
WISCONSIN MEDICAID

UPDATE

ON SCHOOL-BASED SERVICES (SBS)

MARCH 16, 1998

UPDATE 98-12

TO:

CESAs

HMOs and Other Managed
Care Programs

SBS Providers

School Districts

Changes to the SBS Insurance Liability Requirement - Effective July 1, 1997

Insurance liability requirement

Wisconsin Medicaid requires Medicaid providers to seek payment from a recipient's health insurance before seeking payment from Wisconsin Medicaid [42 Code of Federal Regulations, 433.139 (c)]. Recently, Wisconsin Medicaid obtained federal approval allowing SBS providers to assume the health insurance liability amount. Instead of seeking payment from the child's health insurance, SBS providers may absorb these costs themselves.

When insurance liability requirement does not apply

The Medicaid insurance liability requirement *does not apply* for the following school medical services:

- ♦ Multidisciplinary Team (M-Team) assessment, Individualized Education Program (IEP) plan development, and annual reevaluations.
- ♦ School counseling services.
- ♦ School durable medical equipment.
- ♦ School nursing services.
- ♦ School psychological services.
- ♦ School social work services.
- ♦ School speech-language, audiology, and hearing services.
- ♦ School transportation.

SBS providers may seek payment directly from Wisconsin Medicaid without seeking payment from the child's health insurance when the Medicaid insurance liability requirement does not apply.

The Medicaid insurance liability requirement never applies to any school medical service if a child's health insurance policy excludes *all* school medical services from coverage (also known as an "exclusionary clause"). Providers need to contact the child's family or the insurance company to determine if this clause exists.

If the health insurance policy contains an exclusionary clause, providers must bill all SBS services directly to Wisconsin Medicaid. Providers must then document in the child's record that the child's health insurance has an exclusionary clause for school medical services.

When insurance liability requirement applies

The Medicaid insurance liability requirement *applies* for the following school medical services:

- ♦ School occupational therapy (OT) (group or individual).
- ♦ School physical therapy (PT) (group or individual).

SBS providers must choose one of the following three options when the Medicaid insurance liability

requirement applies. Providers may choose different options for each recipient, each month. See the rest of this update for the options and procedures that providers need to follow.

Choose one of three options when insurance liability requirement applies

Option 1: Assume cost of insurance liability for OT and PT

Under this option, providers do not contact or bill a child's health insurance.

Instead of billing health insurance, providers may assume the insurance liability. This is done by not billing Wisconsin Medicaid for one unit of OT (group or individual) and/or one unit of PT (group or individual) for each calendar month.

Procedures to follow for Option 1

- Do not bill Wisconsin Medicaid for the first occurring unit of OT (group or individual) and/or PT (group or individual) during the calendar month.

Bill the remaining OT and/or PT to Wisconsin Medicaid following standard Medicaid procedures as described in Appendix 2 of Part X, the SBS provider handbook.

However, when choosing Option 1, leave element 9 blank. Do not indicate an "other insurance" disclaimer code.

- Providers must document in the child's record the date(s) of service the unit of OT and/or PT was provided for which the provider is assuming the cost of the insurance liability.
- Providers need to retain documentation that they covered the standard monthly insurance liability unit amount for OT and/or PT from a non-federal source of funds instead of billing the child's health insurance.

- Providers do not need to obtain parental permission to assume the cost of insurance liability.

Option 2: Seek payment from child's health insurance

Instead of assuming the cost of the child's health insurance liability, providers may seek payment from the child's health insurance before seeking payment from Wisconsin Medicaid.

Under education law, providers *must* obtain parental permission to bill their health insurance for SBS services.

Federal education regulations allow parents of a child with an IEP receiving SBS services to refuse consent to bill their health insurance (34 Code of Federal Regulations, 303.154) if it results in a cost to the family. Cost to the family includes: reaching the lifetime limit on a policy, an increase in premiums, copayments, deductibles, or other negative consequences.

Procedures to follow for Option 2

- Obtain consent from parents to bill their private health insurance.
- Submit claims to the health insurance company.
- If health insurance denies or partially pays a claim, submit claims to Wisconsin Medicaid following standard Medicaid billing procedures (including "other insurance" disclaimer codes) described in Appendix 2 of Part X, the SBS provider handbook.

Option 3: Do not seek payment from Wisconsin Medicaid for these services

For children with health insurance covering OT and PT in a school setting, SBS providers may choose not to seek payment from Wisconsin Medicaid for these services.

Attachments

To record the services that a child receives, you may use the optional SBS activity log found on pages 5 and 6. Refer to Attachment 1 for an example of how to complete the log if you choose to assume the cost of insurance liability for OT and PT (Option 1). Refer to Attachment 2 for an example of how to complete a HCFA 1500 claim form if you choose Option 1.

Resources to find out whether recipient has health insurance

Providers may use the following resources to find out whether a Medicaid recipient has health insurance:

1. Recipient's Medicaid ID card. Check the card to see if health insurance is listed.
2. Eligibility Hotline (human voice) at (608) 221-9254.
3. Voice Response System at (800) 947-3544 or (608) 221-4247.
4. DIAL-UP (Automated Information System) at (608) 221-4746. You must have a subscription for this service in order to access it. For information on how to subscribe, contact the Electronic Media Claims (EMC) Department at (608) 221-4746.
5. Volume Eligibility at (608) 221-4746. You must have a subscription for this service in order to access it. For information on how to subscribe, contact the EMC Department at (608) 221-4746.

**Attachment 1
Example SBS Activity Log**

1. Month/Year 09/97		3. Student's Name (Last, First, Middle Initial) Recipient, Im A.	
2. School Name Lincoln Elementary		4. Student's Birth Date (MM/DD/YY) XX/XX/XX	
5. Date of service (MM/DD/YY)	6. Procedure code	7. Number of units of service (time, quantity, miles)	8. Describe the specific service or treatment delivered, as well as the the student's response/progress. (Response/progress is not required for transportation.)
09/01/97	W6068	2	Discussed/explained medications with parents and child. Parents will follow up with Dr.
09/02/97	W6056	2 - 1* = 1	amb /c Mulholland walker 30 ft in 4 min, required 3 VC
09/03/97	W6054	2 - 1* = 1	positioning; physical assist x3 to sit midline, trials of switches
09/04/97	W6054	1	eating; spoon placed in hand, 10 scoops /c 4 VC with spilling x3
09/05/97	W6056	1	amb /c Mulholland walker 30 ft in 6 min, required 6 VC
09/08/97	W6056	1	amb /c Mulholland walker 30 ft in 6 min, required 4 VC
09/09/97	W6054	2	eating; spoon placed, 15 scoops /c 4 VC, spills x6
09/11/97	W6056	1	amb /c Mulholland walker 25 ft in 6 min, required 5 VC
09/12/97	W6054	1	positioning @ desk; HOH to reach Big Red Switch
09/15/97	W6056	1	increase tone, passive ROM; knees, hip range WFL; no amb 2 tone and lethargy
09/16/97	W6054	0	No svc, student home ill
09/18/97	W6056	0	No svc, student home ill
09/19/97	W6054	3	PROM BUE; increased tone L UE; 45 min to range WFL
09/22/97	W6056	1	amb /c Mulholland walker 25 ft in 5 min, required 4 VC
9/23/97	W6054	1	positioning; physical assist x6 to sit midline, still weak, lethargy noted
09/25/97	W6056	1	amb /c Mulholland walker 25 ft in 5 min, required 4 VC
09/26/97	W6054	1	eating; easily distracted; HOH to initiate; 8 scoops /c 8 VC, spills x6
09/29/97	W6056	1	prone on thpy ball; head and neck exten 10 sec
09/30/97	W6054	2	eating; trid universal cuff /c spoon; 10 scoops /c 2 prompts @ elbow; spills x2 (macaroni and cheese)

Attachment 2
Example National HCFA 1500 Claim Form
 (Completed from sample SBS Activity Log shown in Attachment 1)

APPROVED OMB 0938 0008

CARRIER
 PATIENT AND INSURED INFORMATION
 PHYSICIAN OR SUPPLIER INFORMATION

HEALTH INSURANCE CLAIM FORM									
1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA RLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/>	1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) 1234567890								
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Recipient, Im A.		3. PATIENT'S BIRTH DATE MM DD YY MM DD YY SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial)					
5. PATIENT'S ADDRESS (No., Street) 609 Willow Street		6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street)					
CITY Anytown		8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>		CITY					
STATE WI		Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>		STATE					
ZIP CODE 55555		TELEPHONE (Include Area Code) (XXX)XXX-XXXX		ZIP CODE					
TELEPHONE (Include Area Code)		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input type="checkbox"/> NO c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		11. INSURED'S POLICY GROUP OR FECA NUMBER					
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO		a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>					
a. OTHER INSURED'S POLICY OR GROUP NUMBER		b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input type="checkbox"/> NO		b. EMPLOYER'S NAME OR SCHOOL NAME					
b. OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>		c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		c. INSURANCE PLAN NAME OR PROGRAM NAME					
c. EMPLOYER'S NAME OR SCHOOL NAME		10d. RESERVED FOR LOCAL USE		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i>					
d. INSURANCE PLAN NAME OR PROGRAM NAME		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.		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize payment of medical benefits to the undersigned physician or supplier for services described below.					
SIGNED _____ DATE _____		14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY					
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE		17a. I.D. NUMBER OF REFERRING PHYSICIAN		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY					
13. RESERVED FOR LOCAL USE		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY		20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO					
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE) 1. S11		22. MEDICAID RESUBMISSION CODE		23. PRIOR AUTHORIZATION NUMBER					
24. DATE(S) OF SERVICE		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							
09 01 97		0		1					
09 02 97 05 08 11		0		1					
09 15 97 22 25 29		0		1					
09 03 97 04 12 23		0		1					
09 09 97 30		0		1					
09 19 97		0		1					
25. FEDERAL TAX I.D. NUMBER		26. PATIENT'S ACCOUNT NO. 1234JED		27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES <input type="checkbox"/> NO <input type="checkbox"/>					
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE(S) OR CREDENTIALS I.M. Authorized MM/DD/YY SIGNED DATE		32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)		28. TOTAL CHARGE \$ XX XX					
33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # I.M. Billing 1 W. Williams Anytown, WI GRP# 76543218		29. AMOUNT PAID \$ 00 00		30. BALANCE DUE \$ XX XX					

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

Example National HCFA 1500 Claim Form

(Completed from sample SBS Activity Log shown in Attachment 1)

APPROVED OMB 0938-0068

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

HEALTH INSURANCE CLAIM FORM										PICA		
1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA BLK LUNG (SSN) <input type="checkbox"/> OTHER (ID) <input type="checkbox"/>										1a. INSURED'S I.D. NUMBER 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 <input type="checkbox"/> M <input checked="" type="checkbox"/> F		4. INSURED'S NAME (Last Name, First Name, Middle Initial)					
5. PATIENT'S ADDRESS (No., Street) 609 Willow Street					6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street)					
CITY Anytown			STATE WI		8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>		CITY		STATE			
ZIP CODE 55555		TELEPHONE (Include Area Code) (XXX)XXX-XXXX			Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>		ZIP CODE		TELEPHONE (INCLUDE AREA CODE) ()			
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)					10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO		11. INSURED'S POLICY GROUP OR FECA NUMBER					
a. OTHER INSURED'S POLICY OR GROUP NUMBER					b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input type="checkbox"/> NO		a. INSURED'S DATE OF BIRTH MM DD YY SEX <input type="checkbox"/> M <input type="checkbox"/> F		b. EMPLOYER'S NAME OR SCHOOL NAME			
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX <input type="checkbox"/> M <input type="checkbox"/> F					c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		c. INSURANCE PLAN NAME OR PROGRAM NAME					
c. EMPLOYER'S NAME OR SCHOOL NAME					10d. RESERVED FOR LOCAL USE		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i>					
d. INSURANCE PLAN NAME OR PROGRAM NAME					12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____					
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (MP) MM DD YY					15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY 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 FROM MM DD YY TO MM DD YY					
19. RESERVED FOR LOCAL USE					20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.					
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. S11					23. PRIOR AUTHORIZATION NUMBER		24. TABLE OF SERVICES					
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
09 26 97		0	1	W6054		1	XX/XX	1				
25. FEDERAL TAX I.D. NUMBER		26. PATIENT'S ACCOUNT NO. 1234JED		27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ XX/XX	29. AMOUNT PAID \$ 00/00	30. BALANCE DUE \$ XX/XX				
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE(S) 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. Billing 1 W. Williams Anytown, WI PIN# GRP# 76543218					

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/83)

PLEASE PRINT OR TYPE

I OHM HCFA 1500 (12-90)
FORM OWCP-1500 FORM RB-1500