This *Update* has been revised since its original publication. Information about BadgerCare Plus Benchmark Plan coverage of routine vision services in Attachment 5 has been corrected. See page 21 of the *Update* for more information.

ForwardHealth
Wisconsin serving you

Update
June 2009

No. 2009-33

Affected Programs: BadgerCare Plus
To: All Providers, HMOs and Other Managed Care Programs

Expansion of the BadgerCare Plus Core Plan for Adults with No Dependent Children

On June 15, 2009, the BadgerCare Plus Core Plan for Adults with No Dependent Children began accepting applications for enrollment from the general public as part of the second phase of Core Plan implementation. July 15, 2009, is the earliest date of coverage and benefits for qualified individuals who apply during the second phase of Core Plan implementation.

This *ForwardHealth Update* describes the second phase of Core Plan implementation. This *Update* also describes changes to Core Plan coverage, policies, and procedures for newly enrolled Core Plan members and Core Plan members who transitioned from the Milwaukee County General Assistance Program and other counties' general assistance medical programs.

Overview of BadgerCare Plus Core Plan Implementation

On January 1, 2009, the Department of Health Services (DHS) introduced the BadgerCare Plus Core Plan for Adults with No Dependent Children, also known as the BadgerCare Plus Core Plan for Childless Adults, as part of Wisconsin's comprehensive health care reform. The Core Plan provides adults who were previously not eligible to enroll in state and federal health programs such as BadgerCare Plus with access to basic health care services including primary care, preventive care, certain generic and over-the-counter (OTC) drugs, and a limited number of brand name drugs.

First Phase

In the first phase of Core Plan implementation, individuals enrolled in the Milwaukee General Assistance Medical Program (GAMP) and certain other counties' general assistance (GA) medical programs were automatically transitioned into the Core Plan effective January 1, 2009. Services were covered under fee-for-service. Effective April 1, 2009, members transitioned from GAMP began their enrollment process in one of the state-contracted HMOs that serve Wisconsin's Medicaid and BadgerCare Plus population.

Second Phase

In the second phase, BadgerCare Plus will begin accepting applications from the general public for enrollment in the Core Plan as of June 15, 2009. The second phase opens enrollment to certain low-income adults with no dependent children. The earliest date of coverage and benefits will be July 15, 2009. Services will be covered under fee-for-service until members are enrolled in an HMO. All new Core Plan members will be required to enroll in an HMO under the following circumstances: there are two or more HMOs in the member's area, or there is one HMO in the member's area and the member resides in a designated rural county where federal requirements allow mandatory HMO enrollment. New Core Plan members will receive HMO enrollment materials in the mail to select an HMO. The

earliest date of HMO enrollment for new Core Plan members will be October 1, 2009.

Application Process for New Members

Applicant Enrollment Requirements

An applicant must meet the following enrollment requirements in order to qualify for the Core Plan:

- Is a Wisconsin resident.
- Is a United States citizen or legal immigrant.
- Is between the ages of 19 and 64.
- Does not have any children under age 19 under his or her care.
- Is not pregnant.
- Is not eligible for or enrolled in Medicaid, the BadgerCare Plus Standard Plan, or the BadgerCare Plus Benchmark Plan. This would not include benefits provided under the Family Planning Waiver (FPW) or those benefits provided to individuals who qualify for Tuberculosis-Related Services Only.
- Is not eligible for or enrolled in Medicare.
- Has a monthly gross income that does not exceed 200 percent of the Federal Poverty Level (FPL).
- Is not covered by health insurance currently or in the previous 12 months.
- Has not had access to employer-sponsored insurance in the previous 12 months and does not have access to employer-subsidized insurance during the month of application or any of the three months following application.

Application Process for New Members

The Core Plan application process will be streamlined and user-friendly. Individuals who wish to enroll may apply for the Core Plan online at *access.wi.gov/* or via the Enrollment Services Center toll-free telephone number, (800) 291-2002. A pre-screening tool at *access.wi.gov/* will help determine which individuals may be eligible to enroll in the Core Plan. Applications for Core Plan members will be processed centrally by the Enrollment Services Center, not by county agencies.

To complete the application process, applicants must meet the following requirements:

- Complete a Health Survey.
- Pay a non-refundable, annual processing fee of $60.00 per individual or per couple for married couples. The fee will be waived for homeless individuals. There are no monthly premiums.

Medicaid-certified providers **cannot** pay the $60.00 application processing fee on behalf of Core Plan applicants. An offer by a Medicaid-certified provider to pay a fee on behalf of a prospective Medicaid member may violate federal laws against kickbacks. These laws are federal criminal statutes that are interpreted and enforced by federal agencies such as the United States Department of Justice and the Department of Health and Human Services' Office of Inspector General.

Conditions That End Member Enrollment in the Core Plan

A member's enrollment will end if the member:

- Becomes eligible for Medicare, Medicaid, the Standard Plan, or the Benchmark Plan.
- Becomes incarcerated or institutionalized in an Institution for Mental Disease (IMD).
- Becomes pregnant.
- No longer resides in the state of Wisconsin.
- Obtains health insurance coverage.
- Turns 65 years of age.

Providers are reminded that the Core Plan does not cover obstetrical services, including the delivery of a child or children. A Core Plan member who becomes pregnant should be referred to the Enrollment Services Center at (800) 291-2002 for more information about enrollment in the Standard Plan or the Benchmark Plan.

Core Plan Member Fact Sheets

Fact sheets providing additional member information about the Core Plan are available at *dhs.wisconsin.gov/badgercareplus/core/index.htm*.

Enrollment Certification Period for Core Plan Members

Once determined eligible for enrollment in the Core Plan, a member's enrollment will begin either on the first or 15th of the month, which ever is first, and will continue through the end of the 12th month. For example, if the individual submits all of his or her application materials, including the application fee, by September 17, 2009, and the DHS reviews the application and approves it on October 6, 2009, the individual is eligible for enrollment beginning on October 15, 2009, the next possible date of enrollment. The enrollment certification period will continue through October 31, 2010.

The enrollment certification period for individuals who qualify for the Core Plan is 12 months, regardless of income changes.

Enrollment Year Under the Core Plan

Definition of an Enrollment Year Under the Core Plan

The Core Plan enrollment year is the time period used to determine service limitations for members in the Core Plan. **Services received while covered under the Standard Plan or the Benchmark Plan do not count toward the enrollment year service limitations in the Core Plan and vice versa.**

The Core Plan enrollment year is defined as the continuous 12-month period beginning on the first day of enrollment (either the first or the 15th day of the month) in the Core Plan and ending on the last day of the 12th full calendar month.

The Core Plan enrollment year will reset if there is a gap in coverage for more than a full calendar month. For example, a member's situation changes for a few months and the member is temporarily ineligible for the Core Plan. More than one month later, the member becomes eligible again and reapplies for the Core Plan. When the member's application is approved and Core Plan coverage begins, the Core Plan enrollment year resets. Core Plan service limitations for this member also reset.

When a member exceeds his or her service limitations, the service is considered noncovered and the member is responsible for payment of the service.

Enrollment Year for Transitioned Members

For persons who transitioned from GAMP or GA on January 1, 2009, 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 DHS to process renewal applications.

If a member who transitioned from GAMP or GA loses eligibility for the Core Plan, that member cannot reapply for enrollment in the Core Plan until June 15, 2009, when 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.

Note: When the member's 2010 enrollment year begins, it will follow the same conditions as that of a nontransitioned member.

Enrollment Year for Members Switching Between the Core Plan and the Benchmark Plan

Special conditions apply to the enrollment year for members who switch between the Core Plan and the Benchmark Plan.

If a member is enrolled in the Core Plan and subsequently becomes eligible for and enrolls in the

Benchmark Plan, his or her enrollment year in the Core Plan automatically ends. A new enrollment year under the Core Plan will begin if the member re-enrolls in the Core Plan at a later date.

If a member is in the Benchmark Plan, becomes temporarily eligible for and enrolls in the Core Plan, then switches back into the Benchmark Plan, the enrollment year for the Benchmark Plan will reset if there has been a gap in coverage for more than one full calendar month. If there has not been a gap in coverage for more than one full calendar month, and if the date of re-enrollment in the Benchmark Plan is within the initially established enrollment year dates, the Benchmark Plan enrollment year will **not** reset.

For example, a member is enrolled in the Benchmark Plan as of July 1, 2009. That member's Benchmark Plan enrollment year is defined as July 1, 2009, through June 30, 2010. The member loses her eligibility for the Benchmark Plan as of September 30, 2009. The member applies for the Core Plan and her enrollment begins on October 15, 2009. (The gap in coverage for this member is less than one full calendar month.) The member becomes ineligible for the Core Plan and the member's enrollment ends on March 31, 2010. The member re-enrolls in the Benchmark Plan, effective April 1, 2010. (The date of re-enrollment in the Benchmark Plan is within the dates of the previous Benchmark Plan enrollment year.) The member's enrollment year under the Benchmark Plan does not reset and is still defined as July 1, 2009, through June 30, 2010.

New ForwardHealth Core Plan Identification Cards

Beginning in July 2009, new members enrolled in the Core Plan will receive a ForwardHealth Core Plan card. All identification cards include the member's name and 10-digit member identification number. The identification cards may be used to verify a member's enrollment, but possession of an identification card does not guarantee enrollment. It is possible that a member will present a card when he or she is not enrolled; therefore, it is essential that providers verify enrollment before providing services.

Core Plan members should call the Enrollment Services Center with questions about enrollment criteria, HMO enrollment, and covered services. The ForwardHealth Core Plan cards include the Enrollment Services Center telephone number on the back. Refer to Attachment 1 of this *Update* for a sample ForwardHealth Core Plan card.

Members who transitioned from GAMP or GA medical programs in January 2009 currently have ForwardHealth cards and will begin receiving ForwardHealth Core Plan cards when they re-enroll in the Core Plan in 2010.

Providers should always check enrollment for a member who presents a ForwardHealth card to verify if the member is enrolled in the Core Plan or in one of the other ForwardHealth programs. (Providers may use the same methods of enrollment verification under the Core Plan as they do for other ForwardHealth programs such as Medicaid. These methods include the ForwardHealth Portal, WiCall, magnetic stripe card readers, and the 270/271 Health Care Eligibility /Benefit Inquiry and Information Response transactions.) Members who present a ForwardHealth card or a ForwardHealth Core Plan card may have been enrolled in a different plan since the card was issued. Providers should be careful to verify the plan in which the member is enrolled and know which services are covered under that plan.

Comprehensive Physical Examination Requirement

Members must have a comprehensive physical exam within the first year of enrollment to remain enrolled in the Core Plan. If the provider does not report the physical exam or if the member does not have a physical exam, the member will not be eligible to re-enroll in the Core Plan after the first year. Refer to Attachment 1 of the December 2008 *ForwardHealth Update* (2008-202), titled "Coverage of Certain Medical Services Under the

BadgerCare Plus Core Plan for Childless Adults," for a complete list of *Current Procedural Terminology* codes that satisfy this requirement.

Note: For transitioned members, a comprehensive physical examination completed within calendar year 2008 by Milwaukee's GAMP, certain other counties' GA medical programs, or another ForwardHealth program, fulfills the member's requirement. For newly enrolled members or transitioned members who renew their enrollment, a comprehensive physical examination completed within 12 months by another ForwardHealth program will fulfill the member's requirement. ForwardHealth will report this information to the member's HMO.

Overview of Covered and Noncovered Services

Core Plan benefits are less comprehensive than Medicaid. Covered services under the Core Plan include the following:

- Physician services, including primary and preventive care and specialists for diagnostic, surgical, and medical services.
- Diagnostic services, including laboratory and radiology.
- Inpatient hospital stays, excluding inpatient hospital psychiatric stays in either an IMD or the psychiatric ward of an acute care hospital and inpatient substance abuse treatment.
- Outpatient hospital visits, excluding all outpatient mental health and substance abuse services.
- Emergency ambulance services.
- Certain emergency dental services.
- Emergency outpatient services.
- Certain generic drugs, some OTC drugs, and a limited number of brand name drugs. Brand name drugs that are not covered by the Core Plan may be covered by BadgerRx Gold.
- Physical therapy (PT), occupational therapy, and speech and language pathology services limited to 20 visits per discipline, per member, per enrollment year. Cardiac rehabilitation visits are covered under PT and are subject to PT service limitations.
- Durable medical equipment (DME) limited to $2,500.00 per enrollment year.
- Disposable medical supplies (DMS), including certain diabetic supplies, ostomy supplies, and other DMS that are required with the use of DME.
- Chiropractic services.

Providers are reminded that drugs, including provider-administered drugs, are reimbursed fee-for-service. A future *Update* will contain more information about pharmacy services covered by the Core Plan.

Services provided by optometrists and ophthalmologists are covered by the Core Plan *except* for routine vision services.

Family planning services provided by a family planning clinic may be covered by the FPW for members who are eligible for that program.

Inpatient mental health services and substance abuse treatment are *not* covered by the Core Plan. Outpatient mental health and substance abuse services are generally *not* covered by the Core Plan. However, some services provided by psychiatrists are covered.

Additional changes to covered services under the Core Plan are described later in this *Update*. Providers should refer to the Online Handbook for service-specific coverage, policies, and procedures under the Core Plan. Attachment 2 lists Core Plan *Updates* published since December 2008.

Refer to Attachments 3 and 4 for information about covered and noncovered services and service limitations. For a table comparing coverage for the Core Plan with the Standard Plan and the Benchmark Plan, refer to Attachment 5.

Chiropractic Services Are Now Covered Under the Core Plan

Effective for dates of service (DOS) on and after July 1, 2009, the Core Plan will cover the same chiropractic services as the Standard Plan. Policies and procedures regarding prior authorization and copayments are the same under the Core Plan as they are under the Standard Plan. Chiropractic services will not be covered by HMOs, so all chiropractic services are reimbursed fee-for-service.

Changes to Coverage of Disposable Medical Supplies

Effective for DOS on and after January 1, 2009, the Core Plan covers ostomy supplies, which includes the following Healthcare Common Procedure Coding System codes:

- A4361 – A4367.
- A4369 – A4395.
- A4397 – A4399.
- A4402 – A4412.
- A4414 – A4420.
- A4423 – A4434.
- A5051 – A5055.
- A5062, A5062 with modifier "22," and A5062 with modifier "59."
- A5063 – A5093.
- A5126.
- A5131.

On July 1, 2009, providers may submit claims for ostomy supplies provided to Core Plan members for DOS on and after January 1, 2009. Claims submitted for ostomy supplies prior to July 1, 2009, cannot be processed by ForwardHealth. Providers who have received payment from Core Plan members for ostomy supplies should refund the entire amount to the member and submit claims to ForwardHealth.

Refer to Attachment 6 for a complete list of DMS covered by the Core Plan. This Attachment replaces the Attachment in the December 2008 *Update* (2008-212), titled "Disposable Medical Supplies Covered Under the BadgerCare Plus Core Plan for Childless Adults."

Changes to Inpatient and Outpatient Hospital Policies

Coverage of inpatient and outpatient hospital services has not changed. Providers should refer to the December 2008 *Update* (2008-213), titled "Inpatient and Outpatient Hospital Services Covered Under the BadgerCare Plus Core Plan for Childless Adults," for more information about coverage of hospital services under the Core Plan.

Copayments

For hospital services provided on and after July 15, 2009, the Core Plan will introduce higher copayment amounts for members with a higher income level.

Copayments for hospital services covered under the Core Plan vary depending on the type of service and the member's income level. Enrollment verification responses in the Portal and Wisconsin's Enrollment Verification System will tell providers if the member is part of the lower or higher income bracket by identifying the member as "BadgerCare Plus Core Plan 1" or "BadgerCare Plus Core Plan 2." Providers are required to use the following guidelines for collecting copayments for hospital services from Core Plan members:

- Core Plan 1 members have income up to and including 100 percent of the FPL and should be charged the lower copayment amounts or exempted from copayment, as applicable.
- Core Plan 2 members have income above 100 percent FPL and up to 200 percent FPL and should be charged the higher copayment amounts.

For members with income up to and including 100 percent of the FPL (Core Plan 1 members), the following copayment policies apply:

- Emergency room services — No copayment.
- Inpatient hospital services — $3.00 per day, with a limit of $75.00 per hospital stay.

- Outpatient hospital services — $3.00 per visit. A visit is defined as all services provided by the same rendering provider on the same DOS, regardless of the number or type of procedures administered.

Copayment for all inpatient and outpatient hospital services for Core Plan 1 members is capped at $300.00 per member, per enrollment year.

For members with income above 100 percent FPL and up to 200 percent FPL (Core Plan 2 members), the following copayment policies apply:

- Emergency room services — $60.00 per visit. A visit is defined as all services provided by the same rendering provider on the same DOS, regardless of the number or type of procedures administered. The emergency room copayment is waived if the member is admitted to the hospital on the same day as the emergency room visit and the inpatient hospital copayment will apply instead.
- Inpatient hospital services — $100.00 per stay.
- Outpatient hospital services — $15.00 per visit.

Copayment for all inpatient and outpatient hospital services for Core Plan 2 members is capped at $300.00 per member, per enrollment year.

Reimbursement

Rates of reimbursement for inpatient and outpatient hospital services covered under the Core Plan will not include hospital access payments or any other type of payment increase funded from the hospital assessment trust fund. Rates for hospital services are published on the Portal at *www.forwardhealth.wi.gov/*.

Changes to Copayment Limits for Physician Services

Effective for DOS on and after July 1, 2009, copayment limits for physician services covered under the Core Plan will be applied per enrollment year. This corrects information about copayment limits in *Update* 2008-202, which stated the copayment limits would be applied per calendar year.

For physician services with copayments, nominal copayments will range from $0.50 to $3.00, with a limit of $30.00 per provider, per enrollment year. Copayments are applied the same way they are applied under the Standard Plan; there is no copayment for emergency services, preventive care, anesthesia, or clozapine management.

Core Plan Members Enrolled in Wisconsin Chronic Disease Program

For Core Plan members who are also enrolled in Wisconsin Chronic Disease Program (WCDP), providers should submit claims for all covered services to the Core Plan first and then to WCDP. For pharmacy services, if both programs deny the pharmacy claim, providers should submit claims to BadgerRx Gold.

Core Plan Members with HIRSP Coverage

Core Plan members may also be enrolled in the Health Insurance Risk Sharing Plan (HIRSP) as long as the member meets the eligibility requirements for both the Core Plan and HIRSP. For Core Plan members who are also enrolled in HIRSP, providers should submit claims for all Core Plan covered services to the Core Plan. For services not covered by the Core Plan, providers should submit claims to HIRSP. HIRSP is always the payer of last resort.

Note: HIRSP will only cover noncovered Core Plan services if the services are covered under the HIRSP benefit.

Enrollment Verification

The Core Plan offers different covered services, noncovered services, and copayments than the Standard Plan or the Benchmark Plan. It is imperative that providers verify a member's enrollment and determine the plan under which he or she is covered. Providers are reminded to *always* verify a member's enrollment *before*

providing services to determine enrollment at the current date (since a member's enrollment status may change) and to discover any limitations to the member's coverage.

Note: The Core Plan charges different copayments for hospital services depending on the member's income level. Members identified as "BadgerCare Plus Core Plan 1" are subject to lower copayments for hospital services. Members identified as "BadgerCare Plus Core Plan 2" are subject to higher copayments for hospital services.

For More Information

For more information or questions regarding the Core Plan, providers may call Provider Services at (800) 947-9627. Core Plan members should contact the Enrollment Services Center at (800) 291-2002.

Information Regarding HMOs

This *Update* contains fee-for-service policy and applies to services members receive on a fee-for-service basis only. For managed care policy, contact the appropriate HMO. HMOs are required to provide at least the same benefits as those provided under fee-for-service arrangements.

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/*.

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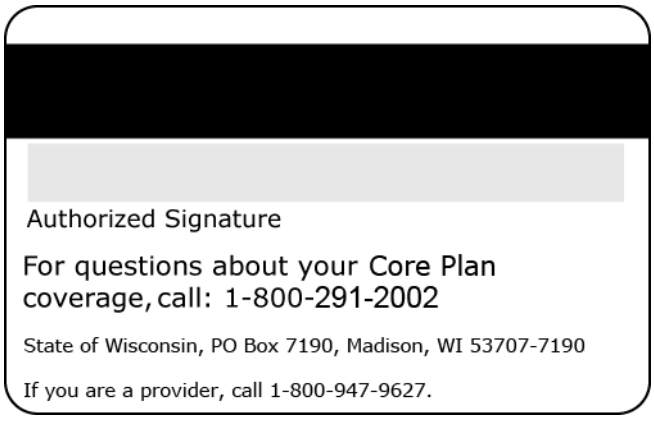
ATTACHMENT 1
ForwardHealth Core Plan Card



ATTACHMENT 2
BadgerCare Plus Core Plan Publications

The following table lists the *ForwardHealth Updates* describing the BadgerCare Plus Core Plan for Adults with No Dependent Children (also known as the BadgerCare Plus Core Plan for Childless Adults) and service-specific coverage, policies, and procedures under the Core Plan. Providers should refer to service-specific *Updates* and the Online Handbook for policy information.

***Update* Title**	***Update* Number**
Introducing the BadgerCare Plus Core Plan for Childless Adults	2008-199
Member Enrollment Verification for BadgerCare Plus Core Plan for Childless Adults	2008-200
Pharmacy Services Covered Under the BadgerCare Plus Core Plan for Childless Adults	2008-201
Coverage of Certain Medical Services Under the BadgerCare Plus Core Plan for Childless Adults	2008-202
Billing Members for Covered and Noncovered Services Under the BadgerCare Plus Core Plan for Childless Adults	2008-203
Tobacco Cessation Products and Services Covered Under the BadgerCare Plus Core Plan for Childless Adults	2008-204
Clozapine and Clozapine Management Services Covered Under the BadgerCare Plus Core Plan for Childless Adults	2008-205
Dental Services Covered Under the BadgerCare Plus Core Plan for Childless Adults	2008-206
End-Stage Renal Disease Services Covered Under the BadgerCare Plus Core Plan for Childless Adults	2008-207
Ambulance Services Covered Under the BadgerCare Plus Core Plan for Childless Adults	2008-208
Family Planning-Related Services Covered Under the BadgerCare Plus Core Plan for Childless Adults	2008-209
Cost Reporting for Federally Qualified Health Centers and Rural Health Clinics Services Covered Under the BadgerCare Plus Core Plan for Childless Adults	2008-210
Durable Medical Equipment Covered Under the BadgerCare Plus Core Plan for Childless Adults	2008-211
Disposable Medical Supplies Covered Under the BadgerCare Plus Core Plan for Childless Adults	2008-212
Inpatient and Outpatient Hospital Services Covered Under the BadgerCare Plus Core Plan for Childless Adults	2008-213
Physical Therapy, Occupational Therapy, and Speech and Language Pathology Services Covered Under the BadgerCare Plus Core Plan for Childless Adults	2008-214

***Update* Title**	***Update* Number**
Changes to Pharmacy Coverage Under the BadgerCare Plus Core Plan for Childless Adults Delayed	2009-12
Clarification of Reimbursement of Dental Services under the BadgerCare Plus Core Plan for Childless Adults	2009-21

ATTACHMENT 3
At-a-Glance Summary of BadgerCare Plus Core Plan Covered Services

The covered services information in the following chart is provided as general information. Providers should refer to their service-specific publications and the Online Handbook for detailed information on covered and noncovered services, copayment amounts and limits, and prior authorization information.

Service	Coverage Under the BadgerCare Plus Core Plan for Adults with No Dependent Children
Chiropractic	Full coverage. There is a $0.50 to $3.00 copayment per service.
Dental	Coverage limited to certain emergency services only. There is no copayment.
Disposable Medical Supplies (DMS)	Coverage of certain diabetic supplies, ostomy supplies, and other DMS that is required with the use of a durable medical equipment (DME) item. There is a $0.50 to $3.00 copayment per priced unit.
Drugs	Broad list of generic drugs, some over-the-counter (OTC) drugs, and a limited number of brand name drugs. Members will be automatically enrolled in BadgerRx Gold. This is a separate program administered by Navitus Health Solutions, which provides a discount on the cost of drugs. There is up to a $5.00 copayment per prescription with a $20.00 limit per provider, per member, per month.
DME	Full coverage up to $2,500.00 per enrollment year. There is a $0.50 to $3.00 copayment per item. Rental items are not subject to copayment but count toward the $2,500.00 annual limit.

Service	Coverage Under the BadgerCare Plus Core Plan for Adults with No Dependent Children
Inpatient Hospital	Full coverage excluding inpatient hospital psychiatric stays in either an Institute of Mental Disease or the psychiatric ward of an acute care hospital and inpatient substance abuse treatment. Copayments are as follows: • $3.00 per day with a $75.00 cap per stay for Core Plan 1 members (members with income up to and including 100 percent of the Federal Poverty Level [FPL]). • $100.00 per stay for Core Plan 2 members (members with income above 100 percent FPL and up to 200 percent FPL). • $300.00 total copayment cap per enrollment year for inpatient and outpatient hospital services.
Mental Health and Substance Abuse Treatment	Coverage limited to mental health therapy services provided by a psychiatrist only. There is a $0.50 to $3.00 copayment per service, limited to $30.00 per provider, per enrollment year.
Outpatient Hospital — Emergency Room	Full coverage. There is no copayment for emergency room services for Core Plan 1members (members with income up to and including 100 percent of the FPL). There is a $60.00 per stay copayment for Core Plan 2 members (members with income above 100 percent FPL and up to 200 percent FPL). The copayment is waived if the member is admitted to the hospital.
Outpatient Hospital	Full coverage excluding outpatient mental health and substance abuse treatment services. Copayments are as follows: • $3.00 per visit for Core Plan 1 members (members with income up to and including 100 percent of the FPL). • $15.00 per visit for Core Plan 2 members (members with income above 100 percent FPL and up to 200 percent FPL). • $300.00 total copayment cap per enrollment year for inpatient and outpatient hospital services.

Service	Coverage Under the BadgerCare Plus Core Plan for Adults with No Dependent Children
Physical Therapy (PT), Occupational Therapy, and Speech and Language Pathology	Full coverage limited to 20 visits per therapy discipline, per enrollment year. (Cardiac rehabilitation visits count toward the 20 visit limit for PT services and are subject to PT limitations.) There is a $0.50 to $3.00 copayment per service. Copayment obligation is limited to the first 30 hours or $1,500.00, whichever occurs first, during one enrollment year (copayment limits are calculated separately for each discipline).
Physician	Full coverage, including laboratory and radiology. There is a $0.50 to $3.00 copayment per service, limited to $30.00 per provider, per enrollment year. There is no copayment for emergency services, preventive care, anesthesia, or clozapine management.
Reproductive Health Services	Family planning services provided by family planning clinics will be covered separately under the Family Planning Waiver program for eligible members.
Smoking Cessation Drugs	Coverage includes prescription generic and OTC tobacco cessation products. Refer to the drug benefit for information on copayments.
Transportation — Ambulance, Specialized Medical Vehicle, Common Carrier	Coverage limited to emergency transportation by ambulance. There is no copayment.

ATTACHMENT 4
Services Not Covered Under the BadgerCare Plus Core Plan

The following services are not covered under the BadgerCare Plus Core Plan for Adults with No Dependent Children:

- Case management.
- Enteral nutrition.
- Hearing services, including hearing instruments, cochlear implants, bone-anchored hearing devices, hearing aid batteries, and repairs.
- Home care services (home health, personal care, private duty nursing).
- Hospice.
- Inpatient mental health and substance abuse treatment services.
- Non-emergency transportation (i.e., common carrier, specialized medical vehicle).
- Nursing home.
- Podiatry services provided by a podiatrist.
- Prenatal Care Coordination.
- Routine vision services (*Current Procedural Terminology* codes 92002-92015); vision materials such as glasses, contact lenses, and ocular prosthetics; repairs to vision materials; and services related to the fitting of contact lenses and spectacles.
- School-Based Services.

ATTACHMENT 5
BadgerCare Plus Core Plan Covered Services Comparison Chart

The covered services information in the following chart is provided as general information. Providers should refer to their service-specific publications and the Online Handbook for detailed information on covered and noncovered services and prior authorization information.

Service	Coverage Under the BadgerCare Plus Standard Plan	Coverage Under the BadgerCare Plus Benchmark Plan	Coverage Under the BadgerCare Plus Core Plan for Adults with No Dependent Children
Chiropractic	Full coverage.	Full coverage.	Full coverage.
Dental	Full coverage.	Limited coverage of preventive, diagnostic, simple restorative, periodontics, and extractions for pregnant women and children. Coverage limited to $750.00 per enrollment year. A $200.00 deductible applies to all services except preventive and diagnostic. Cost-sharing equal to 50 percent of allowable fee on all services. Pregnant women are exempt from deductible and cost-sharing requirements for dental services.	Coverage limited to certain emergency services only.
Disposable Medical Supplies (DMS)	Full coverage.	Coverage of certain diabetic supplies, ostomy supplies, and other DMS that are required with the use of durable medical equipment (DME).	Coverage of certain diabetic supplies, ostomy supplies, and other DMS that are required with the use of DME.

Service	Coverage Under the BadgerCare Plus Standard Plan	Coverage Under the BadgerCare Plus Benchmark Plan	Coverage Under the BadgerCare Plus Core Plan for Adults with No Dependent Children
Drugs	Comprehensive drug benefit with coverage of generic and brand name prescription drugs and some over-the-counter (OTC) drugs.	Generic-only formulary drug benefit with a few generic OTC drugs. Members will be automatically enrolled in BadgerRx Gold. This is a separate program administered by Navitus Health Solutions, which provides a discount on the cost of drugs.	Generic-only formulary drug benefit with a limited number of OTC drugs. Some brand name drugs are covered. Refer to the ForwardHealth Portal for a list of drugs covered under the Core Plan. Members will be automatically enrolled in BadgerRx Gold. This is a separate program administered by Navitus Health Solutions.
DME	Full coverage.	Full coverage up to $2,500.00 per enrollment year. Rental items count toward the $2,500.00 annual limit.	Full coverage up to $2,500.00 per enrollment year. Rental items count toward the $2,500.00 annual limit.
HealthCheck Screenings for Children	Full coverage of HealthCheck screenings and other services for individuals under the age of 21.	Full coverage of HealthCheck screenings and HealthCheck Outreach and Case Management. HealthCheck "Other Services" and Interperiodic services for individuals under the age of 21 are not covered.	Not applicable.

Service	Coverage Under the BadgerCare Plus Standard Plan	Coverage Under the BadgerCare Plus Benchmark Plan	Coverage Under the BadgerCare Plus Core Plan for Adults with No Dependent Children
Hearing Services	Full coverage.	Limited coverage of services provided by an audiologist. Hearing aids, hearing aid batteries, cochlear implants, and bone-anchored hearing devices are not covered.	No coverage.
Home Care Services (Home Health, Private Duty Nursing [PDN], and Personal Care)	Full coverage of PDN, home health, and personal care services.	Full coverage of home health services. Coverage limited to 60 visits per enrollment year. Private duty nursing and personal care services are not covered.	No coverage.
Hospice	Full Coverage.	Full coverage, up to 360 days per lifetime.	No coverage.
Inpatient Hospital	Full coverage.	Full coverage, with the following dollar amount limits per enrollment year: • $6,300.00 for stays in a general acute care hospital for substance abuse. • $7,000.00 for stays in an Institute for Mental Disease (IMD) for substance abuse treatment. Hospital stays for mental health and substance abuse services have a 30-day limit.	Full coverage (not including inpatient psychiatric stays in either an IMD or the psychiatric ward of an acute care hospital and inpatient substance abuse treatment).

Service	Coverage Under the BadgerCare Plus Standard Plan	Coverage Under the BadgerCare Plus Benchmark Plan	Coverage Under the BadgerCare Plus Core Plan for Adults with No Dependent Children
Mental Health and Substance Abuse Treatment	Full coverage (not including room and board).	Coverage of this service is based on the Wisconsin State Employee Health Plan. Covered services include outpatient mental health, outpatient substance abuse (including narcotic treatment), adult mental health day treatment, substance abuse day treatment, child/adolescent day treatment and inpatient hospital stays for mental health and substance abuse. Services not covered are crisis intervention, community support program, comprehensive community services, outpatient mental health and substance abuse services in the home and community for adults, and substance abuse residential treatment. Mental health services have no dollar maximums. Substance abuse services are limited to $7,000.00. Costs of mental health services, including inpatient stays, apply to this overall limit.	Coverage limited to mental health therapy services provided by a psychiatrist only.

Service	Coverage Under the BadgerCare Plus Standard Plan	Coverage Under the BadgerCare Plus Benchmark Plan	Coverage Under the BadgerCare Plus Core Plan for Adults with No Dependent Children
Mental Health and Substance Abuse Treatment (Continued)		Also, there are separate dollar limits for specific substance abuse services: • $4,500.00 for outpatient substance abuse services including $2,700.00 for outpatient services (including narcotic treatment) for substance abuse day treatment. • $6,300.00 for inpatient hospital stays in a general acute care hospital.	
Nursing Home Services	Full coverage.	Full coverage for stays at skilled nursing homes limited to 30 days per enrollment year.	No coverage.
Outpatient Hospital — Emergency Room	Full coverage.	Full coverage.	Full coverage.
Outpatient Hospital	Full coverage.	Full coverage.	Full coverage excluding outpatient mental health and substance abuse treatment services.
Physical Therapy (PT), Occupational Therapy, and Speech and Language Pathology	Full coverage.	Full coverage, limited to 20 visits per therapy discipline, per enrollment year. Also covers up to 36 visits per enrollment year for cardiac rehabilitation provided by a physical therapist. (The cardiac rehabilitation visits do not count towards the 20 PT visits.)	Full coverage limited to 20 visits per therapy discipline, per enrollment year. Cardiac rehabilitation visits are covered as part of PT and are subject to PT limitations.

Service	Coverage Under the BadgerCare Plus Standard Plan	Coverage Under the BadgerCare Plus Benchmark Plan	Coverage Under the BadgerCare Plus Core Plan for Adults with No Dependent Children
Physician	Full coverage, including laboratory and radiology.	Full coverage, including laboratory and radiology.	Full coverage, including laboratory and radiology.
Podiatry	Full coverage.	Full coverage.	No coverage.
Prenatal/Maternity Care	Full coverage, including Prenatal Care Coordination (PNCC), and preventive mental health and substance abuse screening and counseling for women at risk of mental health or substance abuse problems.	Full coverage, including PNCC, and preventive mental health and substance abuse screening and counseling for women at risk of mental health or substance abuse problems.	Not applicable.
Reproductive Health Services	Full coverage, excluding infertility treatments, surrogate parenting, and the reversal of voluntary sterilization.	Full coverage, excluding infertility treatments, surrogate parenting, and the reversal of voluntary sterilization.	Family planning services provided by family planning clinics will be covered separately under the Family Planning Waiver program for eligible members.
Routine Vision	Full coverage including coverage of eyeglasses.	One eye exam per enrollment year, with refraction.	No coverage.
Smoking Cessation Drugs	Coverage includes prescription and OTC tobacco cessation products.	Coverage includes prescription generic and OTC tobacco cessation products.	Coverage includes prescription generic and OTC tobacco cessation products.
Transportation — Ambulance, Specialized Medical Vehicle, Common Carrier	Full coverage of emergency and non-emergency transportation to and from a certified provider for a BadgerCare Plus-covered service.	Coverage limited to emergency transportation by ambulance.	Coverage limited to emergency transportation by ambulance.

ATTACHMENT 6
Disposable Medical Supplies Covered Under the BadgerCare Plus Core Plan

The following table lists Healthcare Common Procedure Coding System procedure codes and modifiers for disposable medical supplies (DMS) covered by the BadgerCare Plus Core Plan for Adults with No Dependent Children for dates of service on and after January 1, 2009. Refer to the DMS maximum allowable fee schedule, available on the ForwardHealth Portal at *www.forwardhealth.wi.gov/*, for maximum allowable fees for the following procedure codes. Disposable medical supplies covered under the Core Plan are subject to change.

Procedure Code	Modifier	Description
A4215	22	Insulin pen needles
A4230	—	Infusion set for external insulin pump, non needle cannula type
A4231	—	Infusion set for external insulin pump, needle type
A4232	—	Syringe with needle for external insulin pump, sterile, 3cc
A4233	—	Replacement battery, alkaline (other than j cell), for use with medically necessary home blood glucose monitor owned by patient, each
A4234	—	Replacement battery, alkaline, j cell, for use with medically necessary home blood glucose monitor owned by patient, each
A4235	—	Replacement battery, lithium, for use with medically necessary home blood glucose monitor owned by patient, each
A4236	—	Replacement battery, silver oxide, for use with medically necessary home blood glucose monitor owned by patient, each
A4250	—	Urine test or reagent strips or tablets (100 tablets or strips)
A4253	KS	Blood glucose test or reagent strips for home blood glucose monitor, per 50 strips TYPE II Diabetics
A4253	KX	Blood glucose test or reagent strips for home blood glucose monitor, per 50 strips TYPE I Diabetics
A4256	—	Normal, low and high calibrator solution/chips
A4258	—	Spring powered device for lancet, each
A4258	22	Insulin pen
A4259	KS	Lancets, per box of 100 TYPE II Diabetics
A4259	KX	Lancets, per box of 100 TYPE I Diabetics
A4361	—	Ostomy faceplate, each
A4362	—	Skin barrier; solid, 4 x 4 or equivalent; each
A4363	—	Ostomy clamp, any type, replacement only, each
A4364	—	Adhesive, liquid or equal, any type, per 50
A4365	—	Adhesive remover wipes, any type, per 50
A4366	—	Ostomy vent, any type, each

Procedure Code	Modifier	Description
A4367	—	Ostomy belt, each
A4369	—	Ostomy skin barrier, liquid (spray, brush, etc.), per oz.
A4371	—	Ostomy skin barrier, powder, per oz.
A4372	—	Ostomy skin barrier, solid 4 x 4 or equivalent, standard wear, with built-in convexity, each
A4373	—	Ostomy skin barrier, with flange (solid, flexible or accordion), with built-in convexity, any size, each
A4375	—	Ostomy pouch, drainable, with faceplate attached, plastic, each
A4376	—	Ostomy pouch, drainable, with faceplate attached, rubber, each
A4377	—	Ostomy pouch, drainable, for use on faceplate, plastic, each
A4378	—	Ostomy pouch, drainable, for use on faceplate, rubber, each
A4379	—	Ostomy pouch, urinary, with faceplate attached, plastic, each
A4380	—	Ostomy pouch, urinary, with faceplate attached, rubber, each
A4381	—	Ostomy pouch, urinary, for use on faceplate, plastic, each
A4382	—	Ostomy pouch, urinary, for use on faceplate, heavy plastic, each
A4383	—	Ostomy pouch, urinary, for use on faceplate, rubber, each
A4384	—	Ostomy faceplate equivalent, silicone ring, each
A4385	—	Ostomy skin barrier, solid 4 x 4 or equivalent, extended wear, without built-in convexity, each
A4387	—	Ostomy pouch, closed, with barrier attached, with built-in convexity (1 piece), each
A4388	—	Ostomy pouch, drainable, with extended wear barrier attached, (1 piece), each
A4389	—	Ostomy pouch, drainable, with barrier attached, with built-in convexity (1 piece), each
A4390	—	Ostomy pouch, drainable, with extended wear barrier attached, with built-in convexity (1 piece), each
A4391	—	Ostomy pouch, urinary, with extended wear barrier attached, (1 piece), each
A4392	—	Ostomy pouch, urinary, with extended wear barrier attached, with built-in convexity (1 piece), each
A4393	—	Ostomy pouch, urinary, with extended wear barrier attached, with built-in convexity (1 piece), each
A4394	—	Ostomy deodorant, with our without lubricant, for use in ostomy pouch, per fluid ounce
A4395	—	Ostomy deodorant for use in ostomy pouch, solid, per tablet
A4397	—	Irrigation supply; sleeve, each
A4398	—	Ostomy irrigation supply; bag, each
A4399	—	cone/catheter, including brush

Procedure Code	Modifier	Description
A4402	—	Lubricant, per ounce
A4404	—	Ostomy ring, each
A4405	—	Ostomy skin barrier, non-pectin based, paste, per ounce
A4406	—	Ostomy skin barrier, pectin-based, paste, per ounce
A4407	—	Ostomy skin barrier, with flange (solid, flexible, or accordion), extended wear, with built-in convexity, 4 x 4 inches or smaller, each
A4408	—	Ostomy skin barrier, with flange (solid, flexible, or accordion), extended wear, with built-in convexity, larger than 4 x 4 inches, each
A4409	—	Ostomy skin barrier, with flange (solid, flexible, or accordion), extended wear, without built-in convexity, 4 x 4 inches or smaller, each
A4410	—	Ostomy skin barrier, with flange (solid, flexible, or accordion), extended wear, without built-in convexity, larger than 4 x 4 inches, each
A4411	—	Ostomy skin barrier, solid 4x4 or equivalent, extended wear, with built-in convexity, each
A4412	—	Ostomy pouch, drainable, high output, for use on a barrier with flange (2 piece system), without filter, each
A4414	—	Ostomy skin barrier, with flange (solid, flexible, or accordion), without built-in convexity, 4 x 4 inches or smaller, each
A4415	—	Ostomy skin barrier, with flange (solid, flexible, or accordion), without built-in convexity, larger than 4 x 4 inches, each
A4416	—	Ostomy pouch, closed, with barrier attached, with filter (1 piece), each
A4417	—	Ostomy pouch, closed; with barrier attached, with built-in convexity, with filter (1 piece), each
A4418	—	Ostomy pouch, closed; without barrier attached, with filter (1 piece), each
A4419	—	Ostomy pouch, closed; for use on barrier with non-locking flange, with filter (2 piece), each
A4420	—	Ostomy pouch, closed; for use on barrier with locking flange (2 piece), each
A4423	—	Ostomy pouch, closed; for use on barrier with locking flange, with filter (2 piece), each
A4424	—	Ostomy pouch, drainable, with barrier attached, with filter (1 piece), each
A4425	—	Ostomy pouch, drainable; for use on barrier with non-locking flange, with filter (2 piece system), each
A4426	—	Ostomy pouch, drainable; for use on barrier with locking flange (2 piece system), each
A4427	—	Ostomy pouch, drainable; for use on barrier with locking flange, with filter (2 piece system), each

Procedure Code	Modifier	Description
A4428	—	Ostomy pouch, urinary, with extended wear barrier attached, with faucet-type tap with valve (I piece), each
A4429	—	Ostomy pouch, urinary, with barrier attached, with built-in convexity, with faucet-type tap with valve (I piece), each
A4430	—	Ostomy pouch, urinary, with extended wear barrier attached, with built-in convexity, with faucet-type tap with valve (I piece), each
A4431	—	Ostomy pouch, urinary; with barrier attached, with faucet-type tap with valve (I piece), each
A4432	—	Ostomy pouch, urinary; for use on barrier with non-locking flange, with faucet-type tap with valve (2 piece), each
A4433	—	Ostomy pouch, urinary; for use on barrier with locking flange (2 piece), each
A4434	—	Ostomy pouch, urinary; for use on barrier with locking flange, with faucet-type tap with valve (2 piece), each
A4556	—	Electrodes (e.g., apnea monitor), per pair
A4557	—	Lead wires, (e.g., apnea monitor), per pair
A4595	—	Electrical stimulator supplies, 2 lead, per month, (e.g. TENS, NMES)
A4605	—	Tracheal suction catheter, closed system, each
A4606	—	Oxygen probe for use with oximeter device, replacement
A4624	—	Tracheal suction catheter, any type other than closed system, each
A4628	—	Oropharyngeal suction catheter, each
A5051	—	Ostomy pouch, closed; with barrier attached (1 piece), each
A5052	—	without barrier attached (I piece), each
A5053	—	for use on faceplate, each
A5054	—	for use on barrier with flange (2 piece), each
A5055	—	Stoma cup
A5062	—	Ostomy pouch, drainable; without barrier attached (1 piece), each
A5062	22	Ostomy pouch, drainable with karaya based barrier attached, without built-in convexity, (1 piece), each
A5062	59	Ostomy pouch, drainable with standard wear barrier attached, without built-in convexity, (1 piece), each
A5063	—	Ostomy pouch, drainable; for use on barrier with flange (2-piece system), each
A5071	—	Ostomy pouch, urinary; with barrier attached (1 piece), each
A5072	—	without barrier attached (1 piece), each
A5073	—	for use on barrier with flange (2 piece), each
A5081	—	Continent device; plug for continent stoma
A5082	—	catheter for continent stoma
A5083	—	Continent device, stoma absorptive cover for continent stoma
A5093	—	Ostomy accessory; convex insert

Procedure Code	Modifier	Description
A5126	—	Adhesive or non-adhesive; disk or foam pad
A5131	—	Appliance cleaner, incontinence and ostomy appliances, per 16 oz.
A7000	—	Canister, disposable, used with suction pump, each
A7001	—	Canister, non-disposable, used with suction pump, each
A7002	—	Tubing, used with suction pump, each
A7003	—	Administration set, with small volume nonfiltered pneumatic nebulizer, disposable
A7004	—	Small volume nonfiltered pneumatic nebulizer, disposable
A7005	—	Administration set, with small volume nonfiltered pneumatic nebulizer, non-disposable
A7006	—	Administration set, with small volume filtered pneumatic nebulizer
A7007	—	Large volume nebulizer, disposable, unfilled, used with aerosol compressor
A7007	22	Sterile water or sterile saline, 1000 ml used with large volume nebulizer
A7008	—	Large volume nebulizer, disposable, prefilled, used with aerosol compressor
A7008	22	Sterile water, heated humidifier use 1650 - 2000 cc
A7008	59	Sterile water, autofeed/heated humidifier use 1650 - 2000 cc
A7009	—	Reservoir bottle, non-disposable, used with large volume ultrasonic nebulizer
A7010	—	Corrugated tubing, disposable, used with large volume nebulizer, 100 feet
A7011	—	Corrugated tubing, non-disposable, used with large volume nebulizer, 10 feet
A7012	—	Water collection device, used with large volume nebulizer
A7013	—	Filter, disposable, used with aerosol compressor
A7014	—	Filter, non-disposable, used with aerosol compressor or ultrasonic generator
A7015	—	Aerosol mask, used with DME nebulizer
A7016	—	Dome and mouthpiece, used with small volume ultrasonic nebulizer
A7018	—	Water, distilled, used with large volume nebulizer, 1000 ml
A7027	—	Combination oral/nasal mask, used with continuous positive airway pressure device, each
A7028	—	Oral cushion for combination oral/nasal mask, replacement only, each
A7029	—	Nasal pillows for combination oral/nasal mask, replacement only, pair
A7030	—	Full face mask used with positive airway pressure device, each
A7031	—	Face mask interface, replacement for full face mask, each
A7032	—	Cushion for use on nasal mask interface, replacement only, each
A7033	—	Pillow for use on nasal cannula type interface, replacement only, pair
A7034	—	Nasal interface (mask or cannula type) used with positive airway pressure device, with or without head strap
A7035	—	Headgear used with positive airway pressure device
A7036	—	Chinstrap used with positive airway pressure device
A7037	—	Tubing used with positive airway pressure device
A7038	—	Filter, disposable, used with positive airway pressure device
A7039	—	Filter, non-disposable, used with positive airway pressure device

Procedure Code	Modifier	Description
A7046	—	Water chamber for humidifier, used with positive airway pressure device, replacement, each
A7525	—	Tracheostomy mask, each
B4035	—	Enteral feeding supply kit; pump fed, per day
S8490	—	Insulin syringes (100 syringes, any size)