wisconsin Medicaid update
and BadgerCare
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Wisconsin Medicaid and BadgerCare Information for Providers

Send provider-based billing claims to Medicare for Part B services

Beginning in January 2001, Wisconsin Medicaid will produce Medicare Part B provider-based billing claims and will forward these claims to providers. Providers are then required to send these claims, along with any additional documentation, to Medicare.

Inside this Update:

Provider-based billing extended to include Medicare Part B

Beginning in January 2001, Wisconsin Medicaid will extend provider-based billing to include Medicare Part B covered services. Wisconsin Medicaid already produces provider-based billing claims for Medicare Part A covered services and commercial health insurance.

Definition and purpose

A provider-based billing claim is a completed claim form that Wisconsin Medicaid sends to providers for services Wisconsin Medicaid has already reimbursed.

The purpose of provider-based billing is to reduce Medicaid costs by ensuring that providers receive maximum reimbursement for services covered by health care plans that are primary to Wisconsin Medicaid (i.e., the first entity responsible to pay a claim).

A provider-based billing claim is created when the following occur:

- Wisconsin Medicaid retroactively identifies that Medicare or commercial health insurance coverage exists for the given dates of service and could reasonably be expected to cover the service.
- The other health care plan requires additional documentation from the provider to process the claim.

Providers should include any pertinent information with the claim(s) before submission and/or provide any additional documentation necessary to ensure carrier consideration of the claim.

Since benefits under Wisconsin Medicaid are secondary to those provided by most commercial insurance, providers are required to seek reimbursement from commercial insurance [HFS 106.03(7), Wis. Admin. Code]. Providers should not bill the recipient for these services.

Provider-Based Billing Summary

Wisconsin Medicaid sends providers a Provider-Based Billing Summary with provider-based billing claims. The summary lists:

- Each Medicaid claim from which a provider-based billing claim form was generated.
- The claim's corresponding claim internal control number (ICN).

Providers should refer to the information included with the Provider-Based Billing Summary when preparing their response.

Within 120 days of receiving the summary

Within 120 days of the date on the Provider-Based Billing Summary, providers are required to provide information to Wisconsin Medicaid documenting that they have:

- Accurately billed the responsible commercial health insurance company.
- Received or have been denied reimbursement from the insurance company.

After 120 days of receiving the summary

If Wisconsin Medicaid does not receive a response within 120 days of the date of the Provider-Based Billing Summary, Wisconsin Medicaid will withhold from future provider payments the amount equal to the original Medicaid payment.

Payment deferral is not a final action. Wisconsin Medicaid will accept documentation of the insurance company's payment, denial, or non-action after 120 days have elapsed; therefore, it is not necessary to request a hearing. Refer to the Coordination of Benefits section of the All-Provider Handbook for provider-based billing instructions.

This *Update* article applies to fee-for-service Medicaid providers only. If you are a Medicaid HMO network provider, contact your managed care organization for more information about its billing procedures. Wisconsin Medicaid HMOs are required to provide at least the same benefits for enrollees as those provided under fee-for-service arrangements. ✦

Payment deferral is not a final action. Wisconsin Medicaid will accept documentation of the insurance company's payment, denial, or non-action after 120 days have elapsed.

BadgerCare eligibility not affected by employment status

This *Update* article is a reminder to providers that individual family members may be eligible for BadgerCare health coverage whether they are employed or not employed. Individual family members are eligible for BadgerCare if they are uninsured and meet the financial and non-financial requirements outlined below.

Coverage under BadgerCare

To be eligible for BadgerCare health care coverage, family members must be uninsured and may be either employed or not employed. BadgerCare covers the following individual family members who meet low-income financial and non-financial requirements:

- Children under age 19 (regardless of whether they are living with their parents).
- Custodial parents living with children under age 19.
- Spouse of a custodial parent of children under age 19.

Financial requirements for BadgerCare

BadgerCare has no asset test. To be financially eligible for BadgerCare, a family must have a countable family income* that does not exceed 185% of the federal poverty level (FPL). Once in BadgerCare, family members remain eligible

for BadgerCare as long as the countable family income does not exceed 200% of the FPL. Refer to the table below for family size/income information.

For more information on financial eligibility for BadgerCare, interested persons should contact their county or tribal human or social services department or a local Wisconsin Works (W-2) agency.

Non-financial requirements for BadgerCare

To be eligible for BadgerCare, each family member applying for coverage must:

- Be uninsured. This means the potential enrollee must:
  - ✓ Not be covered by a health insurance policy (individual or family coverage).
  - ✓ Not have Medicaid or be eligible for Medicaid.
  - ✓ Not have access to employer-sponsored family health insurance where the employer pays 80% or more of the monthly premium.
  - ✓ Not have access to a state employee's family health plan.
- Be a United States citizen or a qualified alien.
- Be a resident of Wisconsin.
- Provide his or her Social Security number.
- Cooperate in locating an absent parent, in establishing paternity, and in establishing a medical support order, if a non-pregnant adult with a child.
- Participate in the Health Insurance Premium Payment (HIPP) program, if applicable. Health Insurance Premium Payment is a program in which BadgerCare enrolls a family in an employer's health plan and pays the premiums and other costs for this insurance.
- Provide information about other available health insurance.

Providers should refer potential enrollees who want more information on BadgerCare eligibility to Recipient Services at (800) 362-3002. Persons interested in applying for BadgerCare should contact their county or tribal human or social services department or a local W-2 agency. ✦

Once in BadgerCare, family members remain eligible for BadgerCare as long as the countable family income does not exceed 200% of the FPL.

* Countable family income for BadgerCare is a family's gross income (before taxes) minus certain disregarded income. Disregarded income includes: A flat $90/month for work-related expenses for each working member of the family; child care costs up to $200/month per child under age 2 and up to $175/month per child age 2 and above; the first $50/month of all child support payments received by the household; and for self-employed persons and farmers, all deductions from gross income allowed under federal tax law except depreciation.

Family Size	Monthly Income Standard		Annual Income Standard	
	185% FPL	200% FPL	185% FPL	200% FPL
1	$1,287.29	$1,391.67	$15,448.00	$16,700.00
2	$1,734.38	$1,875.00	$20,813.00	$22,500.00
3	$2,181.46	$2,358.33	$26,178.00	$28,300.00
4	$2,628.54	$2,841.67	$31,543.00	$34,100.00
5	$3,075.63	$3,325.00	$36,908.00	$39,900.00
6	$3,522.71	$3,808.33	$42,273.00	$45,700.00

Commercial health insurance cost-sharing

This *Update* article clarifies the information on commercial health insurance cost-sharing found in the Coordination of Benefits section of the All-Provider Handbook, which was released in July 2000. Providers may never charge recipients, or anyone financially responsible for Medicaid recipients, for commercial health care cost-sharing amounts (such as copayments, coinsurance, or deductibles).

Commercial health insurance cost-share policy

Providers may not hold Wisconsin Medicaid recipients responsible for any commercial health insurance cost-sharing amounts such as copayments, coinsurance, or deductibles. This is in accordance with federal regulations that prohibit collecting insurance copayments from a Wisconsin Medicaid recipient, or anyone financially responsible for the recipient, in an amount that exceeds Wisconsin Medicaid's copayment for that service.

For example: Betty Badger, a Wisconsin Medicaid recipient, also has commercial health insurance with an $8.00 copayment for each prescription. When Betty has a legend drug prescription filled, the pharmacy may only collect from her the $1.00 Wisconsin Medicaid copayment for legend drug prescriptions. The pharmacy may not collect any portion of the $8.00 commercial health insurance copayment from the recipient.

In addition, Wisconsin Medicaid recipients enrolled in a Medicaid managed care program may not be held responsible for either commercial health insurance cost-sharing obligations or Medicaid copayments for services covered by their managed care program.

Provider billing procedures

Providers are expected to exhaust all existing health insurance sources of payment, including any commercial health insurance, before billing Wisconsin Medicaid. Providers bill Wisconsin Medicaid their usual and customary charge and indicate on the claim the amount paid by the commercial health insurance. This is the amount actually received from the commercial insurer, which may have already been reduced to reflect cost-sharing amounts. Refer to the Claims Submission and Coordination of Benefits sections of the All-Provider Handbook for more information.

Providers may not hold Wisconsin Medicaid recipients responsible for any commercial health insurance cost-sharing amounts such as copayments, coinsurance, or deductibles.

Legislative authority

Federal law requires that providers make a reasonable attempt to collect Medicaid copayments from recipients. However, providers may not deny services to a recipient for failing to make a copayment [Social Security Act 1916(d); Reg 447.15]. Providers may waive the recipient copayment requirement if they determine that the cost of collecting the copayment exceeds the amount to be collected. For more information on copayments, refer to the Recipient Rights and Responsibilities section of the All-Provider Handbook. ✦

What's new on the Medicaid Web site

The Wisconsin Medicaid Web site includes provider and recipient publications, Medicaid contacts and statistics, and eligibility and benefit information. You may visit the Medicaid Web site at *www.dhfs.state.wi.us/medicaid/.*

The following is a list of what has recently been added to the Medicaid Web site:

- December 2000 *Wisconsin Medicaid and BadgerCare Update*.
- Quarterly pharmacy replacement pages.
- Revised maximum fee schedules.
- Updated Medicaid and BadgerCare caseload statistics.

Keep in mind that if you do not have a computer with Internet access, many libraries have access available. ✦

The *Wisconsin Medicaid and BadgerCare Update* is the first source of program policy and billing information for providers.

Although the *Update* refers to Medicaid recipients, all information applies to BadgerCare recipients also.

Wisconsin Medicaid and BadgerCare are administered by the Division of Health Care Financing, Wisconsin Department of Health and Family Services, P.O. Box 309, Madison, WI 53701-0309.

For questions, call Provider Services at (800) 947-9627 or (608) 221-9883 or visit our Web site at *www.dhfs.state.wi.us/medicaid/*.