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

To:

Federally Qualified Health Centers

Podiatrists

Rural Health Clinics

HMOs and Other Managed Care Programs

Maximum allowable fees increase for podiatry services

Effective for dates of service on and after July 1, 2001, Wisconsin Medicaid is increasing its maximum allowable fees for podiatry services.

Podiatry services rate increase

Wisconsin Act 16, the 2001-2003 biennial budget, authorized a 1.065% rate increase in maximum allowable fees for most Wisconsin Medicaid non-institutional providers.

In addition to this increase, Wisconsin Act 16 authorized additional rate increases for selected providers. Therefore, podiatrists will receive a rate increase for selected non-institutional office or other outpatient visits listed in the Attachment of this *Wisconsin Medicaid and BadgerCare Update*. This policy is effective for dates of service on and after July 1, 2001. Refer to the Attachment for procedure codes affected by the new maximum allowable fees.

Providers may obtain updated maximum allowable fee schedules from Wisconsin Medicaid. Refer to the All-Provider Handbook for ordering instructions. Fee schedules, provider handbooks, and *Updates* are also located on the Medicaid Web site at *www.dhfs.state.wi.us/medicaid/*.

Automatic claim adjustments

Wisconsin Medicaid will automatically adjust claims if the amount billed exceeded the previous maximum allowable fee. Wisconsin Medicaid will not automatically adjust paid claims on which the billed amount was equal to or less than the previous maximum allowable fee.

Providers are reminded that:

- They are required to bill Wisconsin Medicaid their usual and customary charges.
- Wisconsin Medicaid will reimburse providers the lesser of either the billed amount or the maximum allowable fee.

Recipient copayments

For services that require a recipient copayment, the copayment amount may change if the Medicaid maximum allowable fee for that service increases to the next highest copayment level.

Providers should verify that they are charging the correct copayment amount for each service. For most services, the following copayment chart applies:

Copayment amounts	
The copayment amounts for each evaluation and management, laboratory, X-ray, and diagnostic service procedure code, based on the maximum allowable fee, are as follows:	
Medicaid maximum allowable fee	**Copayment**
• Up to $10.00	$0.50
• From $10.01 to $25.00	$1.00
• From $25.01 to $50.00	$2.00
• Over $50.00	$3.00
Surgery services (each)	$3.00

For more detailed information about copayments (including copayment guidelines and exemptions) refer to the All-Provider Handbook and to the Podiatry Services Handbook.

Managed care providers

This *Update* contains Medicaid fee-for-service policy and applies to providers of services to recipients on fee-for-service Medicaid only. For Medicaid HMO or managed care policy, contact the appropriate managed care organization. Wisconsin Medicaid HMOs are required to provide at least the same benefits as those provided under fee-for-service arrangements.

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/*.

ATTACHMENT
Maximum allowable fees for podiatry office or other outpatient visits, effective July 1, 2001

The following table reflects the procedure codes in which the rate increase exceeds 1.065%. The type of service code "1" (Medical) applies to all the following procedure codes.

Office or other outpatient services			
Procedure code	**Description**	**Maximum allowable fee**	**Copayment**
99201	Office or other outpatient visit for the evaluation and management of a new patient (10 minutes face-to-face with patient and/or family)	$21.54	$1.00
99202	Office or other outpatient visit for the evaluation and management of a new patient (20 minutes face-to-face with patient and/or family)	$36.24	$2.00
99203	Office or other outpatient visit for the evaluation and management of a new patient (30 minutes face-to-face with patient and/or family)	$54.19	$3.00
99211	Office or other outpatient visit for the evaluation and management of an established patient (5 minutes face-to-face with patient and/or family)	$11.94	$1.00
99212	Office or other outpatient visit for the evaluation and management of an established patient (10 minutes face-to-face with patient and/or family)	$21.50	$1.00
99213	Office or other outpatient visit for the evaluation and management of an established patient (15 minutes face-to-face with patient and/or family)	$29.68	$2.00