

To: Federally Qualified Health Centers, Ophthalmologists, Opticians, Optometrists, HMOs and Other Managed Care Programs

Vision Services Under BadgerCare Plus

BadgerCare Plus, the new state-sponsored health care program, will be implemented in February 2008. This *Update* describes the policies for vision services under BadgerCare Plus.

BadgerCare Plus Overview

In January 2007, Governor Jim Doyle included in his 2007-09 Biennial Budget proposal an innovative state-sponsored health care program to expand coverage to Wisconsin residents and ensure that all children in Wisconsin have access to affordable health care. This new program is called BadgerCare Plus, and it will start on February 1, 2008.

BadgerCare Plus merges family Medicaid, BadgerCare, and Healthy Start into a single program. BadgerCare Plus will expand enrollment to:

- All uninsured children.
- More pregnant women.
- More parents and caretaker relatives.
- Parents with children in foster care who are working to reunify their families.
- Young adults exiting out-of-home care, such as foster care, because they have turned 18 years of age.
- Certain farmers and other self-employed parents and caretaker relatives.

All individuals enrolled in BadgerCare Plus and Wisconsin Medicaid will be referred to as “members.”

BadgerCare Plus is comprised of two benefit plans, the Standard Plan and the Benchmark Plan. The services covered under the BadgerCare Plus Standard Plan are the same as the current Wisconsin Medicaid program; therefore, the term “Standard Plan” will be used in all future *Updates* to

describe the shared policy and billing information. The BadgerCare Plus Benchmark Plan is a more limited plan, modeled after commercial insurance.

New services covered under BadgerCare Plus and Wisconsin Medicaid include over-the-counter tobacco cessation products for all members and mental health and substance abuse screening, preventive mental health counseling, and substance abuse intervention services for pregnant women at risk of mental health or substance abuse problems. Future *Updates* will describe these new benefits in detail.

Refer to the November 2007 *Update* (2007-79), titled “Introduction to BadgerCare Plus — Wisconsin’s New Health Care Program,” for general information on covered and noncovered services, copayments, and enrollment.

Covered and Noncovered Services

Standard Plan

Vision services covered under the Standard Plan are the same as those covered under the current Wisconsin Medicaid program. Refer to the appropriate publications for covered services, policies, and procedures.

Benchmark Plan

Routine eye exams and refraction services are covered under the Benchmark Plan.

Services provided by opticians **are not covered** under the Benchmark Plan.

Glasses, contact lenses, and other vision materials **are not covered** under the Benchmark Plan.

Ophthalmologists should also refer to the December 2007 *Update (2007-99)*, titled “Coverage of Certain Medical Services Under BadgerCare Plus,” for more information about coverage, policies, and procedures.

Service Limitations for the Benchmark Plan

Under the Benchmark Plan, a single eye exam (*Current Procedural Terminology* [CPT] procedure code 92002-92014) and an associated determination of refractive state (CPT procedure code 92015) are covered per member every two enrollment years when performed by an optometrist. The Benchmark Plan will not cover additional eye exams for the same member within the two-year period. The refraction service is covered only when it is administered by the same provider and on the same date of service as the eye exam.

Enrollment Year Under BadgerCare Plus

An enrollment year is defined as the continuous 12-month period beginning the first day of the calendar month in which a member is enrolled in the Benchmark Plan and ending on the last day of the 12th calendar month.

For example, a member completes their BadgerCare Plus application materials by September 25, 2008. During the month of October, the Department of Health and Family Services (DHFS) reviews the application materials and determines that the member is **eligible** for the Benchmark Plan effective September 1, 2008, the first day of the calendar month that the application materials were completed; however, the enrollment year for this member will not begin until October 1, 2008, the first day of the calendar month in which the DHFS actively enrolled the member in the Benchmark Plan. The Benchmark Plan enrollment year for this member is defined as October 1, 2008, through September 30, 2009. **Services received after eligibility is established and before the enrollment year begins are covered under the Benchmark Plan but do not count toward the service limitations.**

Subsequent enrollment years begin on the first day of the calendar month immediately following the end of the previous enrollment year, if there is no coverage gap. If there is a coverage gap for more than one day, the enrollment year will reset to begin on the first day of the month in which the DHFS re-enrolls the member into the Benchmark Plan.

If a member switches from the Benchmark Plan to the Standard Plan, the Benchmark Plan enrollment year

does not reset. For example, a member’s enrollment year under the Benchmark Plan begins March 1, 2008. During the third month, the member’s income status changes and she is now eligible for the Standard Plan effective June 1, 2008. During August, the DHFS determines that the member is no longer eligible for the Standard Plan and effective September 1, 2008, the member returns to the Benchmark Plan. Since there is not a gap in coverage, the initial Benchmark Plan enrollment year is still active. The member must adhere to limits for services received while covered under the Benchmark Plan during the enrollment year period March 1, 2008, through February 28, 2009.

The Benchmark Plan enrollment year is the time period used to determine service limitations for members in the Benchmark Plan. **Services received while covered under the Standard Plan do not count toward the enrollment year service limitations in the Benchmark Plan and vice versa.** If a member switches between the two plans during one enrollment year, service limitations will accumulate separately under each plan.

Prior Authorization

Standard Plan

Prior authorization policy and procedures are the same under the Standard Plan as they are under the current Wisconsin Medicaid program.

Benchmark Plan

Prior authorization is not required for the routine eye exam and refraction service covered under the Benchmark Plan.

Prior authorization policy and procedures for ophthalmologists' services are the same under the Benchmark Plan as they are under the current Wisconsin Medicaid program.

Reimbursement

Providers will be reimbursed for services provided to members at the current Wisconsin Medicaid rate of reimbursement.

Copayments

Standard Plan

Copayment amounts under the Standard Plan are the same as they are under the current Wisconsin Medicaid program. Refer to previously published service-specific publications for more information on copayment amounts.

Policy regarding members who are subject to copayments and members who are exempt from copayments is different than that of the current Wisconsin Medicaid program.

Providers should note that the following Standard Plan members **are subject to copayment** for services where copayment applies:

- Members enrolled in BadgerCare Plus Standard Plan HMOs (previously referred to as Medicaid HMOs).
- Members under 18 years of age with incomes above 100 percent of the Federal Poverty Level (FPL).

Providers are prohibited from collecting copayments from the following Standard Plan members:

- Nursing home residents.
- Pregnant women.
- Members under 18 years of age who are members of a federally recognized tribe.
- Members under 18 years of age with incomes at or below 100 percent of the FPL.

Under the Standard Plan, providers **cannot** deny services if a member fails to make his or her copayment.

Benchmark Plan

The copayment amount for routine eye exams under the Benchmark Plan is \$15.00 per exam. There is no separate copayment for refraction services.

Ophthalmologists should refer to *Update 2007-99* for information about copayments for other covered services.

The following members are exempt from copayment requirements under the Benchmark Plan:

- Pregnant women.
- Members under 18 years of age who are members of a federally recognized tribe.

No other members are exempt from the copayment requirement under the Benchmark Plan.

Under the Benchmark Plan, a provider has the right to deny services if the member fails to make his or her copayment.

Information Regarding BadgerCare Plus HMOs

BadgerCare Plus HMOs are required to provide at least the same benefits as those provided under fee-for-service arrangements. For managed care policy, contact the appropriate managed care organization.

The *BadgerCare Plus Update* is the first source of program policy and billing information for providers. All information applies to Medicaid and BadgerCare Plus unless otherwise noted in the *Update*.

Wisconsin Medicaid and BadgerCare Plus are administered by the Division of Health Care Access and Accountability, 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 dhfs.wisconsin.gov/medicaid/.

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