

To: Blood Banks, Home Health Agencies, Individual Medical Supply Providers, Medical Equipment Vendors, Nurses in Independent Practice, Nursing Homes, Personal Care Agencies, Pharmacies, HMOs and Other Managed Care Programs

Durable Medical Equipment Under BadgerCare Plus

BadgerCare Plus, the new state-sponsored health care program, will be implemented in February 2008. This *Update* describes the policies for durable medical equipment under BadgerCare Plus.

BadgerCare Plus Overview

In January 2007, Governor Jim Doyle included in his 2007-09 Biennial Budget proposal an innovative state-sponsored health care program to expand coverage to Wisconsin residents and ensure that all children in Wisconsin have access to affordable health care. This new program is called BadgerCare Plus, and it will start on February 1, 2008.

BadgerCare Plus merges family Medicaid, BadgerCare, and Healthy Start into a single program. BadgerCare Plus will expand enrollment to:

- All uninsured children.
- More pregnant women.
- More parents and caretaker relatives.
- Parents with children in foster care who are working to reunify their families.
- Young adults exiting out-of-home care, such as foster care, because they have turned 18 years of age.
- Certain farmers and other self-employed parents and caretaker relatives.

All individuals enrolled in BadgerCare Plus and Wisconsin Medicaid will be referred to as “members.”

BadgerCare Plus is comprised of two benefit plans, the Standard Plan and the Benchmark Plan. The services covered

under the BadgerCare Plus Standard Plan are the same as the current Wisconsin Medicaid program; therefore, the term “Standard Plan” will be used in all future *Updates* to describe the shared policy and billing information. The BadgerCare Plus Benchmark Plan is a more limited plan, modeled after commercial insurance.

New services covered under BadgerCare Plus and Wisconsin Medicaid include over-the-counter tobacco cessation products for all members and mental health and substance abuse screening, preventive mental health counseling, and substance abuse intervention services for pregnant women at risk of mental health or substance abuse problems. Future *Updates* will describe these new benefits in detail.

Refer to the November 2007 *Update* (2007-79), titled “Introduction to BadgerCare Plus — Wisconsin’s New Health Care Program,” for general information on covered and noncovered services, copayments, and enrollment.

Covered Services

Standard Plan

Durable medical equipment (DME) covered under the Standard Plan is the same as that covered under the current Wisconsin Medicaid program. Refer to the appropriate publications for covered DME, policies, and procedures. The current DME Index located at dhfs.wisconsin.gov/medicaid/ includes a complete list of covered DME.

Benchmark Plan

Durable medical equipment covered under the Benchmark Plan is the same as that covered under the current Wisconsin Medicaid program with the exception of procedure code V5336 (Repair/Modification Of Augmentative Communicative System Or Device [Excludes Adaptive Hearing Aid]). This DME service is **not covered** under the Benchmark Plan.

Service Limitations for the Benchmark Plan

The Benchmark Plan will reimburse up to \$2,500.00 for DME per member per enrollment year.

Enrollment Year Under BadgerCare Plus

An enrollment year is defined as the continuous 12-month period beginning the first day of the calendar month in which a member is enrolled in the Benchmark Plan and ending on the last day of the 12th calendar month.

For example, a member completes their BadgerCare Plus application materials by September 25, 2008. During the month of October, the Department of Health and Family Services (DHFS) reviews the application materials and determines that the member is **eligible** for the Benchmark Plan effective September 1, 2008, the first day of the calendar month that the application materials were completed; however, the enrollment year for this member will not begin until October 1, 2008, the first day of the calendar month in which the DHFS actively enrolled the member in the Benchmark Plan. The Benchmark Plan enrollment year for this member is defined as October 1, 2008, through September 30, 2009. **Services received after eligibility is established and before the enrollment year begins are covered under the Benchmark Plan but do not count toward the service limitations.**

Subsequent enrollment years begin on the first day of the calendar month immediately following the end of the previous enrollment year if there is no coverage gap. If there is a coverage gap for more than one day, the enrollment year

will reset to begin on the first day of the month in which the DHFS re-enrolls the member into the Benchmark Plan.

If a member switches from the Benchmark Plan to the Standard Plan, the Benchmark Plan enrollment year does not reset. For example, a member's enrollment year under the Benchmark Plan begins March 1, 2008. During the third month, the member's income status changes and she is now eligible for the Standard Plan effective June 1, 2008. During August, the DHFS determines that the member is no longer eligible for the Standard Plan and effective September 1, 2008, the member returns to the Benchmark Plan. Since there is not a gap in coverage, the initial Benchmark Plan enrollment year is still active. The member must adhere to limits for services received while covered under the Benchmark Plan during the enrollment year period March 1, 2008, through February 28, 2009.

The Benchmark Plan enrollment year is the time period used to determine service limitations for members in the Benchmark Plan. **Services received while covered under the Standard Plan do not count toward the enrollment year service limitations in the Benchmark Plan and vice versa.** If a member switches between the two plans during one enrollment year, service limitations will accumulate separately under each plan.

Prior Authorization

Prior authorization policy and procedures are the same under the Standard Plan and the Benchmark Plan as they are under the current Wisconsin Medicaid program.

Reimbursement

Terms of Reimbursement

The DME terms of reimbursement (TOR) have been revised for BadgerCare Plus. Refer to the Attachment of this *Update* for the Medical Supply and Equipment Vendor Terms of Reimbursement for DME providers. The TOR describes how BadgerCare Plus will reimburse providers for services rendered. The conditions outlined in the TOR will

automatically take effect; providers do not need to resubmit certification materials.

Standard Plan

Providers will be reimbursed for DME provided to Standard Plan members at the lesser of the provider's usual and customary charge or the current Wisconsin Medicaid maximum allowable fee. Providers should refer to the current DME Index for a list of maximum allowable fees.

Benchmark Plan

Providers will be reimbursed for DME provided to Benchmark Plan members at the lesser of the provider's usual and customary charge or the current Wisconsin Medicaid maximum allowable fee until the member reaches his or her service limitation of \$2,500.00 per enrollment year.

If BadgerCare Plus covers any portion of the DME charges, providers are required to accept the BadgerCare Plus allowed reimbursement, which is the lesser of the provider's usual and customary charge or the maximum allowable fee, as payment in full. If BadgerCare Plus pays a portion of the claim and the claim exceeds the member's service limitation, providers can balance bill the member for the difference between the allowed reimbursement and the dollar amount actually paid by BadgerCare Plus.

For example, suppose the BadgerCare Plus-allowed reimbursement for a DME item is \$500.00 and the member has expended \$2,200.00 of his or her DME coverage for the enrollment year. BadgerCare Plus will reimburse only \$300.00 before the member has exhausted his or her coverage. The member is responsible for the additional \$200.00. The provider must still accept \$500.00 as payment in full because BadgerCare Plus reimbursed a portion of the charges. The provider must not bill the member for more than \$200.00.

If a member has already met or exceeded his or her DME service limitation, BadgerCare Plus will not reimburse providers for DME provided to that member. The provider

may collect their usual and customary charge from the member.

Copayments

Standard Plan

Copayment amounts under the Standard Plan are the same as they are under the current Wisconsin Medicaid program. Refer to previously published service-specific publications for more information on copayment amounts.

Policy regarding Standard Plan members who are subject to copayments and members who are exempt from copayments is different than that of the current Wisconsin Medicaid program.

Providers should note that the following Standard Plan members **are subject to copayment** for services where copayment applies:

- Members enrolled in BadgerCare Plus Standard Plan HMOs (previously referred to as Medicaid HMOs).
- Members under 18 years of age with incomes above 100 percent of the Federal Poverty Level (FPL).

Providers are prohibited from collecting copayments from the following Standard Plan members:

- Nursing home residents.
- Pregnant women.
- Members under 18 years of age who are members of a federally recognized tribe.
- Members under 18 years of age with incomes at or below 100 percent of the FPL.

Under the Standard Plan, providers **cannot** deny services if a member fails to make his or her copayment.

Benchmark Plan

Copayment for purchased DME is up to \$5.00 per item under the Benchmark Plan. If the BadgerCare Plus reimbursement for the DME is less than \$5.00, the member must be charged the lesser amount.

Nursing home residents who are members of the Benchmark Plan are subject to copayment for DME that is not covered in the nursing home daily rate, such as exceptional supplies.

The following members are exempt from copayment requirements under the Benchmark Plan:

- Pregnant women.
- Members under 18 years of age who are members of a federally recognized tribe.

No other members are exempt from the copayment requirement under the Benchmark Plan.

Under the Benchmark Plan, a provider has the right to deny services if the member fails to make his or her copayment.

Information Regarding BadgerCare Plus HMOs

BadgerCare Plus HMOs are required to provide at least the same benefits as those provided under fee-for-service arrangements. For managed care policy, contact the appropriate managed care organization.

The *BadgerCare Plus Update* is the first source of program policy and billing information for providers. All information applies to Medicaid and BadgerCare Plus unless otherwise noted in the *Update*.

Wisconsin Medicaid and BadgerCare Plus are administered by the Division of Health Care Access and Accountability, Wisconsin Department of Health and Family Services, P.O. Box 309, Madison, WI 53701-0309.

For questions, call Provider Services at (800) 947-9627 or (608) 221-9883 or visit our Web site at dhfs.wisconsin.gov/medicaid/.

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ATTACHMENT

Medical Supply and Equipment Vendor Terms of Reimbursement

(A copy of the "Medical Supply and Equipment Vendor Terms of Reimbursement" is located on the following page.)



DIVISION OF HEALTH CARE ACCESS AND ACCOUNTABILITY
WISCONSIN MEDICAID AND BADGERCARE
PROVIDER SERVICES
6406 BRIDGE ROAD
MADISON WI 53784

Jim Doyle
Governor

Kevin R. Hayden
Secretary

State of Wisconsin

Department of Health and Family Services

Telephone: 800-947-9627
608-221-9883
dhfs.wisconsin.gov/medicaid
dhfs.wisconsin.gov/badgercare

MEDICAL SUPPLY AND EQUIPMENT VENDOR TERMS OF REIMBURSEMENT

The Department of Health and Family Services (DHFS) will establish maximum allowable fees for all covered durable medical equipment (DME) and disposable medical supplies (DMS) provided to Wisconsin Medicaid recipients eligible on the date of service.

The maximum allowable fees for DME and DMS shall be established upon a review of various factors. These factors include a review of usual and customary charges submitted to Wisconsin Medicaid; cost, payment, and charge information from companies that provide DME and DMS; Medicaid payment rates from other states; and the current Medicare fee schedule. Other factors taken into consideration include the Wisconsin State Legislature's Medicaid budget constraints, limits on the availability of federal funding as specified in federal law, and other relevant economic and reimbursement limitations. Maximum allowable fees may be adjusted periodically.

Providers are required to bill their usual and customary charges for equipment, supplies, and services provided. The usual and customary charge is the amount charged by the provider for the same equipment, supplies, or services when provided to non-Medicaid patients. For providers using a sliding fee scale, the usual and customary charge is the median of the individual provider's charge for the product or service when provided to non-Medicaid patients.

Covered DME and DMS shall be reimbursed at the lower of the provider's usual and customary charge or the maximum allowable fee established by the DHFS. Medicaid reimbursement, less appropriate copayments and payments by other insurers, will be considered to be payment in full.

Under the BadgerCare Plus Benchmark Plan, DME charges shall be reimbursed by the DHFS up to the member's coverage limit. When BadgerCare Plus reimburses the provider for any portion of the DME charges, the provider may balance bill the member for the remainder of the BadgerCare Plus allowed reimbursement rate. This will be considered payment in full.

The DHFS will adjust payments made to providers to reflect the amounts of any allowable copayments that the providers are required to collect pursuant to ch. 49, Wis. Stats.

Payments for deductibles and coinsurance payable on an assigned Medicare claim shall be made in accordance with s. 49.46(2)(C), Wis. Stats.

In accordance with federal regulations contained in 42 CFR 447.205, the DHFS will provide public notice in advance of the effective date of any significant proposed change in its methods and standards for setting maximum allowable fees for services.