ForwardHealth
Wisconsin serving you

Update
December 2008

No. 2008-211

Affected Programs: BadgerCare Plus, Medicaid
To: Blood Banks, Home Health Agencies, Individual Medical Supply Providers, Medical Equipment Vendors, Nurses in Independent Practice, Nursing Homes, Personal Care Agencies, Pharmacies, HMOs and Other Managed Care Programs

Durable Medical Equipment Covered Under the BadgerCare Plus Core Plan for Childless Adults

The BadgerCare Plus Core Plan for Childless Adults will be implemented on January 1, 2009, as part of Wisconsin's comprehensive health care reform. This *ForwardHealth Update* describes the coverage and policies for durable medical equipment under the Core Plan.

As a result of the recent downturn in the national economy, the expansion of the Core Plan will be implemented in phases. Phase I, which includes individuals currently enrolled in Milwaukee County's General Assistance Medical Program (GAMP) and other counties' general assistance medical programs, will begin on January 1, 2009. The timeframe for adding new phases will be determined as the Department of Health Services moves forward.

Refer to the December 2008 *Update* (2008-199), titled "Introducing the BadgerCare Plus Core Plan for Childless Adults," for general information about covered and noncovered services, reimbursement, copayment, and enrollment.

BadgerCare Plus Core Plan Overview

The BadgerCare Plus Core Plan for Childless Adults covers basic health care services including primary and preventive care, generic drugs, and a limited number of brand name prescription drugs.

In Milwaukee County, members will receive benefits under the Core Plan on a fee-for-service basis from January 1, 2009, through March 31, 2009. Effective April 1, 2009, Core Plan members in Milwaukee County will be enrolled in the state-contracted HMOs that serve Wisconsin's Medicaid and BadgerCare Plus population. Members will be sent enrollment choice materials beginning in January 2009 and will enroll through Automated Health Systems, Inc., the State's enrollment broker, as they currently do with the BadgerCare Plus population.

Individuals that are converting to the Core Plan from non-Milwaukee County general assistance (GA) programs will receive their Core Plan benefits on a fee-for-service basis.

All members enrolled in the Core Plan will receive a ForwardHealth identification card.

Covered and Noncovered Services

Durable medical equipment (DME) covered under the Core Plan is the same as the DME covered under the BadgerCare Plus Benchmark Plan. Cochlear implants and bone-anchored hearing devices are not covered under the Core Plan.

Refer to the Online Handbook on the ForwardHealth Portal for policies and procedures related to covered DME.

Service Limitations for the Core Plan

The Core Plan will reimburse up to $2,500.00 for DME per member per enrollment year. The cost of DME repairs counts toward this service limitation. Durable medical equipment that exceeds $2,500.00 is considered noncovered.

Enrollment Year Under the Core Plan

For persons who transition from GA or a General Assistance Medical Program (GAMP), the Core Plan enrollment year will be a continuous period of enrollment that begins on January 1, 2009, and ends during January, February, or March of 2010. (The earliest end date for the enrollment year would be January 1, 2010, and the latest end date would be March 31, 2010.) The enrollment year is staggered over three months to allow adequate time for the Department of Health Services to process renewal applications.

If a member who transitioned from GA or GAMP loses eligibility for the Core Plan, that member cannot re-enroll in the Core Plan until the plan becomes available for new members.

If the member becomes eligible for and switches into the Benchmark Plan, the member's enrollment year will reset under the Benchmark Plan.

Prior Authorization

Durable medical equipment providers that currently service the Milwaukee County GAMP will be contacted with instructions for prior authorization for members who transition from GAMP to the Core Plan.

Reimbursement

Providers will be reimbursed for DME provided to Core Plan members at the lesser of the provider's usual and customary charge or the established maximum allowable fee until the member reaches his or her service limitation of $2,500.00 per year.

If BadgerCare Plus covers any portion of the DME charges, providers are required to accept the BadgerCare Plus-allowed reimbursement, which is the lesser of the provider's usual and customary charge or the maximum allowable fee, as payment in full. If BadgerCare Plus pays a portion of the claim and the claim exceeds the member's service limitation, providers can balance bill the member for the difference between the allowed reimbursement and the dollar amount actually paid by BadgerCare Plus.

For example, suppose the BadgerCare Plus-allowed reimbursement for a DME item is $500.00 and the member has expended $2,200.00 of his or her DME coverage for the enrollment year. BadgerCare Plus will reimburse only $300.00 before the member has exhausted his or her coverage. The member is responsible for the additional $200.00. The provider must still accept $500.00 as payment in full because BadgerCare Plus reimbursed a portion of the charges. The provider must not bill the member for more than $200.00.

If a member has already met or exceeded his or her DME service limitation, BadgerCare Plus will not reimburse providers for DME provided to that member. The provider may collect his or her usual and customary charge from the member.

Terms of Reimbursement

The DME terms of reimbursement (TOR) have been revised for the Core Plan. Refer to the Attachment of this *Update* for the Medical Supply and Equipment Vendor Terms of Reimbursement. The TOR describes how BadgerCare Plus will reimburse providers for services rendered. The conditions outlined in the TOR will automatically take effect; providers do not need to resubmit certification materials.

Copayments

Copayment amounts under the Core Plan are the same as they are under the Standard Plan. Refer to the DME Index for copayment amounts.

Note: Rental items and repairs are not subject to a copayment.

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

Enrollment Verification

It is imperative that providers verify a member's enrollment to determine if the member is covered and in which plan the member is enrolled. Providers are reminded to *always* verify a member's enrollment *before* providing services, both to determine that the individual is enrolled for the current date and to discover any limitations to the member's coverage. Providers have several options to obtain enrollment information through Wisconsin's Enrollment Verification System and should refer to the Online Handbook for more information. Refer to the December 2008 *Update* (2008-200), titled "Member Enrollment Verification for BadgerCare Plus Core Plan for Childless Adults," for more information.

For More Information

For more information or questions regarding the Core Plan, providers may call Provider Services at (800) 947-9627.

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

Wisconsin Medicaid, BadgerCare Plus, SeniorCare, and Wisconsin Chronic Disease Program are administered by the Division of Health Care Access and Accountability, Wisconsin Department of Health Services (DHS). The Wisconsin Well Woman Program is administered by the Division of Public Health, Wisconsin DHS.

For questions, call Provider Services at (800) 947-9627 or visit our Web site at *www.forwardhealth.wi.gov/*.

P-1250

ATTACHMENT
Medical Supply and Equipment Vendor Terms of Reimbursement

(A copy of the "Medical Supply and Equipment Vendor Terms of Reimbursement" is located on the following page.)

Jim Doyle
Governor

Karen E. Timberlake
Secretary

State of Wisconsin

Department of Health Services

FORWARDHEALTH

PROVIDER SERVICES
6406 BRIDGE ROAD
MADISON WI 53784

Telephone: 800-947-9627
TTY: 608-221-4746
www.forwardhealth.wi.gov
www.forwardhealth.wi.gov/members

MEDICAL SUPPLY AND EQUIPMENT VENDOR TERMS OF REIMBURSEMENT

The Department of Health Services (DHS) will establish maximum allowable fees for all covered durable medical equipment (DME) and disposable medical supplies (DMS) provided to Wisconsin Medicaid and BadgerCare Plus members eligible on the date of service.

The maximum allowable fees for DME and DMS shall be established upon a review of various factors. These factors include a review of usual and customary charges submitted to Wisconsin Medicaid and BadgerCare Plus; cost, payment, and charge information from companies that provide DME and DMS; Medicaid payment rates from other states; and the current Medicare fee schedule. Other factors taken into consideration include the Wisconsin State Legislature's Medicaid budget constraints, limits on the availability of federal funding as specified in federal law, and other relevant economic and reimbursement limitations. Maximum allowable fees may be adjusted periodically.

Providers are required to bill their usual and customary charges for equipment, supplies, and services provided. The usual and customary charge is the amount charged by the provider for the same equipment, supplies, or services when provided to non-Medicaid patients. For providers using a sliding fee scale, the usual and customary charge is the median of the individual provider's charge for the product or service when provided to non-Medicaid patients.

Covered DME and DMS shall be reimbursed at the lower of the provider's usual and customary charge or the maximum allowable fee established by the DHS. Medicaid reimbursement, less appropriate copayments and payments by other insurers, will be considered to be payment in full.

Under the BadgerCare Plus Benchmark Plan and the BadgerCare Plus Core Plan for Childless Adults, DME charges shall be reimbursed by the DHS up to the member’s coverage limit. When BadgerCare Plus reimburses the provider for any portion of the DME charges, the provider may balance bill the member for the remainder of the BadgerCare Plus allowed reimbursement rate. This will be considered payment in full.

The DHS will adjust payments made to providers to reflect the amounts of any allowable copayments that the providers are required to collect pursuant to ch. 49, Wis. Stats.

Payments for deductibles and coinsurance payable on an assigned Medicare claim shall be made in accordance with s. 49.46(2)(C), Wis. Stats.

In accordance with federal regulations contained in 42 CFR 447.205, the DHS will provide public notice in advance of the effective date of any significant proposed change in its methods and standards for setting maximum allowable fees for services.