wisconsin Medicaid update
department of health and family services
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To:
All providers

Medicaid Copayments

This replaces Medicaid Update 97-36, dated November 12, 1997.

Federal law permits states to charge Medicaid recipients copayments for certain services. The Wisconsin Legislature periodically revises Medicaid copayments.

Provisions of 1997 Wisconsin Act 27, the 1997-99 biennial budget, increased copayment amounts to the maximum allowed under federal law, effective January 1, 1998. This means that when Medicaid fees are increased, copayments for some services may increase also.

To determine the amount of copayment to collect, use the information in this *Update* and the fee schedule.

Provisions of 1997 Wisconsin Act 237, the budget adjustment law, added copayments to transportation by specialized medical vehicle (SMV) and increased allowable fees for noninstitutional providers. Some copayments may have increased due to the allowable fee changes.

To determine the amount of copayment to collect, use the information in this *Update* and the fee schedule. To order a fee schedule, use the revised fee schedule order form included in this *Update*. You also may download fee schedules and the Durable Medical Equipment (DME) Index at no cost through the Medicaid fiscal agent's, EDS, EDS-EPIX bulletin board. The EDS-EPIX bulletin board is a computer system accessible by modem that allows providers to receive software, manuals, and formats directly from their PCs. For downloading instructions, see Appendix 11 of Part A, the all-provider handbook. Appendix 11 is a quick guide to retrieving Wisconsin Medicaid fee schedules using EDS-EPIX. To receive personal assistance or the complete EDS-EPIX User Manual, call the Medicaid fiscal agent, EDS, at (608) 221-4746, and ask for the EMC Department.

Some copayments, such as those for laboratory or x-ray services, are based on the average maximum allowable fee for all services in that category. Other copayments, like those for dental procedures or physician office visits, are based on the maximum allowable fee for each particular service. Providers should verify they are collecting the correct copayment for services.

Copayment Guidelines

- Federal law requires that providers make a reasonable attempt to collect copayments from recipients. However, providers may not deny services to a recipient for failing to make a copayment. [Social Security Act 1916(d); Reg 447.15]
- Providers may waive the recipient copayment requirement if the provider determines that the cost of collecting the copayment exceeds the amount to be collected.
- Providers may not collect recipient copayments in amounts that exceed Medicaid copayments.

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Medicaid Copayments

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- When billing Wisconsin Medicaid, providers should not reduce their usual and customary charge by the copayment; recipient copayment will be automatically deducted from your reimbursement.
- If Medicaid deducts less copayment than the recipient has paid a provider, the provider must return or credit the remainder to the recipient.

Copayment Exceptions

Keep in mind that there are some services and recipients for which there are no copayments. The following are lists of these services and recipients.

The following Medicaid services DO NOT require copayment:

- Anesthesia services.
- Case management services.
- Community care organization services.
- Emergency services.
- Family planning services and supplies if provided in a family planning clinic.
- Hearing instrument batteries.
- Home health services.
- Hospice services.
- Mental health crisis intervention services.
- Personal care services.
- School-based services.

As a provider, you are prohibited by law from requesting copayment from the following recipient groups:

- Children under 18 years old.
- People in nursing homes.
- People in Medicaid HMOs or other Medicaid managed care programs receiving HMO-covered or managed care-covered services.
- Pregnant women who receive medical services related to the pregnancy or to another medical condition that may complicate the pregnancy.

Please share this information with Medicaid recipients.

The Wisconsin Medicaid Update is the first source for provider information including Medicaid policy and billing information.

Wisconsin Medicaid is administered by the Bureau of Health Care Financing, Division of Health, Wisconsin Department of Health and Family Services, P.O. Box 309, Madison, WI 53701-0309.

For provider questions, call the Medicaid fiscal agent, EDS, at (800) 947-9627 or (608) 221-9883.

Copayment Rates

Ambulatory surgery

- Each surgical procedure billed $3.00

Chiropractic services

- Urinalysis $1.00
- X-ray $3.00
- Office visits $1.00
- Chiropractic adjustment $1.00
- Spinal supports (purchase) $3.00
- Spinal supports (rental) none

Dental services

- Based on maximum allowable fees:
  - ✓ Up to $10.00 $0.50
  - ✓ From $10.01 to $25.00 $1.00
  - ✓ From $25.01 to $50.00 $2.00
  - ✓ Over $50.00 $3.00

Disposable Medical Supplies (DMS)

- Based on maximum allowable fees:
  - ✓ Up to $10.00 $0.50
  - ✓ From $10.01 to $25.00 $1.00
  - ✓ From $25.01 to $50.00 $2.00
  - ✓ Over $50.00 $3.00
- Urine or blood test strips (per date of service) $0.50

Durable Medical Equipment (DME) purchase

- Based on maximum allowable fees:
  - ✓ Up to $10.00 $0.50
  - ✓ From $10.01 to $25.00 $1.00
  - ✓ From $25.01 to $50.00 $2.00
  - ✓ Over $50.00 $3.00

HealthCheck Services

- Children under age 18 none
- Recipients ages 18 through 20 $1.00

Hearing services

- Each audiology test $1.00
- Each dispensing fee $3.00
- Each purchased item $3.00
- Each accessory or repair $1.00
- Each special modification $2.00

Hospital services

- Inpatient (each day) $3.00
- Outpatient, except emergency treatment (per visit) $3.00

Inpatient copayment is limited to $75.00 per stay.

Mental health/alcohol and other drug abuse (AODA) therapy (includes individual and group therapy, and psychiatric evaluation)

- Based on maximum allowable fees:
  - ✓ Up to $10.00 $0.50
  - ✓ From $10.01 to $25.00 $1.00
  - ✓ From $25.01 to $50.00 $2.00
  - ✓ Over $50.00 $3.00

Recipient copayment is not required for mental health services provided in a hospital setting. Mental health and AODA services copayment is limited to the first 15 hours or $500 of service per calendar year.

Pharmacies

- Over-the-counter drugs, each prescription (no monthly limit) $0.50
- All legend drugs, each new and refilled prescription $1.00

For all prescription drugs, no more than $5.00 per month at each pharmacy.

Physician, nurse practitioner, or nurse midwife services

- For each evaluation and management service Based on maximum allowable fees:
  - ✓ Up to $10.00 $0.50
  - ✓ From $10.01 to $25.00 $1.00
  - ✓ From $25.01 to $50.00 $2.00
  - ✓ Over $50.00 $3.00
- Each surgery service $3.00
- Each lab service (per date of service) $1.00
- Each x-ray service $3.00

- Each diagnostic service $2.00
- Allergy testing (per date of service) $2.00

Copayment is limited to $30 cumulative per billing provider, per recipient, per calendar year.

Podiatry services

- Each evaluation and management service
  Based on maximum allowable fees:
  - ✓ Up to $10.00 $0.50
  - ✓ From $10.01 to $25.00 $1.00
  - ✓ From $25.01 to $50.00 $2.00
  - ✓ Over $50.00 $3.00
- Each lab service (per date of service) $1.00
- Each x-ray service $3.00
- Each surgery/mycotic condition treatment, casting, strapping and taping $3.00
- Routine foot care $1.00
- Each vascular diagnostic service $2.00

Copayment is limited to $30 cumulative, per billing provider, per recipient, per calendar year.

Rural health clinics

- Each evaluation and management service
  Based on physician maximum allowable fees:
  - ✓ Up to $10.00 $0.50
  - ✓ From $10.01 to $25.00 $1.00
  - ✓ From $25.01 to $50.00 $2.00
  - ✓ Over $50.00 $3.00
- Each surgery service $3.00
- Each lab service (per date of service) $1.00
- Each x-ray service $3.00
- Each diagnostic service $2.00

Copayment is limited to $30 cumulative, per billing provider, per recipient, per calendar year.

Therapies: occupational and physical (not provided in a hospital or school)

Refer to *Wisconsin Medicaid Provider Update* 98-11, dated March 9, 1998, for the most current listing of copayment amounts.

Copayment is limited to either the first 30 hours or $1,500 of services per therapy, per calendar year.

Speech-language pathology services (not provided in a hospital or school)

- All speech-language pathology services $1.00

Copayment is limited to either the first 30 hours or $1,500 of services per therapy, per calendar year.

Transportation

- Each nonemergency ambulance trip $2.00
- Specialized medical vehicle (SMV) services $1.00

Vision care

Optometry services:

- For each evaluation and management service, and diagnostic service
  Based on maximum allowable fees:
  - ✓ Up to $10.00 $0.50
  - ✓ From $10.01 to $25.00 $1.00
  - ✓ From $25.01 to $50.00 $2.00
  - ✓ Over $50.00 $3.00
- Each special and low vision service, test, therapy $0.50
- Each contact lens service $3.00

Eyeglasses:

- New $3.00/pair
- Frame, lens, or temple replacement $2.00/each
- Each repair $0.50