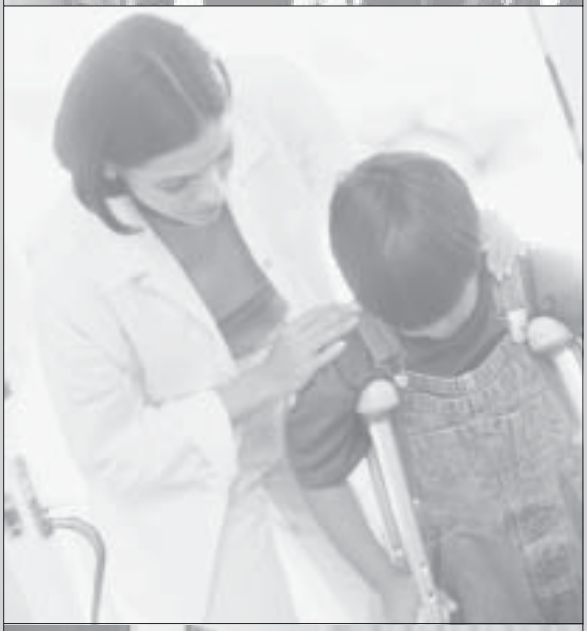
School-Based Services



wisconsin Medicaid and BadgerCare

Information for Providers

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M E M O R A N D U M

DATE: February 23, 2005

TO: Wisconsin Medicaid-Certified School-Based Services Providers and HMOs and Other Managed Care Organizations

FROM: Mark B. Moody, Administrator
Division of Health Care Financing

SUBJECT: Wisconsin Medicaid School-Based Services Handbook

The Division of Health Care Financing (DHCF) is pleased to provide you with a copy of the new Wisconsin Medicaid School-Based Services Handbook. The handbook articulates current Medicaid policies found in the Wisconsin Administrative Code, HFS 101-109, as they apply to the school-based services (SBS) benefit.

The handbook incorporates all current Wisconsin Medicaid policies related to school-based services in a single reference source. The handbook replaces Part X, the School-Based Services Handbook, and the following service-specific *Wisconsin Medicaid and BadgerCare Updates*:

- December 2004 *Update* (2004-94), Licensing Requirements for School-Based Services Providers.
- October 2003 *Update* (2003-151), Requirements for school-based services documentation standards.
- August 2003 *Update* (2003-123), Effective dates for claims submission changes as a result of HIPAA for school-based services.
- June 2003 *Update* (2003-39), Changes to local codes and paper claims for school-based services as a result of HIPAA.
- April 2003 *Update* (2003-22), Signature requirements for school-based services providers.
- April 2003 *Update* (2003-21), Covered nursing services provided under the school-based services benefit.
- August 2002 *Update* (2002-46), Teachers' time covered only for medically related services.
- May 2002 *Update* (2002-22), Specialized medical vehicle and school-based transportation services coverage clarification.
- December 2001 *Update* (2001-46), Clarification of reimbursement for school-based services transportation.
- July 2001 *Update* (2001-10), New reimbursement method and documentation requirements for school-based services transportation.
- November 2000 *Update* (2000-57), Change in occupational therapy prescription requirements.
- September 2000 *Update* (2000-39), New information for school-based services providers.
- August 1999 *Update* (99-36), Therapy services clinical documentation and record-keeping requirements.

- April 1999 *Update* (99-18), Change in prescription requirements for billing Medicaid.
- March 1998 *Update* (98-13), SBS transportation services.
- March 1998 *Update* (98-12), Changes to the SBS insurance liability requirement.
- January 1998 *Update* (97-26, Revised), SBS billing information.
- September 1997 *Update* (97-25), School-based services (SBS) parental consent.

The handbook does not replace the All-Provider Handbook, all-provider *Updates*, the Wisconsin Administrative Code, or Wisconsin Statutes. Subsequent changes to SBS policies will be published first in *Updates* and later in School-Based Services Handbook revisions.

Additional Copies of Publications

All *Updates* and the School-Based Services Handbook can be downloaded from the Medicaid Web site at *dhfs.wisconsin.gov/medicaid/.*

The DHCF would like to thank the Department of Public Instruction and representatives from Milwaukee Public Schools, CESA 5 and CESA 12 for reviewing this handbook.

Important Telephone Numbers

The Wisconsin Medicaid Eligibility Verification System (EVS) is available through the following resources to verify checkwrite information, claim status, prior authorization status, provider certification, and/or recipient eligibility.

Service	Information Available	Telephone Number	Hours
Automated Voice Response (AVR) System (Computerized voice response to provider inquiries.)	Checkwrite Information Claim Status Prior Authorization Status Recipient Eligibility*	(800) 947-3544 (608) 221-4247 (Madison area)	24 hours a day/ 7 days a week
Personal Computer Software and Magnetic Stripe Card Readers	Recipient Eligibility*	Refer to Provider Resources section of the All-Provider Handbook for a list of commercial eligibility verification vendors.	24 hours a day/ 7 days a week
Provider Services (Correspondents assist with questions.)	Checkwrite Information Claim Status Prior Authorization Status Provider Certification Recipient Eligibility*	(800) 947-9627 (608) 221-9883	Policy/Billing and Eligibility: 8:30 a.m. - 4:30 p.m. (M, W-F) 9:30 a.m. - 4:30 p.m. (T) Pharmacy: 8:30 a.m. - 6:00 p.m. (M, W-F) 9:30 a.m. - 6:00 p.m. (T)
Direct Information Access Line with Updates for Providers (Dial-Up) (Software communications package and modem.)	Checkwrite Information Claim Status Prior Authorization Status Recipient Eligibility*	Call (608) 221-4746 for more information.	7:00 a.m. - 6:00 p.m. (M-F)
Recipient Services (Recipients or persons calling on behalf of recipients only.)	Recipient Eligibility Medicaid-Certified Providers General Medicaid Information	(800) 362-3002 (608) 221-5720	7:30 a.m. - 5:00 p.m. (M-F)

* Please use the information exactly as it appears on the recipient's identification card or the EVS to complete the patient information section on claims and other documentation. Recipient eligibility information available through the EVS includes:

- Dates of eligibility.
- Medicaid managed care program name and telephone number.
- Privately purchased managed care or other commercial health insurance coverage.
- Medicare coverage.
- Lock-In Program status.
- Limited benefit information.

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Preface

The Wisconsin Medicaid and BadgerCare School-Based Services Handbook is issued to school-based services (SBS) providers who are Wisconsin Medicaid certified. It contains information that applies to *fee-for-service* Medicaid providers. The Medicaid information in this handbook applies to both Wisconsin Medicaid and BadgerCare. Please note that this handbook does not include additional rules and regulations relating to services outside Medicaid-covered services in schools as required by state and federal law.

Wisconsin Medicaid and BadgerCare are administered by the Department of Health and Family Services (DHFS). Within the DHFS, the Division of Health Care Financing (DHCF) is directly responsible for managing Wisconsin Medicaid and BadgerCare. As of January 2004, BadgerCare extends Medicaid coverage to uninsured children and parents with incomes at or below 185% of the Federal Poverty Level and who meet other program requirements. BadgerCare recipients receive the same health benefits as Wisconsin Medicaid recipients and their health care is administered through the same delivery system.

Wisconsin Medicaid and BadgerCare recipients enrolled in state-contracted HMOs are entitled to at least the same benefits as fee-for-service recipients; however, HMOs may establish their own requirements regarding prior authorization, billing, etc. Information contained in this and other Medicaid publications is used by the DHCF to resolve disputes regarding covered benefits that cannot be handled internally by HMOs under managed care arrangements.

Verifying Eligibility

For services listed in a child's Individualized Education Program, SBS providers are required under state and federal law to provide these services, regardless of Medicaid eligibility. To verify that a recipient is eligible for Wisconsin Medicaid, providers may check with Wisconsin Medicaid's Eligibility Verification System (EVS), which provides eligibility information that providers can access a number of ways.

Refer to the Important Telephone Numbers page at the beginning of this handbook for detailed information on the methods of verifying eligibility.

Handbook Organization

The School-Based Services Handbook consists of the following chapters:

- Provider Information.
- Recipient Information.
- Covered Services.
- Documentation Requirements.
- Coordination of Benefits.
- Claims Submission.
- Reimbursement.

In addition to the School-Based Services Handbook, each Medicaid-certified provider is issued a copy of the All-Provider Handbook. The All-Provider Handbook includes the following sections:

- Claims Submission.
- Coordination of Benefits.
- Covered and Noncovered Services.
- Prior Authorization.
- Provider Certification.
- Provider Resources.
- Provider Rights and Responsibilities.
- Recipient Rights and Responsibilities.

Legal Framework of Wisconsin Medicaid and BadgerCare

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 — Public Health.

Wisconsin Law and Regulation

- Law: Wisconsin Statutes: Sections 49.43-49.499 and 49.665.
- Regulation: Wisconsin Administrative Code, Chapters HFS 101-108.

Handbooks and *Wisconsin Medicaid and BadgerCare Updates* further interpret and implement these laws and regulations.

Handbooks and *Updates*, maximum allowable fee schedules, helpful telephone numbers and addresses, and much more information about Wisconsin Medicaid and BadgerCare are available at the following Web sites:

dhfs.wisconsin.gov/medicaid/
dhfs.wisconsin.gov/badgercare/

Medicaid Fiscal Agent

The DHFS contracts with a fiscal agent, which is currently EDS.

Provider Information

What is the School-Based Services Benefit?

The school-based services (SBS) benefit has been established according to s. 49.45(39), Wis. Stats. This benefit is designed to increase federal funding to Wisconsin schools to help pay for medically related special education and related services. The SBS benefit defines the services that can be reimbursed by Wisconsin Medicaid for medically necessary services provided to Medicaid-eligible children.

Provider Eligibility and Certification

To participate as a Wisconsin Medicaid SBS provider, a school, school district, Cooperative Educational Service Agency (CESA), County Children with Disabilities Education Board (CCDEB), or charter school are required to be certified as a provider under HFS 105.53, Wis. Admin. Code. School-Based Services providers are required to verify that individual staff meet qualifications under ch. PI 34, Wis. Admin. Code, or are licensed under the following:

- Section 441.06, Wis. Stats. (registered nurse).
- Section 441.10, Wis. Stats. (licensed practical nurse).
- Section 448.51, Wis. Stats. (physical therapy [PT]).
- Section 448.961, Wis. Stats. (occupational therapy [OT]).
- Section 459.24, Wis. Stats. (speech and language pathology [SLP]) and hold a certificate of clinical competence from the American Speech-Language-Hearing Association (ASHA).

School districts may be Medicaid certified under a CESA's umbrella certification or be separately certified as a school district, but not both. A CESA applying for SBS certification is required to identify the school districts included in its certification and must notify Wisconsin Medicaid when these districts change. A CESA is required to revise and resubmit Chart A of the SBS Certification Packet whenever the list of school districts included under its certification changes.

This benefit is designed to increase federal funding to Wisconsin schools to help pay for medically related special education and related services.

Certification Process

Refer to the Wisconsin Medicaid Web site at *dhfs.wisconsin.gov/medicaid/* to download the SBS Certification Packet, which includes forms and instructions on how to notify Wisconsin Medicaid of school district changes.

When applying for Wisconsin Medicaid SBS certification, the school district, CESA, CCDEB, or charter school is required to identify any additional Medicaid provider certifications it holds or its providers hold (e.g., physical therapy or therapy group). This ensures that any duplicate provider types are removed.

Individual Provider Licensing Requirements

Wisconsin Medicaid requires individual performing providers to be licensed by the Department of Public Instruction (DPI) for reimbursement under the SBS benefit, with the exception of nurses. Nurses are not required to obtain a DPI license but are encouraged to do so. Individual providers of school-based services are not separately certified by Wisconsin Medicaid.

Speech-language pathologists are required to meet additional certification requirements for reimbursement under the Wisconsin Medicaid SBS benefit. A speech-language pathologist is required to meet one of the following requirements:

- Hold the certificate of clinical competence from ASHA.

- Has completed the educational requirements for the ASHA certificate, has completed or is acquiring the supervised work experience necessary for the ASHA certificate, and has passed the PRAXIS exam in SLP.

Because the DPI licenses individual providers in Wisconsin schools only, out-of-state schools are ineligible to apply for Wisconsin Medicaid SBS certification.

Duplicate Provider Types

According to s. 49.45(39), Wis. Stats., SBS providers are required to submit claims for covered Individualized Education Plan (IEP) services under the school district or CESA's SBS certification and not under another Medicaid provider number. School-Based Services provider certification encompasses, and therefore duplicates, all of the following Wisconsin Medicaid provider certifications:

- Physical therapy group and individual PT providers and PT assistants.
- Occupational therapy group and individual OT providers and OT assistants.
- Speech and hearing clinics.
- Audiology group and audiologists.
- Therapy group.
- Speech and language pathology/therapy group and speech pathologists.
- Rehabilitation agencies.
- Transportation.
- Nurse practitioner group and individual nurse practitioners.
- Nurse group and individual nurses.

The SBS provider (i.e., the school) cannot have duplicate certification numbers. Wisconsin Medicaid removes these duplicate certifications when providers apply for SBS certification.

Individual providers performing services that are in the IEP in the school may be individually certified by Wisconsin Medicaid; however, the services must be billed by the CESA or school district under the SBS benefit. An individual therapist or clinic *cannot* submit claims individually for services provided that are included in the student's IEP.

Nonduplicate Provider Types

School-Based Services providers may be Medicaid certified for other services, provided these services are not covered under the SBS benefit (e.g., HealthCheck screening and prenatal care coordination).

Provider Authority to Subcontract

School-Based Services providers may subcontract with agencies or individuals that are not Medicaid certified to provide services. The SBS provider is responsible for assuring that subcontracted agencies or individuals meet all SBS Medicaid requirements. For example, for the SBS provider to obtain reimbursement for services provided by a contracted occupational therapist in the community, the therapist is required to be licensed by the DPI, which is an SBS Wisconsin Medicaid requirement.

School-Based Services provided by agencies or individuals subcontracted by SBS providers must submit claims to Wisconsin Medicaid under the SBS benefit, listing the SBS provider as the billing provider (not the subcontracted agency or individual).

Communication with Non-School-Based-Services Providers

When a child receives Medicaid services from both SBS and non-SBS providers, these providers are required to communicate with each other to:

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

School-Based Services providers may subcontract with agencies or individuals that are not Medicaid certified to provide services.

Communication between providers is a two-step process in which SBS providers are required to:

1. Determine if a child receives medical services outside the school from other providers.
2. Contact these providers and inform them, on at least an *annual* basis, of services provided by the SBS provider.

School-Based Services providers are required to attempt to find out if children are receiving medical services from providers outside the school. For example, some schools send mass mailings to all parents in an effort to obtain this information. Providers may also request this information from parents in IEP meetings, parent/teacher conferences, and/or telephone conversations. If the parent(s) refuses to provide the information or does not respond, the SBS provider is required to document this in the child's record.

When an SBS provider obtains information about a child receiving services from providers outside the school and the child's parents provide consent to contact these providers, the SBS provider is required to attempt to inform these providers of services delivered in the school. If the provider(s) outside the school does not respond after several good faith attempts, the SBS provider has fulfilled its obligations and needs to document this in the child's record.

School-Based Services providers are required to communicate at least annually with all HMOs and document this in the child's record.

Managed Care Providers

To ensure communication between providers, Wisconsin Medicaid requires that all SBS providers and Medicaid HMOs that share a service area sign a joint Memorandum of Understanding (MOU). Additionally, SBS providers and special managed care program providers in Milwaukee county are also required to sign a joint MOU.

An MOU is a document that sets standards, policies, and procedures to help coordinate services. Wisconsin Medicaid facilitates the development of MOU between SBS providers and Medicaid HMOs by making a list of certified SBS providers available to HMOs on a quarterly basis.

A separate MOU must be signed with each HMO that moves into the SBS provider's area. School-Based Services providers and managed care providers are required to sign an MOU only once and are required to comply with it as long as they remain a certified provider.

School-Based Services providers are required to communicate at least annually with all HMOs and document this in the child's record.

Refer to Appendix 4 of this handbook for a sample MOU.

Special Managed Care Programs

In the future, Wisconsin Medicaid expects to expand the special managed care programs currently offered in Milwaukee county, and also introduce special managed care programs in Dane county. At that time, SBS providers and special managed care program providers in these service areas will be required to sign a joint MOU. Information explaining the expansion and introduction of special managed care programs in Milwaukee and Dane counties will be published in future *Wisconsin Medicaid and BadgerCare Updates*.

For a list of Medicaid HMOs and special managed care programs by county, refer to the Managed Care section of the Medicaid Web site at *dhfs.wisconsin.gov/medicaid/*.

Medicaid Fee-for-Service Providers

Although MOU are not required with Medicaid fee-for-service providers in the community, when a child receives services from both an SBS provider and a Medicaid fee-for-service provider of the same discipline, the SBS provider is required to:

- Contact these providers and inform them, on at least an annual basis, of services provided by the SBS provider.
- Cooperate with Medicaid fee-for-service providers of the same discipline who request copies of the child's IEP or components of the IEP.

Fee-for-service providers include, but are not limited to, clinics, rehabilitation agencies, local health departments, community mental health agencies, tribal health agencies, home care agencies, therapists, therapy groups, and durable medical equipment providers.

Providers Not Certified Under Medicaid

Memoranda of Understanding are not required with providers not certified by Wisconsin Medicaid. However, if a child receives services from both an SBS provider and providers of the same discipline not certified under Wisconsin Medicaid, the SBS provider is required to contact these providers and inform them, on at least an annual basis, of services provided by the SBS provider.

Fee-for-service providers include, but are not limited to, clinics, rehabilitation agencies, local health departments, community mental health agencies, tribal health agencies, home care agencies, therapists, therapy groups, and durable medical equipment providers.

Recipient Information

Recipient Eligibility

Wisconsin Medicaid's Eligibility Verification System

School-Based Services (SBS) providers are required by the state and federal law to provide the services listed in a child's Individualized Education Program (IEP), regardless of Medicaid eligibility. Children must be under age 21 or they must turn 21 years of age during the school term in which services are performed.

Wisconsin Medicaid encourages schools to inform parents that the SBS provider will submit claims to Wisconsin Medicaid for services provided to their child(ren).

To verify that a recipient is eligible for Wisconsin Medicaid, providers may check with Wisconsin Medicaid's Eligibility Verification System (EVS), which provides eligibility information that providers can access a number of ways.

Refer to the Important Telephone Numbers page at the beginning of this handbook for information on methods for verifying eligibility. Refer to the Provider Resources section of the All-Provider Handbook for detailed information on accessing the EVS and eligibility for Wisconsin Medicaid.

Volume Eligibility

Another method the SBS provider may use to verify eligibility is the Medicaid Volume Eligibility System. This system enables SBS providers to make a large number of Wisconsin Medicaid recipient eligibility inquiries. This service is provided at no charge to providers.

To place a volume eligibility inquiry, contact Division of Health Care Financing Electronic Data Interchange Department at (608) 221-9036. The Volume Eligibility System is available to SBS providers only.

Copayment

Copayments are not permitted for school-based services.

Parental Consent

Consent to Provide Medical Services

As required under federal and state education laws, SBS providers are required to obtain parental permission to provide the special education and related services defined in a child's IEP. Refer to the Covered Services chapter of this handbook for further information about the IEP.

Consent to Request Reimbursement from Wisconsin Medicaid

A separate parental consent in addition to that required to provide the child medical services is *not* required for SBS providers to submit claims to Wisconsin Medicaid. However, if a parent withdraws consent in writing, the SBS provider cannot submit claims to Wisconsin Medicaid.

This policy is based on a U.S. Department of Education decision, in which the department reviewed Wisconsin Medicaid's eligibility application form and concluded that parents give consent to request reimbursement from Wisconsin Medicaid when they sign this application form.

Wisconsin Medicaid encourages schools to inform parents that the SBS provider will submit claims to Wisconsin Medicaid for services provided to their child(ren). Refer to Appendix 5 of this handbook for a sample Letter of Consent to Request Reimbursement from Wisconsin Medicaid. Schools may photocopy this sample letter onto the school letterhead and fill in the necessary details for each individual child. Schools also have the option to develop their own letter of consent.

Consent to Bill Commercial Insurance

Under the federal education law, parental consent must be obtained to bill commercial health insurance for school-based services.

Covered Services

Through the school-based services (SBS) benefit, Medicaid-certified SBS providers may request reimbursement from Wisconsin Medicaid for medically necessary covered school-based services provided to Medicaid-eligible children.

Covered School-Based Services

School-Based Services must be identified in the child's Individualized Education Program (IEP) and certain requirements must be met. Covered services include:

- Developmental testing and assessments when resulting in a created or revised IEP.
- Durable medical equipment (DME).
- Nursing.
- Occupational therapy (OT).
- Physical therapy (PT).
- Psychological services, counseling, and social work.
- Speech and language pathology (SLP), audiology, and hearing.
- Transportation.

Providers may submit claims only for *face-to-face* time for school-based services, except DME, where providers may request reimbursement for the equipment itself.

Providers are required to document all face-to-face time for school-based services. Providers may submit claims only for *face-to-face* time for school-based services, except DME, where providers may request reimbursement for the equipment itself. Consultation, monitoring, and coordination are not separately reimbursable by Wisconsin Medicaid. Payment for these services is included in the reimbursement rate for the face-to-face services listed above.

Refer to Appendices 11 and 12 of this handbook for Medicaid-allowable SBS modifiers and procedure codes.

Medical Necessity

All Medicaid-covered services must be medically necessary, as defined in HFS 101.03(96m), Wis. Admin. Code. A school-based service is considered medically necessary when the service:

1. Identifies, treats, manages, or addresses a medical problem, or a mental, emotional, or physical disability.
2. Is identified in the child's IEP.
3. Is necessary for a child to benefit from special education.
4. Is prescribed by a physician when required. Refer to the service-specific information in this chapter for prescription requirements.

Face-to-Face Time

Providers are required to document and may submit claims only for face-to-face encounter time with the child for all school-based services. Wisconsin Medicaid covers only face-to-face time spent with the child for all school-based services. Face-to-face time is the time any SBS personnel, both teachers and medical professionals, spend with the child present in the course of providing a service. This includes:

- Time to obtain and update a history with the child present.
- Direct observation of the child.
- Individualized Education Program team testing and assessment — only for the time when the SBS health professional is in direct contact with the child.
- Delivery of the IEP therapy, psychological counseling, social work, or nursing services.
- Individualized Education Program meetings — only for the time when the child is present at the meeting.

Non-Face-to-Face Time

Wisconsin Medicaid does *not* pay separately for any non-face-to-face time; payment for non-face-to-face time is included in the reimbursement rates for face-to-face services. Non-face-to-face time includes the time that providers spend in preparation and follow-up *without* the child present, including:

- Reviewing and scoring records and tests.
- Writing reports.
- Communication and consultation (without the child present) related to the IEP team or IEP service with other professionals, staff, and parents.
- Meeting with parents regarding the IEP (without the child present).

Cotreatment

Wisconsin Medicaid recognizes that OT, PT, and SLP providers each provide a unique approach to the recipient's treatment. Cotreatment (the simultaneous treatment by two providers of different therapy disciplines during the same time period) may be provided only in circumstances where it is medically necessary to optimize the recipient's rehabilitation. When cotreatment occurs, providers are required to document in the child's record why individual treatment from a single therapist does not provide maximum benefit to the recipient and why two different therapies that treat simultaneously are required.

Individualized Education Program Information

The Wisconsin Medicaid SBS benefit only covers services that are listed in the IEP. Each public school child who receives school-based services must have an IEP. An IEP is a written plan for a child that is developed, reviewed, and revised in accordance with s.115.787, Wis. Stats. The IEP identifies the special education and related services for the child.

Treatment Goals and Care Plan

For Wisconsin Medicaid coverage of school-based services, there must be a care plan (such as the Department of Public Instruction's [DPI's] Individualized Healthcare Plan [IHP]) that identifies treatment goals that are *measurable* and *outcome-oriented*. When the treatment goals identified in the IEP meet these conditions, the IEP is considered the care plan. Otherwise, providers are required to develop a separate care plan that contains measurable and outcome-oriented goals.

The Wisconsin Medicaid SBS benefit only covers services that are listed in the IEP.

Measurable Outcome-Oriented Goals

The child's IEP contains annual goals, including short term objectives or benchmarks that are measurable. For example, a child may have a short-term goal of stepping over objects on the floor without any loss of balance in four out of five trials with the ultimate annual goal of walking through crowded corridors without any falls. The short-term goal is measurable in that the child gains skills in walking safely when confronted by obstacles 80 percent of the time. The annual goal is outcome oriented and measurable in that the number of falls can be tabulated.

Speech and Language Pathology, Audiology, and Hearing Services

Covered Services

Speech and language pathology, audiology, and hearing services are covered for children with speech, language, or hearing disorders that adversely affect the child's functioning. The following services are covered if identified in the child's IEP:

- Evaluation and re-evaluation to determine the child's need for SLP audiology, and/or hearing services (if the service results in the development or revision of an IEP);

recommendations for a course of treatment; and providing direct treatment interventions.
- Individual therapy/treatment or group therapy/treatment in groups of two to seven children.
- Medical equipment identified in the IEP intended for only *one* child for use at school *and* home. Refer to the Durable Medical Equipment section of this chapter for the qualifications necessary to obtain DME under the SBS benefit.

Provider Qualifications

Medicaid-covered SLP, audiology, and hearing services are performed by or under the direction of a speech-language pathologist or audiologist who meets Medicaid's specific licensing and certification requirements.

The Centers for Medicare and Medicaid Services require certain guidelines to be met for federal reimbursement of services that are provided under the direction of a qualified speech-language pathologist or audiologist.

Each school district and Cooperative Educational Service Agency (CESA) is responsible for documenting the qualifications of all of the speech-language pathologists and audiologists who provide services for them. They are also responsible for documenting the provision of services provided under the direction of a speech-language pathologist or audiologist.

Speech-Language Pathologists

A speech-language pathologist providing school-based services is required to be DPI licensed *and* meet one of the following certification conditions:

- The speech-language pathologist holds the certificate of clinical competence from the American Speech-Language-Hearing Association (ASHA).
- The speech-language pathologist has completed the educational requirements and work experience necessary for the ASHA certificate and has passed the PRAXIS exam in SLP.
- The speech-language pathologist has completed the educational requirements for the ASHA certificate, has passed the PRAXIS exam in SLP, and is acquiring supervised work experience to qualify for the certificate.
- The speech-language pathologist provided the services under the direction of a speech-language pathologist who holds ASHA certification or who meets ASHA certification.

Audiologists

An audiologist providing school-based services is required to be DPI licensed *and* meet one of the following certification conditions:

- The audiologist holds a license from Wisconsin Department of Regulation and Licensing (DR&L).
- The audiologist holds the certificate of clinical competence from ASHA.
- The audiologist:
  - ✓ Has completed the educational requirements necessary for the ASHA certificate *and*;
  - ✓ Has successfully completed a minimum of 350 clock-hours of supervised clinical practicum (or is in the process of accumulating that supervised clinical experience under the supervision of a qualified Master's or doctoral-level audiologist) *and*;
  - ✓ Has performed at least nine months of full-time audiology services under the supervision of a qualified Master's or doctoral-level audiologist after obtaining a Master's or doctoral degree in audiology or a related field *and*;
  - ✓ Has passed the PRAXIS Exam in audiology.
- The audiologist provided the service under the direction of an audiologist who holds ASHA certification or who meets ASHA certification requirements.

"Under the Direction of" Guidelines

The Centers for Medicare and Medicaid Services (CMS) require certain guidelines to be met for federal reimbursement of services that are provided under the direction of a qualified speech-language pathologist or audiologist. To ensure funding, Wisconsin

Medicaid requires school districts and CESAs to comply with the federal guidelines.

School-Based Services provided under the direction or supervision of a speech-language pathologist or audiologist must meet the following requirements:

- A supervising speech-language pathologist or audiologist must meet the qualifications listed in the Provider Qualifications section of this chapter.
- The supervising speech-language pathologist or audiologist must see each recipient at the beginning of and periodically during treatment, be familiar with the treatment plan, have continued involvement in the care provided, and review the need for continued services throughout treatment.
- The supervising speech-language pathologist or audiologist must assume professional responsibility for the services provided under his or her direction.
- The supervising speech-language pathologist or audiologist must ensure that the individual working under his or her direction can contact him or her as necessary during the course of treatment.
- A supervising speech-language pathologist or audiologist may not supervise more service providers than is reasonable, ethical, and in keeping with professional practice in order to permit the supervising speech-language pathologist or audiologist to adequately fulfill his or her supervisory obligations and to ensure quality care.
- The entity employing the supervisory speech-language pathologist or audiologist is responsible for ensuring that these standards are met.
- The employing entity is responsible for ensuring that appropriate documentation is maintained to prove that the above requirements were met. The employing entity is also responsible for ensuring that there is appropriate documentation of services provided by the supervising speech-language pathologist or audiologist and by the individuals working under the direction of the supervising speech-language pathologist or audiologist.

Prescription Requirements

Speech and language pathology, audiology, and hearing services require a physician's prescription annually *or* the SBS provider is required to have a Request for a Waiver to Wisconsin Medicaid Prescription Requirements Under the School-Based Services Benefit form, HCF 1134, on file with Wisconsin Medicaid. Refer to Appendix 7 of this handbook for a copy of the form.

Physical Therapy Services

Covered Services

Physical therapy services are covered when they identify, treat, rehabilitate, restore, improve, or compensate for medical problems. The following services are covered if they are identified in the child's IEP:

- Evaluation and re-evaluation to determine the child's need for PT (if the service results in the development or revision of an IEP), recommendations for a course of treatment, and providing direct treatment interventions.
- Individual therapy/treatment or group therapy/treatment in groups of two to seven children.
- Medical equipment identified in the IEP intended for only one child for use at school *and* home.

Medicaid-covered PT services are performed by or under the direction of a licensed DPI physical therapist.

Provider Qualifications

Medicaid-covered PT services are performed by or under the direction of a licensed DPI physical therapist.

Licensed PT providers may only delegate to physical therapy assistants (PTAs) those portions of a child's therapy that are consistent with the PTA's education, training, and experience. Licensed PT providers are required to have direct, face-to-face contact

with PTAs on the premises at least every 14 days.

Prescription Requirements

Physical therapy services require a physician's prescription annually. However, if the SBS provider has a Request for a Waiver to Wisconsin Medicaid Prescription Requirements Under the School-Based Services Benefit form on file with Wisconsin Medicaid, a prescription is only required under limited circumstances as required by the DR&L. Refer to Appendix 7 of this handbook for a copy of the form.

Nursing services must be appropriate for the child's medical needs and specifically identified in the child's IEP.

Occupational Therapy Services

Covered Services

Occupational therapy services are covered when they identify, treat, rehabilitate, restore, improve, or compensate for medical problems that interfere with age-appropriate functional performance. The following services are covered if they are identified in the child's IEP:

- Evaluation and re-evaluation to determine the child's need for OT (if the service results in the development or revision of an IEP), recommendations for a course of treatment, and providing direct treatment interventions.
- Individual therapy/treatment or group therapy/treatment in groups of two to seven children.
- Medical equipment identified in the IEP intended for only one child for use at school *and* home.

Provider Qualifications

Medicaid-covered OT services are performed by or under the direction of a licensed DPI occupational therapist.

Licensed OT providers may only delegate to certified occupational therapy assistants (OTAs) those portions of a child's therapy that are consistent with the OTA's education, training, and experience. Licensed OT providers are required to have direct, face-to-face contact with OTAs on the premises at least every 14 days.

Prescription Requirements

Occupational therapy services require a minimum of one physician's prescription annually *or* the SBS provider is required to have a Request for a Waiver to Wisconsin Medicaid Prescription Requirements Under the School-Based Services Benefit form on file with Wisconsin Medicaid. Refer to Appendix 7 of this handbook for a copy of the form.

Nursing Services

Covered Services

Nursing services must be appropriate for the child's medical needs and specifically identified in the child's IEP. Covered nursing services under the SBS benefit are described in s. HFS 107.36, Wis. Admin. Code. Services include, but are not limited to:

- Evaluation and management services, including screens and referrals for health needs.
- Treatment.
- Medication management.

All time that a nurse spends conducting activities with the child that are included in the child's IEP may be submitted to Wisconsin Medicaid for reimbursement.

Like all school-based services, nursing services identified in the IEP must have outcome-based goals. The goals must be detailed in either the IEP if there are student goals or in the IHP if there are nursing goals. Goals for medication management must be identified as well (e.g., seizure medication to prevent and/or treat seizures).

The child's IEP must identify each specific nursing service (e.g., medication management, suctioning, dressing changes, nebulization treatment, G-tube feeding). The IHP should identify the personnel, by name, who will perform the services.

Durable medical equipment related to nursing services are *not* covered school-based services. Consult with a DME provider to determine whether equipment will be covered under the Medicaid DME benefit.

Provider Qualifications

Medicaid-covered nursing services are performed by a registered nurse (RN), licensed practical nurse (LPN), or are delegated under nursing protocols, according to ch. N 6, Wis. Admin. Code.

Prescription Requirements

Services are required to be prescribed at least *annually* by a physician. Medication management is required to be prescribed annually by a licensed practitioner as defined in s. 118.29(1)(e), Wis. Stats.

Required Documentation

Providers may use one of two methods, *time* or *task*, when documenting and submitting claims for covered nursing services. Refer to the Documentation Requirements section of this handbook for documentation requirements for both methods.

Delegation of Nursing Services

Under the Standards of Practice for Registered Nurses and Licensed Practical Nurses, ch. N 6, Wis. Admin. Code, only RNs may delegate nursing services to an LPN or individual without a medical license. The RN who delegates these services is required to follow nursing protocols pursuant to ch. N 6, Wis. Admin. Code, including training, evaluation, and supervision.

An exception to the rules of nursing delegation in schools is medication administration. Wisconsin law *allows* school staff without a medical license to administer medication provided all protocols of s. 118.29 and 118.291, Wis. Stats., are followed. An RN is required to develop medication administration policies and procedures and train staff in medication administration. Formal nursing delegation is not uniformly required but the determination of need to do so must be made by an RN. However, because Wisconsin Medicaid can only reimburse providers for medical services, under the SBS benefit Wisconsin Medicaid *only* covers medication administration by *unlicensed school staff* when it is a *delegated nursing act* by the RN *and is documented as such*.

Nursing Tasks Reimbursable for Full-Time Health Aides

A school or a prescribing physician may determine it necessary for a child to have a full-time aide. However, Wisconsin Medicaid will *not* reimburse for all the aide's time. Wisconsin Medicaid will reimburse SBS providers *only* for the times associated with performing *specific covered nursing tasks* (e.g., G-tube feeding, suctioning, medication management) identified in the IEP.

Time spent on educational tasks or on monitoring the child is not covered and will not be reimbursed even though a full-time aide may be required. Educational tasks include, but are not limited to, vocabulary development, reinforcement of classroom instruction, and rote learning skills (e.g., counting, name printing, coin labeling). Examples of monitoring include, but are not limited to, having an aide present *in case* the child has a seizure or behavior outburst. Only time spent performing *face-to-face covered nursing tasks* identified in the IEP can be reimbursed.

Medicaid-covered nursing services are performed by a registered nurse (RN), licensed practical nurse (LPN), or are delegated under nursing protocols, according to ch. N 6, Wis. Admin. Code.

Services Provided by Teachers

As stated in s. 1905(a) of the Social Security Act, Wisconsin Medicaid can reimburse providers only for medical services. Therefore, under the SBS benefit, Wisconsin Medicaid can reimburse SBS providers only for the following types of services performed by special education teachers, diagnostic teachers, or DPI-licensed teachers:

- *Individualized Education Program meetings.* Wisconsin Medicaid covers IEP meetings during which Medicaid-covered school-based services are discussed *when the child is present.*
- *Delegated nursing acts.* Although s. 118.29, Wis. Stats., allows school staff to dispense medication without it being a delegated nursing act, Wisconsin Medicaid only covers a medically related service provided by a teacher (or other school personnel) when it is a *delegated nursing act* by the school nurse and documented as such.

School-based testing and assessment services performed by therapists, psychologists, social workers, counselors, and/or nurses are included in the covered school-based services for their respective professional areas and should be billed accordingly.

Psychological Services, Counseling, and Social Work Services

Covered Services

Psychological services, counseling, and social work services include diagnostic or active treatments intended to reasonably improve the child's physical or mental condition. The following services are covered if they are identified in the child's IEP:

- Diagnostic testing and evaluation that assesses cognitive, emotional, and social functioning and self-concept.
- Therapy and treatment that plans, manages, and provides a program of psychological services, counseling, or social work services to children with psychological or behavioral problems.
- Crisis intervention.
- Treatment, psychological counseling, and social work services to individuals or groups of two to 10 individuals.

Provider Qualifications

Psychological services, counseling, and social work services must be performed by a licensed DPI school psychologist, school counselor, or social worker.

Prescription Requirements

Psychological services, counseling, and social work services must be prescribed annually by a physician or licensed Ph.D. psychologist, *or* the SBS provider is required to have a Request for a Waiver to Wisconsin Medicaid Prescription Requirements Under the School-Based Services Benefit form on file with Wisconsin Medicaid. Refer to Appendix 7 of this handbook for a copy of the form.

Other Developmental Testing and Assessments

Covered Services

Wisconsin Medicaid covers other developmental testing, assessments, and consultations when resulting in a new or revised IEP. These services must be performed *face-to-face* with the child by a licensed health professional. Staff providing these services must be DPI-licensed.

Covered school-based developmental and testing services include evaluations, tests, and related activities performed to determine if motor, speech, language, or psychological problems exist, or to detect developmental lags in the determination of eligibility under the Individuals with Disabilities Education Act (IDEA).

School-based testing and assessment services performed by therapists, psychologists, social workers, counselors, and/or nurses are included in the covered school-based services for their respective professional areas and should be billed accordingly.

Provider Qualifications

Other developmental testing, assessments, and consultation services must be performed by a licensed physician or psychiatrist, director of special education and/or pupil services, special education teacher, diagnostic teacher, or other certified school staff. Wisconsin Medicaid only covers this testing and assessment for teachers when it results in a new or revised IEP. All providers are required to be DPI licensed.

Prescription Requirements

A prescription is not required for other developmental testing assessments. However, providers are expected to fully document the rationale for all testing procedures in the child's record. Providers will be notified by Wisconsin Medicaid if prescription requirements for other developmental testing and assessments change.

Transportation Services

Covered Services

Wisconsin Medicaid covers school-based transportation services based on criteria set by the CMS. Refer to Appendix 21 of this handbook for a summary of CMS-covered transportation policy.

School-Based Services providers may submit claims for specialized medical transportation that a child would not otherwise receive in the course of attending school. The specialized medical transportation, which must be listed in the child's IEP, may include, but is not limited to, the following:

- A specialized medical vehicle (SMV) (equipped with a ramp or lift) where the child requires a ramp or lift.
- Transportation in any vehicle where an aide is required to assist the child.
- A specially adapted bus for a child with a disability who is not able to ride a standard school bus.
- A vehicle routed to an area that does not have school bus transportation that the child requires because of a disability.

Wisconsin Medicaid reimburses SBS providers for transportation *only* on days when a child is receiving a covered school-based service (other than transportation) in the following situations:

- Transportation to and from school when a child receives a covered school-based service at school.
- Transportation to and from an off-site location to receive a covered school-based service provided the child is in school that day. In this case, transportation between school and home is *not* covered.

Refer to the Documentation Requirements section and Appendix 20 of this handbook for instructions and examples of how to document claims for reimbursement.

Provider Qualifications

Medicaid-covered specialized medical transportation services must be performed by a school or school-contracted transportation provider.

Prescription Requirements

A prescription is not required for school-based specialized medical transportation services.

Limitations

Individualized Education Programs must include only specialized medical transportation services that a child would not otherwise receive in the course of attending school. For example, a child with special education needs under IDEA, who rides the standard school bus to school with children without disabilities, should not have transportation listed in his or her IEP, and the cost of that bus ride must not be billed to Wisconsin Medicaid as a school-based service.

When specialized medical transportation services are included in the child's IEP, providers may seek reimbursement *only* under the SBS benefit. Claims for school-based transportation services, as described in the IEP, cannot be submitted to Wisconsin Medicaid by SMV providers or billed to a county by county common carrier providers.

Medicaid-covered specialized medical transportation services must be performed by a school or school-contracted transportation provider.

School-Based Services providers have the option to submit a Request for a Waiver to Wisconsin Medicaid Prescription Requirements Under the School-Based Services Benefit form to Wisconsin Medicaid.

Durable Medical Equipment

Covered Services

Durable medical equipment is a covered school-based service when:

- The need for the equipment is identified in the child's IEP.
- Only one child uses the equipment.
- The child uses the equipment at school and at home (the child owns the equipment, not the SBS provider).
- The equipment is *not* covered under Wisconsin Medicaid's DME benefit.

Wisconsin Medicaid reimburses for DME related to SLP, audiology and hearing services, PT, and OT when the equipment meets these criteria. Wisconsin Medicaid does not reimburse for DME related to nursing services under the SBS benefit.

Contact Wisconsin Medicaid or a Medicaid-certified DME supplier to determine if the Medicaid DME benefit covers a particular item.

Prescription Requirements

A prescription is not required for DME when it is provided as a school-based service. Providers will be notified by Wisconsin Medicaid if prescription requirements for DME change.

Prescription Waivers

School-Based Services providers have the option to submit a Request for a Waiver to Wisconsin Medicaid Prescription Requirements Under the School-Based Services Benefit form to Wisconsin Medicaid. This form waives some Medicaid prescription requirements. The waiver covers the following school-based services provided to all Medicaid-eligible children at the school:

- Speech and language pathology, audiology, and hearing services.
- Physical therapy services.
- Occupational therapy services.
- Psychological services, counseling, and social work services.

One prescription waiver request is sufficient for all applicable services. Refer to Appendix 7 of this handbook for a copy of the form.

Submit forms to Wisconsin Medicaid at the following address:

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

Refer to Appendix 6 of this handbook to compare Medicaid prescription requirements for specific service categories with and without a prescription waiver. School-based transportation services do not require a prescription.

Community-Based Therapies and School-Based Services

In addition to covering school-based services, Wisconsin Medicaid reimburses community-based therapists separately for Medicaid services not provided under the SBS benefit that are not in the recipient's IEP.

To determine medical necessity, Wisconsin Medicaid requires community-based therapy providers to obtain prior authorization (PA) for services that could also be reimbursed under the SBS benefit. The medical necessity of school-based services is reviewed in the IEP process, whereas medical necessity is reviewed in the PA process for community therapists.

When adjudicating PA requests for community-based therapies, Wisconsin Medicaid considers the medical necessity of services and other criteria including, but not limited to, whether the service is appropriate, cost-effective, and non-duplicative of other services. As part of the PA process, community therapists submit the child's IEP with their request to provide services.

Medicaid consultants review the IEP in addition to all other required material and records to determine if the child is already receiving services that meet the child's therapy needs. The IEP is not the only material considered when determining medical necessity.

Wisconsin Medicaid's professional consultants *do not* base approval or denial of PA requests on whether the school pursues reimbursement through the SBS benefit. The consultants do not review the SBS claims information. Therefore, whether an SBS provider seeks reimbursement for school-based services does not influence whether a community therapy PA request is approved or denied.

Refer to the Wisconsin Medicaid School-Based Services Fact Sheet in Appendix 8 of this handbook, which may be used to inform parents about the relationship between community therapies and school-based services.

Noncovered Services

The following services are not covered under the SBS benefit, in accordance with HFS 107.36(3), Wis. Admin. Code:

- Art, music, and recreational therapies.
- Diapering.
- Durable medical equipment covered under HFS 107.24, Wis. Admin. Code.
- General classroom instruction and programming. For example, developmental guidance in the classroom.
- General research and evaluation of the effectiveness of school programs.
- Kindergarten or other routine screening provided free of charge unless resulting in an IEP referral.

  Note: HealthCheck screens are reimbursable to Medicaid HealthCheck providers but are not reimbursable under the SBS benefit.

- Nonmedical feeding that is not tube feeding or part of a medical program, such as a behavior management program.
- Program coordination of gifted and talented students or student assistance programs.
- Services, including school health program services, which are not in the child's IEP.
- Services performed by providers who are not certified for school-based services.
- Services that are strictly educational, vocational, or pre-vocational in nature or without a defined medical component. For example, vocabulary development, specialized (adaptive) physical education classes, rote learning skills (e.g., counting, name printing, and coin labeling).
- Staff development and in-services to school staff and parents.

In addition, the following are also not covered under the SBS benefit:

- Any non-face-to-face activities (i.e., the child is not present).
- Any services listed under s. 504 of the Rehabilitation Act of 1973, unless specifically listed in the child's IEP.

Medicaid consultants review the IEP in addition to all other required material and records to determine if the child is already receiving services that meet the child's therapy needs.

Documentation Requirements

Wisconsin Medicaid requires SBS providers to include Individualized Education Program (IEP) information in each child's record.

Medicaid Documentation Standards

Documentation must be kept in each recipient's record, as required under HFS 106.02(9), Wis. Admin. Code.

Refer to the Provider Rights and Responsibilities section of the All-Provider Handbook for general information on preparing and maintaining records.

School-Based Services (SBS) providers are required to follow Wisconsin Medicaid's coverage policies and documentation standards when submitting claims for services provided under the SBS benefit. Failure to do so may result in a federal government audit.

Individualized Education Program Documentation

Wisconsin Medicaid requires SBS providers to include Individualized Education Program (IEP) information in each child's record. All services for the child must be listed in the IEP to be reimbursed by Wisconsin Medicaid. This information must be kept for at least *five years*, regardless of other requirements set by the Department of Public Instruction.

The IEP information must include the following:

- Documentation used to develop an IEP (e.g., IEP Team reports or tests).
- The annual IEP revision that documents any changes in the IEP or related services.
- A description of durable medical equipment (DME), if applicable. (Include the item name, model number or a description, and the invoice, receipt, or cost.)

Documenting Face-to-Face Sessions

In addition to the previously listed items, each child's file must include a signed record documenting each face-to-face session with a provider. Documentation (either electronic or handwritten medical records) must be kept for at least *five years* and include the following information:

- School's name.
- Student's name (including first and last name).
- Student's birth date.
- The prescription for the service, when required.
- Category of service provided (e.g., speech and language pathology).
- Date(s) of service (DOS). Several dates or sessions may be included on one record if they are for the same category of service.
- Time, quantity, or miles provided. (Units are documented when submitting claims.)
- Whether service was provided in a group or individual setting.
- Services that are listed in the IEP.
- Documentation that the child was present at IEP meetings for the meeting to be covered by Wisconsin Medicaid.
- Attendance records verifying the child was in school on the DOS.
- Brief description of the specific service provided. Here are a few examples that include the level of detail Wisconsin Medicaid requires:
  - ✓ Activities of daily living, such as "buttoning skills."
  - ✓ Range of motion (ROM), such as elbow or wrist ROM.
  - ✓ Medication management, Tegretol, 200 mg (oral).
- Student's progress or response to each service delivered (required for nursing services and recommended for all other services). (Progress or response is not

required for transportation or routine transferring.) Monthly progress and response notes are required for all other school-based services.

- Documentation of contacts with fee-for-service providers at least annually (e.g., an SBS speech-language pathologist and a community speech-language pathologist discuss the progress of a student with whom they each work).
- Documentation of contacts with non-Medicaid providers at least annually. Examples of non-Medicaid providers include a physician or nurse practitioner in private practice who is not Medicaid certified.
- Documentation of contacts with state-contracted HMOs at least annually. (Memorandums of Understanding between SBS providers and state-contracted HMOs in their service areas are required.)
- Name and signature of individual who performed service(s).
- Commercial health insurance information (for therapy services only). If a child has commercial health insurance, this includes documentation of billing commercial health insurance or decreasing the units billed to Wisconsin Medicaid.
- Documentation of local matching and certified public expenditures. This documentation must be submitted to Wisconsin Medicaid annually.

Refer to the Provider Rights and Responsibilities section of the All-Provider Handbook for information about standard record keeping requirements. Wisconsin Medicaid does not require a particular format for data collection.

Examples of Medical Records Requiring a Signature

The following is an example list of medical records that require the performer's signature, as outlined in Wisconsin Administrative Code, *Wisconsin Medicaid and BadgerCare Updates*, and Wisconsin Medicaid handbooks. Examples include, but are not limited to:

- Care plans.
- Physician's orders or prescriptions.
- Physician's verbal orders when reduced to writing.
- Progress notes.
- Therapy plans.
- Written protocols.
- All documentation of Medicaid-covered services provided to or for a recipient. Examples include, but are not limited to:
  - ✓ Assessments.
  - ✓ Case notes.
  - ✓ Daily documentation.
  - ✓ Encounter notes.
  - ✓ Flow sheets.
  - ✓ Medication sheets.
  - ✓ Service provision notes.

Electronic Records

Electronic Signature Standards

Schools that maintain patient records by computer rather than hard copy may use electronic signatures. However, such entries must be properly authenticated and dated. Authentication must include signatures, written initials, or computer-secure entry by a unique identifier of a primary author who has reviewed and approved the entry. The school is required to have safeguards to prevent unauthorized access to the records and a process for reconstruction of the records upon request from Wisconsin Medicaid, its fiscal agents, auditors, or other authorized personnel or in the event of a system breakdown. Signatures must be applied when the medical records are charted electronically.

Schools that maintain patient records by computer rather than hard copy may use electronic signatures.

Charting Medical Records Electronically — General Provider Requirements

Charting medical records electronically is subject to the same requirements as paper documentation. In addition, the following requirements apply:

- Providers are required to have a paper or electronic back-up system for charting medical records electronically. This could include having files saved on disk or CD in case of computer failure.
- For audits conducted by the Division of Health Care Financing or the federal government, providers are required to produce paper copies of electronic records.
- Providers are required to have safeguards to prevent unauthorized access to the records.

Documentation of Nursing Services Units

Wisconsin Medicaid recommends SBS providers use the following optional activity logs provided to document SBS nursing activities:

- Optional School-Based Services Activity Log Nursing/Therapy Medical Services (refer to Appendix 18 of this handbook).
- Optional School-Based Services Activity Log Medication Administration (refer to Appendix 19 of this handbook).

The use of these two forms is voluntary. Providers may develop their own activity logs; however, they must include all the requested information in the optional activity logs.

Providers may develop their own activity logs; however, they must include all the requested information in the optional activity logs.

Providers may use one of the following two methods when documenting activities and submitting claims for covered school-based nursing services:

- Time method.
- Task method.

Providers may not use a combination of the time and task methods on the same activity log.

Time Method

There are two different ways to document activities using the time method. Descriptions of both ways are as follows:

- The provider of services can document the *specific times of the day* associated with the tasks (e.g., 8:04 a.m. - 8:34 a.m. — G-tube feeding).
- The provider of services can record the *number of minutes* it took to provide the tasks (e.g., transfer onto toilet — 3 times = 30 minutes total).

Providers may only use one of these types of time method documentation on an activity log.

The provider of services should reflect the total time of Medicaid-reimbursable services for both medication administration and nursing services rendered on their billing sheets. Refer to Appendices 14 and 15 of this handbook for examples of the two types of time method documentation on the Optional School-Based Services Activity Log Nursing/Therapy Medical Services and the Optional School-Based Services Activity Log Medication Administration.

Task Method

The provider of services may choose to use the task method, which is based on the number of times tasks were performed.

For this method, the provider of services is required to do the following:

- Document the number of times each nursing task is provided for each child on a specific day.
- Multiply the number of times a specific task was performed by the unit found on the conversion chart in Appendix 13 of this handbook (e.g., G-tube feeding = 2.0 units per task).
- Document the total units, identifying the DOS.

Refer to Appendices 16 and 17 of this handbook for examples of task method documentation on the Optional School-Based Services Activity Log Nursing/Therapy

Medical Services and the Optional School-Based Services Activity Log Medication Administration.

If a nursing service is performed but is not listed on the conversion chart (e.g., epi-pen auto injection), report the actual time and convert to units using the standard record keeping and billing method (15 minutes = 1.0 unit). If a new task becomes a recurring task and average times need to be established, write to:

Medicaid SBS Policy Analyst
Division of Health Care Financing
PO Box 309
Madison WI 53701-0309

Nursing Services Documentation Requirements

Providers are required to *document in writing and keep on file* the date on which they began using a new method or any time thereafter when methods are changed. Providers are then required to use the same method, whether time or task, for *all* Medicaid-eligible children.

Documentation of nursing services must include the results or outcomes of services (i.e., whether or not the services were effective, the response, and the method used if the initial method did not work). Documentation of results are required for *all* nursing services with the exception of successful transfers.

Nursing Standards of Practice for Documentation

Nurses are required to comply with nursing clinical practice standards for documentation, even though this is not a specific additional Medicaid requirement. These documentation standards must be met whether the SBS provider is using the time or the task method to meet Medicaid's documentation requirements.

Under nursing clinical practice standards, clinical/visit notes give a clear, comprehensive picture of the recipient's continual status, the care being provided, and the response to that care. The nurse is required to be specific about times in his or her charting, especially the exact time of sudden changes in the recipient's condition (e.g., seizure), significant events (e.g., a fall), and nursing actions that include medication administration and other treatments (e.g., tube feedings).

Documentation of Transportation Services Units

Providers may submit claims for SBS transportation to Wisconsin Medicaid using a daily base rate with procedure code T2003 for covered school-based transportation services. The first 20 miles of the trip are included in the daily base rate. The daily base rate is equal to one unit.

For transportation services of more than 20 miles, SBS providers may submit claims using procedure code A0425 in addition to procedure code T2003. Providers may bill the first 20 miles using the base rate procedure code T2003 and then bill the remaining miles of the trip using procedure code A0425, with each additional mile equal to one unit. For those services of more than 20 miles, providers are required to indicate the pickup and drop-off locations and total miles in the child's record. Providers may also choose to bill only the base rate code for children whose mileage exceeds 20 miles.

Note: If the total number of miles is not documented in a child's record, a provider may only use procedure code T2003.

Refer to Appendix 20 for examples demonstrating the use of the school-based transportation services procedure codes.

Providers may submit claims for SBS transportation to Wisconsin Medicaid using a daily base rate with procedure code T2003 for covered school-based transportation services.

Transportation Services Documentation Requirements

Providers are required to include all of the following information in the record of each child who receives school-based transportation services:

- The child's first and last name and date of birth.
- The general service category (transportation).
- The DOS that school-based transportation services were provided.
- Documented verification that the child was in school and received a school-based service other than transportation on the date the transportation was provided.

  Note: It is critical that providers verify that a recipient received a school-based service on a particular day before billing for transportation services for that day.

- The total number of miles, only when seeking reimbursement for more than the 20-mile daily base rate for that day (the provider will need to use procedure code A0425 in addition to T2003 for claims).
- The pick-up and drop-off locations, only when seeking reimbursement for more than the 20-mile daily base rate for that day. If the locations are home or school, these can be described in general terms, such as "home to school" or "school to home." If the school-based service is at a place other than the school, a more specific description including the name of the facility and street address is required.

This information may be included in the trip log.

It is critical that providers verify that a recipient received a school-based service on a particular day before billing for transportation services for that day.

Documentation of Other School-Based Services Units

School-Based Services providers should use the following general guidelines to determine service units for covered school-based services:

- One piece of equipment equals one unit for DME services.
- Fifteen minutes of face-to-face time with the recipient equals one unit for the following services:
  - ✓ Audiology and hearing services.
  - ✓ Counseling services.
  - ✓ Individualized Education Plan assessment.
  - ✓ Individuals with Disabilities Education Act assessment.
  - ✓ Occupational and physical therapy services.
  - ✓ Psychological services.
  - ✓ Social work services.
  - ✓ Speech and language pathology, audiology, and hearing services.

Coordination of Benefits

Commercial Health Insurance Liability Requirement

Wisconsin Medicaid is usually the payer of last resort for any Medicaid-covered service. This means that Wisconsin Medicaid requires Medicaid providers to seek payment from a recipient's commercial or other health insurance before seeking payment from Wisconsin Medicaid (42 CFR s. 433.139[c]). However, school-based services (SBS) providers may also assume the insurance liability amount (the amount that providers are required to bill commercial health insurance before requesting reimbursement from Wisconsin Medicaid). Instead of seeking payment from the child's commercial health insurance, SBS providers may absorb these costs themselves.

Under the SBS benefit, Wisconsin Medicaid requires providers to seek payment from the commercial insurer *only* for physical therapy (PT) and occupational therapy (OT) services before billing Wisconsin Medicaid if a child has commercial health insurance. Providers are required to obtain parental consent to bill a child's commercial health insurance.

Under the SBS benefit, Wisconsin Medicaid requires providers to seek payment from the commercial insurer *only* for physical therapy (PT) and occupational therapy (OT) services before billing Wisconsin Medicaid if a child has commercial health insurance.

Refusal of Parental Consent

If parents refuse consent to bill commercial health insurance, providers may assume liability for the services as described in this section.

When the Commercial Insurance Liability Requirement Does *Not* Apply

Wisconsin Medicaid's insurance liability requirement does *not* apply for the following school-based services:

- Durable medical equipment.
- Development, revision, review, and annual evaluation/re-evaluation of the Individualized Education Plan (IEP).
- Nursing services.
- Other developmental testing and assessments.
- Psychological services, counseling, and social work services.
- Speech and language pathology, audiology, and hearing services.
- Transportation services.

When the insurance liability requirement does not apply, SBS providers are not required to bill commercial health insurance. Instead, they may seek reimbursement directly from Wisconsin Medicaid *without* first seeking payment from the child's commercial health insurance, if any.

If providers obtain parental consent, they may bill the child's commercial health insurance for the previously mentioned school-based services that the insurance liability requirement does not apply to, but Wisconsin Medicaid does not require them to do so.

Exclusionary Clauses

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

If the commercial health insurance policy contains an exclusionary clause, providers are required to submit claims for all school-based services directly to Wisconsin Medicaid, then document in the child's record that the child's commercial health insurance has an exclusionary clause for school medical services.

When Commercial Insurance Liability Requirement Does Apply

The Medicaid insurance liability requirement applies for the following school-based services:

- Occupational therapy — group or individual.
- Physical therapy — group or individual.

School-Based Services providers are required to choose one of the following three options when the Medicaid insurance liability applies:

1. Assume the insurance liability amount.
2. Seek payment from the child's commercial health insurance.
3. Do not seek reimbursement from Wisconsin Medicaid for these services.

Assume the Insurance Liability Amount

Under this option, providers do not contact or bill a child's commercial health insurance. This is achieved by not submitting claims to Wisconsin Medicaid for one unit of OT (group or individual) and/or one unit of PT (group or individual) for each calendar month.

Providers should use the following procedures when assuming the insurance liability amount:

1. Do not submit claims to Wisconsin Medicaid for the first occurring unit of OT (group or individual) or PT (group or individual) during the calendar month.

   Submit claims for the remaining OT and/or PT to Wisconsin Medicaid following the claim instructions. When choosing this option, do not enter an "other insurance" indicator on the claim form.
2. Providers are required to document in the child's record the date(s) of service on which the unit of OT and/or PT was provided for which the SBS provider is assuming the cost of the insurance liability.
3. Providers should retain documentation indicating that they covered the standard monthly insurance liability unit amount for OT and/or PT from a nonfederal source of funds, instead of billing the child's health insurance.

Seek Payment from the Child's Commercial Health Insurance

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

Under education law, providers are required to obtain parental permission to bill the child's commercial health insurance for school-based services.

Federal education regulations allow parents of a child with an IEP receiving school-based services to refuse consent to bill their commercial health insurance if it results in a cost to the family under the Individuals with Disabilities Education Act. Cost to the family includes any of the following:

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

Providers may submit a claim to Wisconsin Medicaid for remaining units not paid by commercial health insurance.

Do Not Seek Payment from Wisconsin Medicaid for Any Services

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

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

Using Billing Services, Billing Agents, or Private Independent Consultants

A billing service or agent cannot base payments from SBS providers on a commission basis, in which reimbursement to the billing service or agent is dependent on reimbursement from Wisconsin Medicaid.

Providers Using a Billing Service or Billing Agent

Providers may either submit claims to Wisconsin Medicaid directly or use a billing service or agent to prepare and submit SBS claims.

A billing service or agent cannot base payments from SBS providers on a commission basis, in which reimbursement to the billing service or agent is dependent on reimbursement from Wisconsin Medicaid. The billing service or agent *may not be paid a percentage* of the reimbursement received from Wisconsin Medicaid. Providers may pay the billing service or agent an hourly rate or a flat fee per week or month.

Providers Contracting with Private Independent Consultants

Providers may use private consultants to provide additional services *other* than ongoing Medicaid claims submissions. Typically, other consultant services are "up-front," short-term activities usually starting when a provider initially plans for or begins a new program. Private consultant activities other than claims submission include nonroutine efforts to clarify the amount and availability of Medicaid reimbursement for school-based services such as:

- Discussions with the SBS provider about additional services that might be claimed.
- Legal and other research regarding Medicaid covered services.
- Negotiation with state and federal officials regarding expanded coverage.

Providers may pay for these consultant services (services other than Medicaid claims submission) based on a percentage of the reimbursement collected from Wisconsin Medicaid, provided the consultant payment (if using the same consultant for billing) is billed and recorded separately from payment for claim preparation and submission services.

Responsibility for Claims

School-Based Services providers are responsible for the accuracy, adherence to Medicaid policy, truthfulness, and completeness of all claims submitted, whether prepared and submitted by the provider or by a billing agency. In addition, private independent consultants are not the final authority on Wisconsin Medicaid policy.

Claims Submission

All claims, whether electronic or paper, are subject to the same Medicaid policy and legal requirements.

Electronic Claims Submission

School-Based Services providers are encouraged to submit claims electronically. Electronic claims submission:

- Reduces processing time.
- Eliminates manual handling of claims.
- Reduces both billing and processing errors.

School-Based Services (SBS) providers are encouraged to submit claims electronically.

The Division of Health Care Financing (DHCF) offers electronic billing software at no cost to providers. To obtain the software, known as Provider Electronic Solutions (PES), providers should call the DHCF Electronic Data Interchange (EDI) Department at (608) 221-9036, e-mail *wiedi@dhfs.state.wi.us*, or request the software from the Medicaid Web site at *dhfs.wisconsin.gov/medicaid/*.

For further information about PES software, refer to the EDI section of the Medicaid Web site.

Paper Claims Submission

Providers submitting paper claims are required to use the CMS 1500 claim form (dated 12/90). Refer to Appendix 9 of this handbook for CMS 1500 claim form completion instructions and Appendix 10 of this handbook for a completed sample claim form.

Wisconsin Medicaid denies claims for school-based services submitted on any paper claim form other than the CMS 1500 claim form.

Wisconsin Medicaid does not provide the CMS 1500 claim form. It may be obtained from any vendor that sells federal forms.

Where to Send Paper Claims

Providers may mail completed CMS 1500 paper claim forms for reimbursement to the following address:

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

Claims Submission Deadline

Wisconsin Medicaid must receive properly completed claims within 365 days from the date the service was provided. This policy applies to initial claims submissions, resubmissions, and adjustment requests, with rare exceptions.

Exceptions to the 365-day claims submission deadline and requirements for submission to Timely Filing can be found in the Claims Submission section of the All-Provider Handbook.

Reimbursement

Wisconsin Medicaid currently reimburses school-based services (SBS) providers 60 percent of federal funding for school-based services and allowable administrative costs. The remaining 40 percent of federal funding is deposited in the State General Fund because of the state's contribution to special education in public schools.

Statewide rates are set by the Department of Health and Family Services for all covered school-based services. Federal matching rates are published in *Wisconsin Medicaid and BadgerCare Updates* and on the Wisconsin Medicaid Web site at *dhfs.wisconsin.gov/medicaid/*.

If an adequate amount of expenditures are not certified on the Certification of Public Expenditures form and School-Based Services Matching Expenditures form, Wisconsin Medicaid will recover payments received for this period.

Certification of Expenditures

To qualify for the full amount of federal Medicaid matching funds provided by the state, SBS providers are required to certify sufficient certified expenditures. This demonstrates that a school district or Cooperative Educational Service Agency's (CESA) expenditures and costs are at least equal to the full Medicaid reimbursement included in federal and nonfederal funds.

If an adequate amount of expenditures are not certified on the Certification of Public Expenditures form, HCF 1003, and School-Based Services Matching Expenditures form, HCF 1004, Wisconsin Medicaid will recover payments received for this period. The Wisconsin Medicaid fee schedule for school-based services contains the contracted rate and is published in *Updates.*

Wisconsin Medicaid will send Certification of Public Expenditures forms to participating school districts and CESAs to be completed and returned annually.

Wisconsin Medicaid Requirements

Since the inception of the Wisconsin Medicaid benefit for school-based services, Wisconsin law has required that all expenditures for school medical services be incurred by the SBS provider, in order for the provider to receive a portion of the federal Medicaid match.

Under HFS 105.53(4), Wis. Admin. Code, Wisconsin Medicaid requires that participating providers submit evidence annually that program requirements for incurring SBS expenses have been met. School-Based Services providers are required to certify an accounting of the total expenditures for Medicaid-covered services provided to Medicaid-eligible children.

The Certification of Public Expenditures form must indicate that the total local expenditures for school-based services were at least equivalent to the sum of the total number of services billed times the contracted rate for each service during the fiscal year.

Submitting Forms

School-Based Services expenditures must be identified on the Certification of Public Expenditures form and the School-Based Services Matching Expenditures form. Providers are required to complete these forms annually and submit them to Wisconsin Medicaid.

The Certification of Public Expenditures form can be found in Appendix 1 of this handbook. The School-Based Services Matching Expenditures Completion Instructions and form may be found in Appendices 2 and 3 of this handbook.

The forms must be signed by an authorized representative of the SBS provider and must include the Medicaid provider number. The forms may be submitted by fax to (608) 266-1096, to the attention of the SBS Policy Analyst, or by mail to the following address:

SBS Policy Analyst/Certification of Public Expenditures
Division of Health Care Financing
PO Box 309
Madison WI 53701-0309

The Centers for Medicare and Medicaid Services require that these forms be submitted to the Department of Health Care Financing. Under federal requirements, provider documentation verifying the amount of certified expenditures must be maintained by the SBS provider for at least five years.

Federally Funded Providers

Providers whose positions are *partially* federally funded may request reimbursement from Wisconsin Medicaid for school-based services. However, these providers may only submit claims to Wisconsin Medicaid for the portion of their services that are locally funded. For example, a provider whose position is 50 percent federally funded may submit claims for only 50 percent of his or her services to Wisconsin Medicaid. Wisconsin Medicaid requires providers to keep appropriate documentation on file to substantiate these claims.

Wisconsin Medicaid does *not* reimburse for services performed by providers whose positions are *entirely* funded by federal dollars.

Appendix

Appendix 1
Certification of Public Expenditures
(for photocopying)

(A copy of the Certification of Public Expenditures is located on the following page.)

WISCONSIN MEDICAID
CERTIFICATION OF PUBLIC EXPENDITURES

Wisconsin Medicaid requires certain information to enable Medicaid to authorize and pay for medical services provided to eligible recipients. The Certification of Public Expenditures form provides Wisconsin Medicaid with certification of expenditures by school districts and Cooperative Educational Service Agencies (CESAs) for Medicaid-covered services. This form will be retained as part of the fiscal documentation for Wisconsin Medicaid.

The Certification of Public Expenditures is used by Wisconsin Medicaid and is a mandatory form. Failure to submit this form by the due date certifying an adequate amount of expenditures may result in the recoupment of Medicaid payments.

Providers may submit the signed Certification of Public Expenditures by fax to (608) 266-1096 to the attention of the school-based services (SBS) Policy Analyst or by mail to the following address:

SBS Policy Analyst/Certification of Public Expenditures
Division of Health Care Financing
PO Box 309
Madison WI 53701-0309

For the purposes of this form, "Medicaid-covered school-based services" include the services identified in HFS 107.36, Wis. Admin. Code, and outlined in the School-Based Services Handbook.

SECTION I — PROVIDER INFORMATION

Report Period	Wisconsin Medicaid Provider Identification Number
Name and Address — Provider	

Wisconsin Medicaid records indicate that during the report period, Wisconsin Medicaid reimbursed this provider a total of

$_____ in federal Medicaid funds, for the Medicaid-covered school-based services.

SECTION II — CERTIFICATION

This is to certify that:

- I am authorized to review, sign, and submit this form on behalf of this school district.
- This provider expended at least $_____ in public funds for Medicaid-covered school-based services, provided to Wisconsin Medicaid recipients during the report period. Further,
  - ✓ These public funds are not obligated to match other federal funds for any federal program.
  - ✓ These public funds are not federal funds, unless they are federal funds that are authorized by federal law to be used to match other federal funds.
- Records documenting these public expenditures are on file and are available for review.
- I have reviewed the foregoing and certify that the information reported is true and correct to the best of my knowledge and belief.

SECTION III — SIGNATURE

SIGNATURE — Authorized Representative	Date Signed
Name — Authorized Representative (print)	Telephone Number — Authorized Representative
Title — Authorized Representative	E-mail Address — Authorized Representative

Appendix 2
School-Based Services Matching Expenditures Completion Instructions
(for photocopying)

(A copy of the School-Based Services Matching Expenditures Completion Instructions is located on the following pages.)

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WISCONSIN MEDICAID
SCHOOL-BASED SERVICES MATCHING EXPENDITURES COMPLETION INSTRUCTIONS

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

The information on the School-Based Services Matching Expenditures form is mandatory. The use of this form is voluntary and providers may develop their own form to certify expenditures as long as it includes all the information on this form and looks exactly like this form.

Providers may submit the completed School-Based Services Matching Expenditures form by fax to (608) 266-1096 to the attention of the school-based services (SBS) Policy Analyst or by mail to the following address:

SBS Policy Analyst/Certification of Public Expenditures
Division of Health Care Financing
PO Box 309
Madison WI 53701-0309

SECTION I — SCHOOL DISTRICT OR COOPERATIVE EDUCATIONAL SERVICES AGENCY INFORMATION

Provide the name and Medicaid provider identification number of the school district or Cooperative Educational Services Agency (CESA) that provided the school-based services. The report period should be based on the state fiscal year that runs from July 1st through June 30th of the appropriate years.

SECTION II — DIRECT AND INDIRECT EXPENDITURES FOR SERVICES PROVIDED TO ALL RECIPIENTS

Element 1 — Direct Expenditures
Provide the direct expenses incurred in providing each type of service (columns A through G) to all recipients during the reporting period consistent with the guidelines in the federal Office of Management and Budget (OMB) Circular A-21. Direct expenses are expenditures that can be identified specifically with each service provided. Direct expenses include expenses for employee salary and fringe benefits, allocated supervisory and administrative salary and fringe benefits, equipment, materials, supplies, allocated support services, physical space, and depreciation. Other types of expenses that can be directly attributed or allocated to each provided service may also be included.

Element 2 — Reimbursement Received
In each column, provide the amount of federal reimbursement received for each type of service during the reporting period.

Element 3 — Direct Expend. Not Reimbursed
In each column, subtract the reimbursement amounts in Element 2 from the total direct expenditure amounts in Element 1. This amount indicates the direct expenditures incurred for providing the services that have not been reimbursed.

Element 4 — Indirect Allocation Percent
In each column, enter the unrestricted indirect cost percentage calculated using the Department of Public Instruction (DPI) local education agency (LEA) indirect rate worksheet. Attach a copy of the worksheet or indirect rate letter from the DPI.

Element 5 — Indirect Expenditures
In each column, multiply the direct expenditures not reimbursed in Element 3 by the unrestricted indirect allocation percentage in Element 4. This amount indicates the indirect expenditures incurred for providing the services.

Element 6 — Total Direct and Indirect Expend.
In each column, add the direct expenditures not reimbursed in Element 3 to the indirect expenditures in Element 5. This amount indicates the total of the direct expenditures not reimbursed and the indirect expenditures for providing the services.

SECTION III — ALLOCATION OF DIRECT AND INDIRECT EXPENDITURES FOR SERVICES PROVIDED TO WISCONSIN MEDICAID RECIPIENTS

Element 7 — Units Provided to All Students

In each column, provide the number of units of service provided to all students for each type of service during the reporting period. The units of service are as follows:

- Columns A through E — each unit of service is 15 minutes.
- Column F — each unit of service is up to 20 miles (the transportation base rate).
- Column G — each unit of service is one piece of equipment.

Optional Allocation Basis

Although it is preferable that the allocation of expenditures to Wisconsin Medicaid be made on the basis of units of service, if this information is not available for all students, the allocation ratio can be based on population. In this case, provide one of the following:

- The number of Wisconsin Medicaid recipients receiving each service compared to the number of all students receiving each service. In each column, provide the number of all students who received each type of service during the reporting period.
- The number of Wisconsin Medicaid recipients receiving all services compared to the number of all students receiving all services. In each column, provide the number of all students who received all services during the reporting period.

Element 8 — Units Prov. to Medicaid Recipients

In each column, report the number of units of service provided to Wisconsin Medicaid recipients for each type of service during the reporting period. The units of service are as follows:

- Columns A through E — each unit of service is 15 minutes.
- Column F — each unit of service is up to 20 miles (the transportation base rate).
- Column G — each unit of service is one piece of equipment.

Optional Allocation Basis

Although it is preferable that the allocation of expenditures be made on the basis of units of service, if this information is not available for all students, the allocation ratio can be based on population. In this case, provide one of the following:

- The number of Wisconsin Medicaid recipients receiving each service compared to the number of all students receiving each service. In each column, provide the number of Wisconsin Medicaid recipients who received each type of service during the reporting period.
- The number of Wisconsin Medicaid recipients receiving all services compared to the number of all students receiving all services. In each column, provide the number of Wisconsin Medicaid recipients who received all services during the reporting period.

Element 9 — Medicaid Allocation Percent

In each column, divide the number of units provided to Wisconsin Medicaid recipients (or the number of Wisconsin Medicaid recipients receiving each service) on Line 8 by the number of units provided to all students (or the number of all students receiving each service.) The percentage should be rounded to at least two decimal points (i.e., 11.25 percent or .1125.)

Element 10 — Allocated Expenditures

In each column, multiply the total direct and indirect expenditures in Element 6 by the Medicaid allocation percentage in Element 9. This amount indicates the direct and indirect expenditures that can be allocated to Wisconsin Medicaid.

Element 11 — TOTAL Columns A through G

Add the expenditures in Columns A through G in Element 10. This amount indicates the total amount of Medicaid expenditures that will be certified on the Certification of Public Expenditures form, HCF 1003.

SECTION IV — CALCULATION OF REQUIRED DISTRICT MATCH

Element 12 — Match Percent

In each column, provide the required district match percentage for the reporting period.

Element 13 — TOTAL

In each column, multiply the allocated expenditures in Element 10 with the required district match percentage in Element 12. This total indicates the amount of expenditures available to match federal Medicaid funding for each type of school-based service provided.

Element 14 — TOTAL Columns A through G

Add the expenditures in columns A through G in Element 13. This total indicates the amount of expenditures that are available to match federal Medicaid funding. This amount is for the school district or CESA's information only.

Appendix 3
School-Based Services Matching Expenditures
(for photocopying)

(A copy of the School-Based Services Matching Expenditures is located on the following page.)

DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Health Care Financing
HCF 1004 (Rev. 12/04)

STATE OF WISCONSIN

WISCONSIN MEDICAID
SCHOOL-BASED SERVICES MATCHING EXPENDITURES

SECTION I — SCHOOL DISTRICT OR COOPERATIVE EDUCATIONAL SERVICES AGENCY INFORMATION

Name — School District or Cooperative Educational Service Agency			Medicaid Provider Number
Report Period Start Date	Report Period End Date	Name — Preparer	Date Prepared

SECTION II — DIRECT AND INDIRECT EXPENDITURES FOR SERVICES PROVIDED TO ALL RECIPIENTS

	COLUMN A SPEECH THERAPY	COLUMN B OCCUPATIONAL THERAPY	COLUMN C PHYSICAL THERAPY	COLUMN D PSYCH. COUNSEL. SOCIAL WORK	COLUMN E NURSING	COLUMN F TRANSPORTATION	COLUMN G DURABLE MEDICAL EQUIP.
1. Direct Expenditures	$	$	$	$	$	$	$
2. Reimbursement Received	$	$	$	$	$	$	$
3. Direct Expend. Not Reimbursed	$	$	$	$	$	$	$
4. Indirect Allocation Percent	%	%	%	%	%	%	%
5. Indirect Expenditures	$	$	$	$	$	$	$
6. Total Direct and Indirect Expend.	$	$	$	$	$	$	$

SECTION III — ALLOCATION OF DIRECT AND INDIRECT EXPENDITURES FOR SERVICES PROVIDED TO WISCONSIN MEDICAID RECIPIENTS

	COLUMN A	COLUMN B	COLUMN C	COLUMN D	COLUMN E	COLUMN F	COLUMN G
7. Units Provided to All Students							
8. Units Prov. to Medicaid Recipients							
9. Medicaid Allocation Percent	%	%	%	%	%	%	%
10. Allocated Expenditures	$	$	$	$	$	$	$

11. TOTAL Columns A – G (Enter this amount on the Certification of Public Expenditures form [HCF 1003]) . . . . . $ _____

SECTION IV — CALCULATION OF REQUIRED DISTRICT MATCH

	COLUMN A	COLUMN B	COLUMN C	COLUMN D	COLUMN E	COLUMN F	COLUMN G
12. Match Percent	%	%	%	%	%	%	%
13. TOTAL	$	$	$	$	$	$	$

14. TOTAL Columns A – G (Expenditures available for matching federal Medicaid funding) . . . . . $ _____

For Office Use Only	**Name — Provider**	**Report Period**

Appendix 4
Sample Memorandum of Understanding Between HMO and Medicaid-Certified School District, CESA, CCDEB, or Charter School for the School-Based Services Benefit

(The Sample Memorandum of Understanding Between HMO and Medicaid-Certified School District, CESA, CCDEB, or Charter School for the School-Based Services Benefit is located on the following page.)

SAMPLE MEMORANDUM OF UNDERSTANDING BETWEEN HMO AND MEDICAID-CERTIFIED SCHOOL DISTRICT, CESA, CCDEB, OR CHARTER SCHOOL FOR THE SCHOOL-BASED SERVICES BENEFIT

School-Based Services (SBS) is a benefit paid fee-for-service by Wisconsin Medicaid for all school-enrolled recipients, including those enrolled in HMOs. The SBS provider is responsible for services listed in a child's Individualized Education Program (IEP), which includes occupational, physical, and speech therapies, nursing services, mental health services, and testing services when provided by the SBS provider. HMOs are responsible for providing and managing medically necessary services outside school settings. However, there are some situations in which schools cannot provide services, such as after school hours, during school vacations, and during the summer. Therefore, avoidance of duplication of services and promotion of continuity of care for Medicaid and BadgerCare HMO recipients requires cooperation, coordination, and communication between the HMO and the SBS provider.

The HMO and the SBS provider agree to facilitate effective communication between agencies, to work to resolve interagency coordination and communication problems, and to inform staff from both the HMO and the SBS provider about the policies and procedures for this cooperation, coordination, and communication. Recognizing that these "clients-in-common" could receive duplicate services and could suffer with problems in continuity of care (e.g., when the school year ends in the middle of a series of treatments), the HMO and the SBS provider agree to cooperate in communicating information about the provision of services and in coordinating care.

This agreement becomes effective on the date the SBS provider is certified by Wisconsin Medicaid or on the date when both the HMO and the SBS provider have signed the agreement, whichever is later. It may be terminated in writing with two weeks' notice by either signer. The SBS provider may be a school district, Cooperative Educational Service Agency (CESA), County Children with Disabilities Education Board (CCDEB), charter school, the Wisconsin School for the Deaf, or the Wisconsin School for the Visually Handicapped.

HMO Contract for (Year)	
Name — HMO	
Title — Authorized HMO Representative	Telephone Number — Authorized HMO Representative
SIGNATURE — Authorized HMO Representative	Date Signed
Name — SBS Provider (school)	
Title — Authorized SBS Provider Representative	Telephone Number — Authorized SBS Provider Representative
SIGNATURE — Authorized SBS Provider Representative	Date Signed

Appendix 5
Letter of Consent to Request Reimbursement from Wisconsin Medicaid (Optional)

(The Letter of Consent to Request Reimbursement from Wisconsin Medicaid is located on the following page.)

Dear Parents:

Through the Medicaid school-based services (SBS) benefit, _____ school district may submit claims to Wisconsin Medicaid for covered services provided to Medicaid-eligible children enrolled in special education programs. These services include: nursing services, physical therapy, occupational therapy, or speech and language pathology services, specialized medical vehicle transportation, durable medical equipment, psychological services, counseling, social work services, and developmental testing and assessment. The program is intended to increase federal funding for special education services provided in Wisconsin schools.

Please complete and return one copy of this form in the self-addressed envelope that is included so that the school district may obtain Wisconsin Medicaid eligibility information and, if appropriate, file claims with Wisconsin Medicaid for reimbursement of services provided to your child. Keep the second copy for your files.

If you have questions, please contact me at:_____.

Sincerely,

_____

(*name and title of school district contact person*)

I, the undersigned, hereby request and authorize _____ school district to release to Wisconsin Medicaid the following information:

- [ ] Official student academic/administrative records (identifying information, grade level completed, grades, class rank, attendance records, and group aptitude and achievement test results).
- [ ] Medical and/or related health records.
- [ ] Psychological evaluations and related reports.
- [ ] Appropriate agency reports.
- [ ] Individualized Education Program.
- [ ] Other (specify)_____.

CONSENTING FOR THE SCHOOL DISTRICT TO BILL FOR WISCONSIN MEDICAID SCHOOL-BASED SERVICES

I understand that:

- My consent to release this information is voluntary.
- My approval **will not** result in denial or limitation of community-based services provided outside the school.
- My refusal to consent **will not** result in denial or limitation of services for my child.
- This permission is valid for one year from the date signed.
- A copy of this form is as effective as the original.

Child's Name_____ Date of Birth_____

Parent's Signature_____ Date Signed_____

Please return this signed form to the school no later than _____.

Appendix 6
Department of Public Instruction and Department of Regulation and Licensing Prescription Requirements for Providing School-Based Services in the School Setting

Service	Current School-Based Services Prescription Requirements[1]	Waiver School-Based Services Prescription Requirements[2,3]	Other Key School-Based Services Requirements
Speech and language pathology, audiology, and hearing services	Annual prescription by a physician.	No prescription requirements.	Services must be identified in the child's Individualized Education Program (IEP).
Occupational therapy	Annual prescription by a physician.	No prescription requirements.	Services must be identified in the child's IEP.
Physical therapy	Annual prescription by a physician.	Prescription only required under limited circumstances as required by the DR&L.	Services must be identified in the child's IEP.
Nursing services	Annual prescription by a physician or a health care professional with prescribing authority.	Annual prescription by a physician or a health care professional with prescribing authority.	Services must be identified in the child's IEP.
Psychological counseling and social work services	Annual prescription by a physician or licensed Ph.D. psychologist.	No prescription requirements.	Services must be identified in the child's IEP.
Other developmental testing and assessments	No prescription requirements.	No prescription requirements.	The activities must result in the development or revision of an IEP.
Transportation	No prescription requirements.	No prescription requirements.	Transportation must be included in the IEP and provided on the *same day* that the child receives another Medicaid-covered school-based service.
Durable medical equipment (DME)	No prescription requirements.	No prescription requirements.	The equipment must: • Be medically necessary. • Be child specific. • Be identified in the IEP. • Belong to the child to use at school and at home. • Not be covered under the Wisconsin Medicaid DME benefit.

[1] Based on Department of Regulation and Licensing (DR&L) requirements. If DR&L prescription requirements change for schools, Wisconsin Medicaid automatically adopts those new requirements.

[2] The waiver requirements are based on the Department of Public Instruction (DPI) requirements. If DPI prescription requirements change for schools, Wisconsin Medicaid automatically adopts those new requirements.

[3] School-Based Services (SBS) providers choosing the waiver option must ensure that the services billed under the SBS benefit meet the necessary requirements for school-based services and are covered services under the SBS benefit.

Appendix 7
Request for a Waiver to Wisconsin Medicaid Prescription Requirements Under the School-Based Services Benefit
(for photocopying)

(A copy of the Request for a Waiver to Wisconsin Medicaid Prescription Requirements Under the School-Based Services Benefit is located on the following page.)

DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Health Care Financing
HCF 1134 (Rev. 12/04)

STATE OF WISCONSIN
HFS 106.13, Wis. Admin. Code

WISCONSIN MEDICAID

REQUEST FOR A WAIVER TO WISCONSIN MEDICAID PRESCRIPTION REQUIREMENTS UNDER THE SCHOOL-BASED SERVICES BENEFIT

Name — School-Based Services (SBS) Provider	Wisconsin Medicaid Provider Number

The SBS provider named above requests a waiver under HFS 106.13, Wis. Admin. Code, for the requirement for obtaining prescriptions under the SBS benefit, following HFS 105.53(2) and 107.36(1) and (2), Wis. Admin. Code, for the following services (check all that apply):

- ❑ Speech and language pathology, audiology, and hearing services.
- ❑ Physical therapy services.
- ❑ Occupational therapy services.
- ❑ Psychological services, counseling, and social work services.

Under this waiver, the SBS provider is required to do all of the following:

- Continue to meet the Department of Public Instruction and Department of Regulation and Licensing standards for prescriptions for services provided to children in the school setting under the SBS benefit.
- Notify the child's HMO, physician, physician specialist, physician assistant, or nurse practitioner regarding the services the child obtains under the SBS benefit at least annually. This activity must be documented in the child's record.
- Document communication with other Medicaid providers at least annually when a child receives similar services from other Medicaid providers. The communication must be documented in the child's record and copies of the child's Individualized Education Program must be supplied to other providers when requested.
- Coordinate care with managed care organizations through Memorandums of Understanding as currently required under the SBS benefit.

Name — SBS Provider Authorized Representative (Type or Print)

SIGNATURE — SBS Provider Authorized Representative	Date Signed
The SBS provider requests this waiver from the Wisconsin Division of Health Care Financing for services provided on and after the following date until this requirement is eliminated through a Wisconsin Administrative Code change.	Effective Date of Waiver Request

Appendix 8
Wisconsin Medicaid School-Based Services Fact Sheet

(The Wisconsin Medicaid School-Based Services Fact Sheet is located on the following page.)

Jim Doyle
Governor

Helene Nelson
Secretary

State of Wisconsin

Department of Health and Family Services

DIVISION OF HEALTH CARE FINANCING
WISCONSIN MEDICAID AND BADGERCARE
RECIPIENT SERVICES
6406 BRIDGE ROAD
MADISON WI 53784
Telephone: 800-362-3002
TTY: 800-362-3002
FAX: 608-221-8815
dhfs.wisconsin.gov/medicaid
dhfs.wisconsin.gov/badgercare

WISCONSIN MEDICAID SCHOOL-BASED SERVICES FACT SHEET

The Wisconsin Medicaid school-based services (SBS) benefit is a way for school districts and Cooperative Educational Service Agencies (CESAs) to receive more federal funds to help pay for medically related special education and associated services. Obtaining reimbursement from Wisconsin Medicaid for these services helps your school district receive more money for your school's budget. In 2004, Wisconsin schools received approximately $20.1 million from Wisconsin Medicaid for school-based services.

Under the SBS benefit:

- School districts, CESAs, County Children with Disabilities Education Boards, and charter schools can seek reimbursement from Wisconsin Medicaid for school-based services, such as speech and language therapy, occupational therapy, and nursing services, if the services are included in the child's Individualized Education Program (IEP).
- Whether or not your child's school district seeks Wisconsin Medicaid reimbursement for school-based services does *not* influence approval or denial of prior authorization (PA) requests for community (non-school-based services) therapies.

Parents should note that Wisconsin Medicaid medical consultants who review PA requests for community therapies:

- Do *not* review SBS claims data.
- Approve community therapy based on medical necessity and *not* on financial limitations.
- Review each child's IEP and any other information regarding therapies received at the school, in the home, or elsewhere when community (non-school-based services) services are requested, regardless of whether or not the school seeks SBS reimbursement. Consultants must review the services your child is currently receiving so that Wisconsin Medicaid does not reimburse for unnecessary services.

Wisconsin Medicaid requires schools and other health care providers to work together to ensure that your child receives coordinated services.

Appendix 9
CMS 1500 Claim Form Completion Instructions

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

Wisconsin Medicaid recipients receive a Medicaid identification card upon being determined eligible for Wisconsin Medicaid. Always verify a recipient's eligibility before providing nonemergency services by using the 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 Provider Resources section of the All-Provider Handbook or the Medicaid Web site at *dhfs.wisconsin.gov/medicaid/* for more information about the EVS.

Element 1 — Program Block/Claim Sort Indicator

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

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 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, 1995, would be 02/03/95) or in MM/DD/YYYY format (e.g., February 3, 1995, would be 02/03/1995). Specify if male or female by placing an "X" in the appropriate box.

Element 4 — Insured's Name (not required)

Element 5 — Patient's Address (not required)

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. Refer to the Coordination of Benefits section of this handbook for more information.

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"), TriCare ("CHA"), or some other ("OTH") commercial health insurance, **and** the service requires other insurance billing according to the Coordination of Benefits section of the All-Provider Handbook, then one of the following three other insurance (OI) explanation codes **must** be indicated in the **first** box of Element 9. The description is not required, nor is the policyholder, plan name, group number, etc. (Elements 9a, 9b, 9c, and 9d are not required.)

Code	Description
OI-P	PAID by commercial health insurance. 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 (not required)

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 (not required)

Element 18 — Hospitalization Dates Related to Current Services (not required)

Element 19 — Reserved for Local Use (not required)

Element 20 — Outside Lab? (not required)

Element 21 — Diagnosis or Nature of Illness or Injury

Enter *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis code **999.9**.

Element 22 — Medicaid Resubmission (not required)

Element 23 — Prior Authorization Number (not required)

Element 24A — Date(s) of Service

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

- When billing for one date of service (DOS), enter the date in MM/DD/YY or MM/DD/YYYY format in the "From" field.
- When billing for two, three, or four DOS on the same detail line, enter the first DOS in MM/DD/YY or MM/DD/YYYY format in the "From" field, and enter the subsequent DOS in the "To" field by listing **only** the date(s) of the month (e.g., DD, DD/DD, or DD/DD/DD). For example, for DOS on December 1, 8, 15, and 22, 2003, indicate 12/01/03 or 12/01/2003 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.
- The same diagnosis is applicable for each procedure.
- The charge for all procedures is identical. (Enter the total charge **per detail line** in Element 24F.)
- The number of services performed on each DOS is identical.
- All procedures have the same family planning indicator, if applicable.

Element 24B — Place of Service

Enter place of service (POS) code "03" (school) for each service listed. This is the only allowable POS code for school-based services (SBS).

Element 24C — Type of Service (not required)

Element 24D — Procedures, Services, or Supplies

Enter the single most appropriate five-character *Current Procedural Terminology* (CPT) code or Healthcare Common Procedure Coding System (HCPCS) code. Wisconsin Medicaid denies claims received without an appropriate CPT or HCPCS procedure code. Refer to Appendix 12 of this handbook for a complete list of procedure codes.

Modifiers

Enter the appropriate modifier(s) in the "Modifier" column of Element 24D. Use a comma(s) to separate more than one modifier. Refer to Appendix 11 of this handbook for a list of valid 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. For example, multiply the rate by the number of SBS units for each line.

Element 24G — Days or Units

Enter the appropriate number of units for each line item. Always use a decimal (e.g., 2.0 units). Refer to Appendices 13 and 20 of this handbook for units of services.

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

Element 24I — EMG (not required)

Element 24J — COB (not required)

Element 24K — Reserved for Local Use (not required)

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 recipient's internal office account number. This number will appear on the Remittance and Status Report and/or the 835 Health Care Claim Payment/Advice electronic 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 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)

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

Enter the name of the provider (exactly as indicated on the provider's notification of certification letter) submitting the claim and the complete mailing address. The minimum requirement is the provider's name, city, state, and ZIP code. At the bottom of Element 33, enter the billing provider's eight-digit Medicaid provider number.

Appendix 10
Sample CMS 1500 Claim Form for School-Based 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, Ima A.

3. PATIENT'S BIRTH DATE MM DD YYYY: MM DD YYYY SEX M [ ] F [X]

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

5. PATIENT'S ADDRESS (No., Street)

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

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

CITY | STATE

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

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

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 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? [ ] YES [ ] NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)
1. 999.9
2. ___.__
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 11	03	03	05	07		03		97110	TM GP	1	XX XX	6.0				
2 11	06	03				03		92506	TM	1	XX XX	1.5				
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 $ XX XX

29. AMOUNT PAID $ 0 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/YYYY
SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
I.M. Billing
1 W. Williams
Anytown, WI 55555 12345678
PIN# 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 11
Modifiers for School-Based Services

The following table lists the nationally recognized modifiers that providers are required to use when submitting claims for school-based services. Modifiers are used to identify Individualized Education Programs (IEP) and/or the type of service that was performed.

Modifier	Description
TM	Individualized Education Program (IEP)
GO	Services delivered under an outpatient occupational therapy plan of care
GP	Services delivered under an outpatient physical therapy plan of care
UA	M-team assessment and IEP, other staff
U1	M-team assessment and IEP, psychological service
U2	Individual IEP, psychological service
U3	Group IEP, psychological service
U4	M-team assessment and IEP counseling service
U5	Individual IEP, counseling service
U6	Group IEP, counseling service
U7	M-team assessment and IEP, social work service
U8	Individual IEP, social work service
U9	Group IEP, social work service

Appendix 12
Procedure Codes for School-Based Services

The following table lists the *Current Procedural Terminology* and Healthcare Common Procedure Coding System procedure codes that providers are to use when submitting claims for school-based services. Providers will need to include the appropriate modifier(s) for each procedure code as indicated in the table. If more than one modifier is listed, providers will be required to include **all** modifiers listed when submitting a claim, or the claim detail line may be denied. Refer to Appendix 11 of this handbook for modifier descriptions.

Procedure Code	Procedure Code Description	Required Modifier(s)
Speech and Language Pathology, Audiology, and Hearing Services		
92506	Evaluation of speech, language, voice, communication, auditory processing, and/or aural rehabilitation status	TM
92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder (includes aural rehabilitation); individual	TM
92508	group, two or more individuals	TM
Occupational Therapy Services		
97003	Occupational therapy evaluation	TM
97110	Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility	TM GO
97150	Therapeutic procedure(s), group (2 or more individuals)	TM GO
Physical Therapy Services		
97001	Physical therapy evaluation (per 15 min)	TM
97110	Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility	TM GP
97150	Therapeutic procedure(s), group (2 or more individuals)	TM GP
Psychological Services		
T1024	Evaluation and treatment by an integrated, specialty team contracted to provide coordinated care to multiple or severely handicapped children, per encounter (Short description: team evaluation & management)	U1
T1024	Evaluation and treatment by an integrated, specialty team contracted to provide coordinated care to multiple or severely handicapped children, per encounter (Short description: team evaluation & management)	U2
T1024	Evaluation and treatment by an integrated, specialty team contracted to provide coordinated care to multiple or severely handicapped children, per encounter (Short description: team evaluation & management)	U3
Counseling Services		
T1024	Evaluation and treatment by an integrated, specialty team contracted to provide coordinated care to multiple or severely handicapped children, per encounter (Short description: team evaluation & management)	U4
T1024	Evaluation and treatment by an integrated, specialty team contracted to provide coordinated care to multiple or severely handicapped children, per encounter (Short description: team evaluation & management)	U5
T1024	Evaluation and treatment by an integrated, specialty team contracted to provide coordinated care to multiple or severely handicapped children, per encounter (Short description: team evaluation & management)	U6

Procedure Code	Procedure Code Description	Required Modifier(s)
Social Work Services		
T1024	Evaluation and treatment by an integrated, specialty team contracted to provide coordinated care to multiple or severely handicapped children, per encounter (Short description: team evaluation & management)	U7
T1024	Evaluation and treatment by an integrated, specialty team contracted to provide coordinated care to multiple or severely handicapped children, per encounter (Short description: team evaluation & management)	U8
T1024	Evaluation and treatment by an integrated, specialty team contracted to provide coordinated care to multiple or severely handicapped children, per encounter (Short description: team evaluation & management)	U9
Nursing Services		
T1001	Nursing assessment/evaluation	TM
T1002	RN* services, up to 15 minutes	TM
T1003	LPN**/LVN*** services, up to 15 minutes	TM
Team Assessment and Individualized Education Program Plan Development by Other School Staff		
T1024	Evaluation and treatment by an integrated, specialty team contracted to provide coordinated care to multiple or severely handicapped children, per encounter (Short description: team evaluation & management)	UA
Durable Medical Equipment		
E1399	Durable medical equipment, miscellaneous	TM
Special Transportation Services		
T2003	Non-emergency transportation; encounter/trip	TM
A0425	Ground mileage, per statue mile	TM

* RN — Registered nurse.

** LPN — Licensed practical nurse.

*** LVN — Licensed vocational nurse.

Appendix 13
Conversion Chart for Wisconsin Medicaid Nursing Services Reimbursement

The following table lists the units for various services nurses provide.

Individualized Education Program (IEP) Nursing Services: Care and Treatment	
Medications	**Standardized Average Nursing Service Units Billable to Wisconsin Medicaid**
G-tube medication	1.0 unit per medication
Oral medication	0.5 units per medication
Injectable medication	1.0 unit per medication
Eye drops	0.5 units per medication
Intravenous medications	2.0 units per task
Topical medications	0.5 units per task
Rectal medications	1.0 unit per task
Other Nursing Tasks	**Standardized Average Nursing Service Units Billable to Wisconsin Medicaid**
G-tube feeding	2.0 units per task
Venting G-tube	0.5 units per task
Intermittent catheterization	2.0 units per task
Tracheotomy care	2.0 units per task
Ostomy care	1.0 unit per task
Hand-held nebulization	0.5 units per task
Aerosol machine nebulization	2.0 units per task
Blood glucose	1.0 unit per task
Suctioning	1.0 unit per task
Continuous oxygen (i.e., time for filling tank)	0.5 units per task
Dressing changes	1.0 unit per task
Chest physiotherapy	2.0 units per task
Vital signs	1.0 unit per task
Vital signs assessment*	1.0 unit per task
Registered nurse — acute problem assessment*	2.0 units per task
Pro re nata (PRN) oxygen	0.5 units per task

Nursing Services: Face-to-face and IEP Team Assessment and Plan Development	
Face-to-face and IEP Team Assessment and Plan Development	**Standardized Average Nursing Service Units Billable to Wisconsin Medicaid**
Initial IEP team assessment*	12 units per task
Re-evaluation for IEP team*	8 units per task
Nursing development testing and assessment*	4 units per task
IEP plan development/IEP team-related activities*	4 units per task

*These tasks can only be performed by a qualified nurse and cannot be delegated.

Appendix 14
Sample Optional School-Based Services Activity Log Nursing/Therapy Medical Services (time method)

(A sample Optional School-Based Services Activity Log Nursing/Therapy Medical Services [time method] is located on the following page.)

DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Health Care Financing
HCF 1198 (Rev. 12/04)

STATE OF WISCONSIN

WISCONSIN MEDICAID

OPTIONAL SCHOOL-BASED SERVICES ACTIVITY LOG
NURSING / THERAPY MEDICAL SERVICES

Name — Student (Last, First, MI)	Name — School	Method Used (Circle One)
Student, Ima G.	Wisconsin Elementary	**Time** **Task**

Date of Service (MM/DD/YY)	**General Service Category**	**Unit of Service** (Time or Units)	**Group or Individual**	**Describe Specific Services Performed**	**Student's Response/ Progress**	**Initials or Signature*** (Of Person Who Performed Service)
10/12/04	nursing	10 a.m. - 10:15 a.m. (15 minutes)	Individual	Post-seizure observation	Alert and oriented x3	*Ima Provider*
10/14/04	nursing	3 times, 5 minutes each (15 minutes) Times between 11 a.m. and 3 p.m.	Individual	Transferring onto toilet	N/A	*Ima Provider*
10/14/04	nursing	3 times, 5 minutes each (15 minutes) Times between 11 a.m. and 3 p.m.	Individual	Transferring off of toilet	N/A	*Ima Provider*

*Initials Key	Signatures — Corresponding Staff	Date Signed (MM/DD/YY)

Therapy services only:

A. Does the recipient have insurance?
❑ Yes ❑ No
(If yes, go to B. If no, stop.)

B. Is there an insurance exclusionary clause for all school-based services?
❑ Yes ❑ No
(If yes, insurance liability does not apply. If no or do not know, go to C.)

C. Check the option selected:
- ❑ Option 1: School assuming insurance liability. (Subtract the first occurring unit of occupational therapy [OT] [group or individual] and/or physical therapy [PT] [group or individual] during the calendar month from the monthly claim for services. Bill the remaining services to Wisconsin Medicaid. Do not indicate an "other insurance" disclaimer code in Element 9 of the CMS 1500 claim form.)
- ❑ Option 2: School seeking insurance payment for OT (group or individual) and/or PT (group or individual). Schools must have parental permission for this option.
- ❑ Option 3: School not seeking Medicaid payment for OT (group or individual) and/or PT (group or individual).

Appendix 15
Sample Optional School-Based Services Activity Log
Medication Administration (time method)

(A sample Optional School-Based Services Activity Log Medication Administration [time method] is located on the following page.)

DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Health Care Financing
HCF 1199 (Rev. 12/04)

STATE OF WISCONSIN

WISCONSIN MEDICAID

OPTIONAL SCHOOL-BASED SERVICES ACTIVITY LOG
MEDICATION ADMINISTRATION

Name — Student (Last, First, MI)	Name — School	Method Used (Circle One)
Student, Ima G.	Wisconsin Elementary	**Time** **Task**

Date of Service (MM/DD/YY)	**Medication Name and Dose**	**Route**	**Time Administered** (Time or Units)	**Took Medication Without Difficulty?** (Yes or No)	**Notes** (All Exceptions Must Be Noted)	**Initials or Signature*** (Of Person Who Administered Medication)
10/12/04	Sustacal, 250 ml., four times a day followed by a 50 cc H_20 flush	G-tube feeding	8 a.m. - 8:30 a.m. (30 minutes)	Yes	N/A	IN.
10/13/04	Sustacal, 250 ml., followed by a 50 cc H_20 flush	G-tube feeding	2 times, 30 minutes each (60 minutes) 11 a.m. - 11:30 a.m. and 2 p.m. - 2:30 p.m.	Yes	N/A	IN.

*Initials Key	Signatures — Corresponding Staff	Date Signed (MM/DD/YY)
IN.	Ima Nurse	10/14/03

Under Standards of Practice for Registered Nurses, ch. N 6.03, Wis. Admin. Code, only registered nurses (RNs) may delegate services to medically unlicensed individuals. For delegated nursing services under the school-based services benefit, the RN responsible for delegating the services must agree to the delegation of the service and is responsible for supervision of the delegatee.

Appendix 16
Sample Optional School-Based Services Activity Log
Nursing/Therapy Medical Services (task method)

(A sample Optional School-Based Services Activity Log Nursing/Therapy Medical Services [task method] is located on the following page.)

DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Health Care Financing
HCF 1198 (Rev. 12/04)

STATE OF WISCONSIN

WISCONSIN MEDICAID

OPTIONAL SCHOOL-BASED SERVICES ACTIVITY LOG
NURSING / THERAPY MEDICAL SERVICES

Name — Student (Last, First, MI)	Name — School	Method Used (Circle One)
Student, Ima G.	Wisconsin Elementary	**Time** **Task**

Date of Service (MM/DD/YY)	**General Service Category**	**Unit of Service** (Time or Units)	**Group or Individual**	**Describe Specific Services Performed**	**Student's Response/ Progress**	**Initials or Signature*** (Of Person Who Performed Service)
10/12/04	nursing	3 times, 9 a.m., 12 p.m., and 3 p.m. (1.5 units)	Individual	Eye drops instilled	Excessive redness	*Ima Provider*

*Initials Key	Signatures — Corresponding Staff	Date Signed (MM/DD/YY)

Therapy services only:

A. Does the recipient have insurance?
❑ Yes ❑ No
(If yes, go to B. If no, stop.)

B. Is there an insurance exclusionary clause for all school-based services?
❑ Yes ❑ No
(If yes, insurance liability does not apply. If no or do not know, go to C.)

C. Check the option selected:
- ❑ Option 1: School assuming insurance liability. (Subtract the first occurring unit of occupational therapy [OT] [group or individual] and/or physical therapy [PT] [group or individual] during the calendar month from the monthly claim for services. Bill the remaining services to Wisconsin Medicaid. Do not indicate an "other insurance" disclaimer code in Element 9 of the CMS 1500 claim form.)
- ❑ Option 2: School seeking insurance payment for OT (group or individual) and/or PT (group or individual). Schools must have parental permission for this option.
- ❑ Option 3: School not seeking Medicaid payment for OT (group or individual) and/or PT (group or individual).

Appendix 17
Sample Optional School-Based Services Activity Log
Medication Administration (task method)

(A sample Optional School-Based Services Activity Log Medication Administration [task method] is located on the following page.)

DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Health Care Financing
HCF 1199 (Rev. 12/04)

STATE OF WISCONSIN

WISCONSIN MEDICAID

OPTIONAL SCHOOL-BASED SERVICES ACTIVITY LOG
MEDICATION ADMINISTRATION

Name — Student (Last, First, MI)	Name — School	Method Used (Circle One)
Student, Ima G.	Wisconsin Elementary	**Time** **Task**

Date of Service (MM/DD/YY)	**Medication Name and Dose**	**Route**	**Time Administered** (Time or Units)	**Took Medication Without Difficulty?** (Yes or No)	**Notes** (All Exceptions Must Be Noted)	**Initials or Signature*** (Of Person Who Administered Medication)
10/12/04	Tegretol, 100 mg	Oral	8 a.m. and 2 p.m., 2 times (2 x .5 units = 1 unit)	No	Difficulty swallowing, swallowed after several attempts both times.	IN
10/13/04	Tegretol, 100 mg	Oral	12 p.m. and 4 p.m., 2 times (2 x .5 units = 1 unit)	Yes	N/A	IN

*Initials Key	Signatures — Corresponding Staff	Date Signed (MM/DD/YY)
IN	Ima Nurse	10/14/04

Under Standards of Practice for Registered Nurses, ch. N 6.03, Wis. Admin. Code, only registered nurses (RNs) may delegate services to medically unlicensed individuals. For delegated nursing services under the school-based services benefit, the RN responsible for delegating the services must agree to the delegation of the service and is responsible for supervision of the delegatee.

Appendix 18
Optional School-Based Services Activity Log
Nursing/Therapy Medical Services
(for photocopying)

(A copy of the Optional School-Based Services Activity Log Nursing/Therapy Medical Services is located on the following page.)

DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Health Care Financing
HCF 1198 (Rev. 12/04)

STATE OF WISCONSIN

WISCONSIN MEDICAID

OPTIONAL SCHOOL-BASED SERVICES ACTIVITY LOG
NURSING / THERAPY MEDICAL SERVICES

Name — Student (Last, First, MI)	Name — School	Method Used (Circle One) **Time** **Task**

Date of Service (MM/DD/YY)	**General Service Category**	**Unit of Service** (Time or Units)	**Group or Individual**	**Describe Specific Services Performed**	**Student's Response/ Progress**	**Initials or Signature*** (Of Person Who Performed Service)

*Initials Key	Signatures — Corresponding Staff	Date Signed (MM/DD/YY)

Therapy services only:

A. Does the recipient have insurance?
❑ Yes ❑ No
(If yes, go to B. If no, stop.)

B. Is there an insurance exclusionary clause for all school-based services?
❑ Yes ❑ No
(If yes, insurance liability does not apply. If no or do not know, go to C.)

C. Check the option selected:
❑ Option 1: School assuming insurance liability. (Subtract the first occurring unit of occupational therapy [OT] [group or individual] and/or physical therapy [PT] [group or individual] during the calendar month from the monthly claim for services. Bill the remaining services to Wisconsin Medicaid. Do not indicate an "other insurance" disclaimer code in Element 9 of the CMS 1500 claim form.)
❑ Option 2: School seeking insurance payment for OT (group or individual) and/or PT (group or individual). Schools must have parental permission for this option.
❑ Option 3: School not seeking Medicaid payment for OT (group or individual) and/or PT (group or individual).

Appendix 19
Optional School-Based Services Activity Log Medication Administration
(for photocopying)

(A copy of the Optional School-Based Services Activity Log Medication Administration is located on the following page.)

DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Health Care Financing
HCF 1199 (Rev. 12/04)

STATE OF WISCONSIN

WISCONSIN MEDICAID

OPTIONAL SCHOOL-BASED SERVICES ACTIVITY LOG
MEDICATION ADMINISTRATION

Name — Student (Last, First, MI)	Name — School	Method Used (Circle One) **Time** **Task**

Date of Service (MM/DD/YY)	**Medication Name and Dose**	**Route**	**Time Administered** (Time or Units)	**Took Medication Without Difficulty?** (Yes or No)	**Notes** (All Exceptions Must Be Noted)	**Initials or Signature*** (Of Person Who Administered Medication)

*Initials Key	Signatures — Corresponding Staff	Date Signed (MM/DD/YY)

Under Standards of Practice for Registered Nurses, ch. N 6.03, Wis. Admin. Code, only registered nurses (RNs) may delegate services to medically unlicensed individuals. For delegated nursing services under the school-based services benefit, the RN responsible for delegating the services must agree to the delegation of the service and is responsible for supervision of the delegatee.

Appendix 20
Examples of School-Based Transportation Services Units

The following examples illustrate how providers can bill for various transportation services trip lengths.

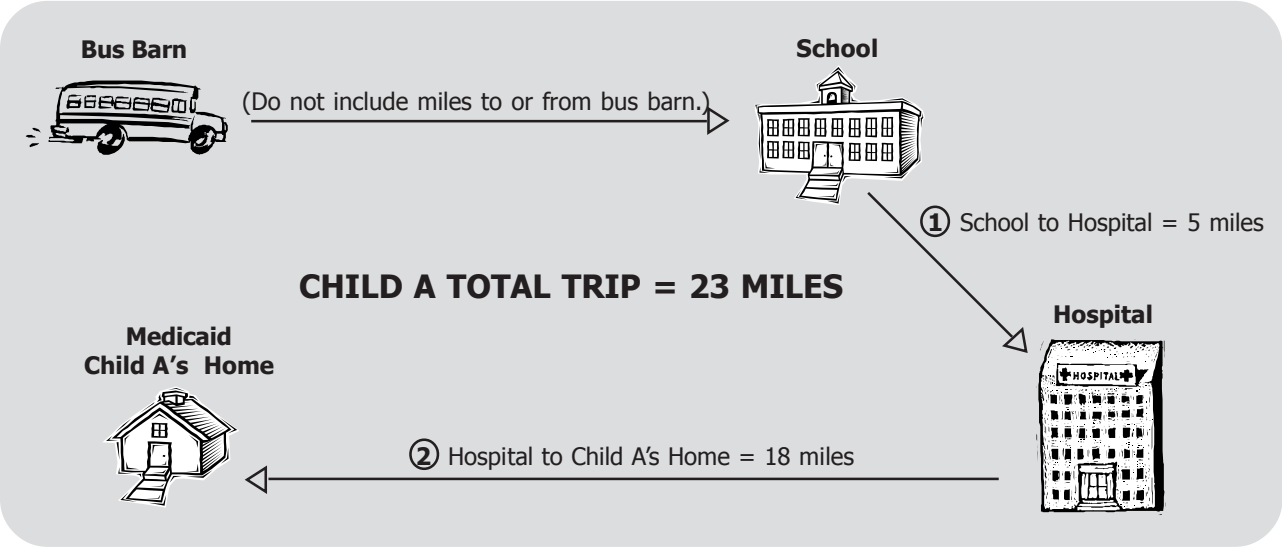
Child A — Trip Over 20 Miles: Example Includes Travel to Non-School-Based Service Site

1. A school-based service other than transportation is provided at the hospital. The bus travels to school and picks up Child A. The bus transports Child A five miles from school to the hospital.
2. The bus transports Child A 18 miles from the hospital to home.

The total miles for Child A's trip is 23 miles. This is more than the daily base rate of 20 miles; therefore, the provider may use the following procedure codes:

- Procedure code T2003 — daily base rate (1 unit).
- Procedure code A0425 — three miles over the daily base rate (3 units).

Note: In this example, the provider can only be reimbursed for transportation from the school to the hospital and for the trip from the hospital to home. The provider cannot be reimbursed for transportation from home to school because no Medicaid-covered school-based service was provided at the school.

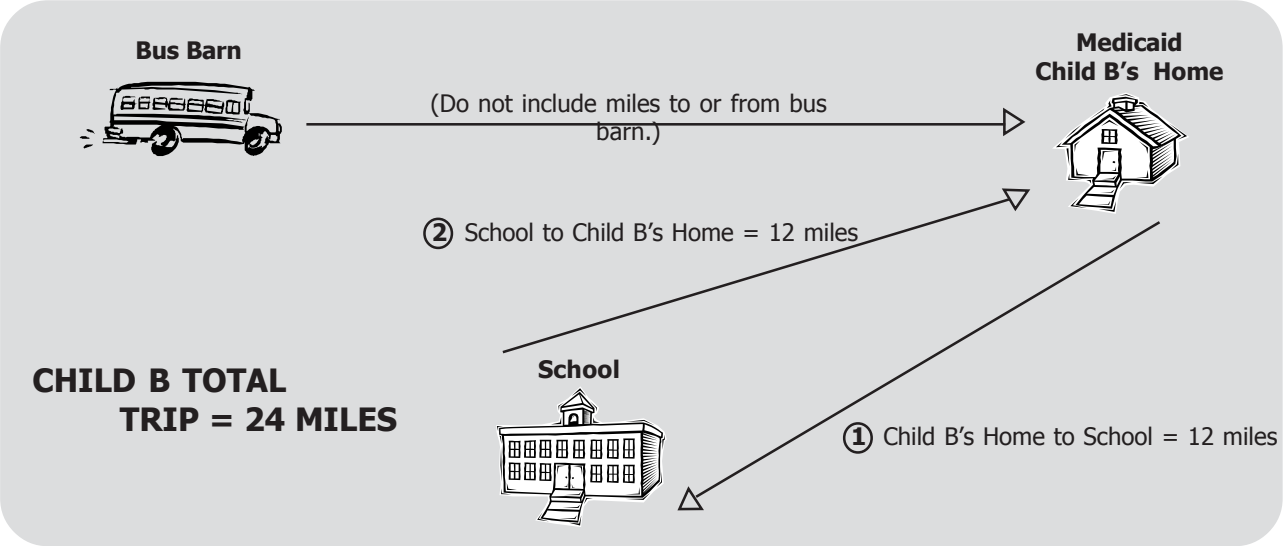


Child B — Trip Over 20 Miles

1. A school-based service other than transportation is provided at school. The bus travels to pick up Child B at home and transports Child B 12 miles to school.
2. The bus transports Child B 12 miles from school to home.

The total miles for Child B's trip is 24 miles. This is more than the daily base rate of 20 miles; therefore, the provider may use the following procedure codes:

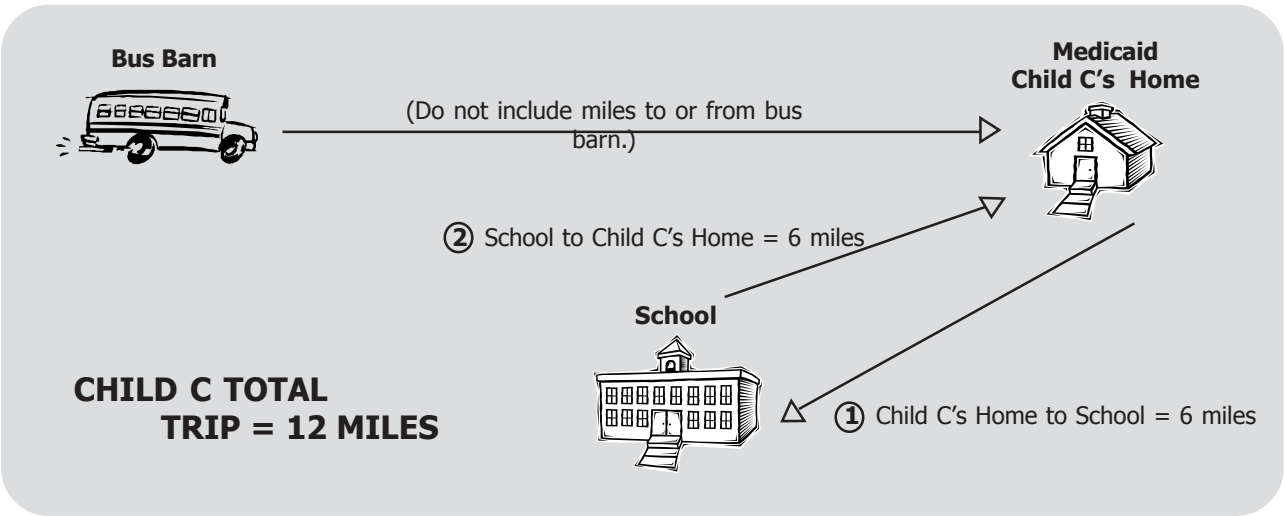
- Procedure code T2003 — daily base rate (1 unit).
- Procedure code A0425 — four miles over the daily base rate (4 units).



Child C — Trip Under 20 Miles

1. A school-based service other than transportation is provided at school. The bus travels to pick up Child C at home and transports Child C six miles to school.
2. The bus transports Child C six miles from school to home.

The total miles for Child C's trip is 12 miles. This is less than the daily base rate of 20 miles; therefore, the provider may use procedure code T2003 — daily base rate (1 unit).



Appendix 21
Centers for Medicare and Medicaid Services School-Based Services Covered Transportation Policy

In August 2001, the Centers for Medicare and Medicaid Services approved Wisconsin Medicaid's State Plan regarding covered school-based services (SBS) transportation policy. The following is Medicaid's SBS State Plan language:

Transportation Policy

Transportation to school and from school

A child's transportation to and from a school certified as an SBS provider is a covered service only if all the following conditions are met:

- The child receives a covered school-based service identified in the child's Individualized Education Plan (IEP) at the school on the day the transportation is provided.
- The SBS provider is financially responsible for providing the transportation.
- The child's medical need for the particular type of transportation is identified in the child's IEP.
- One of the following:
  - √ The vehicle is equipped with and the child requires a ramp or lift.
  - √ An aide is present and the child requires the aide's assistance in the vehicle.
  - √ The child has behavioral problems that do not require the assistance of an aide but that preclude the child from riding on a standard school bus.

Off-site transportation

A child's transportation to and from a site other than the child's "home" school is a covered service only if all the following conditions are met:

- The child receives a covered school-based service identified in the child's IEP at the site on the day the transportation is provided.
- The SBS provider is financially responsible for providing the transportation.
- One of the following:
  - √ Transportation is from the school to an off-site provider and back to school or home.
  - √ Transportation is between home and a "special school." A special school is a school that requires that a child have a disability in order to be enrolled, including, but not limited to, the Wisconsin School for the Deaf or the Wisconsin School for the Visually Handicapped, as defined in ch. PI 12, Wis. Admin. Code.

Glossary of Common Terms

Adjustment
A modified or changed claim that was originally allowed, at least in part, by Wisconsin Medicaid.

Allowed status
A Medicaid or Medicare claim that has at least one service that is reimbursable.

BadgerCare
BadgerCare extends Medicaid coverage through a Medicaid expansion under Titles XIX and XXI to uninsured children and parents with incomes at or below 185% of the Federal Poverty Level and who meet other program requirements. The goal of BadgerCare is to fill the gap between Medicaid and private insurance without supplanting or "crowding out" private insurance.

BadgerCare benefits are identical to the benefits and services covered by Wisconsin Medicaid, and recipients' health care is administered through the same delivery system.

CCDEB
County Children with Disabilities Education Board. A branch of county government providing instructional and therapeutic services to students with disabilities. Five counties in Wisconsin operate a CCDEB: Brown, Camulet, Marathon, Racine, and Walworth.

CESA
Cooperative Educational Service Agency. The unit serving as a connection between the state and school districts within its borders. There are 12 CESAs in Wisconsin. Cooperative Educational Service Agencies coordinate and provide educational programs and services as requested by the school district.

Charter School
A public, nonsectarian school created through a contract or "charter" between the operators and the sponsoring school board or other chartering authority. The Wisconsin charter school law gives charter schools freedom from most state rules and regulations in exchange for greater accountability for results.

CMS
Centers for Medicare and Medicaid Services. An agency housed within the U.S. Department of Health and Human Services (HHS), CMS administers Medicare, Medicaid, related quality assurance programs, and other programs.

CPT
Current Procedural Terminology. A listing of descriptive terms and codes for reporting medical, surgical, therapeutic, and diagnostic procedures. These codes are developed, updated, and published annually by the American Medical Association and adopted for billing purposes by the Centers for Medicare and Medicaid Services (CMS) and Wisconsin Medicaid.

Crossover claim
A Medicare-allowed claim for a dual-entitlee sent to Wisconsin Medicaid for possible additional payment of the Medicare coinsurance and deductible.

DHCF
Division of Health Care Financing. The DHCF administers Wisconsin Medicaid for the Department of Health and Family Services (DHFS) under statutory provisions, administrative rules, and the state's Medicaid plan. The state's Medicaid plan is a comprehensive description of the state's Medicaid program that provides the Centers for Medicare and Medicaid Services (CMS) and the U.S. Department of Health and Human Services (HHS), assurances that the program is administered in conformity with federal law and CMS policy.

DHFS
Wisconsin Department of Health and Family Services. The DHFS administers Wisconsin Medicaid. Its primary mission is to foster healthy, self-reliant individuals and families by promoting independence and community responsibility; strengthening families; encouraging healthy behaviors; protecting vulnerable children, adults, and families; preventing individual and social problems; and providing services of value to taxpayers.

DMS

Disposable medical supplies. Disposable medical supplies are medically necessary items that have a very limited life expectancy and are consumable, expendable, disposable, or nondurable. All prescribed DMS must:

- Be necessary and reasonable for treating a recipient's illness, injury, or disability.
- Be suitable for the recipient's residence.
- Be useful to a recipient who is ill, injured, or disabled.
- Serve a primary medical purpose.

DPI

Department of Public Instruction. The state agency that oversees education for Wisconsin. The DPI is dedicated to children and learning and to providing guidance and information to parents, teachers, and administrators alike.

Dual-entitlee

A recipient who is eligible for both Medicaid and Medicare, either Medicare Part A, Part B, or both.

DME

Durable medical equipment. Durable medical equipment are medically necessary devices that can withstand repeated use. All prescribed DME must:

- Be necessary and reasonable for treating a recipient's illness, injury, or disability.
- Be suitable for the recipient's residence.
- Be useful to a recipient who is ill, injured, or disabled.
- Serve a primary medical purpose.

ECS

Electronic Claims Submission. Claims transmitted via the telephone line and fed directly into Wisconsin Medicaid's claims processing subsystem.

EOB

Explanation of Benefits. Appears on the providers' Remittance and Status (R/S) Reports and informs Medicaid providers of the status of or action taken on their claims.

EVS

Eligibility Verification System. The EVS allows providers to verify recipient eligibility prior to providing services. Providers may access recipient eligibility information through the following methods:

- Wisconsin Medicaid's Automated Voice Response (AVR) system.
- Commercial magnetic stripe card readers.
- Commercial personal computer software and Internet access.
- Wisconsin Medicaid's Provider Services (telephone correspondents).
- Wisconsin Medicaid's Direct Information Access Line with Updates for Providers (Dial-Up).

Fee-for-service

The traditional health care payment system under which physicians and other providers receive a payment for each unit of service provided rather than a capitation payment for each recipient.

Fiscal agent

The Department of Health and Family Services (DHFS) contracts with Electronic Data Systems (EDS) to provide health claims processing services for Wisconsin Medicaid, including provider certification, claims payment, provider services, and recipient services. The fiscal agent also issues identification cards to recipients, publishes information for providers and recipients, and maintains the Wisconsin Medicaid Web site.

HCPCS

Healthcare Common Procedure Coding System. A listing of services, procedures, and supplies offered by physicians and other providers. HCPCS includes *Current Procedural Terminology* (CPT) codes, national alphanumeric codes, and local alphanumeric codes. The national codes are developed by the Centers for Medicare and Medicaid Services (CMS) to supplement CPT codes.

HealthCheck

A program that provides Medicaid-eligible children under age 21 with regular health screenings.

HHS

Department of Health and Human Services. The United States government's principal agency for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves.

The HHS includes more than 300 programs, covering a wide spectrum of activities, including overseeing Medicare and Medicaid; medical and social science research; preventing outbreak of infectious disease; assuring food and drug safety; and providing financial assistance for low-income families.

ICD-9-CM

International Classification of Diseases, Ninth Revision, Clinical Modification. Nomenclature for medical diagnoses required for billing. Available through the American Hospital Association.

IDEA

Individuals with Disabilities Education Act. Federal law that guarantees all children with disabilities access to a free and appropriate public education and the related services and support needed to achieve that education.

IEP

Individualized Education Program. An IEP is a written plan for a child that is developed, reviewed, and revised in accordance with s.115.787, Wis. Stats. The IEP guides the delivery of special education support and services for the child.

Maximum allowable fee schedule

A listing of all procedure codes allowed by Wisconsin Medicaid for a provider type and Wisconsin Medicaid's maximum allowable fee for each procedure code.

Medicaid

Medicaid is a joint federal/state program established in 1965 under Title XIX of the Social Security Act to pay 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.

The purpose of Medicaid is to provide reimbursement for and assure the availability of appropriate medical care to persons who meet the criteria for Medicaid. Medicaid is also known as the Medical Assistance Program, Title XIX, or T19.

Medically necessary

According to HFS 101.03(96m), Wis. Admin. Code, a Medicaid service that is:

a) Required to prevent, identify or treat a recipient's illness, injury or disability; and
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;
   2. Is provided consistent with standards of acceptable quality of care applicable to type of service, the type of provider and the setting in which the service is provided;
   3. Is appropriate with regard to generally accepted standards of medical practice;
   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;
   5. Is of proven medical value or usefulness and, consistent with s. HFS 107.035, is not experimental in nature;
   6. Is not duplicative with respect to other services being provided to the recipient;
   7. Is not solely for the convenience of the recipient, the recipient's family or a provider;
   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
   9. Is the most appropriate supply or level of service that can safely and effectively be provided to the recipient.

PA

Prior authorization. The written authorization issued by the Department of Health and Family Services (DHFS) to a provider prior to the provision of a service.

POS

Place of service. A two-digit code which identifies the place where the service was performed.

R/S Report

Remittance and Status Report. A statement generated by the Medicaid fiscal agent to inform providers regarding the processing of their claims.

SBS benefit

School-Based Services benefit. The SBS benefit has been established by Wisconsin Medicaid according to s. 49.45(39), Wis. Stats. This benefit is designed to increase federal funding to Wisconsin schools to help pay for medically related special education and associated services. The SBS benefit defines the services that can be reimbursed by Wisconsin Medicaid for medically necessary services provided to Medicaid-eligible children.

SMV

Specialized medical vehicle. Specialized medical vehicle providers provide transportation for recipients with a documented physical or mental disability that prevents them from traveling safely in a common carrier or private motor vehicle to Medicaid-covered services.

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