ForwardHealth
Wisconsin serving you

Update
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Affected Programs: BadgerCare Plus Basic Plan, BadgerCare Plus Core Plan
To: Ophthalmologists, Opticians, Optometrists, and HMOs and Other Managed Care Programs

Certain Ophthalmological Examinations Covered Under the BadgerCare Plus Core Plan and the BadgerCare Plus Basic Plan

General ophthalmological services billed with *Current Procedural Terminology* codes 92002-92014 for a member with a qualifying diagnosis are covered under the BadgerCare Plus Core Plan and the BadgerCare Plus Basic Plan. General ophthalmological services billed without a qualifying principal diagnosis code are noncovered under the Core Plan and the Basic Plan.

Coverage with Qualifying Primary Diagnosis

Core Plan

Effective for dates of service (DOS) on and after July 1, 2009, general ophthalmological services billed with *Current Procedural Terminology* (CPT) codes 92002-92014 are covered under the BadgerCare Plus Core Plan if the member's principal diagnosis includes an *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) code from the range 360.00-379.99 with the exception of ICD-9-CM codes 367.0-367.9, 368.02, 368.30-368.34, 368.51-368.59, 368.60-368.69, and 378.40-378.45. General ophthalmological services billed without a qualifying diagnosis code are noncovered services under the Core Plan.

Basic Plan

Effective for DOS on and after July 1, 2010, general ophthalmological services billed with CPT codes 92002-92014 are covered under the BadgerCare Plus Basic Plan if the member's principal diagnosis includes an ICD-9-CM code from the range 360.00 – 379.99 with the exception of ICD-9-CM codes 367.0-367.9, 368.02, 368.30-368.34, 368.51-368.59, 368.60-368.69, and 378.40-378.45. General ophthalmological services billed without a qualifying diagnosis code are noncovered services under the Basic Plan.

General ophthalmological visits billed with CPT codes 92002-92014 and covered under the Basic Plan count toward the 10-visit limit per enrollment year except when provided in any of the following places of service (POS):

- Inpatient hospital (POS 21).
- Outpatient hospital (POS 22).
- Emergency room — hospital (POS 23).
- Ambulatory surgerical center (POS 24).

Determination of Refractive State

Regardless of diagnosis, determination of refractive state is not covered under the Core Plan and the Basic Plan. Claims billed with CPT code 92015 will continue to be denied for Core Plan and Basic Plan members.

Previously Processed Claims for Core and Basic Plan Members

Paid Claims

ForwardHealth will automatically reprocess all paid claims processed between December 1, 2009, and November 30, 2010, for general ophthalmological services for members enrolled in the Core Plan and Basic Plan with DOS on and after July 1, 2009, for the Core Plan and DOS on and after July 1, 2010, for the Basic Plan, regardless of the diagnosis code(s) indicated on the claims. The claim adjustments will apply the corrected policy and determine coverage of general ophthalmological services provided by an ophthalmologist or optometrist based on the primary diagnosis. Adjustments may result in denials of previously paid claims.

Denied Claims

If a provider received a claim denial between December 1, 2009, and November 30, 2010, for general ophthalmological services for members enrolled in the Core Plan or the Basic Plan, the claim may be resubmitted for processing if the following conditions are met:

- The claim is billed with allowable CPT and ICD-9-CM codes.
- The services were provided either on and after July 1, 2009, to a member enrolled in the Core Plan or on and after July 1, 2010, to a member enrolled in the Basic Plan.

Claims that are within the 365-day timely filing limit that were denied may be resubmitted through the normal claims submission process.

For denied claims that exceed the 365-day timely filing limit, providers may use the timely filing appeals process. Claims that are beyond the timely filing deadline must be received by ForwardHealth Timely Filing on or before March 31, 2011. Providers should follow all other applicable billing rules.

Submitting Timely Filing Appeals Requests

Providers may submit a single Timely Filing Appeals Request form, F-13047 (10/08), per batch of claims. When completing the form, providers should place a check in the "ForwardHealth Reconsideration" box and write in the comment section at the bottom of the form, "ForwardHealth automatic adjustment for primary diagnosis code on general ophthalmological service claims for Core Plan and Basic Plan members," to explain the nature of the problem.

For more information on timely filing appeals, refer to the Claims section of the Online Handbook.

Refunding Payments to Members

For claims that were previously denied and now are paid, the provider may have received payment from the member for the service(s). The provider is required to return the full payment amount received from the member for the general ophthalmological services reimbursed by the Core Plan or the Basic Plan. Providers are reminded that BadgerCare Plus reimbursement is considered payment in full, less any required copayment.

Collecting Payment from Members

For claims that were previously paid and are now denied, the provider may collect the charge for the noncovered service(s) from the member if the following conditions were met *prior* to the delivery of the service:

- The member accepted responsibility for payment.
- The provider and member made payment arrangements for the service.

If the member was not informed of his or her financial responsibility for noncovered services prior to the delivery of the service(s), providers are prohibited from collecting payment from members for the services.

Information Regarding Managed Care Organizations

This *ForwardHealth 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 managed care organization (MCO). Managed care organizations are required to provide at least the same benefits as those provided under fee-for-service arrangements.

BadgerCare Plus Basic Plan members are not enrolled in MCOs.

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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