

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

Hospital Services Covered Under the BadgerCare Plus Basic Plan

The Department of Health Services will begin accepting applications for enrollment in the BadgerCare Plus Basic Plan on June 1, 2010, with benefits starting on July 1, 2010. This *ForwardHealth Update* describes the coverage and policies for hospital services under the Basic Plan.

Refer to the June 2010 *Update* (2010-42), titled "Introducing the BadgerCare Plus Basic Plan," for general information about covered and noncovered services, reimbursement, copayment, and enrollment.

Overview of BadgerCare Plus Basic Plan Implementation

In October 2009, enrollment in the BadgerCare Plus Core Plan was closed. Enrollment applications submitted to the Core Plan after the cutoff date are not processed, but the individuals are put on a waitlist.

Individuals on the waitlist for the Core Plan can begin enrolling in the BadgerCare Plus Basic Plan on June 1, 2010, with benefits starting on July 1, 2010. The Basic Plan is a self-funded plan that focuses on providing the Core Plan waitlist members with access to vital, cost-effective primary and preventive care. This option will allow members to have some minimal form of coverage until space becomes available in the Core Plan and will help prevent bankruptcy due to excessive medical debt.

Member participation or non-participation in the Basic Plan does not affect an individual's status on the Core Plan waitlist.

Services for the Basic Plan will be covered under fee-for-service. Basic Plan members will not be enrolled in state-contracted HMOs.

Overview of Hospital Services Covered Under the Basic Plan

The following hospital services are covered under the Basic Plan:

- Inpatient hospital services.
- Outpatient hospital services.
- Rehabilitation hospital stays.
- Emergency room services.

Inpatient Hospital Covered and Noncovered Services

Members enrolled in the Basic Plan are covered for an initial inpatient hospital stay per enrollment year, prior to application of the member's \$7,500.00 hospital deductible. Inpatient hospitals will be reimbursed the full Medicaid diagnosis related group (DRG) base payment, excluding hospital access payments. Providers should note they will only be reimbursed the base component of the DRG and that no outlier costs are reimbursed. Outlier costs may not be billed to the member. During the deductible period, the member is liable for payment at the Basic Plan reimbursement rate, which excludes hospital access

payments and outlier costs. After the member's \$7,500.00 deductible is met, ForwardHealth will reimburse hospital providers the DRG base payment for all additional inpatient stays in that enrollment year, excluding hospital access payments and outlier costs.

Inpatient hospitals are strongly recommended to obtain authorization for services. Reimbursement for services without authorization is not guaranteed by ForwardHealth. Authorization is obtained by calling Provider Services at (800) 947-9627 or via a new ForwardHealth Portal feature. Providers should have the following information on hand when they call to obtain authorization:

- The provider's National Provider Identifier (NPI).
- The type of hospital service (either inpatient or outpatient).
- The member's full name, date of birth, and/or ForwardHealth identification number.
- The date of admittance to the inpatient hospital.
- The "from" date of service (DOS). This is the first DOS that a provider would enter on Form Locator 6 (Statement Covers Period [From – Through]) of the UB-04 claim form.

For more information, refer to the section in this *Update* regarding obtaining authorization via the new Portal feature.

Note: All transplants and transplant-related services are not covered.

Rehabilitation Hospital Stays (Non-psychiatric)

The member's initial stay in a non-psychiatric rehabilitation hospital may count toward the initial covered inpatient hospital stay per enrollment year prior to application of the member's deductible. ForwardHealth will reimburse the provider for up to 14 days (for one continuous stay). This is considered reimbursement in full and the member must not be billed for additional days. After the first visit, inpatient non-psychiatric rehabilitation hospital stays count toward the member's \$7,500.00 deductible. During this time, hospital providers may not bill the member for more than 14 times

the per diem for the entire length of the stay. Rehabilitation stays after the deductible is met are also paid a maximum of 14 times the per diem for the entire length of the stay, with no additional liability accruing to the member.

Rehabilitation hospitals are strongly recommended to obtain authorization before providing services. Reimbursement for services without authorization is not guaranteed by ForwardHealth.

Note: Inpatient psychiatric stays in either an institution for mental disease or the psychiatric ward of an acute care hospital and inpatient hospital substance abuse treatment are not covered.

Copayment

Inpatient hospital services under the Basic Plan have a \$100.00 copayment for nondeductible stays.

Transfers as One Continuous Stay

ForwardHealth will consider transfers from one hospital to another as one continuous inpatient stay. Each hospital is required to obtain authorization before treating the member. When obtaining authorization, providers should indicate that the authorization is for a transfer. Authorization for inpatient transfer may only be provided over the telephone with Provider Services.

Note: All hospitals will be reimbursed for their portion of the continuous stay.

Outpatient Hospital Covered and Noncovered Services

Members enrolled in the Basic Plan are covered for five outpatient hospital visits per enrollment year, prior to application of the member's \$7,500.00 hospital deductible. Some or all of the five outpatient hospital visits included in this service limit may be bypassed if the member's hospital deductible has been met due to one or more inpatient stays. After the member's deductible is met, ForwardHealth will cover all additional outpatient hospital visits in that enrollment year at the Wisconsin Medicaid rate.

Outpatient hospitals are strongly recommended to obtain authorization before providing services. Reimbursement for services without authorization are not guaranteed by ForwardHealth. Authorization is obtained by calling Provider Services at (800) 947-9627 or via a new ForwardHealth Portal feature. Providers should have the following information on hand when they call to obtain authorization:

- The provider's NPI.
- The type of hospital service (either inpatient or outpatient).
- The member's full name, date of birth, and/or ForwardHealth number.
- The date of the outpatient hospital visit, or the "from" DOS. This is the DOS that a provider would enter on Form Locator 6 (Statement Covers Period [From – Through]) of the UB-04 claim form.

Note: All transplants and transplant-related services are not covered.

Dialysis provided in an outpatient hospital setting and billed as an outpatient hospital service are subject to outpatient hospital service limitations.

Copayments

Outpatient hospital services under the Basic Plan have a \$60.00 copayment for nondeductible visits.

Reimbursement

Providers will be reimbursed for outpatient hospital services provided to members enrolled in the Basic Plan at the current Wisconsin Medicaid rate of reimbursement for covered services, except for hospital access payments. The Basic Plan does not reimburse providers for hospital access payments.

Member Deductible for Inpatient and Outpatient Services

The member's deductible is \$7,500.00 per enrollment year for all combined inpatient and outpatient hospital services.

Providers should submit claims to ForwardHealth for *all* hospital services provided to Basic Plan members, regardless of whether the deductible is applied or not. This will ensure that all services provided to the member are applied to the member's deductible.

Inpatient Services

After the member's first inpatient hospital stay, each subsequent inpatient hospital stay will be applied to the member's deductible. During the deductible period, the member is only liable for the amount that Wisconsin Medicaid would have reimbursed the provider for the services. After the deductible is met, ForwardHealth will reimburse any additional inpatient hospital stays for the remainder of the enrollment year at the DRG base rate, excluding outlier costs and hospital access payments. Once the member has satisfied the deductible, no authorization is needed before providing inpatient hospital services.

Outpatient Services

After the member's first five outpatient hospital visits, each subsequent outpatient visit will be applied to the member's deductible. During the deductible period, the member is only liable for the amount that Wisconsin Medicaid would have reimbursed the provider for the services. After the member's deductible is met, ForwardHealth will reimburse any additional outpatient stays for the remainder of the enrollment year at the current Wisconsin Medicaid rate. Once the member has satisfied the deductible, no authorization is needed before providing outpatient hospital services.

New Portal Screen for Member Deductible Status and Authorization Requests

Providers will have access to two new features on the secure provider Portal regarding Basic Plan member deductible information, authorization inquiries, and authorization requests.

The first feature allows providers to search for member information by entering the member's identification number,

and the provider will be able to view the Basic Plan information for the current year and the prior year, if applicable. The following information will display if the inquiry is successful:

- The dates that deductibles were applied towards the member's deductible balance and the amounts of each deductible paid. The beginning balance and the remaining balance will both display, based on claims submitted to ForwardHealth to-date.
- The number of member authorizations used, if any, and any authorizations that were requested by the provider performing the inquiry.

The second feature is an authorization request page that allows providers to request a new Basic Plan authorization for the member. If the request is successful, the provider will receive an authorization tracking number for his or her records.

Providers may also obtain authorization by calling Provider Services at (800) 947-9627.

Emergency Room Covered and Noncovered Services

Members enrolled in the Basic Plan are covered for five emergency room visits per enrollment year. After five visits, the benefit is considered exhausted and any subsequent emergency room visits are not covered. Providers may bill the member the hospital's usual and customary charge for noncovered emergency room visits. Emergency room visits do not count toward the member's deductible. Claims for physician services associated with emergency room visits may be submitted to ForwardHealth separately for reimbursement from an emergency room visit claim.

Copayment

Emergency room visits under the Basic Plan have a \$60.00 copayment 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.

Office Visits

The Basic Plan reimburses providers for 10 office visits per enrollment year. Certain procedure codes count toward the 10-visit limit. Refer to the June 2010 *ForwardHealth Update* (2010-43), titled "Coverage of Certain Medical Services Under the BadgerCare Plus Basic Plan," for a list of procedure codes that count towards the 10-visit limit. If a physician treats the member during an inpatient hospital stay or during an outpatient hospital visit and the physician submits a claim for that member, the physician services billed will *not* count toward the 10-office visit limit. Refer to the *Update* 2010-43 for more information about office visits covered under the Basic Plan.

Definition of an Enrollment Year Under the Basic Plan

The Basic Plan enrollment year is the time period used to determine service limitations for members in the Basic Plan.

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

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 Verification

The Basic Plan offers different covered services, noncovered services, and copayments than the BadgerCare Plus Standard Plan, the BadgerCare Plus Benchmark Plan, and the Core 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.

For More Information

For more information or questions regarding the Basic Plan, providers may call Provider Services at (800) 947-9627. Basic Plan members should contact Member Services at (800) 362-3002.

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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