All Provider

# Covered and Noncovered Services

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**Refer to the Online Handbook for current policy**

wisconsin Medicaid and BadgerCare

Information for Providers

Department of Health and Family Services

# Contacting Wisconsin Medicaid

| **Web Site** | ***dhfs.wisconsin.gov/*** |
|---|---|
| The Web site contains information for providers and recipients about the following:<br>• Program requirements.<br>• Publications.<br>• Forms.<br>• Maximum allowable fee schedules.<br>• Professional relations representatives.<br>• Certification packets. | Available 24 hours a day, seven days a week |
| **Automated Voice Response System** | **(800) 947-3544**<br>**(608) 221-4247** |
| The Automated Voice Response system provides computerized voice responses about the following:<br>• Recipient eligibility.<br>• Prior authorization (PA) status.<br>• Claim status.<br>• Checkwrite information. | Available 24 hours a day, seven days a week |
| **Provider Services** | **(800) 947-9627**<br>**(608) 221-9883** |
| Correspondents assist providers with questions about the following:<br>• Clarification of program requirements.<br>• Recipient eligibility.<br>• Resolving claim denials.<br>• Provider certification. | Available:<br>8:30 a.m. - 4:30 p.m. (M, W-F)<br>9:30 a.m. - 4:30 p.m. (T)<br>Available for pharmacy services:<br>8:30 a.m. - 6:00 p.m. (M, W-F)<br>9:30 a.m. - 6:00 p.m. (T) |
| **Division of Health Care Financing**<br>**Electronic Data Interchange Helpdesk** | **(608) 221-9036**<br>**e-mail: *wiedi@dhfs.state.wi.us*** |
| Correspondents assist providers with *technical* questions about the following:<br>• Electronic transactions.<br>• Companion documents.<br>• Provider Electronic Solutions software. | Available 8:30 a.m. - 4:30 p.m. (M-F) |
| **Web Prior Authorization Technical Helpdesk** | **(608) 221-9730** |
| Correspondents assist providers with Web PA-related *technical* questions about the following:<br>• User registration.<br>• Passwords.<br>• Submission process. | Available 8:30 a.m. - 4:30 p.m. (M-F) |
| **Recipient Services** | **(800) 362-3002**<br>**(608) 221-5720** |
| Correspondents assist recipients, or persons calling on behalf of recipients, with questions about the following:<br>• Recipient eligibility.<br>• General Medicaid information.<br>• Finding Medicaid-certified providers.<br>• Resolving recipient concerns. | Available 7:30 a.m. - 5:00 p.m. (M-F) |

# Handbook Organization

The following tables show the organization of this All-Provider Handbook and list some of the topics included in each section. It is essential that providers refer to service-specific publications for information about service-specific program requirements.

| Certification and Ongoing Responsibilities |
|---|
| • Certification and recertification.<br>• Change of address or status.<br>• Documentation requirements.<br>• Noncertified providers.<br>• Ongoing responsibilities.<br>• Provider rights.<br>• Provider sanctions.<br>• Recipient discrimination prohibited.<br>• Release of billing information. |

| Claims Information |
|---|
| • Follow-up procedures.<br>• Good Faith claims.<br>• Preparing and submitting claims.<br>• Reimbursement information.<br>• Remittance information.<br>• Submission deadline.<br>• Timely filing appeals requests. |

| Coordination of Benefits |
|---|
| • Commercial health insurance.<br>• Crossover claims.<br>• Medicare.<br>• Other Coverage Discrepancy Report, HCF 1159.<br>• Primary and secondary payers.<br>• Provider-based billing. |

| Covered and Noncovered Services |
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| • Collecting payment from recipients.<br>• Covered services.<br>• Emergency services.<br>• HealthCheck "Other Services."<br>• Medical necessity.<br>• Noncovered services. |



| Informational Resources |
|---|
| • Electronic transactions.<br>• Eligibility Verification System.<br>• Maximum allowable fee schedules.<br>• Forms.<br>• Medicaid Web site.<br>• Professional relations representatives.<br>• Provider Services.<br>• Publications. |

| Managed Care |
|---|
| • Covered and noncovered HMO and SSI MCO services.<br>• Enrollee HMO and SSI MCO eligibility.<br>• Enrollment process.<br>• Extraordinary claims.<br>• HMO and SSI MCO claims submission.<br>• Network and non-network provider information.<br>• Provider appeals. |

| Prior Authorization |
|---|
| • Amending prior authorization (PA) requests.<br>• Appealing PA decisions.<br>• Grant and expiration dates.<br>• Prior authorization for emergency services.<br>• Recipient loss of eligibility during treatment.<br>• Renewal requests.<br>• Review process.<br>• Submitting PA requests. |

| Recipient Eligibility |
|---|
| • Copayment requirements.<br>• Eligibility categories.<br>• Eligibility responsibilities.<br>• Eligibility verification.<br>• Identification cards.<br>• Limited benefit categories.<br>• Misuse and abuse of benefits.<br>• Retroactive eligibility. |

# Table of Contents

# Preface

This All-Provider Handbook is issued to all Medicaid-certified providers. The information in this handbook applies to Medicaid and BadgerCare.

Medicaid is a joint federal and state program established in 1965 under Title XIX of the federal Social Security Act. Wisconsin Medicaid is also known as the Medical Assistance Program, WMAP, MA, Title XIX, and T19.

BadgerCare extends Medicaid coverage through a Medicaid expansion under Titles XIX and XXI. The goal of BadgerCare is to fill the gap between Medicaid and private insurance without supplanting or crowding out private insurance. BadgerCare recipients receive the same benefits as Medicaid recipients, and their health care is administered through the same delivery system.

Wisconsin Medicaid and BadgerCare are administered by the Department of Health and Family Services (DHFS). Within the DHFS, the Division of Health Care Financing is directly responsible for managing Wisconsin Medicaid and BadgerCare.



Unless otherwise specified, all information contained in this and other Medicaid publications pertains to services provided to recipients who receive care on a fee-for-service basis. Refer to the Managed Care section of this handbook for information about state-contracted managed care organizations.

## Wisconsin Medicaid and BadgerCare Web Sites

Publications (including provider handbooks and *Wisconsin Medicaid and BadgerCare Updates*), maximum allowable fee schedules, telephone numbers, addresses, and more information are available on the following Web sites:

- *dhfs.wisconsin.gov/medicaid/*.
- *dhfs.wisconsin.gov/badgercare/*.

## Publications

Medicaid publications apply to both Wisconsin Medicaid and BadgerCare. Publications interpret and implement the laws and regulations that provide the framework for Wisconsin Medicaid and BadgerCare. Medicaid publications provide necessary information about program requirements.

## Legal Framework

The following laws and regulations provide the legal framework for Wisconsin Medicaid and BadgerCare:

- Federal Law and Regulation:
  - ✓ Law — United States Social Security Act; Title XIX (42 US Code ss. 1396 and following) and Title XXI.
  - ✓ Regulation — Title 42 CFR Parts 430-498 and Parts 1000-1008 (Public Health).
- Wisconsin Law and Regulation:
  - ✓ Law — Wisconsin Statutes: 49.43-49.499 and 49.665.
  - ✓ Regulation — Wisconsin Administrative Code, Chapters HFS 101-109.

Laws and regulations may be amended or added at any time. Program requirements may not be construed to supersede the provisions of these laws and regulations.

# Covered Services

This chapter contains general information about services covered by Wisconsin Medicaid. The information in this chapter is not all-inclusive. Providers should refer to HFS 101.03(35) and 107, Wis. Admin. Code, and to service-specific publications for more information about Medicaid-covered services.

A covered service is a service, item, or supply for which Medicaid reimbursement is available when *all* program requirements are met.

## Definition

A covered service is a service, item, or supply for which Medicaid reimbursement is available when *all* program requirements are met.

### Program Requirements

For a covered service to meet program requirements, the service must be provided by a qualified Medicaid-certified provider to an eligible recipient. In addition, the service must meet all applicable program requirements, including, but not limited to, medical necessity, prior authorization (PA), claims submission, prescription, and documentation requirements. Refer to the other sections of this handbook and to service-specific publications for more information about program requirements.



#### *Medical Necessity*

Wisconsin Medicaid reimburses only for services that are medically necessary as defined under HFS 101.03(96m), Wis. Admin. Code. Wisconsin Medicaid may deny or recoup payment if a service fails to meet Medicaid medical necessity requirements.

Services defined as "medically necessary" meet the following:

a. Required to prevent, identify, or treat a recipient's illness, injury, or disability; and
b. Meets the following standards:
   1. Is consistent with the recipient's symptoms or with prevention, diagnosis, or treatment of the recipient's illness, injury, or disability;
   2. Is provided consistent with standards of acceptable quality of care applicable to the type of service, the type of provider, and the setting in which the service is provided;
   3. Is appropriate with regard to generally accepted standards of medical practice;
   4. Is not medically contraindicated with regard to the recipient's diagnoses, the recipient's symptoms, or other medically necessary services being provided to the recipient;
   5. Is of proven medical value or usefulness and, consistent with s. HFS 107.035, Wis. Admin. Code, is not experimental in nature;
   6. Is not duplicative with respect to other services being provided to the recipient;
   7. Is not solely for the convenience of the recipient, the recipient's family, or a provider;
   8. With respect to PA of a service and to other prospective coverage determinations made by the Department of Health and Family Services (DHFS), is cost-effective compared to an alternative medically necessary service that is reasonably accessible to the recipient; and
   9. Is the most appropriate supply or level of service that can be safely and effectively provided to the recipient.

#### *Prior Authorization*

About 4 percent of Medicaid services require PA. In most cases, providers are required to obtain PA for those services *before* providing them.

Services that require PA are identified in HFS 107, Wis. Admin. Code, and in service-specific publications. Refer to the Prior Authorization section of this handbook and to service-specific

publications for more information about PA requirements.

### *Services That Do Not Meet Program Requirements*

As stated in HFS 107.02(2), Wis. Admin. Code, Wisconsin Medicaid may deny or recoup payment for covered services that fail to meet program requirements.

Examples of covered services that do not meet program requirements include the following:

- Services for which records or other documentation were not prepared or maintained.
- Services for which the provider fails to meet any or all of the requirements of HFS 106.03, Wis. Admin. Code, including, but not limited to, the requirements regarding timely submission of claims.
- Services that fail to comply with Medicaid requirements or state and federal statutes, rules, and regulations.
- Services that the DHFS, the Peer Review Organization review process, or Wisconsin Medicaid determines to be inappropriate, in excess of accepted standards of reasonableness or less costly alternative services, or of excessive frequency or duration.
- Services provided by a provider who fails or refuses to meet and maintain any of the certification requirements under HFS 105, Wis. Admin. Code.
- Services provided by a provider who fails or refuses to provide access to records.
- Services provided inconsistent with an intermediate sanction or sanctions imposed by the DHFS.

## Emergency Services

In emergency situations, Wisconsin Medicaid modifies certain program requirements and reimbursement procedures. Emergency services are defined in HFS 101.03(52), Wis. Admin. Code, as "those services which are necessary to prevent the death or serious impairment of the health of the individual."

Wisconsin Medicaid does not reimburse for emergency services unless they are Medicaid-covered services.

Additional definitions and procedures for emergencies exist in other situations, such as dental and mental health. Refer to service-specific publications for more information about program requirements for emergency services.

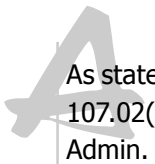
Program requirements and reimbursement procedures may be modified in the following ways:

- Prior authorization or other program requirements may be waived in emergency situations. Refer to the Prior Authorization section of this handbook and to service-specific publications for more information.
- Noncertified providers may be reimbursed for emergency services. Refer to the Certification and Ongoing Responsibilities section of this handbook for more information.
- Non-U.S. citizens may be eligible for Medicaid-covered services in emergency situations. Refer to the Recipient Eligibility section of this handbook for more information.



## Services Not Separately Reimbursable

If reimbursement for a service is included in the reimbursement for the primary procedure or service, it is not separately reimbursable. For example, routine venipuncture is not separately reimbursable but is included in the reimbursement for the laboratory procedure or the laboratory test preparation and handling fee. Also, durable medical equipment (DME) delivery charges are included in the reimbursement for DME items.



As stated in HFS 107.02(2), Wis. Admin. Code, Wisconsin Medicaid may deny or recoup payment for covered services that fail to meet program requirements.

## Recipient Payment for Covered Services

Under state and federal laws, a Medicaid-certified provider may not collect payment from a recipient, or authorized person acting on behalf of the recipient, for Medicaid-covered services even if the services are covered but do not meet program requirements. Denial of a claim by Wisconsin Medicaid does not necessarily render a Medicaid recipient liable. However, a covered service for which PA was denied is treated as a noncovered service. (If a recipient chooses to receive an originally requested service instead of the service approved on a modified PA request, it is also treated as a noncovered service.) If a recipient requests a covered service for which PA was denied (or modified), the provider may collect payment from the recipient if certain conditions are met. Refer to the Collecting Payment from Recipients chapter of this section for more information.

If a provider collects payment from a recipient, or authorized person acting on behalf of the recipient, for a Medicaid-covered service, the provider may be subject to program sanctions including termination of Medicaid certification. Providers should refer to the Certification and Ongoing Responsibilities section of this handbook for more information about provider sanctions.

Under state and federal laws, a Medicaid-certified provider may not collect payment from a recipient, or authorized person acting on behalf of the recipient, for Medicaid-covered services even if the services are covered but do not meet program requirements.

# Noncovered Services



This chapter contains general information about services not covered by Wisconsin Medicaid. The information in this chapter is not all-inclusive. Providers should refer to chs. HFS 101.03(103) and 107, Wis. Admin. Code, and to service-specific publications for more information. In addition, providers should refer to Appendix 1 of this section for a general list of noncovered services as it appears in HFS 107.03, Wis. Admin. Code.

A noncovered service is a service, item, or supply for which Medicaid reimbursement is not available.

## Definition

A noncovered service is a service, item, or supply for which Medicaid reimbursement is not available.

## Recipient Payment for Noncovered Services



A provider may collect payment from a recipient for noncovered services if certain conditions are met. Refer to the Collecting Payment from Recipients chapter of this section for more information.

Providers may not collect payment from a recipient, or authorized person acting on behalf of the recipient, for certain noncovered services or activities provided in connection with covered services, including the following:

- Charges for missed appointments.
- Charges for telephone calls.
- Charges for time involved in completing necessary forms, claims, or reports.
- Translation services.

### Missed Appointments

The federal Centers for Medicare and Medicaid Services does not allow state Medicaid programs to permit providers to collect payment from a recipient, or authorized person acting on behalf of the recipient, for a missed appointment.

#### *Avoiding Missed Appointments*

Wisconsin Medicaid offers the following suggestions to help avoid missed appointments:

- Remind recipients of upcoming appointments (by telephone or postcard) prior to scheduled appointments.
- Encourage the recipient to call his or her county/tribal social or human services agency if transportation is needed.
- If the appointment is made through the HealthCheck screening or targeted case management programs, encourage the staff from those programs to ensure that the scheduled appointments are kept.

### Translation Services

Translation services are considered part of the provider's overhead cost and are not separately reimbursable by Wisconsin Medicaid. Providers may not collect payment from a recipient, or authorized person acting on behalf of the recipient, for translation services.

Providers should contact the Affirmative Action and Civil Rights Compliance Officer at (608) 266-9372 for information about when translation services are required by federal law. Providers may also write to:

AA/CRC Office
1 W Wilson St Rm 561
PO Box 7850
Madison WI 53707-7850

# Collecting Payment from Recipients

Medicaid providers may not collect payment from a recipient, or authorized person acting on behalf of the recipient, *except* for the following:

- Required recipient copayments for certain services. (Refer to the Recipient Eligibility section of this handbook for more information.)
- Commercial insurance payments made to the recipient. (Refer to the Coordination of Benefits section of this handbook for more information.)
- Spenddown. (Refer to the Recipient Eligibility section of this handbook for more information.)
- Charges for a private room in a nursing home or hospital. (Refer to service-specific publications for more information.)
- Noncovered services if certain conditions are met.
- Covered services for which prior authorization (PA) was denied (or an originally requested service for which a PA request was modified) if certain conditions are met. These services are treated by Wisconsin Medicaid as noncovered services.
- Services provided to a recipient in a limited benefit category when the services are not covered under the limited benefit and if certain conditions are met.

If a provider inappropriately collects payment from a recipient, or authorized person acting on behalf of the recipient, that provider may be subject to program sanctions including termination of Medicaid certification. Refer to the Certification and Ongoing Responsibilities section of this handbook for more information about provider sanctions.

## Conditions That Must Be Met

A recipient may request a noncovered service, a covered service for which PA was denied (or modified), or a service that is not covered under the recipient's limited benefit category. The charge for the service may be collected from the recipient if the following conditions are met *prior* to the delivery of that service:

- The recipient accepts responsibility for payment.
- The provider and recipient make payment arrangements for the service.

Providers are strongly encouraged to obtain a *written* statement in advance documenting that the recipient has accepted responsibility for the payment of the service.

Furthermore, the service must be separate or distinct from a related, covered service. For example, a vision provider may provide a recipient with eyeglasses covered by Wisconsin Medicaid but then, upon the recipient's request, provide and charge the recipient for anti-glare coating, which is a noncovered service. Charging the recipient is permissible in this situation because the anti-glare coating is a separate service and can be added to the lenses at a later time.

Providers are strongly encouraged to obtain a *written* statement in advance documenting that the recipient has accepted responsibility for the payment of the service.

# HealthCheck "Other Services"

On occasion, a HealthCheck screening may identify the need for health care services that are not otherwise covered by Wisconsin Medicaid or that exceed Medicaid limitations.

HealthCheck is Wisconsin Medicaid's federally mandated program known nationally as Early and Periodic Screening, Diagnosis, and Treatment (EPSDT). HealthCheck services consist of a comprehensive health screening of Medicaid recipients under 21 years of age. On occasion, a HealthCheck screening may identify the need for health care services that are not otherwise covered by Wisconsin Medicaid or that exceed Medicaid limitations. These services are called HealthCheck "Other Services." Federal law requires that these services be reimbursed by Wisconsin Medicaid through HealthCheck "Other Services" if they are medically necessary and prior authorized. The purpose of HealthCheck "Other Services" is to assure that medically necessary medical services are available to recipients under 21 years of age.



For a service to be reimbursed through HealthCheck "Other Services," the following requirements must be met:

- The condition being treated is identified in a HealthCheck screening that occurred within 365 days of the prior authorization (PA) request for the service.
- The service is provided to a recipient who is under 21 years of age.
- The service may be covered under federal Medicaid law.
- The service is medically necessary and reasonable.
- The service is prior authorized by Wisconsin Medicaid before it is provided.
- Services currently covered by Wisconsin Medicaid are not considered acceptable to treat the identified condition.

Wisconsin Medicaid has the authority to do all of the following:

- Review the medical necessity of all requests.
- Establish criteria for the provision of such services.
- Determine the amount, duration, and scope of services as long as limitations are reasonable and maintain the preventive intent of the HealthCheck program.

## Prior Authorization

To receive PA for HealthCheck "Other Services," providers are required to submit the following:

- A completed Prior Authorization Request Form (PA/RF), HCF 11018 (or Prior Authorization Dental Request Form [PA/DRF], HCF 11035, or Prior Authorization Request for Hearing Instrument Audiological Services [PA/HIAS1], HCF 11020).
  - ✓ The provider should write "HealthCheck Other Services" in *red ink* at the top of the form.
  - ✓ The provider may omit the procedure code if he or she is uncertain what it is. The Medicaid consultant will assign one for approved services.
- The appropriate service-specific PA attachment.
- Verification that a comprehensive HealthCheck screening has been provided within 365 days prior to Wisconsin Medicaid's receipt of the PA request. The date and provider of the screening must be indicated.
- Necessary supporting documentation.

Call Provider Services at (800) 947-9627 or (608) 221-9883 for more information about HealthCheck "Other Services" and to determine the appropriate PA attachment.

# Appendix

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Refer to the Online Handbook
for current policy

# Appendix 1

# Services Not Covered by Wisconsin Medicaid

The following specific services are not covered by Wisconsin Medicaid. This list is not all-inclusive. Refer to service-specific publications for more information about noncovered services.

## HFS 107.03 "Services not covered"

HFS 107.03, Wis. Admin. Code, defines "services not covered" under Wisconsin Medicaid to include the following:

(1) Charges for telephone calls;
(2) Charges for missed appointments;
(3) Sales tax on items for resale;
(4) Services provided by a particular provider that are considered experimental in nature;
(5) Procedures considered by the department to be obsolete, inaccurate, unreliable, ineffectual, unnecessary, imprudent or superfluous;
(6) Personal comfort items, such as radios, television sets and telephones, which do not contribute meaningfully to the treatment of an illness;
(7) Alcoholic beverages, even if prescribed for remedial or therapeutic reasons;
(8) Autopsies;
(9) Any service requiring prior authorization for which prior authorization is denied, or for which prior authorization was not obtained prior to the provision of the service except in emergency circumstances;
(10) Services subject to review and approval pursuant to s. 150.21, Stats., but which have not yet received approval;
(11) Psychiatric examinations and evaluations ordered by a court following a person's conviction of a crime, pursuant to s. 972.15, Stats.;
(12) Consultations between or among providers, except as specified in s. HFS 107.06(4)(e);
(13) Medical services for adult inmates of the correctional institutions listed in s. 302.01, Stats.;
(14) Medical services for a child placed in a detention facility;
(15) Expenditures for any service to an individual who is an inmate of a public institution or for any service to a person 21 to 64 years of age who is a resident of an institution for mental disease (IMD), unless the person is 21 years of age, was a resident of the IMD immediately prior to turning 21 and has been continuously a resident since then, except that expenditures for a service to an individual on convalescent leave from an IMD may be reimbursed by MA.
(16) Services provided to recipients when outside the United States, except Canada or Mexico;
(17) Separate charges for the time involved in completing necessary forms, claims or reports;
(18) Services provided by a hospital or professional services provided to a hospital inpatient are not covered services unless billed separately as hospital services under s. HFS 107.08 or 107.13(1) or as professional services under the appropriate provider type. No recipient may be billed for these services as noncovered;
(19) Services, drugs and items that are provided for the purpose of enhancing the prospects of fertility in males or females, including but not limited to the following:
    (a) Artificial insemination, including but not limited to intra-cervical and intra-uterine insemination;
    (b) Infertility counseling;
    (c) Infertility testing, including but not limited to tubal patency, semen analysis or sperm evaluation;
    (d) Reversal of female sterilization, including but not limited to tubouterine implantation, tubotubal anastomoses or fimbrioplasty;
    (e) Fertility-enhancing drugs used for the treatment of infertility;
    (f) Reversal of vasectomies;
    (g) Office visits, consultations and other encounters to enhance the prospects of fertility; and
    (h) Other fertility-enhancing services and items;

(20) Surrogate parenting and related services, including but not limited to artificial insemination and subsequent obstetrical care;
(21) Ear lobe repair;
(22) Tattoo removal;
(23) Drugs, including hormone therapy, associated with transsexual surgery or medically unnecessary alteration of sexual anatomy or characteristics;
(24) Transsexual surgery;
(25) Impotence devices and services, including but not limited to penile prostheses and external devices and to insertion surgery and other related services; and
(26) Testicular prosthesis.

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