" would not meet the Medicaid application of this standard because no impairments, functional limitations, or disabilities have been identified. The reviewer would question how the requested service treats an illness, injury, or disability. If the therapist identified tight hamstrings but provided no evidence that hamstring contractures were causing any functional problems, the same questions remain.

If instead, the physical therapist's evaluation identified functional limitations including problems with climbing, frequent falls when walking from the bus to home, or other restrictions in outdoor mobility due to tight hamstrings, it may be appropriate to authorize a limited course of PT. In this case, PT may be necessary to improve dynamic range of motion and lower extremity strength, to facilitate functional skill acquisition, and to educate the recipient/caregivers on a home program including recommendations about when to seek medical attention for developing problems, such as worsening contractures.

Example 2: A nine-year-old is an independent household ambulator and presents with hypotonic trunk muscles. He has been receiving OT for the past six months. The new PA request includes continued treatment strategies of trunk elongation and rib cage mobilization with ongoing goals of preparing for strengthening/stability exercises and preventing frequent respiratory infections. No documentation of trunk range of motion, upper body strength testing, or frequency of respiratory infection is provided.

Measurable goals reflect treatment that is expected to reduce identified impairments, produce sustained changes in function, and are necessary to describe how treatment will affect injury, illness, or disability. The medical necessity of the POC would be questioned because no deficits are reported and no evidence is provided to support that soft tissue mobilization has resulted or would likely result in any sustainable change in the client's trunk control or any improvement in functional performance over time. The PA documentation does not support that a correlation exists between improving rib cage mobility and decreasing the client's susceptibility to respiratory infections. The PA request would be returned requesting this additional information.

Example 3: A PA is submitted for SLP services for a four-year-old child. The child only speaks at home and was referred by the family doctor for an SLP assessment. The standardized/non-standardized tests performed by the SLP provider indicate that the child's receptive and expressive language skills are age appropriate. The PA requests SLP services twice per week to improve the child's social language skills. In this situation, the Medicaid consultant may question if the services of an SLP provider are required, since the standardized tests indicate the child's language skills are age appropriate and do not identify an injury, illness, or disability potentially remediable by an SLP provider.

(b) Meets the following standards:

1. Is consistent with the recipient's symptoms, or with prevention, diagnosis or treatment of the recipient's illness, injury or disability;

Example 1: The client is a 35-year-old with cerebral palsy who is seven weeks post ankle fusion. Prior to surgery, she had been able to ambulate with a walker in her home. The PA request includes a PT POC to assess and/or teach transfer skills and evaluate orthotics and equipment needs. This POC reflects a situation where episodic therapy is warranted to maximize functional capacity following an orthopedic intervention. This PA request would be approved because it is consistent with treatment of the client's recent change in medical condition.

Example 2: A 16-year-old with a remote history of anoxic brain injury is dependent for all activities of daily living. An OT PA request is submitted to increase head control at midline from the recipient's current level of 3-5 seconds to 5-10 seconds. No progress has been documented in this area following extensive intervention to improve head control. When functional limitations persist for long periods and have not been remediable, compensatory strategies may be more appropriate. The PA request would be returned for additional information to support the benefit of continued direct treatment for improving head control as an effective or functional intervention.

Example 3: A PA is submitted for SLP services for a 45-year-old recipient diagnosed with mental retardation, emotional disturbance, and seizure disorder. His sheltered workshop supervisor referred the client for an SLP evaluation because over the past two months, both workshop staff and home caregivers have had difficulties understanding him due to decreased speaking rate and slurred speech. Upon assessment, the recipient's regression appears to coincide with the start of a new medication.

Without additional information, the Medicaid consultant would return the PA request questioning whether the recipient's decreased intelligibility may be related to the medication. Documentation of sufficient clinical information may then result in approval of SLP services for a brief episode of care to improve intelligibility.

2. Is provided consistent with standards of acceptable quality of care applicable to the type of service, the type of provider and the setting in which the service is provided;

Example: A PA request for sensory integration therapy is submitted for a nine-year-old with pervasive developmental disorder. Goals include decreased behavioral outbursts in natural environments like a noisy gym or shopping mall, improved sleeping patterns, and better ability to "self regulate." The PA would be returned asking the provider to explain how skills learned in therapy would be generalized from the controlled environment of the clinic setting to the child's natural environment(s) of home, school, or community. The Medicaid consultant may further question whether these issues would be more appropriately addressed by a behavioral therapist or through a consistent behavioral management home program.

3. Is appropriate with regard to generally accepted standards of medical practice;

Example 1: A PA is submitted with the therapist reporting that an individual is "not testable" or with the majority of the therapy evaluation obtained from unstructured observation or from other sources. If the treating therapist is unable to establish an individual's baseline functional skills and limitations, it will be impossible to later evaluate and document any changes that may result from therapeutic intervention. Initiating treatment without performing a comprehensive assessment that includes baseline measurements of the individual's abilities and physical impairments is not appropriate with regard to generally accepted standards of practice. If a problem area is not/ cannot be tested during the initial evaluation, it should be explained why data could not be obtained and that

subsequent PAs will contain baseline data for reported problem areas as well as interval progress. This PA would be returned asking for additional information.

Example 2: An occupational therapist working with a child with a history of dysphagia submits a PA request with a goal for the child to tolerate a wider variety of foods. No clinical assessment of the child's oral motor/swallowing skills or results from a radiological swallow study have been documented to indicate that the proposed oral intake is safe. The PA request would be returned requesting this additional clinical information to assure that the treatment goals are appropriate.

4. Is not medically contraindicated with regard to the recipient's diagnoses, the recipient's symptoms or other medically necessary services being provided to the recipient;

Example: An 85-year-old is eight weeks post hip fracture with subsequent open reduction and internal fixation. The POC submitted with the PA includes goals of transferring with assistive device, achieving independence on stairs, and increasing unilateral weight bearing for improved balance, strength, and endurance while walking. No weight bearing restrictions or hip precautions are included in the information submitted. In the absence of this standard medical information, the reviewer may question whether the goals are appropriate (or possibly contraindicated) depending on the recommended postoperative hip precautions. Also, the requested frequency or intensity of therapy may be inappropriate depending on the recipient's weight bearing status.

Example 2: For a recipient with the recent onset of dysphagia and a swallow study that indicates aspiration, an oral motor evaluation and initial course of treatment is medically necessary to see if swallowing abilities can be improved. If a subsequent request is submitted that indicates the individual has been unable to maintain his or her weight with oral feedings or if clinical signs of aspiration such as cough or respiratory infection persist, then continued SLP services to address improving oral feeding skills without assessing the need for further dietary modifications (change in liquid/solid consistency) may be medically contraindicated. This PA would be returned for additional clinical information to support the safety of the requested therapy.

5. Is of proven medical value or usefulness and, consistent with s. HFS 107.035, is not experimental in nature;

In assessing whether a service is experimental in nature, the Department of Health and Family Services (DHFS) shall consider whether the service is a proven effective treatment for the condition for which it is intended or used, as evidenced by:

- The current and historical judgment of the medical community (as reflected by medical research, studies, or publications in peer-reviewed journals).
- The extent to which other health insurers provide coverage for the service.
- The current judgment of experts or specialists in the medical area for which the service is to be used.
- The judgment of the Wisconsin Medicaid Medical Audit Committee of the Wisconsin Medical Society or of any other committee that may be under contract to the DHFS as identified in Wisconsin Administrative Code.

The following interventions have been determined to be experimental: Facilitated Communication and Auditory Integration Therapy. The Wisconsin Medical Society has also determined that electrical stimulation for the treatment of open wounds can only be applied to Stage III or IV decubiti. Prior authorization for continued treatment is considered only if granulation tissue has formed or a 25 percent reduction in the affected area has occurred within 45 days of initiating electrical stimulation. Any PA request for electrical stimulation that falls outside these parameters is considered unproven and would be denied.

6. Is not duplicative with respect to other services being provided to the recipient;

Example 1: A 78-year-old with a diagnosis of Alzheimer's disease resides in a nursing home that specializes in the care of Alzheimer patients. The client transfers with moderate assistance and receives PT two times per week for gait training and to improve transfer skills. The client's transfer and ambulation skills have not progressed over the past month and the nursing staff has been instructed in safe transfer and ambulation techniques. The PT POC recommends continued PT services designed to maintain the client's abilities, stating that the client requires the skills of a therapist because she has Alzheimer's. Caregivers who have been properly instructed by a physical therapist regarding the client's unique set of problems should be skilled in working with this patient. Therefore, this PA request would be denied because it is duplicative to the client's maintenance care program.

Example 2: A child with autism is receiving intensive behavioral services with treatment goals of improved peer play, turn taking, sharing, and concentrating on conversation. The OT PA request includes goals for the child to participate in a group game following rules with proper sequencing and attention to task. In this case, the requested therapy is not coordinated with the goals and activities of all other medical, educational, and vocational disciplines involved with the client. The clinical intent of both services appears to be directed toward achieving the same outcome. Therefore, the PA request would be returned for clarification.

Example 3: A PA request is submitted for SLP services for a six-year-old child diagnosed with developmental delays and dysphagia. All of the child's nutrition is provided by mouth. The diet is modified to ground consistency solids and thickened liquids. The child currently receives SLP services at school and the Individualized Education Plan (IEP) includes facilitation of oral motor exercises supervised by an aide five times per week for 20-30-minute sessions. The school SLP provider re-evaluates the child's oral motor skills monthly. The POC submitted by the community-based provider focuses on oral motor exercises. In this situation, the Medicaid consultant may question if the requested service is duplicative of the services being performed in the school.

7. Is not solely for the convenience of the recipient, the recipient's family or a provider;

Example 1: A child with a history of traumatic brain injury receives PT services at school during the academic year. The IEP does not include recommendations for Extended School Year PT over the summer months. Physical therapy services are being requested at a community-based clinic during the summer because, without therapy, the client's day lacks structured activities. Unless the services being requested require the professional skills of a therapist, the request may be viewed as an alternative to recreational or other community-based activities and appears to be submitted solely for convenience.

Example 2: An OT PA request is submitted to provide range of motion and strengthening. The individual has skills that are sufficient to perform the program at home with supervision or in a community or recreational setting. In this case, the PA would be returned for additional information to explain why the skills of a therapist are required.

Example 3: A PA request is submitted for SLP services for a 38-year old diagnosed with developmental delays.The recipient lives in a group home and communicates with an augmentative communication device. Previous therapy and product manuals have been provided for the client and caregivers to program and use the device. The PA requests SLP services for the purpose of creating a new communication page for the device. In this case, the Medicaid consultant would question if the service being requested is solely for convenience and if the recipient's caregiver or family member familiar with the device could create a new page.

8. With respect to prior authorization of a service and to other prospective coverage determinations made by the department, is cost-effective compared to an alternative medically necessary service which is reasonably accessible to the recipient; and

Example 1: A physical therapist has requested therapy services three times per week to work on a POC that is focused on repetition of skills to build endurance. A PA request for PT services at this frequency would be modified or denied. It would be more cost-effective for the client to work on building endurance through a home exercise program. Modification would allow the therapist to monitor the client's progress and to revise the home program as needed, instead of providing direct therapy to work on repetition of an already achieved skill. Programs that involve ongoing muscle strengthening and fitness often involve instructing the client to carry out activities independent of assistance or stressing recreational activities that encourage mobility and reinforce functional movement.

Example 2: An OT PA request is received to provide range of motion for a client who resides in a nursing home. A restorative nursing plan is in place and meets the functional needs of this individual. The therapy POC being requested does not include more advanced functional outcomes requiring the skills of a therapist. Occupational therapy services, in addition to restorative nursing, are not cost-effective and the PA request would be denied.

9. Is the most appropriate supply or level of service that can safely and effectively be provided to the recipient.

Example: A 10-year-old child with cerebral palsy has received many years of OT. His current level of functional upper extremity dressing skills includes the ability to push his arm through his sleeve only when the shirt is held over his head and the sleeve is held in place for him. No volitional grasp or release is demonstrated. The OT POC is submitted for ongoing direct treatment to improve independent living skills. For this individual, it appears that he has reached a plateau, that no functional gains in upper extremity dressing skills can reasonably be anticipated, and that compensatory strategies and equipment are the most appropriate level of service that can be effectively provided. The direct skills of an occupational therapist may no longer be necessary at this time to maximize his functional performance. A more appropriate level of service may be provided by an occupational therapist on a consultative basis to monitor compensatory strategies and equipment and to evaluate further direct OT needs.

Example 2: A PA is submitted for SLP services to improve intelligibility in a nine-year-old child with a diagnosis of dyskinetic cerebral palsy. A review of the child's extensive therapy history indicates that there has been little functional improvement in the child's intelligibility. Standardized tests and subjective reporting also indicate that the child's intelligibility has not changed appreciably in three years despite receiving both school and community-based SLP services. The child has acquired an augmentative communication device to supplement his speech. In this situation, the Medicaid consultant would question if community-based SLP services focused on improving intelligibility remains the most appropriate level of service that can be effectively provided to this recipient.

Appendix 17

General Principles for Physical Therapy, Occupational Therapy, and Speech and Language Pathology Prior Authorization Requests

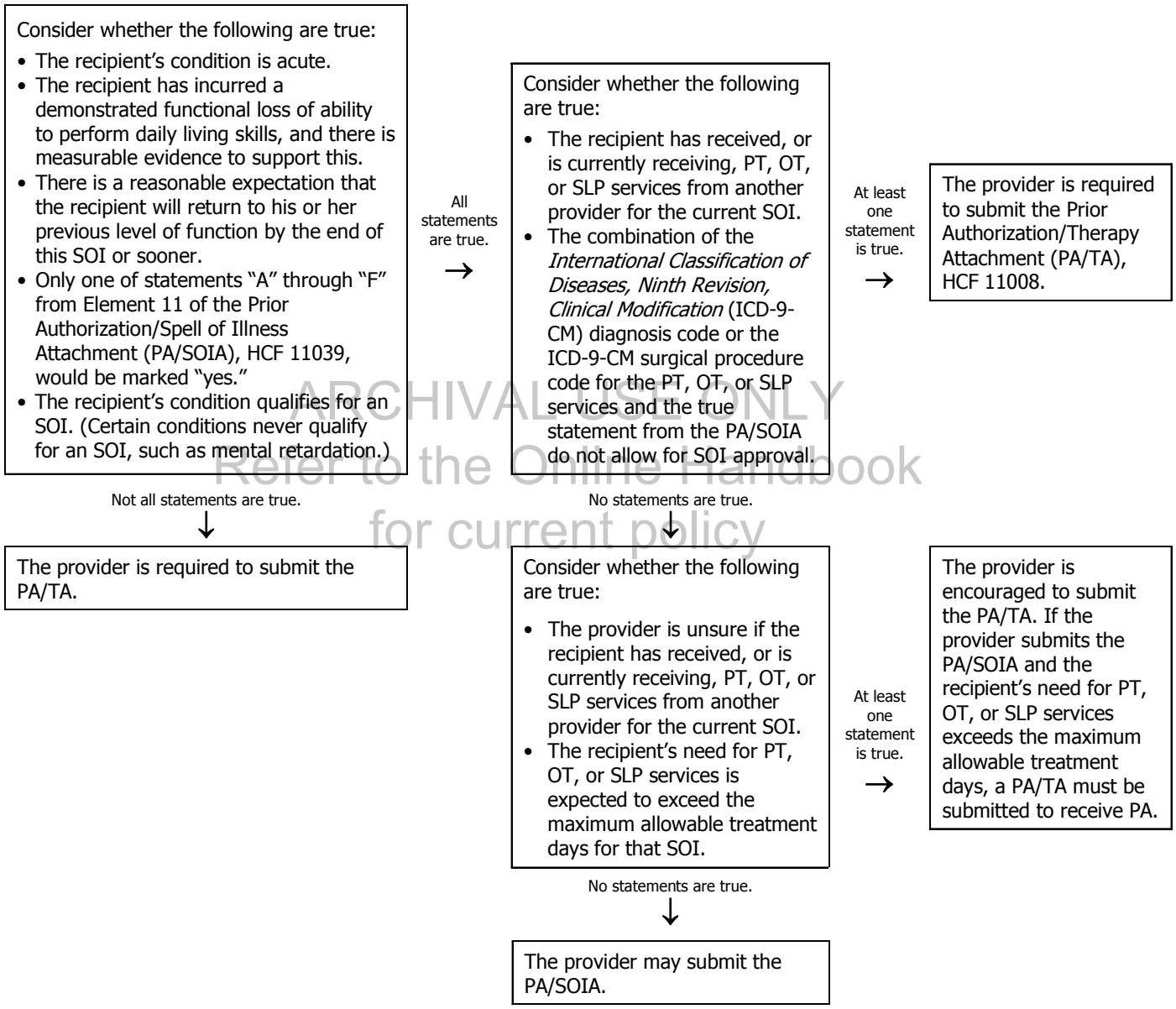
A prior authorization (PA) request for extension of therapy services, maintenance therapy services, or services that always require PA may be approved if the documentation provided establishes the following:

- Services are reasonably expected to be effective in achieving predictable and functional results for the recipient.
- Services are coordinated with the goals and activities of all other medical, educational, and vocational disciplines involved with the recipient.
- Services are cost-effective when compared with other available services that meet the recipient's treatment needs.
- Professional skills of a physical therapy (PT), occupational therapy (OT), or speech and language pathology (SLP) provider are required to meet the recipient's functional needs and therapy treatment needs.
- Treatment goals are reasonable given the recipient's current age and health status.
- Pertinent medical and social history is provided in sufficient detail to support that attainment of treatment goals would result in measurable and sustained benefit to the recipient.
- Frequency and duration of the requested services are based on the estimated length of time required for the recipient to realistically achieve the treatment goals.
- Medical diagnosis and problem statement (treatment diagnosis) identify the specific treatment needs of the recipient.
- Progress statements are objective, measurable, and demonstrate the desired outcome from the PT, OT, or SLP services in terms of functional improvements that can be generalized to settings outside the immediate treatment environment.
- Short-term objectives are realistic and attainable by the end of the requested PA.
- Long-term objectives describe the predicted functional changes expected by the end of the episode of care (not necessarily at the end of the requested PA).
- A plan to educate the recipient or caregiver and transition responsibility of the PT, OT, or SLP program.

Appendix 18

Extension of Therapy vs. Spell of Illness

The following flow chart may be used to determine whether a request for extension of therapy services or spell of illness (SOI) is appropriate. Physical therapy (PT), occupational therapy (OT), or speech and language pathology (SLP) providers may always choose to request extension of therapy services instead of SOI. However, Wisconsin Medicaid will not approve a request for SOI when extension of therapy services is necessary.



Appendix 19

Allowable ICD-9-CM Codes for Physical Therapy Spell of Illness Approval (Organized by Codes)

Physical therapy (PT) providers should use the following chart to determine the allowable combinations of *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) codes and statements for spell of illness (SOI) approval. Only one of statements "A" through "F" from the Prior Authorization/Spell of Illness Attachment (PA/SOIA), HCF 11039, must be true for SOI approval. The combination of the true statement and the primary ICD-9-CM diagnosis code or the ICD-9-CM surgical procedure code is then used by Wisconsin Medicaid to assign the maximum allowable treatment days for the SOI. Statement "G" must also be true for SOI approval, but it is not used to determine the maximum allowable treatment days.

The statements below are from Element 11 of the PA/SOIA:

A. The recipient experienced the onset of a new neuromuscular disease, injury, or condition six weeks ago or less.

B. The recipient experienced the onset of a new musculoskeletal disease, injury, or condition six weeks ago or less.

C. The recipient experienced the onset of a new problem or complication associated with physiologic disease, injury, or condition six weeks ago or less.

D. The recipient experienced the onset of a new psychological disease, injury, or condition six weeks ago or less.

E. The recipient experienced an exacerbation of a pre-existing condition six weeks ago or less.

F. The recipient experienced a regression of his or her condition due to lack of therapy six weeks ago or less.

AND

G. There is a reasonable expectation that the recipient will return to his or her previous level of function by the end of this SOI or sooner.

Note: Statement "D" does not apply to PT services.

Columns "A" through "F" in the following chart correspond to statements "A" through "F" from Element 11 of the PA/SOIA. The number of days that follow each letter represent the maximum allowable treatment days that correspond with the condition identified in that statement.

The following instructions describe how to use this chart:

1. Find the appropriate ICD-9-CM code and description. The diagnosis codes are listed before the surgical procedure codes. The code descriptions are organized alphabetically within these categories (Element 10 of the PA/SOIA).
2. Follow the row across to determine which statement(s) corresponds with the ICD-9-CM code (Element 11 of the PA/SOIA).
3. Follow the appropriate column(s) up to determine the maximum allowable treatment days for the corresponding combination of the ICD-9-CM code and statement.

Some ICD-9-CM codes have more than one allowable statement for SOI approval. Physical therapy providers should determine which statement best describes the recipient's condition.

Only the ICD-9-CM codes listed in the following chart are available for SOI approval. If the ICD-9-CM code for the PT service is not listed, the provider should submit the Prior Authorization Request Form (PA/RF), HCF 11018, and the Prior Authorization/Therapy Attachment (PA/TA), HCF 11008.

Appendix 19 (Continued)

Primary ICD-9-CM Diagnosis Code Description	Primary ICD-9-CM Diagnosis Code	A 19 Days	B 11 Days	C 15 Days	D N/A*	E 16 Days	F 17 Days
Abdominal aneurysm, ruptured	441.3			X			
Acute infective polyneuritis (Guillain-Barre syndrome; postinfectious polyneuritis)	357.0	X				X	
Acute, but ill-defined, cerebrovascular disease (incl., CVA)	436	X				X	
Ankylosing spondylitis and other inflammatory spondylopathies	720.0-720.9		X				
Anoxic brain damage	348.1	X				X	X
Aortic aneurysm of unspecified site, ruptured	441.5			X			
Arterial embolism and thrombosis of abdominal aorta	444.0			X			
Arterial embolism and thrombosis of thoracic aorta	444.1			X			
Bacterial meningitis	320.0-320.9	X					
Benign paroxysmal positional vertigo	386.11			X			
Brachial neuritis or radiculitis NOS	723.4	X					
Cauda equina syndrome	344.6	X					
Cerebral embolism	434.10-434.11	X				X	
Cerebral laceration and contusion	851.0-851.99	X				X	
Cerebral thrombosis	434.00-434.01	X				X	
Cervicalgia	723.1	X					
Cervicobrachial syndrome (diffuse)	723.3	X					
Complications due to internal joint prosthesis	996.77		X				
Complications due to other internal orthopedic device, implant, and graft	996.78		X				
Complications of reattached extremity or body part	996.91-996.99		X				
Complications of transplanted organ	996.80-996.89			X			
Contracture of joint	718.4						X
Decubitis ulcer	707.0			X			
Diabetes mellitus	250.0-250.93	X					
Disorders of other cranial nerves	352.0-352.9	X					
Dissection of aorta	441.00-441.03			X			
Encephalitis, myelitis, and encephalomyelitis	323.0-323.9	X					
Encephalopathy, unspecified	348.3	X				X	X
Epilepsy	345.0-345.91			X			
Facial nerve disorders (incl., Bell's palsy)	351.0-351.9	X					
Fracture of lower limb	820-829.1		X				
Fracture of pelvis	808.0-808.9		X				
Fracture of upper limb	810-819.1		X				
Gangrene	785.4			X			
Gas gangrene	040.0			X			
Gouty arthropathy	274.0		X				
Head injury, unspecified	959.01	X				X	
Headache	784.0			X			
Hemplegia and hemiparesis	342.0-342.92	X				X	
Human immunodeficiency virus (HIV) infection	042			X		X	
Huntington's chorea	333.4	X				X	
Infection and inflammatory reaction due to internal joint prosthesis	996.66		X				
Infection and inflammatory reaction due to other internal orthopedic device, implant, and graft	996.67		X				
Internal derangement of knee (incl., Meniscal tears and chondromalacia of patella)	717.0-717.7		X				
Intervertebral disc disorders	722.0-722.93		X				
Intracerebral hemorrhage	431	X				X	
Intracranial injury of other and unspecified nature	854.0-854.19	X				X	

Appendix 19
(Continued)

Primary ICD-9-CM Diagnosis Code Description	Primary ICD-9-CM Diagnosis Code	A 19 Days	B 11 Days	C 15 Days	D N/A*	E 16 Days	F 17 Days
Juvenile chronic polyarthritis	714.30-714.33		X			X	
Kyphoscoliosis and scoliosis	737.30-737.39		X				
Late effects of acute poliomyelitis	138	X					
Late effects of cerebrovascular disease	438.0-438.9					X	
Malignant neoplasm of brain	191.0-191.9	X					
Malignant neoplasm of head, face, and neck	195.0	X					
Mechanical complication of internal orthopedic device, implant, and graft	996.4		X				
Meniere's disease	386.0			X			
Meningitis due to other organisms	321.0-321.8	X					
Meningitis of unspecified cause	322.0-322.9	X					
Migraine	346.0-346.9			X			
Mononeuritis of lower limb and unspecified site	355.0-355.9	X					
Mononeuritis of upper limb and mononeuritis multiplex (incl., Carpal tunnel syndrome)	354.0-354.9	X					
Motor neuron disease (incl., Amyotrophic lateral sclerosis)	335.20-335.29	X				X	
Multiple sclerosis	340	X				X	
Myasthenia gravis	358.0	X				X	
Nerve root and plexus disorders	353.0-353.9	X					
Nontraumatic extradural hemorrhage	432.0	X				X	
Orthostatic hypotension	458.0			X			
Osteoarthosis and allied disorders	715.0-715.9		X				
Other and unspecified intracranial hemorrhage following injury	853.0-853.19	X				X	
Other choreas	333.5	X				X	
Other disorders of synovium, tendon, and bursa (incl., synovitis and tenosynovitis)	727.0-727.09		X				
Other lymphedema	457.1			X		X	
Other unspecified disorders of back (incl., Lumbago, sciatica, backache)	724.0-724.9		X				
Parkinson's disease	332.0-332.1	X				X	
Pathologic fracture	733.10-733.19		X				
Pathological dislocation of joint	718.2		X				
Peripheral enthesopathies and allied syndromes (incl., adhesive capsulitis of shoulder, rotator cuff syndrome, epicondylitis, bursitis, tendinitis)	726.0-726.9		X				
Peroneal muscular atrophy (Charcot-Marie-Tooth disease)	356.1	X					
Postmastectomy lymphedema syndrome	457.0			X		X	
Raynaud's syndrome	443.0			X			
Reflex sympathetic dystrophy	337.20-337.29			X			
Rheumatoid arthritis	714.0		X			X	
Secondary malignant neoplasm of brain and spinal cord	198.3	X					
Secondary malignant neoplasm of other parts of nervous system	198.4	X					
Sickle-cell anemia	282.60-282.69			X		X	
Spasmodic torticollis	333.83		X				
Spinocerebellar disease (ataxias)	334.0-334.9	X				X	
Spondylosis and allied disorders	721.0-721.9		X				
Sprains and strains of joints and adjacent muscles	840-848.9		X				
Subarachnoid hemorrhage	430	X				X	
Subarachnoid, subdural, and extradural hemorrhage, following injury	852.0-852.59	X				X	
Subdural hemorrhage	432.1	X				X	

Appendix 19
(Continued)

Primary ICD-9-CM Diagnosis Code Description	Primary ICD-9-CM Diagnosis Code	A 19 Days	B 11 Days	C 15 Days	D N/A*	E 16 Days	F 17 Days
Systemic lupus erythematosus	710.0			X			
Systemic sclerosis	710.1			X			
Temporomandibular joint disorders	524.60-524.69		X				
Thoracic aneurysm, ruptured	441.1			X			
Thoracoabdominal aneurysm, ruptured	441.6			X			
Torticollis, unspecified	723.5		X				
Toxic encephalopathy	349.82	X				X	X
Traumatic amputation of arm and hand (complete) (partial)	887.0-887.7		X				
Traumatic amputation of foot (complete) (partial)	896.0-896.3		X				
Traumatic amputation of leg(s) (complete) (partial)	897.0-897.7		X				
Traumatic amputation of other finger(s) (complete) (partial)	886.0-886.1		X				
Traumatic amputation of thumb (complete) (partial)	885.0-885.1		X				
Traumatic amputation of toe(s) (complete) (partial)	895.0-895.1		X				
Trigeminal nerve disorders (incl., Trigeminal neuralgia)	350.1-350.9	X					
Ulcer of lower limbs, except decubitus ulcer	707.10-707.9			X			
ICD-9-CM Surgical Procedure Code Description	**ICD-9-CM Surgical Procedure Code**	**A** 19 Days	**B** 11 Days	**C** 15 Days	**D** N/A*	**E** 16 Days	**F** 17 Days
Amputation of lower limb	84.10-84.19		X				
Amputation of upper limb	84.00-84.09		X				
Arthroplasty and repair of hand, fingers, and wrist	81.71-81.79		X				
Arthroplasty and repair of shoulder and elbow	81.80-81.85		X				
Excision of intervertebral disc	80.51		X				
Excision or destruction of intervertebral disc, unspecified	80.50		X				
Extracranial ventricular shunt	02.31-02.39	X				X	
Five-in-one repair of knee	81.42		X				
Incision of cerebral meninges	01.31	X				X	
Intervertebral chemonucleolysis	80.52		X				
Joint replacement of lower extremity	81.51-81.59		X				
Mastectomy	85.41-85.48		X				
Other craniectomy	01.25	X				X	
Other craniotomy	01.24	X				X	
Repair of cerebral meninges	02.11-02.14	X				X	
Revision, removal, and irrigation of ventricular shunt	02.41-02.43	X				X	
Rotator cuff repair	83.63		X				
Spinal fusion	81.00-81.08		X				
Triad knee repair	81.43		X				

*Statement "D" does not apply to PT services.

Appendix 20

Allowable ICD-9-CM Codes for Physical Therapy Spell of Illness Approval (Organized by Statements)

Physical therapy (PT) providers should use the following chart to determine the allowable combinations of *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) codes and statements for spell of illness (SOI) approval. Only one of statements "A" through "F" from the Prior Authorization/Spell of Illness Attachment (PA/SOIA), HCF 11039, must be true for SOI approval. The combination of the true statement and the primary ICD-9-CM diagnosis code or the ICD-9-CM surgical procedure code is then used by Wisconsin Medicaid to assign the maximum allowable treatment days for the SOI. Statement "G" must also be true for SOI approval, but it is not used to determine the maximum allowable treatment days.

The statements below are from Element 11 of the PA/SOIA:

A. The recipient experienced the onset of a new neuromuscular disease, injury, or condition six weeks ago or less.

B. The recipient experienced the onset of a new musculoskeletal disease, injury, or condition six weeks ago or less.

C. The recipient experienced the onset of a new problem or complication associated with physiologic disease, injury, or condition six weeks ago or less.

D. The recipient experienced the onset of a new psychological disease, injury, or condition six weeks ago or less.

E. The recipient experienced an exacerbation of a pre-existing condition six weeks ago or less.

F. The recipient experienced a regression of his or her condition due to lack of therapy six weeks ago or less.

AND

G. There is a reasonable expectation that the recipient will return to his or her previous level of function by the end of this SOI or sooner.

Note: Statement "D" does not apply to PT services.

Each chart is specific to one of the above statements. The statement and the maximum allowable treatment days are provided at the top of each chart.

The following instructions describe how to use these charts:

1. Find the chart that corresponds to the true statement (Element 11 of the PA/SOIA).
2. Find the appropriate ICD-9-CM code and description. The diagnosis codes are listed before the surgical procedure codes. The code descriptions are organized alphabetically within these categories (Element 10 of the PA/SOIA).
3. If the ICD-9-CM code is listed in the chart, refer to the statement at the top of the chart for the maximum allowable treatment days for the corresponding combination of the ICD-9-CM code and statement.
4. If the ICD-9-CM code is not listed in the chart, the combination of the code and statement does not allow for SOI approval. The ICD-9-CM code may be listed under another statement.

Some ICD-9-CM codes have more than one allowable statement for SOI approval. Physical therapy providers should determine which statement best describes the recipient's condition.

Only the ICD-9-CM codes listed in the following charts are available for SOI approval. If the ICD-9-CM code for the PT service is not listed, the provider should submit the Prior Authorization Request Form (PA/RF), HCF 11018, and the Prior Authorization/Therapy Attachment (PA/TA), HCF 11008.

Appendix 20
(Continued)

Statement A — The recipient experienced the onset of a new neuromuscular disease, injury, or condition six weeks ago or less. Providers will be allowed **19 days** for an SOI with one of the following ICD-9-CM codes.	
Primary ICD-9-CM Diagnosis Code Description	**Primary ICD-9-CM Diagnosis Code**
Acute infective polyneuritis (Guillain-Barre syndrome; postinfectious polyneuritis)	357.0
Acute, but ill-defined, cerebrovascular disease (incl., CVA)	436
Anoxic brain damage	348.1
Bacterial meningitis	320.0-320.9
Brachial neuritis or radiculitis NOS	723.4
Cauda equina syndrome	344.6
Cerebral embolism	434.10-434.11
Cerebral laceration and contusion	851.0-851.99
Cerebral thrombosis	434.00-434.01
Cervicalgia	723.1
Cervicobrachial syndrome (diffuse)	723.3
Diabetes mellitus	250.0-250.93
Disorders of other cranial nerves	352.0-352.9
Encephalitis, myelitis, and encephalomyelitis	323.0-323.9
Encephalopathy, unspecified	348.3
Facial nerve disorders (incl., Bell's palsy)	351.0-351.9
Head injury, unspecified	959.01
Hemplegia and hemiparesis	342.0-342.92
Huntington's chorea	333.4
Intracerebral hemorrhage	431
Intracranial injury of other and unspecified nature	854.0-854.19
Late effects of acute poliomyelitis	138
Malignant neoplasm of brain	191.0-191.9
Malignant neoplasm of head, face, and neck	195.0
Meningitis due to other organisms	321.0-321.8
Meningitis of unspecified cause	322.0-322.9
Mononeuritis of lower limb and unspecified site	355.0-355.9
Mononeuritis of upper limb and mononeuritis multiplex (incl., Carpal tunnel syndrome)	354.0-354.9
Motor neuron disease (incl., Amyotrophic lateral sclerosis)	335.20-335.29
Multiple sclerosis	340
Myasthenia gravis	358.0
Nerve root and plexus disorders	353.0-353.9
Nontraumatic extradural hemorrhage	432.0
Other and unspecified intracranial hemorrhage following injury	853.0-853.19
Other choreas	333.5
Parkinson's disease	332.0-332.1
Peroneal muscular atrophy (Charcot-Marie-Tooth disease)	356.1
Secondary malignant neoplasm of brain and spinal cord	198.3
Secondary malignant neoplasm of other parts of nervous system	198.4
Spinocerebellar disease (ataxias)	334.0-334.9
Subarachnoid hemorrhage	430
Subarachnoid, subdural, and extradural hemorrhage, following injury	852.0-852.59
Subdural hemorrhage	432.1
Toxic encephalopathy	349.82
Trigeminal nerve disorders (incl., Trigeminal neuralgia)	350.1-350.9
ICD-9-CM Surgical Procedure Code Description	**ICD-9-CM Surgical Procedure Code**
Extracranial ventricular shunt	02.31-02.39
Incision of cerebral meninges	01.31
Other craniectomy	01.25
Other craniotomy	01.24
Repair of cerebral meninges	02.11-02.14
Revision, removal, and irrigation of ventricular shunt	02.41-02.43

Appendix 20
(Continued)

Statement B — The recipient experienced the onset of a new musculoskeletal disease, injury, or condition six weeks ago or less. Providers will be allowed **11 days** for an SOI with one of the following ICD-9-CM codes.	
Primary ICD-9-CM Diagnosis Code Description	**Primary ICD-9-CM Diagnosis Code**
Ankylosing spondylitis and other inflammatory spondylopathies	720.0-720.9
Complications due to internal joint prosthesis	996.77
Complications due to other internal orthopedic device, implant, and graft	996.78
Complications of reattached extremity or body part	996.91-996.99
Fracture of lower limb	820-829.1
Fracture of pelvis	808.0-808.9
Fracture of upper limb	810-819.1
Gouty arthropathy	274.0
Infection and inflammatory reaction due to internal joint prosthesis	996.66
Infection and inflammatory reaction due to other internal orthopedic device, implant, and graft	996.67
Internal derangement of knee (incl., Meniscal tears and chondromalacia of patella)	717.0-717.7
Intervertebral disc disorders	722.0-722.93
Juvenile chronic polyarthritis	714.30-714.33
Kyphoscoliosis and scoliosis	737.30-737.39
Mechanical complication of internal orthopedic device, implant, and graft	996.4
Osteoarthosis and allied disorders	715.0-715.9
Other disorders of synovium, tendon, and bursa (incl., synovitis and tenosynovitis)	727.0-727.09
Other unspecified disorders of back (incl., Lumbago, sciatica, backache)	724.0-724.9
Pathologic fracture	733.10-733.19
Pathological dislocation of joint	718.2
Peripheral enthesopathies and allied syndromes (incl., adhesive capsulitis of shoulder, rotator cuff syndrome, epicondylitis, bursitis, tendinitis)	726.0-726.9
Rheumatoid arthritis	714.0
Spasmodic torticollis	333.83
Sprains and strains of joints and adjacent muscles	840-848.9
Temporomandibular joint disorders	524.60-524.69
Torticollis, unspecified	723.5
Traumatic amputation of arm and hand (complete) (partial)	887.0-887.7
Traumatic amputation of foot (complete) (partial)	896.0-896.3
Traumatic amputation of leg(s) (complete) (partial)	897.0-897.7
Traumatic amputation of other finger(s) (complete) (partial)	886.0-886.1
Traumatic amputation of thumb (complete) (partial)	885.0-885.1
Traumatic amputation of toe(s) (complete) (partial)	895.0-895.1
ICD-9-CM Surgical Procedure Code Description	**ICD-9-CM Surgical Procedure Code**
Amputation of lower limb	84.10-84.19
Amputation of upper limb	84.00-84.09
Arthroplasty and repair of hand, fingers, and wrist	81.71-81.79
Arthroplasty and repair of shoulder and elbow	81.80-81.85
Excision of intervertebral disc	80.51
Excision or destruction of intervertebral disc, unspecified	80.50
Five-in-one repair of knee	81.42
Intervertebral chemonucleolysis	80.52
Joint replacement of lower extremity	81.51-81.59
Mastectomy	85.41-85.48
Rotator cuff repair	83.63
Spinal fusion	81.00-81.08
Triad knee repair	81.43

Appendix 20
(Continued)

Statement C — The recipient experienced the onset of a new problem or complication associated with physiologic disease, injury, or condition six weeks ago or less. Providers will be allowed **15 days** for an SOI with one of the following ICD-9-CM codes.	
Primary ICD-9-CM Diagnosis Code Description	**Primary ICD-9-CM Diagnosis Code**
Abdominal aneurysm, ruptured	441.3
Aortic aneurysm of unspecified site, ruptured	441.5
Arterial embolism and thrombosis of abdominal aorta	444.0
Arterial embolism and thrombosis of thoracic aorta	444.1
Benign paroxysmal positional vertigo	386.11
Complications of transplanted organ	996.80-996.89
Decubitis ulcer	707.0
Dissection of aorta	441.00-441.03
Epilepsy	345.0-345.91
Gangrene	785.4
Gas gangrene	040.0
Headache	784.0
Human immunodeficiency virus (HIV) infection	042
Meniere's disease	386.0
Migraine	346.0-346.9
Orthostatic hypotension	458.0
Other lymphedema	457.1
Postmastectomy lymphedema syndrome	457.0
Raynaud's syndrome	443.0
Reflex sympathetic dystrophy	337.20-337.29
Sickle-cell anemia	282.60-282.69
Systemic lupus erythematosus	710.0
Systemic sclerosis	710.1
Thoracic aneurysm, ruptured	441.1
Thoracoabdominal aneurysm, ruptured	441.6
Ulcer of lower limbs, except decubitus ulcer	707.10-707.9

Statement D — The recipient experienced the onset of a new psychological disease, injury, or condition six weeks ago or less. **This statement does not apply to PT services.**

Statement E — The recipient experienced an exacerbation of a pre-existing condition six weeks ago or less. Providers will be allowed **16 days** for an SOI with one of the following ICD-9-CM codes.	
Primary ICD-9-CM Diagnosis Code Description	**Primary ICD-9-CM Diagnosis Code**
Acute infective polyneuritis (Guillain-Barre syndrome; postinfectious polyneuritis)	357.0
Acute, but ill-defined, cerebrovascular disease (incl., CVA)	436
Anoxic brain damage	348.1
Cerebral embolism	434.10-434.11
Cerebral laceration and contusion	851.0-851.99
Cerebral thrombosis	434.00-434.01
Encephalopathy, unspecified	348.3
Head injury, unspecified	959.01
Hemplegia and hemiparesis	342.0-342.92
Human immunodeficiency virus (HIV) infection	042
Huntington's chorea	333.4
Intracerebral hemorrhage	431
Intracranial injury of other and unspecified nature	854.0-854.19
Juvenile chronic polyarthritis	714.30-714.33

Appendix 20
(Continued)

Statement E (continued) — The recipient experienced an exacerbation of a pre-existing condition six weeks ago or less. Providers will be allowed **16 days** for an SOI with one of the following ICD-9-CM codes.	
Primary ICD-9-CM Diagnosis Code Description	**Primary ICD-9-CM Diagnosis Code**
Late effects of cerebrovascular disease	438.0-438.9
Motor neuron disease (incl., Amyotrophic lateral sclerosis)	335.20-335.29
Multiple sclerosis	340
Myasthenia gravis	358.0
Nontraumatic extradural hemorrhage	432.0
Other and unspecified intracranial hemorrhage following injury	853.0-853.19
Other choreas	333.5
Other lymphedema	457.1
Parkinson's disease	332.0-332.1
Postmastectomy lymphedema syndrome	457.0
Rheumatoid arthritis	714.0
Sickle-cell anemia	282.60-282.69
Spinocerebellar disease (ataxias)	334.0-334.9
Subarachnoid hemorrhage	430
Subarachnoid, subdural, and extradural hemorrhage, following injury	852.0-852.59
Subdural hemorrhage	432.1
Toxic encephalopathy	349.82
ICD-9-CM Surgical Procedure Code Description	**ICD-9-CM Surgical Procedure Code**
Extracranial ventricular shunt	02.31-02.39
Incision of cerebral meninges	01.31
Other craniectomy	01.25
Other craniotomy	01.24
Repair of cerebral meninges	02.11-02.14
Revision, removal, and irrigation of ventricular shunt	02.41-02.43

Statement F — The recipient experienced a regression of his or her condition due to lack of therapy six weeks ago or less. Providers will be allowed **17 days** for an SOI with one of the following ICD-9-CM codes.	
Primary ICD-9-CM Diagnosis Code Description	**Primary ICD-9-CM Diagnosis Code**
Anoxic brain damage	348.1
Contracture of joint	718.4
Encephalopathy, unspecified	348.3
Toxic encephalopathy	349.82

Appendix 21

Allowable ICD-9-CM Codes for Occupational Therapy Spell of Illness Approval (Organized by Codes)

Occupational therapy (OT) providers should use the following chart to determine the allowable combinations of *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) codes and statements for spell of illness (SOI) approval. Only one of statements "A" through "F" from the Prior Authorization/Spell of Illness Attachment (PA/SOIA), HCF 11039, must be true for SOI approval. The combination of the true statement and the primary ICD-9-CM diagnosis code or the ICD-9-CM surgical procedure code is then used by Wisconsin Medicaid to assign the maximum allowable treatment days for the SOI. Statement "G" must also be true for SOI approval, but it is not used to determine the maximum allowable treatment days.

The statements below are from Element 11 of the PA/SOIA:

A. The recipient experienced the onset of a new neuromuscular disease, injury, or condition six weeks ago or less.

B. The recipient experienced the onset of a new musculoskeletal disease, injury, or condition six weeks ago or less.

C. The recipient experienced the onset of a new problem or complication associated with physiologic disease, injury, or condition six weeks ago or less.

D. The recipient experienced the onset of a new psychological disease, injury, or condition six weeks ago or less.

E. The recipient experienced an exacerbation of a pre-existing condition six weeks ago or less.

F. The recipient experienced a regression of his or her condition due to lack of therapy six weeks ago or less.

AND

G. There is a reasonable expectation that the recipient will return to his or her previous level of function by the end of this SOI or sooner.

Columns "A" through "F" in the following chart correspond to statements "A" through "F" from Element 11 of the PA/SOIA. The number of days that follow each letter represent the maximum allowable treatment days that correspond with the condition identified in that statement.

The following instructions describe how to use this chart:

1. Find the appropriate ICD-9-CM code and description. The diagnosis codes are listed before the surgical procedure codes. The code descriptions are organized alphabetically within these categories (Element 10 of the PA/SOIA).
2. Follow the row across to determine which statement(s) corresponds with the ICD-9-CM code (Element 11 of the PA/SOIA).
3. Follow the appropriate column(s) up to determine the maximum allowable treatment days for the corresponding combination of the ICD-9-CM code and statement.

Some ICD-9-CM codes have more than one allowable statement for SOI approval. Occupational therapy providers should determine which statement best describes the recipient's condition.

Only the ICD-9-CM codes listed in the following chart are available for SOI approval. If the ICD-9-CM code for the OT service is not listed, the provider should submit the Prior Authorization Request Form (PA/RF), HCF 11018, and the Prior Authorization/Therapy Attachment (PA/TA), HCF 11008.

Appendix 21 (Continued)

Primary ICD-9-CM Diagnosis Code Description	Primary ICD-9-CM Diagnosis Code	A 12 Days	B 16 Days	C 18 Days	D 0 Days	E 8 Days	F 11 Days
Acute infective polyneuritis (Guillain-Barre syndrome; postinfectious polyneuritis)	357.0	X				X	
Acute, but ill-defined, cerebrovascular disease (incl., CVA)	436	X				X	
Affective personality disorder, unspecified	301.10				X		
Affective psychoses	296.0-296.9				X		
Anoxic brain damage	348.1	X				X	
Anxiety states (incl., panic disorder)	300.00-300.09				X		
Bacterial meningitis	320.0-320.9	X					
Brachial plexus lesions	353.0	X					
Cerebral embolism	434.10-434.11	X				X	
Cerebral laceration and contusion	851.0-851.99	X				X	
Cerebral thrombosis	434.00-434.01	X				X	
Chronic depressive personality disorder	301.12				X		
Contracture of joint	718.4						X
Contracture of palmar fascia (Dupuytren's contracture)	728.6		X				
Diabetes mellitus	250.0-250.93	X					
Disorders of other cranial nerves	352.0-352.9	X					
Encephalitis, myelitis, and encephalomyelitis	323.0-323.9	X					
Encephalopathy, unspecified	348.3	X				X	X
Epilepsy	345.0-345.91			X			
Explosive personality disorder	301.3				X		
Facial nerve disorders (incl., Bell's palsy)	351.0-351.9	X					
Fracture of lower limb	820-829.1		X				
Fracture of pelvis	808.0-808.9		X				
Fracture of upper limb	810-819.1		X				
Ganglion and cyst of synovium, tendon, and bursa	727.40-727.49		X				
Head injury, unspecified	959.01	X				X	
Hemplegia and hemiparesis	342.0-342.92	X				X	
Human immunodeficiency virus (HIV) infection	042			X		X	
Huntington's chorea	333.4	X				X	
Intracerebral hemorrhage	431	X				X	
Intracranial injury of other and unspecified nature	854.0-854.19	X				X	
Juvenile chronic polyarthritis	714.30-714.33		X			X	
Late effects of acute poliomyelitis	138	X					
Late effects of cerebrovascular disease	438.0-438.9					X	
Malignant neoplasm of brain	191.0-191.9	X					
Malignant neoplasm of head, face, and neck	195.0	X					
Meningitis due to other organisms	321.0-321.8	X					
Meningitis of unspecified cause	322.0-322.9	X					
Mononeuritis of upper limb and mononeuritis multiplex (incl., Carpal tunnel syndrome)	354.0-354.9	X					
Motor neuron disease (incl., Amyotrophic lateral sclerosis)	335.20-335.29	X				X	
Multiple sclerosis	340	X				X	
Myasthenia gravis	358.0	X				X	
Nontraumatic extradural hemorrhage	432.0	X				X	
Obsessive-compulsive disorders	300.3				X		
Organic personality syndrome	310.1				X		
Osteoarthosis and allied disorders	715.0-715.9		X				
Other and unspecified intracranial hemorrhage following injury	853.0-853.19	X				X	
Other choreas	333.5	X				X	
Other lymphedema	457.1			X		X	
Other nonorganic psychoses	298.0-298.9				X		
Other tenosynovitis of hand and wrist	727.05		X				
Paranoid personality disorder	301.0				X		
Paranoid state (Delusional disorders)	297.0-297.9				X		

Appendix 21
(Continued)

Primary ICD-9-CM Diagnosis Code Description	Primary ICD-9-CM Diagnosis Code	A 12 Days	B 16 Days	C 18 Days	D 0 Days	E 8 Days	F 11 Days
Parkinson's disease	332.0-332.1	X				X	
Pathologic fracture	733.10-733.19		X				
Peripheral enthesopathies and allied syndromes (incl., adhesive capsulitis of shoulder, rotator cuff syndrome, epicondylitis, bursitis, tendinitis)	726.0-726.9		X				
Peroneal muscular atrophy (Charcot-Marie-Tooth disease)	356.1	X				X	
Postmastectomy lymphedema syndrome	457.0			X		X	
Psychoses with origin specific to childhood	299.0-299.9				X		
Radial styloid tenosynovitis (de Quervain's disease)	727.04		X				
Reflex sympathetic dystrophy	337.20-337.29			X			
Rheumatoid arthritis	714.0		X			X	
Rupture of tendon, nontraumatic (rotator cuff, long head of biceps, hand/wrist extensor/flexor tendons)	727.60-727.64		X				
Schizophrenic disorders	295.0-295.9				X		
Secondary malignant neoplasm of brain and spinal cord	198.3	X					
Secondary malignant neoplasm of other parts of nervous system	198.4	X					
Sickle-cell anemia	282.60-282.69			X		X	
Spinocerebellar disease (ataxias)	334.0-334.9	X				X	
Sprains and strains of joints and adjacent muscles	840-848.9		X				
Subarachnoid hemorrhage	430	X				X	
Subarachnoid, subdural, and extradural hemorrhage, following injury	852.0-852.59	X				X	
Subdural hemorrhage	432.1	X				X	
Systemic lupus erythematosus	710.0			X			
Systemic sclerosis	710.1			X			
Temporomandibular joint disorders	524.60-524.69			X			
Toxic encephalopathy	349.82	X				X	X
Traumatic amputation of arm and hand (complete) (partial)	887.0-887.7		X				
Traumatic amputation of foot (complete) (partial)	896.0-896.3		X				
Traumatic amputation of leg(s) (complete) (partial)	897.0-897.7		X				
Traumatic amputation of other finger(s) (complete) (partial)	886.0-886.1		X				
Traumatic amputation of thumb (complete) (partial)	885.0-885.1		X				
Traumatic amputation of toe(s) (complete) (partial)	895.0-895.1		X				
Trigeminal nerve disorders (incl., Trigeminal neuralgia)	350.1-350.9	X					
Trigger finger (acquired)	727.03		X				
ICD-9-CM Surgical Procedure Code Description	**ICD-9-CM Surgical Procedure Code**	**A** 12 Days	**B** 16 Days	**C** 18 Days	**D** 0 Days	**E** 8 Days	**F** 11 Days
Amputation of lower limb	84.10-84.19		X				
Amputation of upper limb	84.00-84.09		X				
Arthroplasty and repair of hand, fingers, and wrist	81.71-81.79		X				
Arthroplasty and repair of shoulder and elbow	81.80-81.85		X				
Extracranial ventricular shunt	02.31-02.39	X				X	
Incision of cerebral meninges	01.31	X				X	
Mastectomy	85.41-85.48		X				
Other craniectomy	01.25	X				X	
Other craniotomy	01.24	X				X	
Repair of cerebral meninges	02.11-02.14	X				X	
Revision, removal, and irrigation of ventricular shunt	02.41-02.43	X				X	
Rotator cuff repair	83.63		X				

Appendix 22

Allowable ICD-9-CM Codes for Occupational Therapy Spell of Illness Approval (Organized by Statements)

Occupational therapy (OT) providers should use the following chart to determine the allowable combinations of *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) codes and statements for spell of illness (SOI) approval. Only one of statements "A" through "F" from the Prior Authorization/Spell of Illness Attachment (PA/SOIA), HCF 11039, must be true for SOI approval. The combination of the true statement and the primary ICD-9-CM diagnosis code or the ICD-9-CM surgical procedure code is then used by Wisconsin Medicaid to assign the maximum allowable treatment days for the SOI. Statement "G" must also be true for SOI approval, but it is not used to determine the maximum allowable treatment days.

The statements below are from Element 11 of the PA/SOIA:

A. The recipient experienced the onset of a new neuromuscular disease, injury, or condition six weeks ago or less.

B. The recipient experienced the onset of a new musculoskeletal disease, injury, or condition six weeks ago or less.

C. The recipient experienced the onset of a new problem or complication associated with physiologic disease, injury, or condition six weeks ago or less.

D. The recipient experienced the onset of a new psychological disease, injury, or condition six weeks ago or less.

E. The recipient experienced an exacerbation of a pre-existing condition six weeks ago or less.

F. The recipient experienced a regression of his or her condition due to lack of therapy six weeks ago or less.

AND

G. There is a reasonable expectation that the recipient will return to his or her previous level of function by the end of this SOI or sooner.

Each chart is specific to one of the above statements. The statement and the maximum allowable treatment days are provided at the top of each chart.

The following instructions describe how to use these charts:

1. Find the chart that corresponds to the true statement (Element 11 of the PA/SOIA).
2. Find the appropriate ICD-9-CM code and description. The diagnosis codes are listed before the surgical procedure codes. The code descriptions are organized alphabetically within these categories (Element 10 of the PA/SOIA).
3. If the ICD-9-CM code is listed in the chart, refer to the statement at the top of the chart for the maximum allowable treatment days for the corresponding combination of the ICD-9-CM code and statement.
4. If the ICD-9-CM code is not listed in the chart, the combination of the code and statement does not allow for SOI approval. The ICD-9-CM code may be listed under another statement.

Some ICD-9-CM codes have more than one allowable statement for SOI approval. Occupational therapy providers should determine which statement best describes the recipient's condition.

Only the ICD-9-CM codes listed in the following charts are available for SOI approval. If the ICD-9-CM code for the OT service is not listed, the provider should submit the Prior Authorization Request Form (PA/RF), HCF 11018, and the Prior Authorization/Therapy Attachment (PA/TA), HCF 11008.

Appendix 22
(Continued)

Statement A — The recipient experienced the onset of a new neuromuscular disease, injury, or condition six weeks ago or less. Providers will be allowed **12 days** for an SOI with one of the following ICD-9-CM codes.	
Primary ICD-9-CM Diagnosis Code Description	**Primary ICD-9-CM Diagnosis Code**
Acute infective polyneuritis (Guillain-Barre syndrome; postinfectious polyneuritis)	357.0
Acute, but ill-defined, cerebrovascular disease (incl., CVA)	436
Anoxic brain damage	348.1
Bacterial meningitis	320.0-320.9
Brachial plexus lesions	353.0
Cerebral embolism	434.10-434.11
Cerebral laceration and contusion	851.0-851.99
Cerebral thrombosis	434.00-434.01
Diabetes mellitus	250.0-250.93
Disorders of other cranial nerves	352.0-352.9
Encephalitis, myelitis, and encephalomyelitis	323.0-323.9
Encephalopathy, unspecified	348.3
Facial nerve disorders (incl., Bell's palsy)	351.0-351.9
Head injury, unspecified	959.01
Hemplegia and hemiparesis	342.0-342.92
Huntington's chorea	333.4
Intracerebral hemorrhage	431
Intracranial injury of other and unspecified nature	854.0-854.19
Late effects of acute poliomyelitis	138
Malignant neoplasm of brain	191.0-191.9
Malignant neoplasm of head, face, and neck	195.0
Meningitis due to other organisms	321.0-321.8
Meningitis of unspecified cause	322.0-322.9
Mononeuritis of upper limb and mononeuritis multiplex (incl., Carpal tunnel syndrome)	354.0-354.9
Motor neuron disease (incl., Amyotrophic lateral sclerosis)	335.20-335.29
Multiple sclerosis	340
Myasthenia gravis	358.0
Nontraumatic extradural hemorrhage	432.0
Other and unspecified intracranial hemorrhage following injury	853.0-853.19
Other choreas	333.5
Parkinson's disease	332.0-332.1
Peroneal muscular atrophy (Charcot-Marie-Tooth disease)	356.1
Secondary malignant neoplasm of brain and spinal cord	198.3
Secondary malignant neoplasm of other parts of nervous system	198.4
Spinocerebellar disease (ataxias)	334.0-334.9
Subarachnoid hemorrhage	430
Subarachnoid, subdural, and extradural hemorrhage, following injury	852.0-852.59
Subdural hemorrhage	432.1
Toxic encephalopathy	349.82
Trigeminal nerve disorders (incl., Trigeminal neuralgia)	350.1-350.9
ICD-9-CM Surgical Procedure Code Description	**ICD-9-CM Surgical Procedure Code**
Extracranial ventricular shunt	02.31-02.39
Incision of cerebral meninges	01.31
Other craniectomy	01.25
Other craniotomy	01.24
Repair of cerebral meninges	02.11-02.14
Revision, removal, and irrigation of ventricular shunt	02.41-02.43

Appendix 22
(Continued)

Statement B — The recipient experienced the onset of a new musculoskeletal disease, injury, or condition six weeks ago or less. Providers will be allowed **16 days** for an SOI with one of the following ICD-9-CM codes.	
Primary ICD-9-CM Diagnosis Code Description	**Primary ICD-9-CM Diagnosis Code**
Contracture of palmar fascia (Dupuytren's contracture)	728.6
Fracture of lower limb	820-829.1
Fracture of pelvis	808.0-808.9
Fracture of upper limb	810-819.1
Ganglion and cyst of synovium, tendon, and bursa	727.40-727.49
Juvenile chronic polyarthritis	714.30-714.33
Osteoarthosis and allied disorders	715.0-715.9
Other tenosynovitis of hand and wrist	727.05
Pathologic fracture	733.10-733.19
Peripheral enthesopathies and allied syndromes (incl., adhesive capsulitis of shoulder, rotator cuff syndrome, epicondylitis, bursitis, tendinitis)	726.0-726.9
Radial styloid tenosynovitis (de Quervain's disease)	727.04
Rheumatoid arthritis	714.0
Rupture of tendon, nontraumatic (rotator cuff, long head of biceps, hand/wrist extensor/flexor tendons)	727.60-727.64
Sprains and strains of joints and adjacent muscles	840-848.9
Traumatic amputation of arm and hand (complete) (partial)	887.0-887.7
Traumatic amputation of foot (complete) (partial)	896.0-896.3
Traumatic amputation of leg(s) (complete) (partial)	897.0-897.7
Traumatic amputation of other finger(s) (complete) (partial)	886.0-886.1
Traumatic amputation of thumb (complete) (partial)	885.0-885.1
Traumatic amputation of toe(s) (complete) (partial)	895.0-895.1
Trigger finger (acquired)	727.03
ICD-9-CM Surgical Procedure Code Description	**ICD-9-CM Surgical Procedure Code**
Amputation of lower limb	84.10-84.19
Amputation of upper limb	84.00-84.09
Arthroplasty and repair of hand, fingers, and wrist	81.71-81.79
Arthroplasty and repair of shoulder and elbow	81.80-81.85
Mastectomy	85.41-85.48
Rotator cuff repair	83.63

Statement C — The recipient experienced the onset of a new problem or complication associated with physiologic disease, injury, or condition six weeks ago or less. Providers will be allowed **18 days** for an SOI with one of the following ICD-9-CM codes.	
Primary ICD-9-CM Diagnosis Code Description	**Primary ICD-9-CM Diagnosis Code**
Epilepsy	345.0-345.91
Human immunodeficiency virus (HIV) infection	042
Other lymphedema	457.1
Postmastectomy lymphedema syndrome	457.0
Reflex sympathetic dystrophy	337.20-337.29
Sickle-cell anemia	282.60-282.69
Systemic lupus erythematosus	710.0
Systemic sclerosis	710.1
Temporomandibular joint disorders	524.60-524.69

Appendix 22
(Continued)

Statement D — The recipient experienced the onset of a new psychological disease, injury, or condition six weeks ago or less. Providers will be allowed **zero days** for an SOI with one of the following ICD-9-CM codes.	
Primary ICD-9-CM Diagnosis Code Description	**Primary ICD-9-CM Diagnosis Code**
Affective personality disorder, unspecified	301.10
Affective psychoses	296.0-296.9
Anxiety states (incl., panic disorder)	300.00-300.09
Chronic depressive personality disorder	301.12
Explosive personality disorder	301.3
Obsessive-compulsive disorders	300.3
Organic personality syndrome	310.1
Other nonorganic psychoses	298.0-298.9
Paranoid personality disorder	301.0
Paranoid state (Delusional disorders)	297.0-297.9
Psychoses with origin specific to childhood	299.0-299.9
Schizophrenic disorders	295.0-295.9

Statement E — The recipient experienced an exacerbation of a pre-existing condition six weeks ago or less. Providers will be allowed **eight days** for an SOI with one of the following ICD-9-CM codes.	
Primary ICD-9-CM Diagnosis Code Description	**Primary ICD-9-CM Diagnosis Code**
Acute infective polyneuritis (Guillain-Barre syndrome; postinfectious polyneuritis)	357.0
Acute, but ill-defined, cerebrovascular disease (incl., CVA)	436
Anoxic brain damage	348.1
Cerebral embolism	434.10-434.11
Cerebral laceration and contusion	851.0-851.99
Cerebral thrombosis	434.00-434.01
Encephalopathy, unspecified	348.3
Head injury, unspecified	959.01
Hemplegia and hemiparesis	342.0-342.92
Human immunodeficiency virus (HIV) infection	042
Huntington's chorea	333.4
Intracerebral hemorrhage	431
Intracranial injury of other and unspecified nature	854.0-854.19
Juvenile chronic polyarthritis	714.30-714.33
Late effects of cerebrovascular disease	438.0-438.9
Motor neuron disease (incl., Amyotrophic lateral sclerosis)	335.20-335.29
Multiple sclerosis	340
Myasthenia gravis	358.0
Nontraumatic extradural hemorrhage	432.0
Other and unspecified intracranial hemorrhage following injury	853.0-853.19
Other choreas	333.5
Other lymphedema	457.1
Parkinson's disease	332.0-332.1
Peroneal muscular atrophy (Charcot-Marie-Tooth disease)	356.1
Postmastectomy lymphedema syndrome	457.0
Rheumatoid arthritis	714.0
Sickle-cell anemia	282.60-282.69
Spinocerebellar disease (ataxias)	334.0-334.9
Subarachnoid hemorrhage	430
Subarachnoid, subdural, and extradural hemorrhage, following injury	852.0-852.59
Subdural hemorrhage	432.1
Toxic encephalopathy	349.82

Appendix 22
(Continued)

Statement E (continued) — The recipient experienced an exacerbation of a pre-existing condition six weeks ago or less. Providers will be allowed **eight days** for an SOI with one of the following ICD-9-CM codes.	
ICD-9-CM Surgical Procedure Code Description	**ICD-9-CM Surgical Procedure Code**
Extracranial ventricular shunt	02.31-02.39
Incision of cerebral meninges	01.31
Other craniectomy	01.25
Other craniotomy	01.24
Repair of cerebral meninges	02.11-02.14
Revision, removal, and irrigation of ventricular shunt	02.41-02.43

Statement F — The recipient experienced a regression of his or her condition due to lack of therapy six weeks ago or less. Providers will be allowed **11 days** for an SOI with one of the following ICD-9-CM codes.	
Primary ICD-9-CM Diagnosis Code Description	**Primary ICD-9-CM Diagnosis Code**
Contracture of joint	718.4
Encephalopathy, unspecified	348.3
Toxic encephalopathy	349.82

Appendix 23

Allowable ICD-9-CM Codes for Speech and Language Pathology Spell of Illness Approval (Organized by Codes)

Speech and language pathology (SLP) providers should use the following chart to determine the allowable combinations of *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) codes and statements for spell of illness (SOI) approval. Only one of statements "A" through "F" from the Prior Authorization/Spell of Illness Attachment (PA/SOIA), HCF 11039, must be true for SOI approval. The combination of the true statement and the primary ICD-9-CM diagnosis code or the ICD-9-CM surgical procedure code is then used by Wisconsin Medicaid to assign the maximum allowable treatment days for the SOI. Statement "G" must also be true for SOI approval, but it is not used to determine the maximum allowable treatment days.

The statements below are from Element 11 of the PA/SOIA:

A. The recipient experienced the onset of a new neuromuscular disease, injury, or condition six weeks ago or less.

B. The recipient experienced the onset of a new musculoskeletal disease, injury, or condition six weeks ago or less.

C. The recipient experienced the onset of a new problem or complication associated with physiologic disease, injury, or condition six weeks ago or less.

D. The recipient experienced the onset of a new psychological disease, injury, or condition six weeks ago or less.

E. The recipient experienced an exacerbation of a pre-existing condition six weeks ago or less.

F. The recipient experienced a regression of his or her condition due to lack of therapy six weeks ago or less.

AND

G. There is a reasonable expectation that the recipient will return to his or her previous level of function by the end of this SOI or sooner.

Note: Statements "C," "D," and "F" do not apply to SLP services.

Columns "A" through "F" correspond to statements "A" through "F" from Element 11 of the PA/SOIA. The number of days that follow each letter represent the maximum allowable treatment days that correspond with the condition identified in that statement.

The following instructions describe how to use this chart:

1. Find the appropriate ICD-9-CM code and description. The diagnosis codes are listed before the surgical procedure codes. The code descriptions are organized alphabetically within these categories (Element 10 of the PA/SOIA).
2. Follow the row across to determine which statement(s) corresponds with the ICD-9-CM code (Element 11 of the PA/SOIA).
3. Follow the appropriate column(s) up to determine the maximum allowable treatment days for the corresponding combination of the ICD-9-CM code and statement.

Some ICD-9-CM codes have more than one allowable statement for SOI approval. Speech and language pathology providers should determine which statement best describes the recipient's condition.

Only the ICD-9-CM codes listed in the following chart are available for SOI approval. If the ICD-9-CM code for the SLP service is not listed, the provider should submit the Prior Authorization Request Form (PA/RF), HCF 11018, and the Prior Authorization/Therapy Attachment (PA/TA), HCF 11008.

Appendix 23 (Continued)

Primary ICD-9-CM Diagnosis Code Description	Primary ICD-9-CM Diagnosis Code	A 16 Days	B 16 Days	C N/A*	D N/A*	E 12 Days	F N/A*
Abdominal aneurysm, ruptured	441.3	X					
Acute infective polyneuritis (Guillain-Barre syndrome; postinfectious polyneruritis)	357.0	X					
Acute, but ill-defined, cerebrovascular disease (incl., CVA)	436	X					
Anoxic brain damage	348.1	X					
Aortic aneurysm of unspecified site, ruptured	441.5	X					
Aphasia	784.3	X					
Arterial embolism and thrombosis of abdominal aorta	444.0	X					
Arterial embolism and thrombosis of thoracic aorta	444.1	X					
Bacterial meningitis	320.0-320.9	X					
Benign neoplasm of lip, oral cavity, and pharynx	210.0-210.9	X	X				
Cellulitis and perichondritis of larynx	478.71	X					
Cerebral cysts	348.0	X					
Cerebral edema	348.5	X					
Cerebral embolism	434.10-434.11	X					
Cerebral laceration and contusion	851.0-851.99	X					
Cerebral thrombosis	434.00-434.01	X					
Complications of transplanted organ	996.80-996.89	X					
Compression of brain	348.4	X					
Concussion, with prolonged loss of consciousness and return to pre-existing conscious level	850.3	X					
Concussion, with prolonged loss of consciousness without return to pre-existing conscious level	850.4	X					
Cyst of pharynx or nasopharynx	478.26	X					
Diabetes insipidus	253.5	X					
Diabetes mellitus	250.0-250.93	X					
Diffuse diseases of connective tissue	710.0-710.9	X				X	
Disorders of other cranial nerves	352.0-352.9	X					
Dissection of aorta	441.00-441.03	X					
Edema of larynx	478.6	X					
Edema of pharynx or nasopharynx	478.25	X					
Encephalitis, myelitis, and encephalomyelitis	323.0-323.9	X					
Encephalopathy, unspecified	348.3	X					
Epilepsy	345.0-345.91	X					
Facial nerve disorders (incl., Bell's palsy)	351.0-351.9	X					
Head injury, unspecified	959.01	X				X	
Hemplegia and hemiparesis	342.0-342.92	X				X	
Huntington's chorea	333.4	X				X	
Intracerebral hemorrhage	431	X					
Intracranial injury of other and unspecified nature	854.0-854.19	X					
Laryngeal spasm	478.75	X					
Late effects of cerebrovascular disease	438.0-438.9					X	
Malignant neoplasm of brain	191.0-191.9	X					
Malignant neoplasm of head, face, and neck	195.0	X					
Meningitis due to other organisms	321.0-321.8	X					
Meningitis of unspecified cause	322.0-322.9	X					
Motor neuron disease (incl., Amyotrophic lateral sclerosis)	335.20-335.29	X					
Multiple sclerosis	340	X				X	
Myasthenia gravis	358.0	X				X	
Nontraumatic extradural hemorrhage	432.0	X					
Other and unspecified intracranial hemorrhage following injury	853.0-853.19	X					
Other choreas	333.5	X				X	
Other disease of larynx (incl., abscess, necrosis, obstruction, pachyderma, and ulcer of larynx)	478.79	X					

Appendix 23
(Continued)

Primary ICD-9-CM Diagnosis Code Description	Primary ICD-9-CM Diagnosis Code	A 16 Days	B 16 Days	C N/A*	D N/A*	E 12 Days	F N/A*
Other diseases of pharynx or nasopharynx	478.29	X					
Other diseases of vocal cords (incl., abscess, cellulitis, granuloma)	478.5	X					
Other speech disturbance (incl., dysarthria, dysphasia, slurred speech)	784.5	X					
Paralysis of vocal cords or larynx	478.30-478.34	X					
Parapharyngeal abscess	478.22	X					
Parkinson's disease	332.0-332.1	X				X	
Polyp of vocal cord or larynx	478.4	X					
Retropharyngeal abscess	478.24	X					
Secondary malignant neoplasm of brain and spinal cord	198.3	X					
Secondary malignant neoplasm of other parts of nervous system	198.4	X					
Spinocerebellar disease (ataxias)	334.0-334.9	X					
Stenosis of larynx	478.74	X					
Subarachnoid hemorrhage	430	X					
Subarachnoid, subdural, and extradural hemorrhage, following injury	852.0-852.59	X					
Subdural hemorrhage	432.1	X					
Swelling, mass, or lump in head and neck	784.2	X					
Syringomyelia and syringobulbia	336.0	X					
Thoracic aneurysm, ruptured	441.1	X					
Thoracoabdominal aneurysm, ruptured	441.6	X					
Toxic encephalopathy	349.82	X					
Trigeminal nerve disorders (incl., Trigeminal neuralgia)	350.1-350.9	X					
Unspecified disease of spinal cord (incl., cord compression)	336.9	X					
Voice disturbance	784.40-784.49	X					
ICD-9-CM Surgical Procedure Code Description	**ICD-9-CM Surgical Procedure Code**	**A** 16 Days	**B** 16 Days	**C** N/A*	**D** N/A*	**E** 12 Days	**F** N/A*
Complete glossectomy	25.3	X					
Correction of cleft palate	27.62	X					
Excision of destruction of lesion or tissue of pharynx	29.31-29.39	X					
Excision of larynx	30.0-30.4	X					
Extracranial ventricular shunt	02.31-02.39	X					
Other craniectomy	01.25	X					
Other craniotomy	01.24	X					
Partial glossectomy	25.2	X					
Pharyngotomy	29.0	X					
Radical glossectomy	25.4	X					
Repair of cleft lip	27.54	X					
Repair of larynx	31.61-31.69	X					
Revision of cleft palate repair	27.63	X					
Revision, removal, and irrigation of ventricular shunt	02.41-02.43	X					

*Statements "C," "D," and "F" do not apply to SLP services.

Appendix 24

Allowable ICD-9-CM Codes for Speech and Language Pathology Spell of Illness Approval (Organized by Statements)

Speech and language pathology (SLP) providers should use the following chart to determine the allowable combinations of *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) codes and statements for spell of illness (SOI) approval. Only one of statements "A" through "F" from the Prior Authorization/Spell of Illness Attachment (PA/SOIA), HCF 11039, must be true for SOI approval. The combination of the true statement and the primary ICD-9-CM diagnosis code or the ICD-9-CM surgical procedure code is then used by Wisconsin Medicaid to assign the maximum allowable treatment days for the SOI. Statement "G" must also be true for SOI approval, but it is not used to determine the maximum allowable treatment days.

The statements below are from Element 11 of the PA/SOIA:

A. The recipient experienced the onset of a new neuromuscular disease, injury, or condition six weeks ago or less.

B. The recipient experienced the onset of a new musculoskeletal disease, injury, or condition six weeks ago or less.

C. The recipient experienced the onset of a new problem or complication associated with physiologic disease, injury, or condition six weeks ago or less.

D. The recipient experienced the onset of a new psychological disease, injury, or condition six weeks ago or less.

E. The recipient experienced an exacerbation of a pre-existing condition six weeks ago or less.

F. The recipient experienced a regression of his or her condition due to lack of therapy six weeks ago or less.

AND

G. There is a reasonable expectation that the recipient will return to his or her previous level of function by the end of this SOI or sooner.

Note: Statements "C," "D," and "F" do not apply to SLP services.

Each chart is specific to one of the above statements. The statement and the maximum allowable treatment days are provided at the top of each chart.

The following instructions describe how to use these charts:

1. Find the chart that corresponds to the true statement (Element 11 of the PA/SOIA).
2. Find the appropriate ICD-9-CM code and description. The diagnosis codes are listed before the surgical procedure codes. The code descriptions are organized alphabetically within these categories (Element 10 of the PA/SOIA).
3. If the ICD-9-CM code is listed in the chart, refer to the statement at the top of the chart for the maximum allowable treatment days for the corresponding combination of the ICD-9-CM code and statement.
4. If the ICD-9-CM code is not listed in the chart, the combination of the code and statement does not allow for SOI approval. The ICD-9-CM code may be listed under another statement.

Some ICD-9-CM codes have more than one allowable statement for SOI approval. Speech and language pathology providers should determine which statement best describes the recipient's condition.

Only the ICD-9-CM codes listed in the following charts are available for SOI approval. If the ICD-9-CM code for the SLP service is not listed, the provider should submit the Prior Authorization Request Form (PA/RF), HCF 11018, and the Prior Authorization/Therapy Attachment (PA/TA), HCF 11008.

Appendix 24
(Continued)

Statement A — The recipient experienced the onset of a new neuromuscular disease, injury, or condition six weeks ago or less. Providers will be allowed **16 days** for an SOI with one of the following ICD-9-CM codes.	
Primary ICD-9-CM Diagnosis Code Description	**Primary ICD-9-CM Diagnosis Code**
Abdominal aneurysm, ruptured	441.3
Acute infective polyneuritis (Guillain-Barre syndrome; postinfectious polyneruritis)	357.0
Acute, but ill-defined, cerebrovascular disease (incl., CVA)	436
Anoxic brain damage	348.1
Aortic aneurysm of unspecified site, ruptured	441.5
Aphasia	784.3
Arterial embolism and thrombosis of abdominal aorta	444.0
Arterial embolism and thrombosis of thoracic aorta	444.1
Bacterial meningitis	320.0-320.9
Benign neoplasm of lip, oral cavity, and pharynx	210.0-210.9
Cellulitis and perichondritis of larynx	478.71
Cerebral cysts	348.0
Cerebral edema	348.5
Cerebral embolism	434.10-434.11
Cerebral laceration and contusion	851.0-851.99
Cerebral thrombosis	434.00-434.01
Complications of transplanted organ	996.80-996.89
Compression of brain	348.4
Concussion, with prolonged loss of consciousness and return to pre-existing conscious level	850.3
Concussion, with prolonged loss of consciousness without return to pre-existing conscious level	850.4
Cyst of pharynx or nasopharynx	478.26
Diabetes insipidus	253.5
Diabetes mellitus	250.0-250.93
Diffuse diseases of connective tissue	710.0-710.9
Disorders of other cranial nerves	352.0-352.9
Dissection of aorta	441.00-441.03
Edema of larynx	478.6
Edema of pharynx or nasopharynx	478.25
Encephalitis, myelitis, and encephalomyelitis	323.0-323.9
Encephalopathy, unspecified	348.3
Epilepsy	345.0-345.91
Facial nerve disorders (incl., Bell's palsy)	351.0-351.9
Head injury, unspecified	959.01
Hemplegia and hemiparesis	342.0-342.92
Huntington's chorea	333.4
Intracerebral hemorrhage	431
Intracranial injury of other and unspecified nature	854.0-854.19
Laryngeal spasm	478.75
Malignant neoplasm of brain	191.0-191.9
Malignant neoplasm of head, face, and neck	195.0
Meningitis due to other organisms	321.0-321.8
Meningitis of unspecified cause	322.0-322.9
Motor neuron disease (incl., Amyotrophic lateral sclerosis)	335.20-335.29
Multiple sclerosis	340
Myasthenia gravis	358.0
Nontraumatic extradural hemorrhage	432.0
Other and unspecified intracranial hemorrhage following injury	853.0-853.19
Other choreas	333.5
Other disease of larynx (incl., abscess, necrosis, obstruction, pachyderma, and ulcer of larynx)	478.79
Other diseases of pharynx or nasopharynx	478.29
Other diseases of vocal cords (incl., abscess, cellulitis, granuloma)	478.5
Other speech disturbance (incl., dysarthria, dysphasia, slurred speech)	784.5

Appendix 24
(Continued)

Statement A (continued) — The recipient experienced the onset of a new neuromuscular disease, injury, or condition six weeks ago or less. Providers will be allowed **16 days** for an SOI with one of the following ICD-9-CM codes.	
Primary ICD-9-CM Diagnosis Code Description	**Primary ICD-9-CM Diagnosis Code**
Paralysis of vocal cords or larynx	478.30-478.34
Parapharyngeal abscess	478.22
Parkinson's disease	332.0-332.1
Polyp of vocal cord or larynx	478.4
Retropharyngeal abscess	478.24
Secondary malignant neoplasm of brain and spinal cord	198.3
Secondary malignant neoplasm of other parts of nervous system	198.4
Spinocerebellar disease (ataxias)	334.0-334.9
Stenosis of larynx	478.74
Subarachnoid hemorrhage	430
Subarachnoid, subdural, and extradural hemorrhage, following injury	852.0-852.59
Subdural hemorrhage	432.1
Swelling, mass, or lump in head and neck	784.2
Syringomyelia and syringobulbia	336.0
Thoracic aneurysm, ruptured	441.1
Thoracoabdominal aneurysm, ruptured	441.6
Toxic encephalopathy	349.82
Trigeminal nerve disorders (incl., Trigeminal neuralgia)	350.1-350.9
Unspecified disease of spinal cord (incl., cord compression)	336.9
Voice disturbance	784.40-784.49
ICD-9-CM Surgical Procedure Code Description	**ICD-9-CM Surgical Procedure Code**
Complete glossectomy	25.3
Correction of cleft palate	27.62
Excision of destruction of lesion or tissue of pharynx	29.31-29.39
Excision of larynx	30.0-30.4
Extracranial ventricular shunt	02.31-02.39
Other craniectomy	01.25
Other craniotomy	01.24
Partial glossectomy	25.2
Pharyngotomy	29.0
Radical glossectomy	25.4
Repair of cleft lip	27.54
Repair of larynx	31.61-31.69
Revision of cleft palate repair	27.63
Revision, removal, and irrigation of ventricular shunt	02.41-02.43

Statement B — The recipient experienced the onset of a new musculoskeletal disease, injury, or condition six weeks ago or less. Providers will be allowed **16 days** for an SOI with one of the following ICD-9-CM codes.	
Primary ICD-9-CM Diagnosis Code Description	**Primary ICD-9-CM Diagnosis Code**
Benign neoplasm of lip, oral cavity, and pharynx	210.0-210.9

Statement C — The recipient experienced the onset of a new problem or complication associated with physiologic disease, injury, or condition six weeks ago or less. **This statement does not apply to SLP services.**

Appendix 24
(Continued)

Statement D — The recipient experienced the onset of a new psychological disease, injury, or condition six weeks ago or less. **This statement does not apply to SLP services.**

Statement E — The recipient experienced an exacerbation of a pre-existing condition six weeks ago or less. Providers will be allowed **12 days** for an SOI with one of the following ICD-9-CM codes.

Primary ICD-9-CM Diagnosis Code Description	**Primary ICD-9-CM Diagnosis Code**
Diffuse diseases of connective tissue	710.0-710.9
Head injury, unspecified	959.01
Hemplegia and hemiparesis	342.0-342.92
Huntington's chorea	333.4
Late effects of cerebrovascular disease	438.0-438.9
Multiple sclerosis	340
Myasthenia gravis	358.0
Other choreas	333.5
Parkinson's disease	332.0-332.1

Statement F — The recipient experienced a regression of his or her condition due to lack of therapy six weeks ago or less. **This statement does not apply to SLP services.**

Appendix 25

Prior Authorization Request Form (PA/RF) Completion Instructions for Physical Therapy, Occupational Therapy, and Speech and Language Pathology 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 all applicable service-specific attachments, including the Prior Authorization/Therapy Attachment (PA/TA), HCF 11008, the Prior Authorization/Spell of Illness Attachment (PA/SOIA), HCF 10039, or the Prior Authorization/Birth to 3 Therapy Attachment (PA/B3), HCF 11011, to Wisconsin Medicaid by fax at (608) 221-8616 or by mail to the following address:

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

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 the appropriate three-digit processing type from the list below. The processing type is a three-digit code used to identify the category of service requested. Use processing type "999" (Other) only if the requested category of service is not found in the list below. Prior authorization and SOI requests will be returned without adjudication if one of the following processing types is not indicated:

- 111 — Physical Therapy (PT).
- 112 — Occupational Therapy (OT).
- 113 — Speech and Language Pathology (SLP).
- 114 — SOI for PT.
- 115 — SOI for OT.
- 116 — SOI for SLP.
- 160 — Birth to 3 (B-3) for PT.
- 161 — B-3 for OT.
- 162 — B-3 for SLP.
- 999 — Other (use only if the requested category or service is not listed above).

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.

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

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/procedure requested.

Appendix 25
(Continued)

Element 11 — Start Date — SOI
Do not complete this element unless requesting an SOI. Enter the date of onset for the SOI in MM/DD/YY format.

Element 12 — First Date of Treatment — SOI
Do not complete this element unless requesting an SOI. Enter the date of the first treatment for the SOI in MM/DD/YY format.

Element 13 — Diagnosis — Secondary Code and Description
Enter the appropriate secondary ICD-9-CM diagnosis code and description relevant to the service/procedure requested, if applicable. If requesting an SOI, leave this element blank.

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 requesting an SOI, leave this element blank.

Element 15 — Performing Provider Number
Enter the eight-digit Medicaid provider number of the provider who will be performing the service, *only* if this number is different from the billing provider number listed in Element 4. If the treating therapist is the therapy assistant, enter the provider number of the supervising therapist. Rehabilitation agencies and outpatient hospital PT, OT, and SLP providers do not indicate a performing provider number.

Element 16 — Procedure Code
Enter the appropriate procedure code for each service/procedure requested. If requesting a B-3 service, leave this element blank.

Element 17 — Modifiers
Enter the "GP" modifier for PT services and the "GO" modifier for OT services. No modifier is needed for SLP services. Do not enter the "TF" modifier or the "TL" modifier.

Element 18 — POS
Enter the appropriate place of service code designating where the requested service/procedure would be provided/performed.

Element 19 — Description of Service
Enter the written description corresponding to the appropriate procedure code for each service/procedure requested. If requesting a B-3 service, enter "Birth to 3" and the therapy discipline as the description (e.g., "Birth to 3 occupational therapy services" for OT services).

Element 20 — QR
Enter the appropriate quantity for the number of dates of service being requested for each procedure code listed. If requesting an SOI or a B-3 service, leave this element blank.

Element 21 — Charge
Enter the usual and customary charge for each procedure code listed. If the quantity is greater than "1," multiply the quantity by the charge for each service/procedure requested. Enter that total amount in this element. If requesting an SOI or a B-3 service, leave this element blank.

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

Element 22 — Total Charges
Enter the anticipated total charge for this request. If requesting an SOI or a B-3 service, leave this element blank.

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

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.

Appendix 26

Sample Prior Authorization Request Form (PA/RF) for Physical Therapy 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
Therapy Group **1 W. Williams** **Anytown, WI 55555**	**(XXX) XXX-XXXX**	**111**
	4. Billing Provider's Medicaid Provider Number **12345678**	

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, Ima**	9. Sex — Recipient ☐ M ☒ F	

SECTION III — DIAGNOSIS / TREATMENT INFORMATION

10. Diagnosis — Primary Code and Description	11. Start Date — SOI	12. First Date of Treatment — SOI
436 — CVA		
13. Diagnosis — Secondary Code and Description **437.0 — Cerebral atherosclerosis**	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
87654321	**97116**	**GP**				**11**	**Gait training/transferring 15 min x 3/wk x 11 wk**	**33**	**XXX.XX**
87654321	**97110**	**GP**				**11**	**Strengthening exercises 15 min x 3/wk x 11 wk**	**33**	**XXX.XX**
87654321	**97032**	**GP**				**11**	**E Stim**	**33**	**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	24. Date Signed
I. M. Provider	**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 27

Sample Prior Authorization Request Form (PA/RF) for Occupational Therapy 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
Therapy Group **1 W. Williams** **Anytown, WI 55555**	**(XXX) XXX-XXXX**	**112**
	4. Billing Provider's Medicaid Provider Number **12345678**	

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, Ima**	9. Sex — Recipient ❑ M ☒ F	

SECTION III — DIAGNOSIS / TREATMENT INFORMATION

10. Diagnosis — Primary Code and Description	11. Start Date — SOI	12. First Date of Treatment — SOI
436 — CVA		
13. Diagnosis — Secondary Code and Description	14. Requested Start Date	
437.0 — Cerebral atherosclerosis		

15. Performing Provider Number	16. Procedure Code	17. Modifiers 1	2	3	4	18. POS	19. Description of Service	20. QR	21. Charge
87654321	**97110**	**GO**				**11**	**Strengthening exercises 15 min x 3/wk x 11 wk**	**33**	**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	24. Date Signed
I. M. Provider	**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 28

Sample Prior Authorization Request Form (PA/RF) for Speech and Language Pathology 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. Billing **1 W. Williams** **Anytown, WI 55555**	**(XXX) XXX-XXXX**	**113**
	4. Billing Provider's Medicaid Provider Number **12345678**	

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, Ima**	9. Sex — Recipient ☐ M ☒ F	

SECTION III — DIAGNOSIS / TREATMENT INFORMATION

10. Diagnosis — Primary Code and Description	11. Start Date — SOI	12. First Date of Treatment — SOI
315.31 — Language Delays		
13. Diagnosis — Secondary Code and Description	14. Requested Start Date	
783.4 — Developmental Delays	**MM/DD/YY**	

15. Performing Provider Number	16. Procedure Code	17. Modifiers 1	2	3	4	18. POS	19. Description of Service	20. QR	21. Charge
87654321	**92506**					**11**	**Speech/Language Evaluation**	**1**	**XXX.XX**
87654321	**92507**					**11**	**Speech/Language Therapy**	**17**	**XXX.XX**
87654321	**92508**					**11**	**Group Speech/Language Therapy**	**17**	**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	24. Date Signed
I.M. Provider	**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

Appendix 29

Prior Authorization/Therapy Attachment (PA/TA) Completion Instructions

(A copy of the Prior Authorization/Therapy Attachment [PA/TA] Completion Instructions is located on the following pages.)

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WISCONSIN MEDICAID

PRIOR AUTHORIZATION / THERAPY ATTACHMENT (PA/TA) 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, they may attach additional pages if more space is needed. Providers should refer to their service-specific handbook for service restrictions and additional documentation requirements. They should provide enough information for Wisconsin Medicaid medical consultants to make a reasonable judgment about the case.

Each provider is required to submit sufficient detailed information. Sufficient detailed information on a PA request means enough clinical information regarding the recipient to meet Wisconsin Medicaid's definition of "medically necessary." "Medically necessary" is defined in HFS 101.03(96m), Wis. Admin. Code. Each PA request is unique, representing a specific clinical situation. Therapists typically consider a number of issues that influence a decision to proceed with therapy treatment at a particular frequency to meet a particular goal. Those factors that influence treatment decisions should be documented on the PA request. Medicaid therapy consultants will consider documentation of those same factors to determine whether or not the request meets Wisconsin Medicaid's definition of "medically necessary." Medicaid consultants cannot "fill in the blanks" for a provider if the documentation is insufficient or unclear. The necessary level of detail may vary with each PA request and within the various sections of a PA request.

These directions are formatted to correspond to each required element on the Prior Authorization/Therapy Attachment (PA/TA), HCF 11008. The **bold** headings directly reflect the name of the element on the PA/TA. The proceeding text reflects instructions, hints, examples, clarifications, etc., that will help the provider document medical necessity in sufficient detail.

Attach the completed PA/TA to the Prior Authorization Request Form (PA/RF), HCF 11018, 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

The provider should be sure of the following:

- The recipient's name corresponds with the Medicaid identification number listed.
- The recipient's Medicaid identification number has 10 digits.
- The recipient is currently Medicaid eligible.
- The provider's name corresponds with the Medicaid identification number listed.
- The provider's Medicaid number has eight digits.

SECTION I — RECIPIENT / PROVIDER INFORMATION

Element 1 — Name — Recipient

Enter the recipient's last name, first name, and middle initial. Use the Medicaid Eligibility Verification System (EVS) to obtain the correct spelling of the recipient's name. If the name or the spelling of the name on the Medicaid identification card and the EVS do not match, use the spelling from the EVS. Refer to the Informational Resources section of the All-Provider Handbook for ways to access the EVS.

Element 2 — Recipient Medicaid ID Number

Enter the recipient's 10-digit Medicaid identification number. Do not enter any other numbers or letters.

Element 3 — Age — Recipient
Enter the age of the recipient in numerical form (e.g., 16, 21, 60).

Element 4 — Name and Credentials — Therapist
Enter the treating therapist's name and credentials. If the treating therapist is a therapy assistant, enter the name of the supervising therapist and the name of the therapy assistant.

Element 5 — Therapist's Medicaid Provider No.
Enter the treating therapist's eight-digit Medicaid provider number. If the treating therapist is the therapy assistant, enter the provider number of the supervising therapist. Rehabilitation agencies do not indicate a performing provider number.

Element 6 — Telephone No. — Therapist
Enter the treating therapist's telephone number, including area code and extension (if applicable). If the treating therapist is a therapy assistant, enter the telephone number of the supervising therapist.

Element 7 — Name — Referring / Prescribing Physician
Enter the referring or prescribing physician's name.

Note: All of the information in this section must be complete, accurate, and exactly the same as the information from the EVS and on the PA/RF before the PA request is forwarded to a Medicaid consultant. *Incomplete or inaccurate information will result in a returned PA request.*

Element 8 — Requesting PA for Physical Therapy (PT), Occupational Therapy (OT), Speech and Language Pathology (SLP)
Check the appropriate box on the PA/TA for the type of therapy service being requested.

Element 9 — Total Time Per Day Requested
Enter the anticipated number of minutes a typical treatment session will require. It is expected the requested minutes per session will be consistent with the recipient's history, age, attention span, cognitive ability, medical status, treatment goals, procedures, rehabilitation potential, and any other intervention the recipient receives. Intensity of intervention is determined by rate of change, rather than level of severity.

Element 10 — Total Sessions Per Week Requested
Enter the number of treatment days per week requested. It is expected the requested number of treatment days per week will be consistent with the recipient's history, medical status, treatment goals, rehabilitation potential, and any other intervention the recipient receives. Intensity of intervention is determined by rate of change, rather than level of severity.

Element 11 — Total Number of Weeks Requested
Enter the number of weeks of treatment requested. The requested duration should be consistent with the recipient's history, medical status, treatment goals, rehabilitation potential, and any other intervention the recipient receives. The requested duration should correspond to the number of weeks required to reach the goals identified in the plan of care (POC). Intensity of intervention is determined by rate of change, rather than level of severity.

Element 12 — Requested Start Date
Enter the requested grant date for this PA request in MM/DD/YYYY format.

SECTION II — PERTINENT DIAGNOSES / PROBLEMS TO BE TREATED

Element 13 — Provide a description of the recipient's current treatment diagnosis, any underlying conditions, and problem(s) to be treated, including dates of onset.

Indicate the pertinent medical diagnoses that relate to the reasons for providing therapy for the recipient at this time *and* any underlying conditions that may affect the POC or outcome (e.g., dementia, cognitive impairment, medications, attention deficits). Include dates of onset for all diagnoses. If the date of onset is unknown, state "unknown."

If this documentation is on a previous PA request and is still valid, indicate "this documentation may be found on PA No. XXXXXXX." Providers should review this information for accuracy each time that they submit a PA request.

Note: Avoid copying the same information on subsequent PA requests without verifying that the information continues to be accurate. A PA request may be returned if it appears as if there has been no change documented under Section II, but other sections of the PA suggest there have been some changes to the recipient's medical/functional condition/need.

Example 1: A recipient without cognitive impairment may attain a goal to learn a task in one to three visits. However, achieving the same treatment goal for a cognitively impaired recipient may require additional visits. Knowledge of the recipient's cognitive abilities is critical to understanding the need for the requested additional visits.

Example 2: When the recipient has a medical diagnosis, such as Parkinson's disease or a pervasive developmental disorder, it is necessary to document the medical diagnosis *as well as* the problem(s) being treated. Listing the problem(s) to be treated without a medical diagnosis, or vice versa, is insufficient.

SECTION III — BRIEF PERTINENT MEDICAL / SOCIAL INFORMATION

Element 14 — Include referral information, living situation, previous level of function, any change in medical status since previous PA request(s), and any other pertinent information.

The Medicaid consultant needs to understand the complete "picture" of the recipient and take into consideration the recipient's background, personal needs, status, change in status, etc. Sufficient, but pertinent, documentation of a recipient's medical/social status may include the following:

- Conditions that may affect the recipient's outcome of treatment.
- Evidence that this recipient will benefit from therapy at this time.
- Reasons why a Medicaid-reimbursed service is being requested at this time (this is helpful when this is not a new diagnosis or is a continuing episode of care for this recipient).

The provider's documentation must include the factors considered when developing the recipient's POC. Such factors may include the following:

- Reasons for referral.
- Referral source (e.g., a second opinion, nursing personnel having difficulty with carry-over program, school therapist referred because school does not have equipment to make orthotics).
- Reason(s) the recipient's medical needs are not met under current circumstances.
- Recent changes (e.g., change in medical status, change in living status) with reference dates.
- Recipient's goal (e.g., recipient's motivation to achieve a new goal may have changed).
- Recipient's living situation.
- Residence (e.g., nursing home vs. independent living).
- Caregiver (who is providing care [specific name not required], how frequently available, ability to follow through with instructions, etc.).
- If caregiver is required — the level of assistance required, the amount of assistance required, the type of assistance required.
- Degree of family support.
- Equipment and/or environmental adaptations used by the recipient.
- Brief history of the recipient's previous functional status.
- Prior level of function.
- Level of function after last treatment episode with reference dates.
- Cognition/behavior/compliance.
- Any other pertinent information that indicates a need for therapy services at this time.

SECTION IV — PERTINENT THERAPY INFORMATION

Element 15 — Document the chronological history of treatment provided for the treatment diagnoses (identified under Section II), dates of those treatments, and the recipient's functional status following those treatments.

Summarize previous episodes of care, if applicable, in the chart provided in this section. If this is a new patient, include history taken from the recipient, recipient's caregivers, or patient file. Include knowledge of other therapy services provided to the recipient (e.g., if requesting a PA for SLP, include any PT or OT the recipient may have received as well). Be concise, but informative.

Element 16 — List other service providers that are currently accessed by the recipient for those treatment diagnoses identified under Section II (i.e., home health, school, behavior management, home program, dietary services, therapies). Briefly document the coordination of the therapy treatment plan with these other service providers. Documentation may include telephone logs, summarization of conversations or written communication, copies of plans of care (POC), staffing reports, or received written reports.

Document the coordination of the therapy treatment plan with other service providers that may be working to achieve the same, or similar, goals for the recipient. If there are no other providers currently treating the recipient, indicate "not applicable" in the space provided.

Element 17 — Check the appropriate box (on the PA/TA) and circle the appropriate form, if applicable.

- ❑ **The current Individualized Education Program (IEP) / Individualized Family Service Plan (IFSP) / Individual Program Plan (IPP) is attached to this PA request.**
- ❑ **The current IEP / IFSP / IPP is attached to PA number_____.**
- ❑ **There is no IEP / IFSP / IPP because _____.**
- ❑ **Cotreatment with another therapy provider is within the POC.**
- ❑ **Referenced report(s) is attached (list any report[s])_____.**

The IEP, IFSP, and IPP are reports used as follows:

- Individualized Education Plan — A written plan for a 3- to 21-year-old child who receives exceptional education services in school.
- Individualized Family Service Plan — A written plan for a 0- to 3-year-old child who receives therapy services through the Birth to 3 Program.
- Individualized Program Plan — A written active treatment plan for individuals who reside in an Intermediate Care Facility for the Mentally Retarded.

Submission of the IEP, IFSP, and IPP with the PA request is required if the recipient is receiving services that require one of the above written plans.

This section is included as a quick reference to remind providers to attach the necessary documentation materials to the PA request and to remind providers to document cotreatment, if applicable, in their POC.

Cotreatment is when two therapy types provide their respective services to one recipient during the same treatment session. For example, occupational therapists and physical therapists treat the recipient at the same time or occupational therapists and speech-language pathologists treat the recipient at the same time. It is expected that the medical need for cotreatment be documented in both providers' POC and that *both* PA requests are submitted *in the same envelope*.

Other "referenced reports" may be swallow studies, discharge summaries, surgical reports, dietary reports, or psychology reports. These reports should be submitted with the PA request when the information in those reports influenced the provider's treatment decision making and were referenced elsewhere in the PA request. Prior authorization requests submitted without the required or referenced documentation attached to the PA request will be returned to the provider.

SECTION V — EVALUATION (COMPREHENSIVE RESULTS OF FORMAL / INFORMAL TESTS AND MEASUREMENTS THAT PROVIDE A BASELINE FOR THE RECIPIENT'S FUNCTIONAL LIMITATIONS)

Element 18 — Attach a copy of the initial evaluation or the most recent evaluation or re-evaluation, *or* indicate the PA number with which this information was previously submitted.

- ❑ **Comprehensive initial evaluation attached. Date of initial comprehensive evaluation _____.**
- ❑ **Comprehensive initial evaluation submitted with PA number _____.**
- ❑ **Current re-evaluation attached. Date of most current evaluation or re-evaluation(s) _____.**
- ❑ **Current re-evaluation submitted with PA number _____.**

A copy of the comprehensive evaluation for the current episode of care (for the current problem being treated) must be included with the PA request or submitted previously with another PA request, regardless of when treatment was initiated and regardless of the reimbursement source at the time of the comprehensive evaluation. An evaluation defining the recipient's overall functional abilities and limitations with baseline measurements from which a POC is established is necessary for the Medicaid consultant to understand the recipient's needs and the request.

The initial evaluation must:

(1) Establish a baseline for identified limitations — The evaluation should provide baseline measurements that establish a performance (or ability) level *using units of objective measurement that can be consistently applied when reporting subsequent status*. It is very important to use consistent units of measurement throughout documentation or be able to explain why the units of measurement changed.

Example 1: If the functional limitation is "unable to brush teeth," the limiting factor may be due to strength, range of motion, cognition, sensory processing, or equipment needs. The baseline should establish the status of identified limiting factors. Such factors may include the following:

- Range of motion measurements in degrees.
- Eye-hand coordination as measured by a testing tool or units of speed and accuracy.
- Oral sensitivity as measured by an assessment tool or type of reaction to specific kinds of textures or temperatures at specific oral cavity/teeth location.
- Grasp deficits including type of grasp and grip strength.

Later on, subsequent progress must be described using the same terms (e.g., grip strength increased by 2 pounds).

Example 2: If the functional limitation is "unable to sit long enough to engage in activities," indicate "the recipient can short sit for two minutes, unsupported, before losing his balance to the left." Later on, progress can be documented in terms of time.

(2) Relate the functional limitations to an identified deficit — The evaluation must be comprehensive enough that another, independent clinician would reasonably reach the same conclusion regarding the recipient's functional limitation.

Example 1: The recipient is referred to therapy because "she doesn't eat certain types of foods." The evaluation should clearly indicate the reason for not eating those certain foods. A deficit has not been identified if testing indicates the recipient only eats Food "B." Some deficit examples (for not eating a variety of foods) are: cleft palate, oral defensiveness, lip closure, tongue mobility, an aversion to food, aspiration, attention span, or recipient is G-tube fed and is therefore not hungry. The identified deficit must be objectively measured and quantified (i.e., a baseline — refer to [1]).

Example 2: The recipient is referred to therapy because "he cannot go up and down stairs safely." The evaluation should clearly indicate the reasons for this functional limitation. A deficit has not been identified if the results of testing indicate the recipient can only step up three inches. Strength, range of motion, balance, sensory processing, motivation, etc., must be assessed and documented to identify the deficit causing the functional limitation (i.e., objectively tested, measured, and quantified on the evaluation).

A re-evaluation is the process of performing selected tests and measures (after the initial evaluation) in the targeted treatment area(s) to evaluate progress, functional ability, treatment effectiveness, and/or to modify or redirect intervention. The re-evaluation must be submitted with the PA request whenever it is necessary to update the recipient's progress/condition. Using the same tests and measurements as used in the initial evaluation is essential to reviewing status/progress. If new tests or measurements are used in the re-evaluation, explain why a different measurement tool was used.

SECTION VI — PROGRESS

Element 19 — Describe progress in specific, measurable, objective, and functional terms (using consistent units of measurement) that are related to the goals / limitations, *since treatment was initiated or last authorized*.

If this information is concisely written in other documentation prepared for the provider's/therapist's records, attach and write "see attached" in the space provided.

Document the goal or functional limitation in the left column on the PA/TA. Indicate the corresponding status for that goal or limitation *as of the previous PA request or since treatment was initiated (whichever is most recent)* in the middle column on the PA/TA. Indicate the corresponding status of that goal or limitation *as of the date of the current PA request* (do not use "a month ago" or "when last seen" or "when last evaluated") in the right column of the PA/TA. Progress relates to the established baseline, previous goals, and identified limitations. Use the same tests and measurements as those units of measurement used in the baseline description.

The following information is necessary to evaluate the medical necessity of the PA request:

- Progress documented in specific, measurable, and objective terms.
- Use of words that are specific, measurable, or objective (words such as: better, improved, calmer, happier, pleasant, less/more, not as good, not as reliable, longer, more prolonged, and "goal not met," are not specific, measurable, or objective. These do not convey to the Medicaid consultant if or how much progress has been achieved). The following examples are specific, measurable, and objective:
  Example 1: Strength increased from *poor* to *fair*, as determined with a Manual Muscle Test.
  Example 2: Speech intelligibility improved from 30 percent to 70 percent, per standardized measurement.

- Consistent use of the same tests and measurements and units of measurement.
  Example: A progress statement that notes the recipient can now eat hamburgers does not correlate to his goal of articulation and the baseline established for articulation.
- Progress must demonstrate the recipient has learned new skills and therefore has advanced or improved in function *as a result of* treatment intervention. "If treatment of underlying factors, such as increase in endurance, strength or range of motion or decrease in pain does not improve the performance of functional activities, then improvement is not considered to be significant" (Acquaviva, p. 85).

  "Significant functional progress: Must result from treatment rather from maturation or other uncontrolled factors, must be real, not random, must be important, not trivial" (Bain and Dollaghan).

- Significant functional progress must have been demonstrated within the past six months for continued therapy PA approval. Prior authorization requests for treatment when the recipient has not advanced or improved function within six months cannot be approved per HFS 107.16(3)(e)1, 107.17(3)(e)1, and 107.18(3)(e)1, Wis. Admin. Code.
- Prior authorization requests for maintenance therapy must demonstrate the functional purpose (medical necessity) of treatment, as "progress" is not necessarily applicable to maintenance programs. The Medicaid consultant will look for evidence that there is a continued functional purpose for the recipient as a result of skilled therapeutic intervention, in accordance with the Wisconsin Administrative Code and applicable *Wisconsin Medicaid and BadgerCare Updates*.

SECTION VII — PLAN OF CARE

Element 20 — Identify the specific, measurable, objective, and functional goals for the recipient (to be met by the end of this PA request) and both of the following:
(1) Indicate the therapist-required skills / treatment techniques that will be used to meet each goal.
(2) Designate (with an asterisk[*]) which goals are reinforced in a carry-over program.

If the POC is concisely written in other documentation prepared for the recipient's records, attach and write "see attached" in the space provided.

Examples for this section include:
1. GOAL: Client will be 80 percent intelligible in conversation as judged by an unfamiliar listener.
   Plan of care: Oral motor exercises, environmental cues, articulation skills.
2. GOAL: Client will increase vocabulary with five new words as reported by parent.
   Plan of care: Sing songs, read books, and use adjectives and adverbs in conversation.*
3. GOAL: Client will ascend stairs reciprocally without assistance.
   Plan of care: Gastrocnemius and gluteus medius strengthening.
4. GOAL: Client will transfer into and out of tub with verbal cues.
   Plan of care: Prepare bathroom and client for transfer; provide consistent verbal cues as rehearsed in PT.*
5. GOAL: Client will demonstrate ability to button ½-inch button on dress shirt independently using any pinch pattern.
   Plan of care: Graded finger grasp/pinch strengthening, eye-hand coordination, and bilateral hand use.
6. GOAL: Client will catch/throw a 10" ball.
   Plan of care: Practice play catch while sitting using a variety of objects (e.g., Nerf® ball, plastic ball, beach ball, volleyball, or balloon).*

It is very important to:
- Use consistent units of measurement.
- Document those elements of a treatment plan that only a skilled therapist could implement (e.g., 1, 3, and 5 above).
- Designate (with an asterisk [*]) those goals or interventions the provider has instructed other caregivers or the recipient to incorporate into the recipient's usual routine in his or her usual environment (such as 2, 4, and 6 above where kicking a ball, jumping, throwing a ball, building endurance, rote activities, who/what/where questions, using appropriate pronouns, choosing new foods, etc., are part of the overall POC).
- Write goals consistent with functional limitations and identified deficit as described in the evaluation and status statements (Section V) or progress section (Section VI).

Example: The evaluation identified the functional limitation and deficits corresponding to the above examples. Examples of limitations and deficits may include:
1. The client is not intelligible in conversation due to poor tongue control.
2. The 24-month-old client cannot express his needs because he has the vocabulary of a 16-month-old.
3. The client cannot get to his bedroom independently because of *poor* muscle strength.
4. The client cannot safely get into the bathtub because he has poor short-term memory and is easily distractible.
5. The client cannot dress independently because of decreased fine-motor skills as tested on the Peabody and he lacks all functional pinch patterns.
6. The client cannot use hands/arms bilaterally because of poor left upper-extremity proximal stability.

SECTION VIII — REHABILITATION POTENTIAL

Element 21 — Complete the following sentences based upon the professional assessment.

(1) Upon discharge from this episode of care, the recipient will be able to

Describe what the recipient will be able to *functionally do* at the end of this episode of care (not necessarily the end of the PA request) based upon the professional assessment. Discharge planning begins at the initial evaluation. At the initial evaluation the therapist should be able to determine the amount/type of change the recipient is capable of making based upon all the factors presented at the evaluation. Statements such as "will be age appropriate," "will resume prior level of function," "will have effects of multiple sclerosis minimized," or "will eat all foods" are vague and frequently are not achievable with the patient population therapists encounter. More recipient-specific or definitive statements of prognosis would be the following examples:

- "Return to home to live with spouse support."
- "Communicate basic needs and wants with her peers."
- "Go upstairs to his bedroom by himself."
- "Get dressed by herself."
- "Walk in the community with stand-by assistance for safety."
- "Walk to the dining room with or without assistive device and the assistance of a nurse's aide."
- "Swallow pureed foods."

(2) Upon discharge from this episode of care, the recipient may continue to (list supportive services)

Indicate what community or therapy services the recipient may continue to require at the end of this episode of care. Examples include the following:

- "Range of motion program by caregivers."
- "Infrequent (be specific) screening by therapist to assure maintenance of skills."
- "A communication book."
- "Behavior management services."
- "Dietary consultation."
- "Supervision of (a task) by a caregiver."

(3) The recipient / recipient's caregivers support the therapy POC by the following activities and frequency of carryover

Describe what activities the recipient and/or caregivers do or do not do with the recipient that will affect the outcome of treatment.

(4) It is estimated this episode of care will end (provide approximate end time)

Establish an anticipated time frame for the recipient to meet his or her realistic functional goals (e.g., two weeks, two months, two years).

These specific questions are asked to avoid one-word responses (e.g., "good"). Information beyond a one-word response provides the Medicaid consultant with additional detail that supports the justification that therapy services are necessary to meet the recipient's goals. Wisconsin Medicaid recognizes that the statements in this section are considered professional judgments and may not reflect the actual outcome of treatment.

Element 22 — Signature — Providing Therapist
The providing therapist's signature is required at the end of the PA/TA.

Element 23 — Date Signed
Enter the month, day, and year the PA/TA was signed (in MM/DD/YYYY format) by the providing therapist.

Element 24 — Signature — Recipient or Recipient Caregiver (optional)
The recipient's or recipient caregiver's signature is optional at this time, but it is encouraged (as a means to review what has been requested on the recipient's behalf on the PA request).

Element 25 — Date Signed
Enter the month, day, and year the PA/TA was signed (in MM/DD/YYYY format) by the recipient or recipient's caregiver (if applicable).

If the required documentation is missing from the request form, the request will be returned to the provider for the missing information.

REMINDER: The PA/RF must be filled out completely (i.e., all sections completed). Attach the completed PA/TA and any other documentation to the PA/RF.

REFERENCES

Acquaviva, J.D., ed. (1992). Effective Documentation for Occupational Therapy. Rockville, Maryland, The American Occupational Therapy Association, Inc.

Bain and Dollaghan (1991). Language, Speech and Hearing Services in Schools, 13.

Moyers, P.A. (1999). "The Guide to Occupational Therapy Practice." American Journal of Occupational Therapy (Special Issue), 53 (3).

American Physical Therapy Association, 2001, Guide to Physical Therapist Practice, Physical Therapy, 81 (1).

American Physical Therapy Association, 1997, Guide to Physical Therapist Practice, Physical Therapy, 77 (11).

American Speech-Language and Hearing Association, 1997, Cardinal Documents.

American Occupational Therapy Association Standards of Practice.

American Physical Therapy Association Standards of Practice.

American Speech-Language and Hearing Association Standards of Practice.

Wisconsin Administrative Code.

Appendix 30

Prior Authorization/Therapy Attachment (PA/TA) (for photocopying)

(A copy of the Prior Authorization/Therapy Attachment [PA/TA] is located on the following pages.)

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DEPARTMENT OF HEALTH AND FAMILY SERVICES **STATE OF WISCONSIN**
Division of Health Care Financing
HCF 11008 (Rev. 06/03)

WISCONSIN MEDICAID

PRIOR AUTHORIZATION / THERAPY ATTACHMENT (PA/TA)

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/Therapy Attachment (PA/TA) Completion Instructions, HCF 11008A.

SECTION I — RECIPIENT / PROVIDER INFORMATION

1. Name — Recipient (Last, First, Middle Initial)	2. Recipient Medicaid ID Number	3. Age — Recipient

4. Name and Credentials — Therapist	5. Therapist's Medicaid Provider No.	6. Telephone No. — Therapist

7. Name — Referring / Prescribing Physician

8. Requesting PA for

❑ Physical Therapy (PT) ❑ Occupational Therapy (OT) ❑ Speech and Language Pathology (SLP)

9. Total Time Per Day Requested	10. Total Sessions Per Week Requested

11. Total Number of Weeks Requested	12. Requested Start Date

SECTION II — PERTINENT DIAGNOSES / PROBLEMS TO BE TREATED

13. Provide a description of the recipient's current treatment diagnosis, any underlying conditions, and problem(s) to be treated, including dates of onset.

SECTION III — BRIEF PERTINENT MEDICAL / SOCIAL INFORMATION

14. Include referral information, living situation, previous level of function, any change in medical status since previous PA request(s), and any other pertinent information.

SECTION IV — PERTINENT THERAPY INFORMATION

15. Document the chronological history of treatment provided for the diagnoses (identified under Section II), dates of those treatments, and the recipient's functional status following those treatments.

Provider Type (e.g., OT, PT, SLP)	Dates of Treatment	Functional Status After Treatment

Continued

SECTION IV — PERTINENT THERAPY INFORMATION (Continued)

16. List other service providers that are currently accessed by the recipient for those treatment diagnoses identified under Section II (i.e., home health, school, behavior management, home program, dietary services, therapies). Briefly document the coordination of the therapy treatment plan with these other service providers. Documentation may include telephone logs, summarization of conversations or written communication, copies of plans of care (POC), staffing reports, or received written reports.

17. Check the appropriate box and circle the appropriate form, if applicable.

- ❑ The current Individualized Education Program (IEP) / Individualized Family Service Plan (IFSP) / Individual Program Plan (IPP) is attached to this PA request.
- ❑ The current IEP / IFSP / IPP is attached to PA number _____.
- ❑ There is no IEP / IFSP / IPP because _____
  _____.
- ❑ Cotreatment with another therapy provider is within the POC.
- ❑ Referenced report(s) is attached (list any report[s]) _____.

SECTION V — EVALUATION (COMPREHENSIVE RESULTS OF FORMAL / INFORMAL TESTS AND MEASUREMENTS THAT PROVIDE A BASELINE FOR THE RECIPIENT'S FUNCTIONAL LIMITATIONS)

18. Attach a copy of the initial evaluation or the most recent evaluation or re-evaluation, **or** indicate the PA number with which this information was previously submitted.

- ❑ Comprehensive initial evaluation attached. Date of initial comprehensive evaluation _____.
- ❑ Comprehensive initial evaluation submitted with PA number _____.
- ❑ Current re-evaluation attached. Date of most current evaluation or re-evaluation(s) _____.
- ❑ Current re-evaluation submitted with PA number _____.

SECTION VI — PROGRESS

19. Describe progress in specific, measurable, objective, and functional terms (using consistent units of measurement) that are related to the goals / limitations, *since treatment was initiated or last authorized*.

Goal / Limitation	Previous Status / Date (MM/DD/YY)	Status as of Date of PA Request / Date (MM/DD/YY)

(If this information is concisely written in other documentation prepared for the provider's / therapist's records, attach and write "see attached" in the space above.)

Continued

SECTION VII — PLAN OF CARE

20. Identify the specific, measurable, objective, and functional goals for the recipient (to be met by the end of this PA request) and both of the following:
    (1) Indicate the therapist-required skills / treatment techniques that will be used to meet each goal.
    (2) Designate (with an asterisk [*]) which goals are reinforced in a carry-over program.

(If the POC is concisely written in other documentation prepared for the recipient's records, attach and write "see attached" in the space above.)

SECTION VIII — REHABILITATION POTENTIAL

21. Complete the following sentences based upon the professional assessment.
    (1) Upon discharge from this episode of care, the recipient will be able to

    (2) Upon discharge from this episode of care, the recipient may continue to (list supportive services)

    (3) The recipient / recipient's caregivers support the therapy POC by the following activities and frequency of carryover

    (4) It is estimated this episode of care will end (provide approximate end time)

22. SIGNATURE — Providing Therapist	23. Date Signed
24. SIGNATURE — Recipient or Recipient Caregiver (optional)	25. Date Signed

Appendix 31

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

(A copy of the Prior Authorization/Spell of Illness Attachment [PA/SOIA] Completion Instructions is located on the following pages.)

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WISCONSIN MEDICAID
PRIOR AUTHORIZATION / SPELL OF ILLNESS ATTACHMENT (PA/SOIA) 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 the Prior Authorization/Spell of Illness Attachment (PA/SOIA), HCF 11039, is voluntary when requesting SOI. Providers may develop their own form as long as it includes all the information on this form and is formatted exactly like this form. Failure to supply the information requested by the form may result in denial of Medicaid payment for the services.

Attach the completed PA/SOIA to the Prior Authorization Request Form (PA/RF), HCF 11018, 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

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

An SOI ends when the maximum allowable treatment days have been used or when the physical therapy (PT), occupational therapy (OT), or speech and language pathology (SLP) services are no longer required, whichever comes first. If, near the end of the maximum allowable treatment days, the skills of a PT, OT, or SLP provider are still needed, the provider should submit the PA/RF and the Prior Authorization/Therapy Attachment (PA/TA), HCF 11008, to continue services.

SECTION I — RECIPIENT INFORMATION

Element 1 — Name — Recipient
Enter the recipient's last name, followed by his or her first name and middle initial. Use the Medicaid Eligibility Verification System (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 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. Do not enter any other numbers or letters in this field.

SECTION II — PROVIDER INFORMATION

Element 4 — Name and Credentials — Therapist
Enter the name and credentials of the primary therapist participating in therapy services for the recipient. If the performing provider is a therapy assistant, enter the name of the supervising therapist.

Element 5 — Therapist's Medicaid Provider Number
Enter the performing provider's eight-digit provider number. If the performing provider is a therapy assistant, enter the provider number of the supervising therapist. Rehabilitation agencies do not indicate a performing provider.

Element 6 — Telephone Number — Therapist
Enter the performing provider's telephone number, including the area code, of the office, facility, or place of business. If the performing provider is a therapy assistant, enter the telephone number of the supervising therapist.

Element 7 — Name — Prescribing Physician
Enter the name of the prescribing physician.

SECTION III — DOCUMENTATION

Element 8
Enter an "X" in the appropriate box to indicate a PT, OT, or SLP SOI request.

Element 9 — Requested Start Date
Enter the requested start date for service(s) in MM/DD/YY format (e.g., June 30, 2003, would be 06/30/03).

Element 10 — Primary *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) Diagnosis Code or ICD-9-CM Surgical Procedure Code
Enter the appropriate primary ICD-9-CM diagnosis code or surgical procedure code.

Element 11
Enter an "X" in the appropriate box to indicate "yes" or "no" in response to each statement. Only one of "A" through "F" must be marked "yes" in addition to "G" for SOI approval. Otherwise, the PT, OT, or SLP provider should submit the PA/RF and the PA/TA.

Element 12 — Signature — Therapist Providing Evaluation / Treatment
The signature of the therapist providing evaluation/treatment must appear in the space provided.

Element 13 — Date Signed
Enter the month, day, and year the PA/SOIA was signed in MM/DD/YY format.

Appendix 32

Prior Authorization/Spell of Illness Attachment (PA/SOIA) (for photocopying)

(A copy of the Prior Authorization/Spell of Illness Attachment [PA/SOIA] is located on the following pages.)

(This page was intentionally left blank.)

DEPARTMENT OF HEALTH AND FAMILY SERVICES **STATE OF WISCONSIN**
Division of Health Care Financing
HCF 11039 (Rev. 06/03)

WISCONSIN MEDICAID
PRIOR AUTHORIZATION / SPELL OF ILLNESS ATTACHMENT (PA/SOIA)

Providers may submit spell of illness (SOI) requests by fax to Wisconsin Medicaid 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/Spell of Illness Attachment (PA/SOIA) Completion Instructions, HCF 11039A.

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 — Therapist	5. Therapist's Medicaid Provider Number

6. Telephone Number — Therapist	7. Name — Prescribing Physician

SECTION III — DOCUMENTATION

8. Requesting SOI for ❑ Physical Therapy (PT) ❑ Occupational Therapy (OT) ❑ Speech and Language Pathology (SLP)

9. Requested Start Date	10. Primary *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) Diagnosis Code or ICD-9-CM Surgical Procedure Code

11. Indicate "yes" or "no" in response to *each* of the following statements (Only one of "A" through "F" in addition to "G" must be marked "yes" for SOI approval. Otherwise, the PT, OT, or SLP provider should submit the Prior Authorization Request Form [PA/RF], HCF 11018, and the Prior Authorization / Therapy Attachment [PA/TA], HCF 11008).

A. The recipient experienced the onset of a new neuromuscular disease, injury, or condition six weeks ago or less.	❑ Yes	❑ No
B. The recipient experienced the onset of a new musculoskeletal disease, injury, or condition six weeks ago or less.	❑ Yes	❑ No
C. The recipient experienced the onset of a new problem or complication associated with physiologic disease, injury, or condition six weeks ago or less.	❑ Yes	❑ No
D. The recipient experienced the onset of a new psychological disease, injury, or condition six weeks ago or less.	❑ Yes	❑ No
E. The recipient experienced an exacerbation of a pre-existing condition six weeks ago or less.	❑ Yes	❑ No
F. The recipient experienced a regression of his or her condition due to lack of therapy six weeks ago or less.	❑ Yes	❑ No
AND		
G. There is a reasonable expectation that the recipient will return to his or her previous level of function by the end of this SOI or sooner.	❑ Yes	❑ No

I hereby certify that the documentation of the date of onset, exacerbation, or regression of the recipient's disease, injury, or condition is as stated above. The specific start date of the SOI is maintained in the recipient's medical record at my facility and I acknowledge that the SOI ends when the services of a therapist are no longer required or after the maximum allowable treatment days have been used, whichever comes first.

12. **SIGNATURE** — Therapist Providing Evaluation / Treatment	13. Date Signed

Continued

Examples of statements A-F from Element 11:

A. The recipient experienced the onset of a new neuromuscular disease, injury, or condition six weeks ago or less. Examples of this situation include, but are not limited to, the following:

- Diabetic neuropathy.
- Multiple sclerosis.
- Parkinson's disease.
- Stroke-hemiparesis.

B. The recipient experienced the onset of a new musculoskeletal disease, injury, or condition six weeks ago or less. Examples of this situation include, but are not limited to, the following:

- Amputation.
- Complications associated with surgical procedures.
- Fracture.
- Strains and sprains.

C. The recipient experienced the onset of a new problem or complication associated with physiologic disease, injury, or condition six weeks ago or less. Examples of this situation include, but are not limited to, the following:

- Cardio-pulmonary conditions.
- Severe pain.
- Vascular condition.

D. The recipient experienced the onset of a new psychological disease, injury, or condition six weeks ago or less. Examples of this situation include, but are not limited to, the following:

- Affective disorders.
- Organic conditions.
- Thought disorders.

E. The recipient experienced an exacerbation of a pre-existing condition six weeks ago or less. Examples of this situation include, but are not limited to, the following:

- Multiple sclerosis.
- Parkinson's disease.
- Rheumatoid arthritis.
- Schizophrenia.

F. The recipient experienced a regression of his or her condition due to lack of therapy six weeks ago or less. Examples of this situation include, but are not limited to, the following:

- Decrease of functional ability.
- Decrease of mobility.
- Decrease of motion.
- Decrease of strength.

Appendix 33

Prior Authorization/Birth to 3 Therapy Attachment (PA/B3) (for photocopying)

(A copy of the Prior Authorization/Birth to 3 Therapy Attachment [PA/B3] is located on the following page.)

DEPARTMENT OF HEALTH AND FAMILY SERVICES **STATE OF WISCONSIN**
Division of Health Care Financing
HCF 11011 (Rev. 01/03)

WISCONSIN MEDICAID
PRIOR AUTHORIZATION / BIRTH TO 3 THERAPY ATTACHMENT (PA/B3)

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.

REMINDER TO PROVIDERS
All services must meet the rules and regulations of Wisconsin Medicaid as found in HFS 101-108, Wis. Admin. Code. Prior authorization does not guarantee payment for the service.

SUBMITTING PRIOR AUTHORIZATION REQUESTS
Attach the completed Prior Authorization/Birth to 3 Therapy Attachment (PA/B3) to the Prior Authorization Request Form (PA/RF), HCF 11018, 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

Name — Recipient (Last, First, Middle Initial)	Recipient Medicaid Identification Number
Name — Therapist (Last, First, Middle Initial)	Therapist's or Rehabilitation Agency's Medicaid Provider Number

By my signature below, I hereby attest that the following is true:

- I am providing an evaluation completed for the purpose of determining the recipient's eligibility for the Birth to 3 (B-3) Program or for the purpose of initiating and/or providing therapy services as part of the Individualized Family Service Plan (IFSP) developed for the recipient.

OR

- I am providing ongoing therapy services and I certify that all of the following are true:
  - ✓ The IFSP for the child named above was or will be developed and implemented in accordance with the requirements set forth in HFS 90, Wis. Admin. Code.
  - ✓ The therapy services I am providing to the recipient named above are as stated in the child's current and valid IFSP.
  - ✓ The frequency and duration of services I am providing to the child named above reflects the frequency and duration of services listed in the recipient's IFSP.
  - ✓ The recipient of the services is enrolled in a B-3 Program for all dates of service and is younger than three years of age.
  - ✓ I am a therapist employed by a B-3 Program or am under agreement with a B-3 agency to provide B-3 services.
  - ✓ The therapy services provided meet all the applicable rules and regulations as stated in HFS 101-108, Wis. Admin. Code, and *Wisconsin Medicaid and BadgerCare Updates*.
  - ✓ I understand that I am required to maintain a record of services provided to the child named above, per HFS 106, Wis. Admin. Code.

SIGNATURE — Therapist	Date Signed (MM/DD/YYYY)

Appendix 34

CMS 1500 Claim Form Instructions for Physical Therapy, Occupational Therapy, and Speech and Language Pathology Services

Use the following claim form completion instructions, *not* the element descriptions printed on the claim form, to avoid denied claims or inaccurate 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

In the Medicaid check box, enter claim sort indicator "T" for physical therapy (PT), occupational therapy (OT), and speech and language pathology (SLP) services. Enter "M" for PT, OT, and SLP services provided by a rehabilitation agency. Enter "P" for PT, OT, and SLP services provided by an outpatient hospital.

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). 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") insurance only, 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 in part or in full 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.

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 bill 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 34
(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).

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

If a provider bills an unlisted (or not otherwise specified) procedure code, a description of the procedure must be indicated in this element. If Element 19 does not provide enough space for the procedure description, or if a provider is billing multiple unlisted procedure codes, documentation must be attached to the claim describing the procedure(s). In this instance, indicate "See Attachment" in Element 19.

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.

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 procedure using the following guidelines:

- When billing for one DOS, enter the date in MM/DD/YY 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 6/01/05 or 6/01/2005 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:

- 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.

Element 24B — Place of Service

Enter the appropriate two-digit POS code for each service.

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.

Element 24G — Days or Units

Enter the appropriate number of units for each line item. Always use a decimal (e.g., 1.0 units).

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

Element 24I — EMG (not required)

Element 24J — COB (not required)

Element 24K — Reserved for Local Use

Enter the eight-digit Medicaid provider number of the performing provider for each procedure if that number is different than the billing provider number in Element 33. Any other information entered in this element may cause claim denial.

Note: Rehabilitation agencies and outpatient hospital PT, OT, and SLP providers do not indicate a performing provider number.

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

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)

Enter the name and address of the facility where the services were provided only when submitting claims for POS codes "31" or "32." It is not necessary to add any information in this element for any other POS.

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. Minimum requirement is the provider's name, address, city, state, and ZIP code. At the bottom of Element 33, enter the billing provider's eight-digit Medicaid provider number.

Appendix 35

Sample CMS 1500 Claim Form for Physical Therapy Services

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

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

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 1234567890

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Recipient, Im A.

3. PATIENT'S BIRTH DATE MM DD YY: MM DD YY SEX M ☒ F ☐

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

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

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 ☐

CITY: STATE:

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

Employed ☐ Full-Time Student ☐ Part-Time Student ☐

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-7

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.

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

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

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

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

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

17a. I.D. NUMBER OF REFERRING PHYSICIAN: B12345

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

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

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

1. 436 3.

2. 437.0 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 08 04 05	06 10	11		97116	GP	1	XX XX	6.0				12345678
2 08 20 05		11		97110	GP	2	XX XX	1.5				12345678
3												
4												
5												
6												

PHYSICIAN OR SUPPLIER INFORMATION

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 MM/DD/YY

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

I.M. Therapist
1 W. Williams
Anytown, WI 55555

PIN# 87654321 GRP#

(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 36

Sample CMS 1500 Claim Form for Occupational Therapy Services

PICA

HEALTH INSURANCE CLAIM FORM

PICA

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

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 1234567890

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Recipient, Im A.

3. PATIENT'S BIRTH DATE MM DD YY: MM DD YY | SEX M ☐ F ☒

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

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

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 ☐

CITY | STATE

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

Employed ☐ Full-Time Student ☐ Part-Time Student ☐

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

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES ☐ NO ☐

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

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

b. AUTO ACCIDENT? YES ☐ NO ☐ PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES ☐ NO ☐

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

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

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

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

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: IM Referring

17a. I.D. NUMBER OF REFERRING PHYSICIAN: B12345

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

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

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

1. 436
2. 437.0
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 10 20 05	23 27	11		97150	GO TF	1	XX XX	6.0				
2 10 23 05		12		97110	GO TF TL	2	XX XX	1.0				
3												
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.)

J.M. Authorized MM/DD/YY

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

Rehabilitation Agency
1 W. Williams
Anytown, WI 55555

PIN# 87654321 GRP#

CARRIER

PATIENT AND INSURED INFORMATION

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 37

Sample CMS 1500 Claim Form for Speech and Language Pathology Services

PICA

HEALTH INSURANCE CLAIM FORM

PICA

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

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 1234567890

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Recipient, Im A.

3. PATIENT'S BIRTH DATE MM DD YY: MM DD YY | SEX: M ☐ F ☒

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

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

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):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: M-7

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES ☐ NO ☐

a. INSURED'S DATE OF BIRTH MM DD YY | SEX: M ☐ F ☐

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

b. AUTO ACCIDENT? YES ☐ NO ☐ PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES ☐ NO ☐

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

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

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

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

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

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

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

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

1. 436
2. 437.0
3.
4.

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

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 09 04 05	07 10	11		92507		1	XX XX	3.0				12345678
2 09 07 05		11		92508		1	XX XX	1.0				12345678
3												
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 $ 00.00

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.)

J.M. Authorized MM/DD/YY

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

I.M. Pathologist
1 W. Williams
Anytown, WI 55555

PIN# 87654321 GRP#

CARRIER

PATIENT AND INSURED INFORMATION

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

Appendix 38
General Information About the Birth to 3 Program

Wisconsin Medicaid includes Birth to 3 (B-3) information in this handbook because many B-3 participants are also Medicaid recipients who receive physical therapy (PT), occupational therapy (OT), or speech and language pathology (SLP) services.

To obtain telephone numbers for any of the county B-3 programs in Wisconsin, call the First Step Hotline at (800) 642-STEP (7837).

Requirements for Providers

Title 34 CFR Part 303 for B-3 services requires all health, social service, education, and tribal programs receiving federal funds, including Medicaid providers, to do the following:

- Identify children who may be eligible for B-3 services. This includes children with developmental delays, atypical development, disabilities, and children who are substantiated as abused or neglected. Refer these children to the appropriate county B-3 program within two working days of identification. For example, if a provider's health exam or developmental screen indicates that a child may have a qualifying disability or developmental delay, the child must be referred to the county B-3 program for evaluation. (Providers are encouraged to explain the need for the B-3 referral to the child's parents or guardians.)
- Cooperate and participate with B-3 service coordination as indicated in the child's Individualized Family Services Plan (IFSP).
- Deliver B-3 services in the child's natural environment, unless otherwise specified in the IFSP.
- Assist parents or guardians of children receiving B-3 services to maximize their child's development and participate fully in implementation of their child's IFSP.

Birth to 3 Eligibility Criteria

A child from birth up to (but not including) age 3 is eligible for B-3 services if the child meets one of the following criteria:

- The individual has a diagnosed physical or mental condition that has a high probability of resulting in a developmental delay.
- The individual has at least a 25 percent delay in one or more of the following areas of development:
  - ✓ Cognitive development.
  - ✓ Physical development, including vision and hearing.
  - ✓ Communication skills.
  - ✓ Social or emotional development.
  - ✓ Adaptive development, which includes self-help skills.
- Atypical development affects the child's overall development, as determined by a qualified team using professionally acceptable procedures and informed clinical opinion.

Individualized Family Services Plan

A B-3 participant receives an IFSP developed by an interdisciplinary team that includes the child's family. The IFSP provides a description of the outcomes, strategies, supports, services appropriate to meet the needs of the child and family, and the natural environment settings where services will be provided. All B-3 services must be identified in the child's IFSP.

According to B-3 Program requirements, the child's IFSP service coordinator is responsible for facilitating the development of the IFSP, based on team decisions and consensus. The service coordinator is expected to assure IFSP development in a timely manner and to provide all team members with a full copy of the completed IFSP.

The county B-3 program is responsible for ensuring that:

- Evaluation, service coordination, IFSP development, and protection of rights have no cost to the parents or guardians.
- Other services identified under HFS 90.11(4), Wis. Admin. Code, are provided in accordance with the IFSP.

The county B-3 program determines parental liability for the cost of the program in accordance with state administrative guidelines.

Provision of Services In the Child's Natural Environment

Federal regulations require that providers deliver all B-3 services in the child's "natural environment," to the maximum extent possible. "Natural environment" is defined in both 34 CFR Part 303 and HFS 90.03(25), Wis. Admin. Code, as "settings that are natural or normal for the child's age peers who have no disability." In addition to a family home, natural environments may include family child care, community settings (e.g., YMCA), early childhood education settings, inclusive child care centers, or other settings where most of the children do not have disabilities. Natural environments do not include medical facilities such as therapy clinics, physician clinics, rehabilitation agencies, outpatient hospitals, or other center-based settings where most of the participating children have disabilities. The child's IFSP team determines which settings are appropriate for the delivery of B-3 services based on the needs of the child. Services should be provided in the places where the child's family and other caregivers can be present and learn therapy approaches. Carryover also occurs when approaches are integrated into the day-to-day activities of the child and family.

Birth to 3 services may be provided in a setting other than a natural environment only when outcomes cannot be satisfactorily achieved in the child's natural environment. When services are not provided in a natural environment, the IFSP must include a justification of the extent to which services will be provided in an alternative setting.

Medicaid PT, OT, or SLP providers receive an enhanced reimbursement when PT, OT, or SLP services are provided in the natural environment of a B-3 participant. To receive the enhanced reimbursement, providers are required to indicate the "TL" modifier when submitting claims for services provided in the natural environment.

Administration and Regulations

In Wisconsin, B-3 services are administered at the local level by county departments of community programs, human service departments, public health agencies, or any other public agency designated or contracted by the county board of supervisors. The Department of Health and Family Services monitors, provides technical assistance, and offers other services to county B-3 agencies.

The enabling federal legislation for the B-3 Program is 34 CFR Part 303. The enabling state legislation is s. 51.44, Wis. Stats., and the regulations are found in ch. HFS 90, Wis. Admin. Code.

Appendix 39

Procedures to Follow When the Birth to 3 Agency Pays the Commercial Health Insurance Liability

Federal regulations (34 CFR Part 303) allow a Birth to 3 (B-3) participant's parents or guardians to refuse consent to bill their commercial health insurance if it would result in a cost to the family, such as:

- Reaching the lifetime limit on a policy.
- An increase in premiums, copayments, or deductibles.

Birth to 3 agencies may reimburse the commercial health insurance liability when both of the following occur:

- The Medicaid recipient participates in the B-3 Program and is receiving B-3 services.
- The parents or guardians do not allow their Medicaid provider or Medicaid managed care program to bill their commercial health insurance first.

These procedures do not apply when the following occur:

- The recipient is not covered by commercial health insurance.
- The parents or guardians give consent to submit claims to their commercial health insurance.
- The services are not B-3 services.

When a county B-3 program pays the commercial health insurance liability, the provider is required to follow normal claims submission procedures to submit the balance of the charges to Wisconsin Medicaid.

Step 1 The provider identifies the billed amount per month per therapy discipline.

Step 2 The provider submits the claim to the county B-3 program.

Step 3 The county B-3 program identifies the monthly commercial health insurance liability amount per discipline. The amounts are as follows:

- $127 for PT services.
- $118 for OT services.
- $106 for SLP services.

For any month in which the monthly billed amount is less than the monthly commercial health insurance liability amount, the county B-3 program pays the entire amount owed up to the commercial health insurance liability for that therapy discipline.

Step 4 The county B-3 program pays the commercial health insurance liability amount. When reimbursing the provider, the county B-3 program should send copies of:

- The Explanation of Benefits (EOB) notice.
- The invoice.

When the provider works for the county B-3 program, the provider should clearly identify the accounting transactions in the agency's records. Providers should retain the EOB notice in the recipient's record.

Step 5 When submitting the claim to Wisconsin Medicaid, the provider should indicate his or her usual and customary charge, the amount paid by the B-3 agency, and the appropriate other insurance indicator to indicate that the commercial liability was received.

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