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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 Recipient 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

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Collecting Payment from Recipients

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

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.

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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 Request for Dental Services Form [PA/DRF], HCF 11035, or Prior Authorization Request for Hearing Instrument Audiological Services [PA/HEAS1], 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.

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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 commission 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 a correctional institution under 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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