BEHAVIORAL HEALTH REHABILITATION SERVICES PROVIDER HANDBOOK

CONTENTS

I. PROCEDURES TO REQUEST PRIOR AUTHORIZATION OF TSS SERVICES

A. SUPPORTING DOCUMENTATION

Documentation submitted in support of a request for TSS services is expected to reflect the currently requested period of prescribed treatment as dictated by the child's/adolescent's behavioral health treatment needs.

To assess a request to prior authorize (PA) TSS services, the Office of Medical Assistance Programs (OMAP) will review the following information:

1. A properly completed Outpatient Service Authorization Request Form (MA-97). (See Section III.A. – III.C. for an example of a properly completed MA- 97, as well as instructions for completion.)

2. The most recent face-to-face strengths-based Psychiatric or Psychological Evaluation or re-evaluation of the child/adolescent signed by the evaluator/prescriber and performed not more than 60 days prior to the requested begin date of services, or 60 days prior to the continuation of TSS services.

3. One or more Interagency Service Planning Team (ISPT) Sign-In/Concurrence Forms.

    a. If an ISPT meeting was required, the completed ISPT Sign-In/Concurrence Form including an explanation for any disagreement, among team members, with planned service intervention.
    b. If only ISPT input was required, the ISPT Sign-In/Concurrence Form reflecting input (including an explanation for any disagreement among team members) and the completed ISPT Sign-In/Concurrence Form from the initial ISPT meeting.

4. A detailed treatment plan.

5. A complete Plan of Care Summary listing all MA and non-MA funded services the recipient is receiving or is expected to receive during the authorization period.

6. For all TSS services being provided by a subcontractor, a completed copy of the "Subcontract Agreement Form" (see Attachment 4 to MA Bulletin 50-98-05).

A copy of all of the items of supporting documentation described in Items 1-6 must be retained in the recipient's file and made readily available for review and copying by the Department as required under 55 Pa.Code § 1101.51(e).

B. REVIEW OF DOCUMENTATION FOR MEDICAL NECESSITY

In evaluating a request for TSS services, the determination of whether the requested services are medically necessary will take into account the three criteria of Level of Care, Documentation Supporting the Need for Services and Active Treatment, as described below:

1. Level of Care:

Level of care is the intensity of the requested services in relation to the degree of the individual's behavioral health needs. The intensity of service represents the number of hours requested for the prescribed service. The purpose of reviewing for level of care information is to determine if the service intensity being requested is consistent and appropriate for the child's safety and behavioral issues.

Documentation will be reviewed for evidence that the requested hours reflect the requested level of therapeutic services the child is to receive, any safety issues and the degree of psychiatric impairment. Therapeutic services are individual one-to-one, face-to-face interventions to treat a behavioral health need. Safety issues encompass any signs of endangerment or other catastrophic event that exacerbates the child's behavioral symptoms or impacts the parent's ability to manage the child's behavior. Degree of psychiatric impairment relates to diagnosis or severity of the individual's behavior health needs.

All requests are reviewed in relation to whether the request is an initial request or a continued care request. If the request for service is a continued care request, it is reviewed in relation to hours being the same, more or less than previously requested and in relation to the child's progress or lack thereof.

2. Documentation Supporting the Need for Services:

Documentation is information submitted which supports the service requested. Information submitted will be reviewed for evidence that the information explains the rationale for why TSS services rather than other more traditional outpatient treatment services are being requested; describes how the TSS service is anticipated to assist with the child's needs; describes the child and family relationship and their integration into the community; provides a complete treatment history; a diagnosis; a detailed treatment plan with measurable goals and objectives; and any involvement of an interagency team.

Supporting documentation will be reviewed for evidence of the following:

Psychiatric/Psychological Evaluation is expected to outline specific elements of medical necessity and absence of need for psychiatric hospitalization. The evaluation includes a description of the child and the behavioral health problems he or she is experiencing, diagnoses in all five axes, current services being received, and a specific recommendation for TSS services, as well as a complete description of the child in relation to his family and community.

The documentation will be reviewed for evidence that the psychiatric/psychological evaluation includes, at a minimum:

(a) Identifying information that fully describes the child:

i. Name
ii. Age
iii. Sex
iv. Race
v. Family members
vi. Place of residence (family home, group home, RTF, etc.)
vii. Involvement with other child-serving systems, such as Children and Youth Services or Juvenile Justice
viii. School information, including but not limited to, current grade, grades repeated, eligibility for special education and educational programs previously or currently tried
ix. Developmental history, including relevant prenatal history, early milestones, identification of any early illnesses or injuries

(b) Treatment History that provides description of specific mental health or behavioral health rehabilitation services previously provided to the child including, but not limited to, inpatient psychiatric hospitalization, psychiatric partial hospitalization, outpatient clinic services, family-based mental health services, medications, residential treatment facility services, drug and alcohol services, mental retardation services, behavioral health rehabilitation services such as TSS and Mobile Therapy. The Treatment History is expected to include the child's response to treatment.

(c) Mental Status Examination (performed during a face-to-face evaluation) that includes evaluation and documentation of:

i. Presence/Absence of homicidal ideation
ii. Presence/Absence of suicidal ideation-a plan, signs of self-injurious behavior, threats or attempts
iii. Presence/Absence of psychosis-thought content. Any impairment of thinking secondary to mental retardation, developmental delays or organic causes.
iv. Orientation to person, place and time.
v. Manner of Relating-activity level, distractibility, inattentiveness, or aggressiveness.
vi. Goals and ideas-describe the child's, if age appropriate, ideas and understanding of the treatment goals, specific concerns, family relationships and desires for the future.

(d) Child and Family Strengths:

i. The child's and family's strengths and resources
ii. The situations, times, and places when the child functions effectively without support
iii. Each family member's ability to support each other and the child in coping with the child's emotional disturbance
iv. Inter-relationships between family members
v. The other community supports used by the child and family, such as YMCA, Big Brothers, 4-H, etc.

(e) Current Services:

i. List the types of services (mental health, mental retardation, drug and alcohol, etc.) and the frequency, location and length of time the child/family are receiving each service and the child/family's response to the services
ii. If TSS or other behavioral health rehabilitation services are currently being provided to the child and family, include: all behavioral health rehabilitation services being provided (i.e., Mobile Therapy, Behavioral Specialist Consultant), settings where services are provided, intensity (frequency, length of time of each intervention, etc.), goals and objectives of the services, clinical relationship to other behavioral health rehabilitation service, and the child's response to treatment
iii. Medication: If the child is receiving psychotropic medication, list the name of the medication, dosage, presence of side effects and effectiveness. If the child has a diagnosed disorder that is responsive to treatment by medication, but is not taking medication, explain why medication has/is not been used.

(f) Diagnoses in all five axes:

i. Axis I - Major Mental Health Disorders, Drug and Alcohol problems*
ii. Axis II - Developmental Disorders, Personality Disorders*
iii. Axis III - Physical illnesses*
iv. Axis IV - Psychosocial Stressors*
v. Axis V – Children's Global Assessment Scale*

* There must be an entry for all axes. AT A MINIMUM, there should be a diagnosis in either Axis I or II. If no diagnosis applies for a particular axis, please identify with "N/A".

(g) Recommendation for TSS services that specify the number of hours per week of TSS services determined to meet the child's behavioral health needs, specific settings in which TSS services will be provided, and specific interventions and goals to be achieved through delivery of TSS services.

(h) Other Recommendations

Other treatment recommendations, global and specific (e.g., other needed services, interventions for the team to consider; psychotropic medication referral or recommendation; additional assessment(s); community referral(s) and natural supports; consultation with primary care physician).

3. Active Treatment: Active Treatment documentation provides evidence that the child and family are receiving (or will receive if the requested service is approved) effective treatment for the child's behavioral health needs. This documentation will be reviewed for evidence of: caretaker and child participation in the development of the care plan; coordination of care; documentation of clinical improvement or a plan to achieve such improvement; specific goals and objectives for school, home and community-based TSS services and the use of medication if appropriate.

(a) The treatment plan includes a summary of the goals, objectives, and behavioral interventions proposed to address the child's behavioral health issues in the environments in which the child exhibits a behavioral health treatment need; an explanation of the appropriate settings and time allocations for the TSS worker; and a description of any changes or updates from previous treatment plans in

sufficient detail for the reviewer to fully understand the planned goals, objectives, and interventions and their clinical relationship to each other. The individualized treatment plan interventions are to be based on the child's and family's strengths specific to the child/family and not on "typical" interventions used for a certain diagnosis. The supporting documentation will be reviewed for evidence that the treatment plan includes, at a minimum:

i. Specific goals for the child and family and the services requested to meet the goals.
ii. Measurable and/or observable objectives and target dates to be reached by the child and family in order to meet the above identified goals, specific to the environment within which the child's interventions will occur (e.g., school, home, community setting, etc.).
iii. Specific interventions to be used in order to reach the identified objectives and goals, specific to the environment within which they will occur, identifying: the person performing the intervention(s), specific intervention(s) to be used, the setting where the intervention(s) should be used, and specific intervention(s) planned to encourage child and family independence in the management of the behavioral health interventions.

(b) Updating of previous treatment plans to address progress (or lack thereof) toward accomplishment of previously identified goals and/or objectives, new interventions to be used to reach previously identified objectives and identification of new goals, objectives and interventions.

(c) Signature(s) of parent/guardian and child if 14 years of age or older that signifies their input in the development of and agreement with the treatment plan. If a signature cannot be obtained, an explanation for why the signature is not present should be included.

(d) Caretaker/Child Participation - Following Child and Adolescent Services System Program (CASSP) principles, services planned are expected to be child centered and family focused, with the family and the child participating in all stages of decision making and treatment planning. Evidence of this participation is reflected by including the parent and child in the evaluation process, at interagency team meetings, the development of the treatment plan and concurrence of the need for a TSS worker to deliver the planned interventions.

(e) Coordination of Care - The CASSP principles involve a collaboration of multiple systems in order to build on the strengths of the child, family, and community. The collaboration is to result in use of the most appropriate, least restrictive, and least intrusive service available to meet the child and family's needs. Representatives from each system are to participate in goal development. The documentation will be reviewed for evidence of collaboration that includes, at a minimum:

(i) An ISPT meeting or, when TSS services are prescribed after the initial ISPT meeting, ISPT input within 60 days prior to the requested service start date for first authorization requests and for reauthorization requests as the ISPT meeting or ISPT input is required. Documentation provides evidence that the multi-system approach to treatment is being utilized currently for this child's services, unless this is an initial ISPT, and agreement or disagreement with the planned treatment by the parent, child, and all involved agencies including the county MH/MR representative.

(ii) Signature (or documentation of participation by phone) on the ISPT Sign-In/Concurrence Form (Attachment 1), if an ISPT meeting or ISPT input is required. If an ISPT meeting is required and a signature cannot be obtained, an explanation for the reasons why the signature is not present should be included. Interventions discussed at the ISPT meeting or ISPT input should also be included. If only ISPT input is required, submit the ISPT Sign-In/Concurrence Forms from both the initial ISPT meeting and the ISPT input.

(iii) On the ISPT Sign-In/Concurrence Form, documentation of the date that behavioral health services were first requested, whether in writing, by telephone or in person, from a county or BHR service provider; the individual making the request; and the county/BHR service provider to which the request was made, and of the dates of the initial evaluation in which each behavioral health rehabilitation service was prescribed.

(iv) Plan of Care Summary to identify contact/responsible person for each service identified (including Children and Youth caseworker, juvenile probation officer, outpatient clinic, outpatient therapist, etc.)

(f) Clinical Improvement - Clinical improvement is measured by attainment of, or movement towards attainment of, identified goals and objectives through evidence of ongoing assessment and monitoring of the status of progress must be documented.

C. SUBMISSION ADDRESS

The completed packet of PA request information must be sent to:

The Office of Medical Assistance Programs
Prior Authorization (PA) 1150 Waiver Services
P.O. Box 8188
Harrisburg, Pennsylvania 17105-8188

D. TIMEFRAME FOR SUBMISSION

Requests to initiate services should be submitted as soon as possible, and the request must reflect the date on which the provider requests that the TSS services be authorized to begin. OMAP recommends that initial requests be submitted 30 days prior to the requested service start date to assure timely initiation of and continuity of service delivery. Requests to reauthorize services should be submitted 30 days before the end of the current authorization period to ensure continuity of medically necessary care and avoid any breaks in payment for the service delivery. To accommodate situations where requests are submitted less than 30 days before the requested service start date, the PA request will be reviewed for medical necessity and, if approved, authorized as described in Section E below.

E. EFFECTIVE DATE OF APPROVAL

OMAP will review all correctly completed requests for medical necessity and issue a decision within 21 days of receipt. If OMAP fails to issue a decision within 21 days of receipt, the request for service is deemed approved. Requested services determined to be medically necessary will be approved as follows:

- If the request is received before new services are initiated, or before an existing authorization for services expires, OMAP will approve the request as of the begin date of service for the new request period.

Example: If the services are to begin May 1, and the provider's request is received by OMAP by April 1, OMAP will approve medically necessary services effective May 1.

Example: If the approval notice will not be issued until after the anticipated start date. NOTE: If the services are determined not to be medically necessary and the provider initiated services May 1, the provider will not be paid for the services, as the services are non-compensable.

- If the request is received after the services are initiated, OMAP will authorize medically necessary services effective the date the submitted information is received. Any services rendered prior to the date approved by OMAP will not be paid. These services are non-compensable.

  Example: Services are initiated April 1, but, the provider does not submit the properly prepared PA request for approval until April 15. The request is received by OMAP on April 17. If the requested service is determined to be medically necessary, it will be approved as of April 17. Services rendered between April 1 and April 16 inclusive will not be eligible for payment, as the services are non-compensable.

  NOTE: Providers are at risk of nonpayment if they initiate services prior to receiving approval from OMAP.

F. INCORRECT or INCOMPLETE REQUESTS

OMAP will ask the provider for additional information if necessary to assist the medical review staff to reach a decision. If the provider does not provide the additional information in sufficient time for OMAP to consider it before the time for action on the request expires, prior authorization will be denied. To receive authorization to render the services, the provider will have to submit a new and complete request.

G. NOTICE of OMAP'S DECISION

OMAP will issue a prior authorization notice indicating OMAP's decision to the provider, prescriber, recipient, and if requested, the County MH/MR Administrator.

If the request for TSS services is denied or the approved services are different from the services requested, the recipient has the right to appeal the Department's decision. The recipient has 30 days from the date of the prior authorization notice to submit the appeal in writing to the address listed on the notice. If the recipient has been receiving the services that are being reduced, changed, or denied and an appeal is hand delivered or postmarked within 10 days of the date of the notice, the services will continue until a decision is made on the appeal.

H. PROCESSING CHANGES IN PRESCRIPTION

The Department must be made aware of all changes in the prescription, whether an increase or decrease in requested units.

1. A request to increase units during the period already approved by the Department requires prior authorization. The approval for an increase in units will be effective the date the provider is notified of approval of the increase in hours. The approval of an increase in hours per week of TSS services will not exceed the current authorization period. An abbreviated documentation process has been established, requiring:
    a. The completion of the Notification of Increase or Decrease Form (Attachment 2),
    b. A completed MA 97,
    c. A Psychiatric/Psychological Addendum (face-to-face not required),
    d. A revised treatment plan, and
    e. When the request for an increase in TSS services occurs during the authorization period for which an ISPT meeting or ISPT input was required, evidence that the ISPT members have agreed to the increase, or an explanation for any disagreement.

    This information must be sent to the address found in Section I.C. (submission address)

2. A request to decrease units during the prior approval periods does not require prior authorization. A decrease in units will be effective the date of the psychiatric/psychological evaluation. The prescription for the decrease in hours per week of TSS services is not to exceed the current authorization period. However, the Department must be notified. Providers must:
    a. Complete the Notification of Increase or Decrease Form (Attachment 2),
    b. Complete a Psychiatric/Psychological Addendum (face-to-face not required),
    c. When the request for a decrease in TSS services occurs during the authorization period for which an ISPT meeting or ISPT input was required, provide evidence that the ISPT has agreed to the decrease, or an explanation for any disagreement, and
    d. Submit all of the documents to OMAP via facsimile at (717) 705-8179 within 5 business days of the decision to decrease the services.

INTERAGENCY SERVICE PLANNING TEAM SIGN-IN/CONCURRENCE FORM Attachment 1

A COPY OF THE FRONT AND BACK OF THIS FORM MUST BE GIVEN TO THE PARENT/GUARDIAN/RECIPIENT

Recipient Last Name:		Recipient First Name:	
Recipient Identification Number (10 Digits):		Recipient County of Eligibility (2 Numeric Code):	
Date of Meeting (MM/DD/YYYY):			

Dates of Initial Evaluation in which each Behavioral Health Rehabilitation Service was Prescribed (MM/DD/YYYY):

TSS		MT		BSC	

DATE THAT BEHAVIORAL HEALTH SERVICES WERE FIRST REQUESTED: (MM/DD/YYYY): _____

TO WHICH COUNTY/BH-MCO/PROVIDER: _____

BY WHOM: _____RELATIONSHIP TO RECIPIENT:_____

I AGREE THAT THE ABOVE INFORMATION IS CORRECT (PARENT/GUARDIAN/RECIPIENT)

SIGNATURE:

_____

CONFIDENTIAL INFORMATION WILL BE DISCUSSED DURING THIS INTERAGENCY MEETING. MY SIGNATURE BELOW SIGNIFIES THAT I AGREE THAT I WILL NOT DISCLOSE THIS INFORMATION WITHOUT THE APPROPRIATE WRITTEN CONSENT OF THE PARENT/GUARDIAN/RECIPIENT AND AS PERMITTED BY STATE AND FEDERAL LAWS AND REGULATIONS. AT THE END OF THE MEETING I ALSO INDICATED WHETHER I AGREE OR DISAGREE WITH THE GOALS OF THE TREATMENT PLAN, RECOMMENDED SERVICES, AND THE PLAN OF CARE SUMMARY DEVELOPED DURING THIS MEETING.

Name (include title or credentials)	Relationship to child/adolescent	Agency (if applicable) and PHONE #	Agree	Disagree*	Method of Participation**

*Any disagreement must be explained in a memo that is included in the child/adolescent's record and included with the Outpatient Services Authorization Request (MA-97) if applicable.

** P= In Person S=Speakerphone RO=Report Only (Not present, but submitted information) NP=Invited but not present (include explanation for absence).

THERE IS IMPORTANT INFORMATION ON THE BACK OF THIS FORM.

In completing the field “Date That Behavioral Health Services Were First Requested”, please fill in the date that you (or someone else with your consent) first asked any BHR (wrap-around) provider, county MH/MR worker or behavioral health managed care plan for assistance in obtaining behavioral health services. Also fill in the name of the agency, county or MCO that was asked for assistance, the name of the person (maybe you) who asked and that person’s relationship to your child.

Any complaints and problems associated with access to services should be initially directed to providers, counties or managed care organizations (if applicable). Complaints and problems not resolved in a timely manner can be directed to the following contacts in the Commonwealth’s regional field offices of the Office of Mental Health and Substance Abuse Services:

REGIONAL FIELD OFFICE	TELEPHONE#
Northeast (Scranton) Field Office	570-963-4335
Southeast (Norristown) Field Office	610-313-5844
Central (Harrisburg) Field Office	717-705-8396
Western (Pittsburgh) Field Office	412-565-5226

Attachment 2

NOTIFICATION OF CHANGES IN PRESCRIPTION FOR TSS SERVICES

1. Provider Name: _____
2. Provider Number: _____
3. Provider Contact Person: _____
4. Provider Contact Person's Phone Number: (____) ____-_____
5. Prior Authorization Number: _____
6. Recipient's Name: _____
7. Recipient's MA Number: _____
8. Initial Prescription's Total Number of Units*: _____
9. Number of Units approved through Prior Authorization: _____
10. New Prescription's Total Number of Units: _____

A Psychiatric/Psychological Addendum MUST be attached for all increases or decreases in the recipient's prescription. (Face-to-face is not required).

*One Unit of TSS equals ½ hour of face-to-face service.

II. EXPEDITED REVIEW PROCESS (FEE-FOR-SERVICE)

There may be a situation in which the child/adolescent is at immediate risk of a more restrictive placement and/or the child/adolescent's behavioral or emotional disorder warrants a more expeditious review than the usual 21-day review of a request for behavioral health rehabilitation services that must be prior authorized. Those situations involve transition (movement of a child)[1], risk of out of home placement of child[2], a family crisis[3] or some other similarly unexpected or unanticipated need for services. Requests for reauthorization of services are not expected to be expedited reviews.

A. PROCEDURE

(1) The prescriber or provider must submit all of the documentation described in Section I.A. of the Procedures to Request Prior Authorization and Submit Claims for Therapeutic Staff Support (TSS) Services Section. This information is to be forwarded to:

The Office of Medical Assistance Programs
Prior Authorization (PA) 1150 Waiver Services
P.O. Box 8188
Harrisburg, Pennsylvania 17105-8188

(2) At the same time the prescriber or provider submits the MA 97 packet to OMAP, the prescriber/provider must contact the County MH/MR Administrator (of the child's county of residence) or designee to request an expedited review, and describe the child/adolescent's presenting psychiatric status that warrants an expedited review. The County MH/MR Administrator will be responsible for the completion of The Request For Expedited Behavioral Health Rehabilitation Services (Fee-For-Service) form (Attachment 3) within one business day of the request, identifying whether expedited review is needed because of transition, placement, family crisis or some other similarly unexpected or unanticipated need.

B. PROCESS

If the County MH/MR Administrator or designee agrees with the need for an expedited review, the County Administrator will notify the appropriate OMHSAS Field Office (Pittsburgh, Harrisburg, Scranton, Philadelphia) staff of the request. The OMHSAS Field Office staff must have a plan for phone coverage to respond to requests whenever the designated staff person is unavailable.

If the Field Office agrees with the request, within one business day the Field Office will:

(1) Sign the Request For Expedited Behavioral Health Rehabilitation Services form,
(2) Telephone OMAP to notify it of the request, and
(3) Forward the request to OMAP, via facsimile. OMAP will review the request for medical necessity and render a decision within three business days of receipt of the Request for Expedited Behavioral

Health Rehabilitation Services Form, provided OMAP has received the MA 97 packet. If OMAP has not received the MA 97 packet, OMAP will render a decision within three business days of the receipt of the MA 97 packet.

If the Field Office does not agree with the necessity for an Expedited Review, the Field Office will communicate this action to the County MH/MR Administrator who will in turn notify the prescriber or provider that the request should be submitted as a routine prior authorization request. (See directions under Section I.A.)

If there is no response by either the County MH/MR Administrator or the OMHSAS Field Office staff within two business days, the prescriber or provider may contact the OMHSAS Field Office staff.

[1]Transition involves movement of a child from
(a) inpatient hospitalization to home, or
(b) residential setting to home.

[2]Placement - Prevent placement into
(a) inpatient psychiatric facility, or
(b) mental health residential facility.

[3]Family crisis - Disruption of family capacity to provide for the behavioral health needs of the child.

Attachment 3

REQUEST FOR EXPEDITED BEHAVIORAL HEALTH SERVICES
(FEE-FOR-SERVICE)

1. RECIPIENT'S NAME: _____
   RECIPIENT #: _____

2. COUNTY: _____

3. PROVIDER CONTACT PERSON: _____
   PROVIDER NAME: _____
   PHONE NUMBER: (___) ___-____
   FAX NUMBER: (___) ___-____
   ADDRESS: _____

4. PRESCRIBER NAME :_____
   PHONE NUMBER: (___) ___-____
   FAX NUMBER: (___) ___-____

5. SERVICE REQUESTED: _____
   UNITS REQUESTED: _____
   DATE REQUESTED_____
   START DATE REQUESTED: _____

6. REASON FOR EXPEDITED REVIEW Describe the child's/adolescent's psychiatric/ behavioral status that warrants a review.

_____

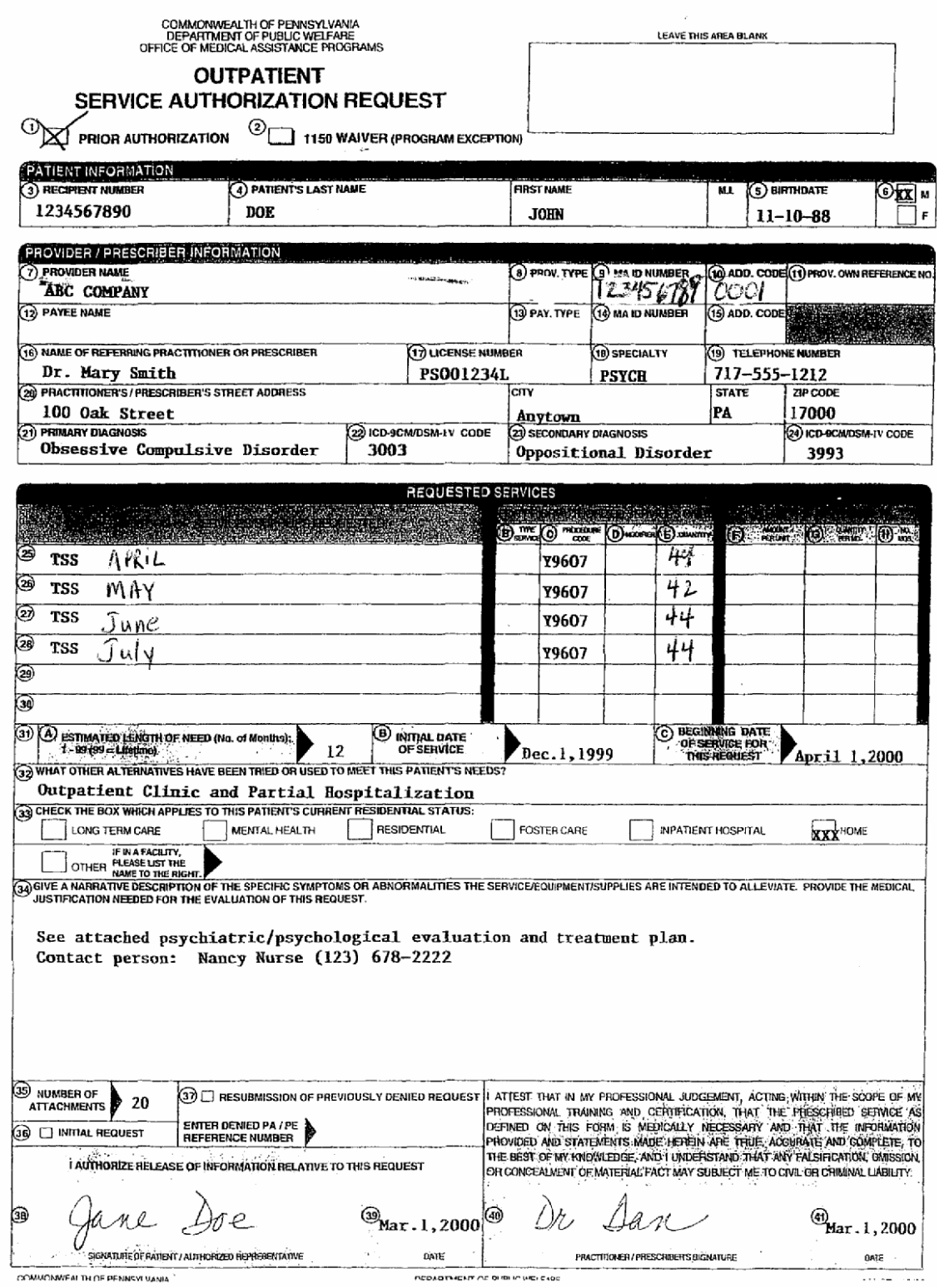
SIGNATURE of OMHSAS FIELD OFFICE STAFF

_____

PHONE NUMBER

III. FORMS AND INSTRUCTIONS

A. EXAMPLE OF COMPLETED MA-97 FORM



COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE
OFFICE OF MEDICAL ASSISTANCE PROGRAMS

LEAVE THIS AREA BLANK

OUTPATIENT
SERVICE AUTHORIZATION REQUEST

(1) [X] PRIOR AUTHORIZATION (2) [ ] 1150 WAIVER (PROGRAM EXCEPTION)

PATIENT INFORMATION

(3) RECIPIENT NUMBER	(4) PATIENT'S LAST NAME	FIRST NAME	M.I.	(5) BIRTHDATE	(6)
1234567890	DOE	JOHN		11-10-88	[XX] M [ ] F

PROVIDER / PRESCRIBER INFORMATION

(7) PROVIDER NAME	(8) PROV. TYPE	(9) MA ID NUMBER	(10) ADD. CODE	(11) PROV. OWN REFERENCE NO.
ABC COMPANY		12345678	0001	

(12) PAYEE NAME	(13) PAY. TYPE	(14) MA ID NUMBER	(15) ADD. CODE

(16) NAME OF REFERRING PRACTITIONER OR PRESCRIBER	(17) LICENSE NUMBER	(18) SPECIALTY	(19) TELEPHONE NUMBER
Dr. Mary Smith	PS001234L	PSYCH	717-555-1212

(20) PRACTITIONER'S / PRESCRIBER'S STREET ADDRESS	CITY	STATE	ZIP CODE
100 Oak Street	Anytown	PA	17000

(21) PRIMARY DIAGNOSIS	(22) ICD-9CM/DSM-IV CODE	(23) SECONDARY DIAGNOSIS	(24) ICD-9CM/DSM-IV CODE
Obsessive Compulsive Disorder	3003	Oppositional Disorder	3993

REQUESTED SERVICES

	(B) TYPE SERVICE	(C) PROCEDURE CODE	(D) MODIFIER	(E) QUANTITY	(F) AMOUNT BILLED	(G) QUANTITY PAYABLE	(H) NO. DAYS
(25) TSS APRIL		T9607		44			
(26) TSS MAY		T9607		42			
(27) TSS June		T9607		44			
(28) TSS July		T9607		44			
(29)							
(30)							

(31) (A) ESTIMATED LENGTH OF NEED (No. of Months): 1 - 99 (99 = Lifetime) 12 (B) INITIAL DATE OF SERVICE Dec.1,1999 (C) BEGINNING DATE OF SERVICE FOR THIS REQUEST April 1,2000

(32) WHAT OTHER ALTERNATIVES HAVE BEEN TRIED OR USED TO MEET THIS PATIENT'S NEEDS?
Outpatient Clinic and Partial Hospitalization

(33) CHECK THE BOX WHICH APPLIES TO THIS PATIENT'S CURRENT RESIDENTIAL STATUS:
[ ] LONG TERM CARE [ ] MENTAL HEALTH [ ] RESIDENTIAL [ ] FOSTER CARE [ ] INPATIENT HOSPITAL [XXX] HOME
[ ] OTHER IF IN A FACILITY, PLEASE LIST THE NAME TO THE RIGHT.

(34) GIVE A NARRATIVE DESCRIPTION OF THE SPECIFIC SYMPTOMS OR ABNORMALITIES THE SERVICE/EQUIPMENT/SUPPLIES ARE INTENDED TO ALLEVIATE. PROVIDE THE MEDICAL JUSTIFICATION NEEDED FOR THE EVALUATION OF THIS REQUEST.

See attached psychiatric/psychological evaluation and treatment plan.
Contact person: Nancy Nurse (123) 678-2222

(35) NUMBER OF ATTACHMENTS 20
(36) [ ] INITIAL REQUEST
(37) [ ] RESUBMISSION OF PREVIOUSLY DENIED REQUEST
ENTER DENIED PA / PE REFERENCE NUMBER

I AUTHORIZE RELEASE OF INFORMATION RELATIVE TO THIS REQUEST

(38) Jane Doe — SIGNATURE OF PATIENT / AUTHORIZED REPRESENTATIVE
(39) Mar.1,2000 — DATE

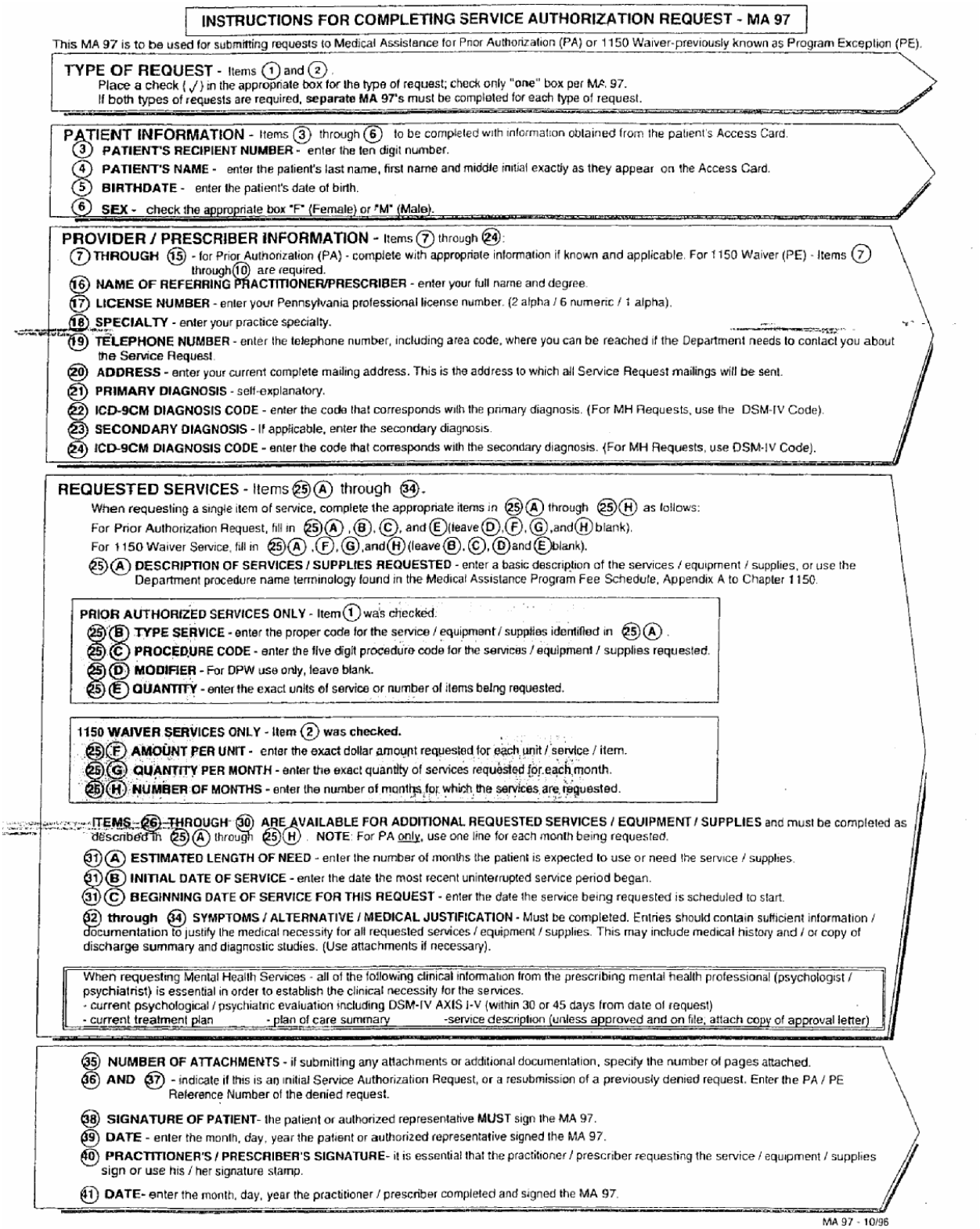
I ATTEST THAT IN MY PROFESSIONAL JUDGEMENT, ACTING WITHIN THE SCOPE OF MY PROFESSIONAL TRAINING AND CERTIFICATION, THAT THE PRESCRIBED SERVICE AS DEFINED ON THIS FORM IS MEDICALLY NECESSARY AND THAT THE INFORMATION PROVIDED AND STATEMENTS MADE HEREIN ARE TRUE, ACCURATE AND COMPLETE, TO THE BEST OF MY KNOWLEDGE, AND I UNDERSTAND THAT ANY FALSIFICATION, OMISSION, OR CONCEALMENT OF MATERIAL FACT MAY SUBJECT ME TO CIVIL OR CRIMINAL LIABILITY.

(40) Dr Dan — PRACTITIONER / PRESCRIBER'S SIGNATURE
(41) Mar.1,2000 — DATE

COMMONWEALTH OF PENNSYLVANIA — DEPARTMENT OF PUBLIC WELFARE

B. INSTRUCTIONS FOR COMPLETION OF THE MA-97 (Reverse side of MA-97)

Updated instructions for completion of the MA-97 form are on the WEB at
http://www.dpw.state.pa.us/omap/provinf/maforms/omapma97.pdf



INSTRUCTIONS FOR COMPLETING SERVICE AUTHORIZATION REQUEST - MA 97

This MA 97 is to be used for submitting requests to Medical Assistance for Prior Authorization (PA) or 1150 Waiver-previously known as Program Exception (PE).

TYPE OF REQUEST - Items (1) and (2).
Place a check (√) in the appropriate box for the type of request; check only "one" box per MA 97.
If both types of requests are required, **separate MA 97's** must be completed for each type of request.

PATIENT INFORMATION - Items (3) through (6) to be completed with information obtained from the patient's Access Card.
(3) **PATIENT'S RECIPIENT NUMBER** - enter the ten digit number.
(4) **PATIENT'S NAME** - enter the patient's last name, first name and middle initial exactly as they appear on the Access Card.
(5) **BIRTHDATE** - enter the patient's date of birth.
(6) **SEX** - check the appropriate box "F" (Female) or "M" (Male).

PROVIDER / PRESCRIBER INFORMATION - Items (7) through (24):
(7) **THROUGH** (15) - for Prior Authorization (PA) - complete with appropriate information if known and applicable. For 1150 Waiver (PE) - Items (7) through (10) are required.
(16) **NAME OF REFERRING PRACTITIONER/PRESCRIBER** - enter your full name and degree.
(17) **LICENSE NUMBER** - enter your Pennsylvania professional license number. (2 alpha / 6 numeric / 1 alpha).
(18) **SPECIALTY** - enter your practice specialty.
(19) **TELEPHONE NUMBER** - enter the telephone number, including area code, where you can be reached if the Department needs to contact you about the Service Request.
(20) **ADDRESS** - enter your current complete mailing address. This is the address to which all Service Request mailings will be sent.
(21) **PRIMARY DIAGNOSIS** - self-explanatory.
(22) **ICD-9CM DIAGNOSIS CODE** - enter the code that corresponds with the primary diagnosis. (For MH Requests, use the DSM-IV Code).
(23) **SECONDARY DIAGNOSIS** - If applicable, enter the secondary diagnosis.
(24) **ICD-9CM DIAGNOSIS CODE** - enter the code that corresponds with the secondary diagnosis. (For MH Requests, use DSM-IV Code).

REQUESTED SERVICES - Items (25)(A) through (34).
When requesting a single item of service, complete the appropriate items in (25)(A) through (25)(H) as follows:
For Prior Authorization Request, fill in (25)(A), (B), (C), and (E) (leave (D), (F), (G), and (H) blank).
For 1150 Waiver Service, fill in (25)(A), (F), (G), and (H) (leave (B), (C), (D) and (E) blank).
(25)(A) **DESCRIPTION OF SERVICES / SUPPLIES REQUESTED** - enter a basic description of the services / equipment / supplies, or use the Department procedure name terminology found in the Medical Assistance Program Fee Schedule, Appendix A to Chapter 1150.

PRIOR AUTHORIZED SERVICES ONLY - Item (1) was checked.
(25)(B) **TYPE SERVICE** - enter the proper code for the service / equipment / supplies identified in (25)(A).
(25)(C) **PROCEDURE CODE** - enter the five digit procedure code for the services / equipment / supplies requested.
(25)(D) **MODIFIER** - For DPW use only, leave blank.
(25)(E) **QUANTITY** - enter the exact units of service or number of items being requested.

1150 WAIVER SERVICES ONLY - Item (2) was checked.
(25)(F) **AMOUNT PER UNIT** - enter the exact dollar amount requested for each unit / service / item.
(25)(G) **QUANTITY PER MONTH** - enter the exact quantity of services requested for each month.
(25)(H) **NUMBER OF MONTHS** - enter the number of months for which the services are requested.

ITEMS (26) THROUGH (30) ARE AVAILABLE FOR ADDITIONAL REQUESTED SERVICES / EQUIPMENT / SUPPLIES and must be completed as described in (25)(A) through (25)(H). **NOTE**: For PA only, use one line for each month being requested.
(31)(A) **ESTIMATED LENGTH OF NEED** - enter the number of months the patient is expected to use or need the service / supplies.
(31)(B) **INITIAL DATE OF SERVICE** - enter the date the most recent uninterrupted service period began.
(31)(C) **BEGINNING DATE OF SERVICE FOR THIS REQUEST** - enter the date the service being requested is scheduled to start.
(32) **through** (34) **SYMPTOMS / ALTERNATIVE / MEDICAL JUSTIFICATION** - Must be completed. Entries should contain sufficient information / documentation to justify the medical necessity for all requested services / equipment / supplies. This may include medical history and / or copy of discharge summary and diagnostic studies. (Use attachments if necessary).

When requesting Mental Health Services - all of the following clinical information from the prescribing mental health professional (psychologist / psychiatrist) is essential in order to establish the clinical necessity for the services.
- current psychological / psychiatric evaluation including DSM-IV AXIS I-V (within 30 or 45 days from date of request)
- current treatment plan - plan of care summary -service description (unless approved and on file, attach copy of approval letter)

(35) **NUMBER OF ATTACHMENTS** - if submitting any attachments or additional documentation, specify the number of pages attached.
(36) **AND** (37) - indicate if this is an initial Service Authorization Request, or a resubmission of a previously denied request. Enter the PA / PE Reference Number of the denied request.
(38) **SIGNATURE OF PATIENT**- the patient or authorized representative **MUST** sign the MA 97.
(39) **DATE** - enter the month, day, year the patient or authorized representative signed the MA 97.
(40) **PRACTITIONER'S / PRESCRIBER'S SIGNATURE**- it is essential that the practitioner / prescriber requesting the service / equipment / supplies sign or use his / her signature stamp.
(41) **DATE**- enter the month, day, year the practitioner / prescriber completed and signed the MA 97.

MA 97 - 10/96

C. TSS SPECIFIC INSTRUCTIONS FOR COMPLETING MA-97

Item 17 License Number (of referring practitioner or prescriber) MUST

Items 25-28 (A) Description of the services requested MUST
Use one line for each month of TSS services requested.

(B) Type Service "TS" LEAVE BLANK

(C) Procedure Code "Y9607" MUST

(D) Modifier LEAVE BLANK

(E) Quantity MUST
Enter the exact number of units ordered.
TSS must be requested in ½ hour increments.

Item 34 Narrative Description of the specific symptoms. MUST
Enter the name and telephone number of a contact person at the enrolled provider's office.

D. Instructions for Completing the ISPT Sign-In/Concurrence Form

The revised ISPT Sign-In/Concurrence Form must be used at ISPT meetings held on or after the effective date of MA Bulletin 08-04-05 et al. Requests for prior authorization of services submitted on or after January 1, 2005, for which an ISPT meeting or input is required, must include an accurately completed revised ISPT Sign-In/Concurrence Form.

In the fee-for-service delivery system, the ISPT Sign-In/Concurrence Form may not be altered.

- Complete the "recipient identification number" field with the recipient's CIS NUMBER (10 digits)
- Complete the "recipient county of eligibility" field with the 2 digit numeric code assigned to the county in which the recipient was determined eligible for MA (See Attachment A for a list of the numeric codes assigned to each county).

The sections of the ISPT Sign-In/Concurrence Form the "date that behavioral health services were first requested" and the "dates of initial evaluation in which each behavioral health rehabilitation service was prescribed" should be completed for children/adolescents whose initial evaluations were on or after the effective date of MA Bulletin 08-04-05 et al. These fields must be completed on subsequent ISPT Sign-In/Concurrence Forms, but the information will change only if a new service is prescribed.

- Complete the "date that behavioral health services were first requested date" field with the date that behavioral health services were first requested by the family or by a representative of the family acting with the concurrence of the family from a county, a BH-MCO, or a BHR service provider.

- Complete the "dates of initial evaluation in which each behavioral health rehabilitation service was prescribed - TSS, MT, BSC" field(s) with the date of the initial psychiatric or psychological evaluation prescribing the individual BHR service.

An initial evaluation is an evaluation in which each BHR service was first prescribed. If more than one service was prescribed in the same evaluation, the date of that evaluation should be entered in the field for each service that was prescribed. If a particular service was not prescribed, a zero should be entered in that field. If a particular service was added either by a psychological or psychiatric addendum or by a subsequent evaluation, the date of the addendum or evaluation that added the service should be inserted in the field for that service.

If the initial evaluation in which a BHR service was prescribed was prior to the effective date of MA Bulletin 08-04-05 et al., a zero should be entered in the "Dates of Initial Evaluation in which each Behavioral Health Rehabilitation Service was Prescribed" and the "Date That Behavioral Health Services Were First Requested" fields.

COUNTY CODES (Use One Only)

01 Adams
02 Allegheny
03 Armstrong
04 Beaver
05 Bedford
06 Berks
07 Blair
08 Bradford
09 Bucks
10 Butler
11 Cambria
12 Cameron
13 Carbon
14 Centre
15 Chester
16 Clarion
17 Clearfield
18 Clinton
19 Columbia
20 Crawford
21 Cumberland
22 Dauphin
23 Delaware
24 Elk
25 Erie
26 Fayette
27 Forest
28 Franklin
29 Fulton
30 Greene
31 Huntingdon
32 Indiana
33 Jefferson
34 Juniata
35 Lackawanna
36 Lancaster
37 Lawrence
38 Lebanon
39 Lehigh
40 Luzerne
41 Lycoming
42 McKean
43 Mercer
44 Mifflin
45 Monroe
46 Montgomery
47 Montour
48 Northampton
49 Northumberland
50 Perry
51 Philadelphia
52 Pike
53 Potter
54 Schuylkill
55 Snyder
56 Somerset
57 Sullivan
58 Susquehanna
59 Tioga
60 Union
61 Venango
62 Warren
63 Washington
64 Wayne
65 Westmoreland
66 Wyoming
67 York

CMS-1500 Billing Guide for PROMISe™ Therapeutic Staff Support (TSS)/Mobile Therapy/Behavioral Specialist Consultant Providers

Purpose of the document

The purpose of this document is to provide a block-by-block reference guide to assist the following provider types in successfully completing the CMS-1500 claim form:

- **Therapeutic Staff Support**
- **Mobile Therapy**
- **Behavioral Specialist Consultant**

Document format

This document contains a table with four columns. Each column provides a specific piece of information as explained below:

- **Block Number** – Provides the block number as it appears on the claim.
- **Block Name** – Provides the block name as it appears on the claim.
- **Block Code** – Lists a code that denotes how the claim block should be treated. They are:
  - **M** – Indicates that the claim block must be completed.
  - **A** – Indicates that the claim block must be completed, if applicable.
  - **O** – Indicates that the claim block is optional.
  - **LB** – Indicates that the claim block should be left blank.
  - *** –** Indicates special instruction for block completion.
- **Notes** – Provides important information specific to completing the claim block. In some instances, the Notes section will indicate provider specific block completion instructions.

CMS-1500 Billing Guide for PROMISe™ TSS/Mobile Therapy/BSC Services Providers

IMPORTANT INFORMATION FOR CMS-1500 CLAIM FORM COMPLETION

Note #1: If you are submitting handwritten claim forms you must use **blue** or **black** ink.

Note #2 When completing the following blocks of the CMS-1500, **do not use decimal points and be sure to enter dollars and cents**:

1. Block 24F ($Charges)
2. Block 24K (Reserved for Local Use)
3. Block 28 (Total Charge)
4. Block 29 (Amount Paid)

If you fail to enter both dollars and cents, your claim may process incorrectly. For example, if your usual charge is sixty-five dollars and you enter 65, your usual charge may be read as .65 cents.

Example #1: When completing Block 24F, enter your usual charge to the general public, without a decimal point. You must include the dollars and cents. If your usual charge is sixty-five dollars, enter:

24F	
$CHARGES	
65	00

Example #2: When completing Block 24K, you are reporting a payment from an insurance company other than Medicare. Enter the payment as follows, including dollars and cents:

24K
RESERVED FOR LOCAL USE
2200

Example #3: When completing Block 28, you are reporting the sum of claim line charges. Enter the total charge as follows, including dollars and cents:

28	
Total Charges	
65	00

Example #4: When completing Block 29, you are reporting patient pay assigned by the County Assistance Office (CAO). Enter patient pay as follows, including dollars and cents:

29	
Amount Paid	
50	00

CMS-1500 Billing Guide for PROMISe™ TSS/Mobile Therapy/BSC Services Providers

You must follow these instructions to complete the CMS-1500 claim when billing Medical Assistance. **Do not imprint, type, or write any information on the upper right hand portion of the form.** This area is used to stamp the Internal Control Number (ICN), which is vital to the processing of your claim. Do not submit a photocopy of your claim to Medical Assistance.

Block No.	Block Name	Block Code	Notes
1	Type of Claim	M	Place an **X** in the Medicaid box.
1a	Insured's ID Number	M	Enter the 10-digit recipient number found on the ACCESS card. If the recipient number is not available, access the Eligibility Verification System (EVS) by using the recipient's Social Security Number (SSN) and date of birth (DOB). The EVS response will then provide the 10-digit recipient number to use for this block.
2	Patient's Name	O	It is recommended that this field be completed to enable Medical Assistance (MA) to research questions regarding a claim.
3	Patient's Birthdate and Sex	O	Enter the patient's date of birth using an 8-digit MM|DD|CCYY (month, day, century, and year) format (e.g., 02|15|1978) and indicate the patient's gender by placing an X in the appropriate box.
4	Insured's Name	A	If the patient has health insurance other than MA, list the name of the insured here. Enter the name of the insured except when the insured and the patient are the same - then the word **SAME** may be entered. If there is no other insurance other than MA, leave this block blank.
5	Patient's Address	O	Enter the patient's address.
6	Patient's Relationship to the Insured	A	Check the appropriate box for the patient's relationship to the insured listed in Block 4.

CMS-1500 Billing Guide for PROMISe™ TSS/Mobile Therapy/BSC Services Providers

Block No.	Block Name	Block Code	Notes
7	Insured's Address	A	Enter the insured's address and telephone number except when the address is the same as the patient's, then enter the word **SAME**. Complete this block only when Block 4 is completed.
8	Patient Status	O	Place an **X** in the appropriate blocks to describe the patient's status.
Please note that Blocks 9, and 9a through 9d are used to indicate **Secondary** insurance information. For example, if a recipient has Aetna, Blue Shield, and Medical Assistance, the information regarding Aetna (the primary payer) would be placed in Blocks 11 and 11a through 11d. The information regarding Blue Shield (the secondary payer) would be placed in Blocks 9 and 9a through 9d.			
9	Other Insured's Name	A	If the patient has another health insurance secondary to the insurance named in Block 11, enter the last name, first name, and middle initial of the insured if it is different from the patient named in Block 2. If the patient and the insured are the same, enter the word **SAME.** If the patient has MA coverage only, leave the block blank.
9a	Other Insured's Policy and Group Number	A	This block is identifies a secondary insurance other than MA, **and** the primary insurance listed in 11a-d. Enter the policy number and the group number of any secondary insurance that is available. Only use Blocks 9a-d, if you have completed Blocks 11a-d, and a secondary policy is available. (For example, the patient may have both Blue Cross and Aetna benefits available.)
9b	Other Insured's Date of Birth	A	If a secondary insurance exists, enter the other insured's date of birth. Please make sure the date is in an 8-digit MM|DD|CCYY (month, day, century, and year) format (e.g., 03|01|1978) and indicate the patient's gender by placing an X in the appropriate box.
9c	Employer's Name or School Name	A	Enter the name of the other insured's employer.

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Block No.	Block Name	Block Code	Notes
9d	Insurance Plan Name or Group Name	A	Enter the other insured's insurance plan name or group name.
10a-10c	Is Patient's Condition Related To:	A	Complete the block by placing an **X** in the appropriate **YES** or **NO** box to indicate whether the patient's condition is related to employment, auto accident, or other accident (e.g., liability suit) as it applies to one or more of the services described in Block 24d. For auto accidents, enter the state's 2-digit postal code for the state in which the accident occurred in the PLACE block (e.g., PA for Pennsylvania).
10d	Reserved For Local Use	O	It is optional to enter the 9-digit social security number of the policyholder if the policyholder is not the recipient.
Please note that Blocks 11, and 11a through 11d are used to indicate **Primary** insurance information. For example, if a recipient has Aetna and Medical Assistance, the information regarding Aetna (the primary payer) would be placed in Blocks 11 and 11a through 11d. If the recipient has two other insurance plans, for example, Aetna, Blue Shield, and Medical Assistance, the information regarding Aetna would be placed in Blocks 11, 11a through 11d and the Blue Shield (the secondary payer) information would be placed in Blocks 9 and 9a through 9d.			
11	Insured's Policy Group or FECA Number	A/A	Enter the policy number and group number of the primary insurance other than MA.
11a	Insured's Date of Birth and Sex	A/A	Enter the insured's date of birth in an 8-digit MM|DD|CCYY (month, day, century, and year) format (e.g., 03|01|1978) and insured's gender if it is different than Block 3.
11b	Employer's Name or School Name	A	Enter the name of the other insured's employer for the primary insurance.

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Block No.	Block Name	Block Code	Notes
11c	Insurance Plan Name or Program Name	A	List the name and address of the primary insurance listed in Block 11.
11d	Is There Another Health Benefit Plan?	A	If the patient has another resource available to pay for the service, bill the other resource before billing MA. If the **YES** box is checked, Blocks 9a-d must be completed with the information on the additional resource.
12	Patient's or Authorized Person's Signature and Date	M/M	The recipient's signature or **Signature Exception** must appear in this field. Also, enter the date of claim submission in an 8-digit MMDDCCYY format (e.g., 03012004) with no slashes, hyphens, or dashes.) **Note:** Please refer to Section 6 of the PA PROMISe™ Provider Handbook for the 837 Professional/CMS-1500 Claim Form for additional information on obtaining patients signatures.
13	Insured's or Authorized Person's Signature	O	If completed, this block should contain the signature of the insured, if the insured is not the patient.
14	Date of Current:	O	If completed, enter the date of the current illness (first symptom), injury (accident date), or pregnancy in an 8-digit MM|DD|CCYY (month, day, century, and year) format (e.g., 03|01|2004).
15	If Patient Has Had Same or Similar Illness	O	If the patient has had the same or similar illness, list the date of the first onset of the illness in an 8-digit MM|DD|CCYY (month, day, century, and year) format (e.g., 03|01|2002).

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Block No.	Block Name	Block Code	Notes
16	Dates Patient Unable to Work in Current Occupation	O	If completed, enter the **FROM** and **TO** dates in an 8-digit MM|DD|CCYY (month, day, century, and year) format (e.g., 03|01|2003), only if the patient is unable to work due to the current illness or injury. This block is only necessary for Worker's Compensation cases. It must be left blank for all other situations.
17	Name of Referring Physician or Other Source	M	Enter the name and degree of the referring or prescribing practitioner, when applicable.
17A	I.D. Number of Referring Physician	M	Enter the **license number** of the referring or prescribing practitioner named in Block 17 (e.g., MD123456X). If the practitioner's license number was issued after June 29, 2001, enter the number in the new format (e.g., MD123456). If an out-of-state provider orders the service, enter the 2-digit State abbreviation, followed by six 9's, and an X. For example, a prescribing practitioner from New Jersey would be entered as NJ999999X.
18	Hospitalization Dates Related to Current Services	LB	Do not complete this block.

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Block No.	Block Name	Block Code	Notes
19	Reserved For Local Use	A/A	This field must be completed with attachment type codes, when applicable. Attachment type codes begin with the letters "AT", followed by a 2-digit number (i.e., AT05). Enter up to four, 4-character alphanumeric attachment type codes. When entering more than one attachment type code, separate the codes with a comma (,). DPW does not require that you attach insurance statements to the claim **(with the exception of Medicare claims). (If the recipient has Medicare and MA, see *note on the following page.)** However, the type of statements on file is required, and the codes in this block provide that information. Attachment Type Code AT99 indicates that remarks are attached. Remarks must be placed on an 8-1/2" x 11" sheet of white paper clipped to your claim. Remember, when you have a remarks sheet attached, include your provider number and the recipient's number on the top left-hand corner of the page. *For a complete listing and description of Attachment Type Codes, please refer to the CMS-1500 Claim Form Desk Reference, located in Appendix A of the handbook.*
		A	**Qualified Small Businesses** Qualified small businesses must always enter the following message in Block 19 (Reserved for Local Use) of the CMS-1500, in addition to any applicable attachment type codes: "(Name of Vendor) is a qualified small business concern as defined in 4 Pa Code §2.32."

***Note:** If the recipient has coverage through Medicare Part B and MA, this claim should automatically cross over to MA for payment of any applicable deductible or co-insurance. If the claim does not cross over from Medicare and you are submitting the claim directly to MA, enter AT05 in Block 19 and attach the Explanation of Medicare Benefits to the claim. Do not show any amount in Block 24K. See MA Bulletin 99-94-07 for more details.

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Block No.	Block Name	Block Code	Notes
20	Outside Lab?	LB	Do not complete this block.
21	Diagnosis or Nature of Illness or Injury	M/A	Enter the most specific 3-4-or 5-digit ICD-9-CM code that describes the diagnosis. The primary ICD-9-CM code (21.1) must be completed. The secondary, tertiary, and fourth diagnosis codes are must if applicable.
22	Medicaid Resubmission	A/A	This block has two uses: 1) When resubmitting a rejected claim. If resubmitting a rejected claim, enter the 13-digit internal control number (ICN) of the **ORIGINAL** rejected claim in the right portion of this block (e.g., | 1103123523123). 2) When submitting a claim adjustment for a previously approved claim**.** If submitting a claim adjustment, enter ADJ in the left portion of the block and the **LAST APPROVED** 13-digit ICN, a space and the 2-digit line number from the RA Statement in the right portion of the block (e.g., ADJ | 1103123523123 01). **Note:** If your claim was submitted prior to the implementation of PROMISe™, enter the 10-digit claim reference number (CRN) in place of the ICN.

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Block No.	Block Name	Block Code	Notes
23	Prior Authorization Number	A	Enter the 10-digit authorization number, when applicable. **Prior Authorization and Program Exception (PE.) –** If services were approved through PA or PE, the authorization number must be entered in this block. **Do not include prior authorized services on the same claim with services that do not require prior authorization**. Failure to follow this instruction will cause your claim(s) to deny. Although your services may have been prior authorized or approved via Program Exception with "Z" modifiers for monthly billing, ***do not use the "Z" modifiers*** when submitting claims to PROMISe™. Refer to Section 7 of the CMS-1500 Provider Handbook for additional information regarding prior authorization and your specific provider type.

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Block No.	Block Name	Block Code	Notes
24A	Dates of Service	M/M	**Therapeutic Staff Support** Enter the date in an 8-digit format (mmddccyy) in the "**From** or **To**" portion of this block (not both). TSS Services must be billed on a monthly basis. Enter the last date of the month for which you are billing. **Mobile Therapy** Enter the date in an 8-digit format (mmddccyy) in the "**From** or **To**" portion of this block (not both). If the same service was provided on consecutive days, enter the first day of the service in the **From** column and the last day of service in the **To** column. Use an 8-digit (MMDDCCYY) format to record the From and To dates, (e.g. 03012004). If the dates are not consecutive, separate claim lines must be used. **Behavioral Specialist Consultant (BSC)** Enter the date in an 8-digit format (mmddccyy) in the "**From** or **To**" portion of this block (not both). If the same service was provided on consecutive days, enter the first day of the service in the **From** column and the last day of service in the **To** column. Use an 8-digit (MMDDCCYY) format to record the From and To dates, (e.g. 03012004). If the dates are not consecutive, separate claim lines must be used.

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Block No.	Block Name	Block Code	Notes
24B	Place of Service	M	Enter the 2-digit place of service code that indicates where the service was performed. **Therapeutic Staff Support (TSS)** **12** – Home **99** – Community **Behavioral Specialist Consultant** **11** - Office **12** – Home **99** – Community **Mobile Therapy** **12** – Home **99** - Community *If you have a question regarding a specific procedure code and it's compensable place of service, please contact the Provider Inquiry Unit at DPW. See the DPW Internet site for the appropriate telephone number.*
24C	Type of Service	LB	Do not complete this block.
24D	Procedures, Services, or Supplies (CPT/HCPCS & Modifier)	M/A/A	List the procedure code(s) for the service(s) being rendered and any applicable modifier(s). In the first section of the block, enter the procedure code that describes the service provided. In the second and third sections of the block, enter up to four applicable modifiers. *For compensable procedure code modifier combinations, please refer to the PA* PROMISe™ *fee schedule accessible via the DPW Internet site.*
24E	Diagnosis Code	M	This block may contain up to four digits. If the service was provided for the primary diagnosis, in Block 21, enter 1. If provided for the secondary diagnosis, enter 2. If provided for the tertiary diagnosis, enter 3, and for the fourth diagnosis, enter 4**.**

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Block No.	Block Name	Block Code	Notes
24F	$Charges	M	Enter your usual charge to the general public for the service(s) provided. If billing for multiple units of service, multiply your usual charge by the number of units billed and enter that amount. For example, if your usual charge is sixty-five dollars, enter **6500**.
24G	Days or Units	M	Enter the number of units, services, or items provided.
24H	EPSDT/Family Planning	A	Enter the 2-digit visit code, if applicable. Visit codes are especially important if providing services that do not require copay (e.g., for a pregnant recipient). Please note that recipient's under the age of 18 are exempt from copayment. A visit code is not necessary when submitting a claim for a recipient under the age of 18. *For a complete listing and description of Visit Codes, please refer to the CMS-1500 Claim Form Desk Reference, located in Appendix A of the handbook.*
24I	EMG	LB	Do not complete this block.
24J	COB (Coordination of Benefits)	A	Enter the 1-digit resource code if applicable. Refer to EVS for third party resource information. *For a complete listing and description of Resource Codes, please refer to the CMS-1500 Claim Form Desk Reference, located in Appendix A of the handbook.*
24K	Reserved For Local Use	A	This block is used for other insurance payments, excluding Medicare. Enter the amount paid by another insurance company. Complete Block 19 with the appropriate number of attachments and attachment type codes. If payment was received from more than one resource <u>other than Medicare</u>, place the total of both resources in this block.
25	Federal Tax I.D. Number	M	Enter the provider's Federal Tax Employer Identification Number (EIN) or SSN and place an **X** in the appropriate block.

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Block No.	Block Name	Block Code	Notes
26	Patient's Account Number	O	**Use of this block is strongly recommended**. It can contain up to 10 alpha, numeric, or alphanumeric characters and can be used to enter the patient's account number or name. Information in this block will appear in the first column of the Detail Page in the RA Statement and will help identify claims if an incorrect recipient number is listed.
27	Accept Assignment?	LB	Do not complete this block.
28	Total Charge	O	Enter the sum of lines one through six in column 24F.
29	Amount Paid	A	If a patient is to pay a portion of their medical bills as determined by the local County Assistance Office (CAO), enter the amount to be paid by the patient. Patient pay is only applicable if notification is received from the local CAO on a PA 162RM form. **Do not enter copay in this block.**
30	Balance Due	LB	Do not complete this block.
31	Signature of Physician or Supplier Including Degree or Credentials	M/M	This block must contain the signature of the provider rendering the service. A signature stamp is acceptable if the provider authorizes its use and assumes responsibility for the information on the claim. If submitting by computer-generated claims, this block can be left blank; however, a Signature Transmittal Form (MA 307) must be sent with the claim(s). Enter the date the claim was submitted in this block in an 8-digit (MMDDCCYY) format (e.g. 03012004).
32	Name and Address of Facility Where Services Were Rendered	LB	Do not complete this block.

CMS-1500 Billing Guide for PROMISe™ TSS/Mobile Therapy/BSC Services Providers

Block No.	Block Name	Block Code	Notes
33	Physician's/ Supplier's Billing Name, Address, Zip Code, and Telephone Number (PIN # & GRP #)	LB/LB & M/M	Do not complete the first portion of this block (PIN#). Enter the 9-digit PA PROMISe™ provider number of the individual provider rendering the service and the applicable 4-digit service location (e.g., **1234567892101**) in the second portion of this block. **Do not use slashes, hyphens, or spaces.** The second portion of this block (GRP#) is completed when a rendering provider does not assign payment to a PA PROMISe™ enrolled group or facility. In this instance, the rendering provider is both the rendering provider and billing provider.