wisconsin Medicaid update and BadgerCare

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Wisconsin Medicaid and BadgerCare Information for Providers

To:

Federally Qualified Health Centers
Nurse Practitioners
Nurse Midwives
Physician Assistants
Physician Clinics
Physicians
Rural Health Clinics
HMOs and Other Managed Care Programs

Maximum allowable fee increases for physician services

Effective for dates of service (DOS) on and after July 1, 2002, the following changes were made to reimbursement rates for physician services:

- An across-the-board 1.095% rate increase in maximum allowable fees for all physician services, except laboratory services, obstetric services, and injections.
- Primary care reimbursement rates apply to all physicians regardless of specialty.
- Reimbursement rates for global obstetric care and its components have increased.

Across-the-board 1.095% reimbursement rate increase

Wisconsin Act 16, the 2001-2003 biennial budget, authorized a 1.095% rate increase in maximum allowable fees for most Wisconsin Medicaid non-institutional providers. This applied to all physician services except for laboratory services which may be increased to no more than the current Medicare allowable fee, and injections which are reimbursed at cost. Obstetric care services received a targeted increase described later in this *Wisconsin Medicaid and BadgerCare Update*.

Wisconsin Medicaid automatically paid claims for dates of service (DOS) on and after July 1, 2002, with either the lesser of the billed amount or the new reimbursement rates. Providers will not be required to submit adjustment requests to receive the new rate.

Primary care reimbursement rates

In addition to the 1.095% across-the-board increase, Wisconsin Act 16 authorized a targeted rate increase. This increase was used to establish a uniform reimbursement rate for providers performing physician services (primarily surgery services and office visits) effective for DOS on and after July 1, 2002. Prior to this, the primary care reimbursement rate applied only to physicians with certain specialties.

Nurse midwives and physician assistants will continue to receive 90% of the physician reimbursement rate for these services.

Obstetric care services rate increase

Effective July 1, 2002, Wisconsin Medicaid increased reimbursement rates for global obstetric care and its components. Refer to the Attachment of this *Update* for a list of affected obstetric care procedure codes and the new maximum allowable fees. Nurse midwives and physician assistants will continue to receive 90% of the physician reimbursement rate for these services.

Health Personnel Shortage Area incentive

Eligible providers using the appropriate modifiers will continue to receive enhanced reimbursement rates for physician services when the services are eligible for Health Personnel Shortage Area (HPSA) incentive payments (HP and HK modifiers). For more information on the HPSA incentive payment, refer to the Physician Services Handbook.

Recipient copayments

For those services that require recipient copayment, the copayment amount for a particular service 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. The following copayment chart applies:

Copayment amounts	
Evaluation and management services* (each office visit, hospital admission, or consultation):	
• 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
Laboratory services (each)	$1.00
Radiology services (each)	$3.00
Surgery services (each)	$3.00
Diagnostic services (each)	$2.00
Allergy testing (per DOS)	$2.00

*Copayment amounts are based on the maximum allowable fee for each procedure code.

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

Maximum daily reimbursement rate

Effective for DOS on and after July 1, 2002, the maximum allowable amount a physician, nurse practitioner, or nurse midwife may be reimbursed for all services performed per recipient on the same DOS may not exceed $2,308.43.

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Updated maximum allowable fee schedules

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 located on the Medicaid Web site at *www.dhfs.state.wi.us/medicaid/*.

Information regarding Medicaid HMOs

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, PO 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 obstetric care services

The following table reflects the new reimbursement rates for affected procedure codes for global obstetric care and its components effective for dates of service on and after July 1, 2002. The type of service (TOS) code "2" (surgery) applies to all the following procedure codes. (Nurse midwives should use TOS code "9.")

Obstetric care services		
Procedure code	**Description**	**Maximum allowable fee* (as of July 1, 2002)**
59400	Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care	$1,137.94
59409	Vaginal delivery only (with or without episiotomy and/or forceps);	$612.43
59410	including postpartum care	$654.25
59425	Antepartum care only; 4-6 visits	$292.82
59426	7 or more visits	$502.08
59430	Post-partum care only (separate procedure)	$101.59
59510	Routine obstetric care including antepartum care, cesarean delivery, and postpartum care	$1,355.34
59514	Cesarean delivery only;	$808.72
59515	including postpartum care	$997.44
59610	Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care, after previous cesarean delivery	$1,210.45
59612	Vaginal delivery only, after previous cesarean delivery (with or without episiotomy, and/or forceps);	$648.96
59614	including postpartum care	$722.87
59618	Routine obstetric care including antepartum care, cesarean delivery, and postpartum care, following attempted vaginal delivery after previous cesarean delivery	$1,365.89
59620	Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery;	$808.72
59622	including postpartum care	$997.44
W6000	Antepartum care; initial visit	$78.38
W6001	two or three visits	$30.00

*Physician assistants and nurse midwives are reimbursed 90% of the payment allowed for the physician who would have otherwise performed the service. Nurse practitioners are reimbursed the same amount as physicians for these services. Refer to the Physician Services Handbook for more information on Medicaid reimbursement.