ForwardHealth Portal

Maximum Allowable Fee Schedule User Guide

Date Last Updated: April 26, 2012

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1 Introduction

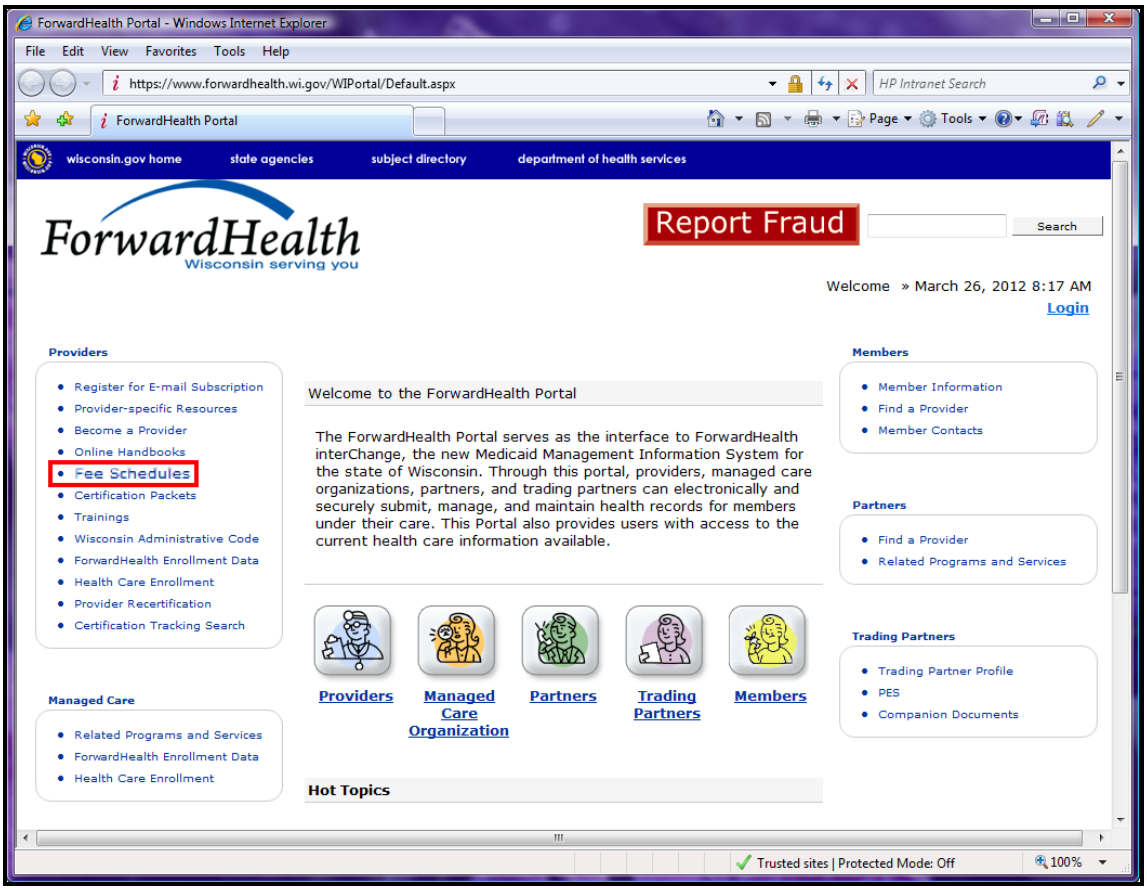
For most services, Wisconsin Medicaid reimburses providers the lesser of the billed amount or the maximum allowable fee established by the Department of Health Services based on legislative directives.

Maximum allowable fee information is available on the ForwardHealth Portal in the following forms:

- Interactive fee schedule. Interactive fee schedules provide coverage information as well as maximum allowable fees for all reimbursable procedure codes.
- Downloadable fee schedule in text (TXT) files. The downloadable TXT files provide basic maximum allowable fee information for BadgerCare Plus by provider service area.
- A Portable Document Format (PDF) version (Archive). The PDF reports are only intended to help users transition to the interactive schedules or the TXT files.

2 Access the Max Fee Schedules Page

1. Access the ForwardHealth Portal at https://www.forwardhealth.wi.gov/.



ForwardHealth Portal Page

2. Click **Fee Schedules** located in the Providers menu.

   The Max Fee Schedules page will be displayed.

Max Fee Schedules Page

On the Max Fee Schedules page, users can choose the following options:

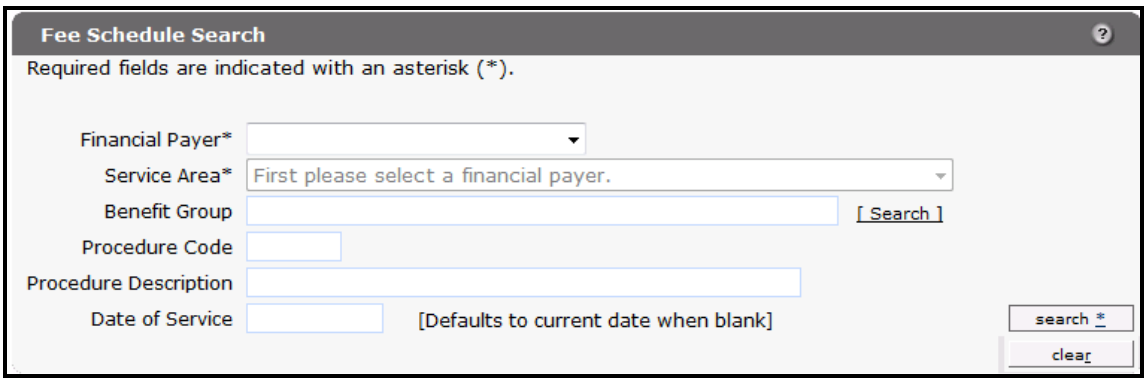
- *Begin using the interactive max fee schedule*.
- *Download complete max fee schedules*.
- *Drug Search Tool*.

3 Interactive Fee Schedules

3.1 Fee Schedule Search Page

1. Click **Begin using the interactive max fee schedule** on the Max Fee Schedules page.

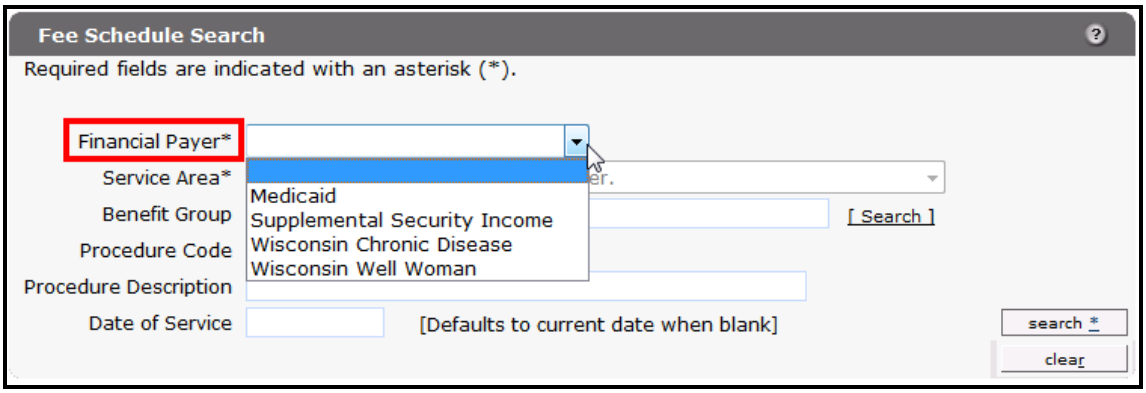
   The Fee Schedule Search page will be displayed.



Fee Schedule Search Page

2. Select a financial payer from the Financial Payer drop-down menu.

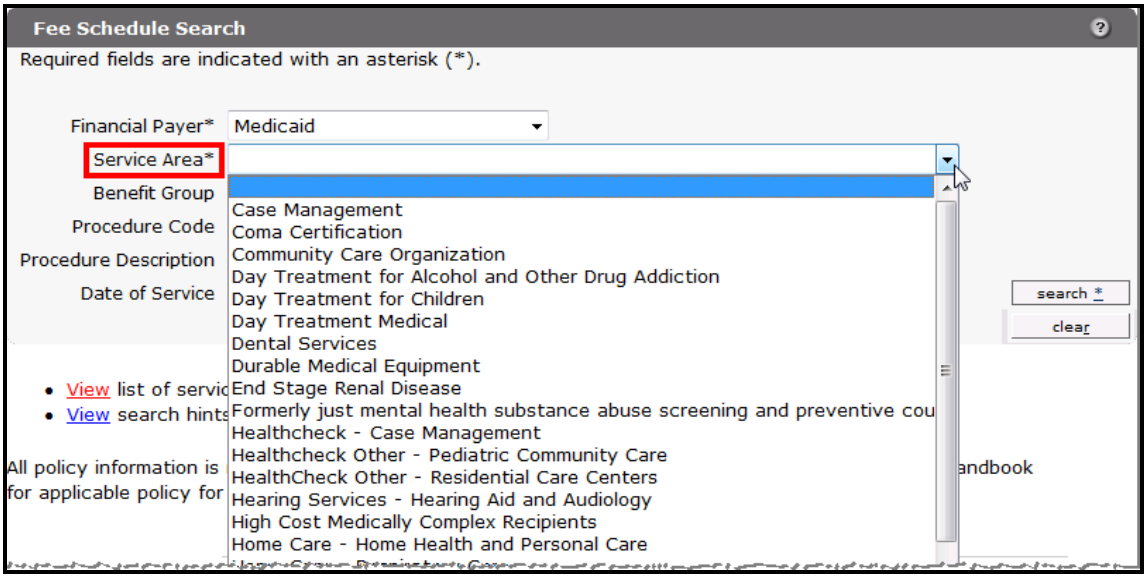
Note: Medicaid is the financial payer for Wisconsin Medicaid and BadgerCare Plus.



Financial Payer Drop-down Menu

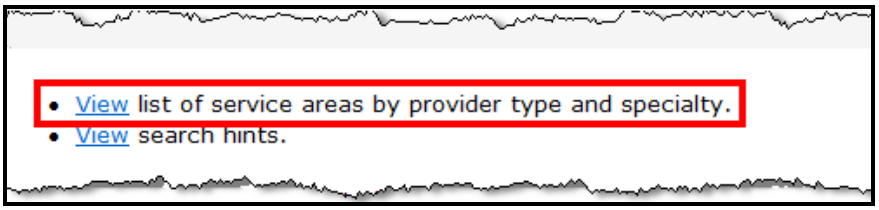
The Financial Payer field is a required field. A financial payer must be selected before information for other fields is selected or entered.

3. Select a service area from the Service Area drop-down menu (required).



Service Area Drop-down Menu

To view provider types and specialties by service area, click **View list of service areas by provider type and specialty** located at the bottom of the Fee Schedule Search page.



View List of Service Areas by Provider Type and Specialty Link

After selecting a financial payer and service area, users can continue their search by entering information in any of the following fields:

- Benefit Group. Refer to *Section 3.1.1 Search by Benefit Group* for more information.
- Procedure Code. Refer to *Section 3.1.2 Search by Procedure Code* for more information.
- Procedure Description. Refer to *Section 3.1.3 Search by Procedure Description* for more information.

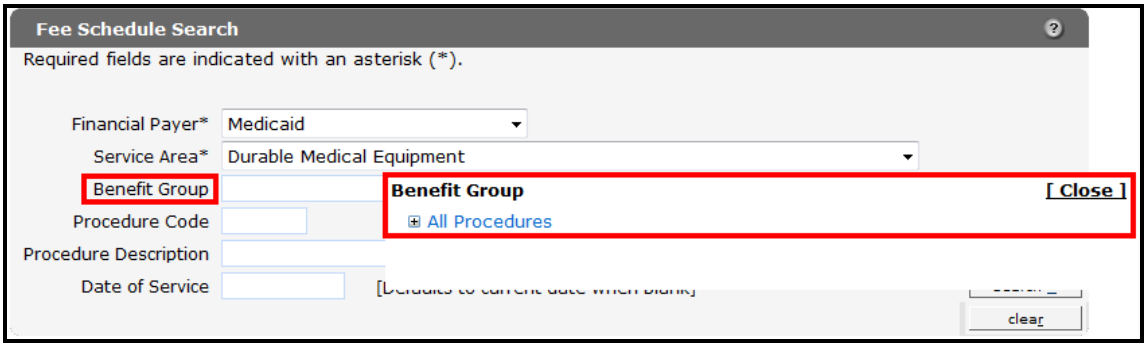
Note: If you need to change the query information, click **Clear** to clear all the selected and entered information from the fields.

3.1.1 Search by Benefit Group

The Benefit Group field lists a range of either Healthcare Common Procedure Coding System (HCPCS) procedure codes or *Current Procedural Terminology* (CPT) procedure codes.

1. Click **Search** to the right of the Benefit Group field.

   The Benefit Group search box will be displayed.



Benefit Group Search Box

2. Click ⊞ next to All Procedures.

   The HCPCS and CPT options will be displayed.

HCPCS and CPT Options

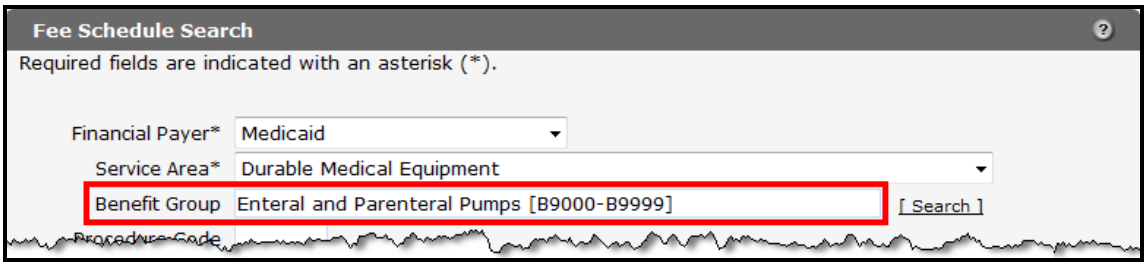
3. Depending on the set of benefit groups you wish to view, click ⊞ next to HCPCS or CPT.

   A list of benefit groups will be displayed.

Benefit Groups

4. Expand the list as necessary.
5. Select the applicable benefit group.

The Benefit Group search box will close and the selection will populate the Benefit Group field.



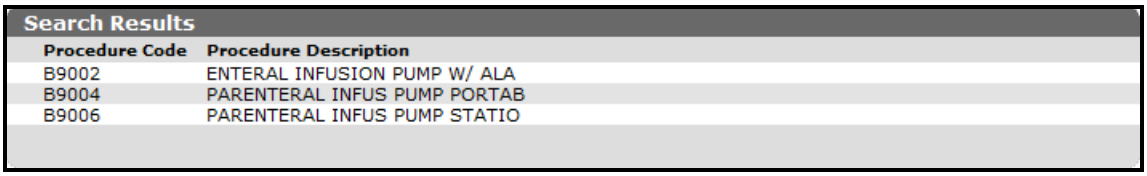
Benefit Group Field Populated with Selected Benefit Group

6. Enter the date of service (DOS) using MM/DD/CCYY format in the Date of Service field.

   The Date of Service field will display the current date if left blank.

7. Click **Search**.

   A Search Results panel listing the procedure codes for the selected benefit group will be displayed at the bottom of the page.



Search Results Panel

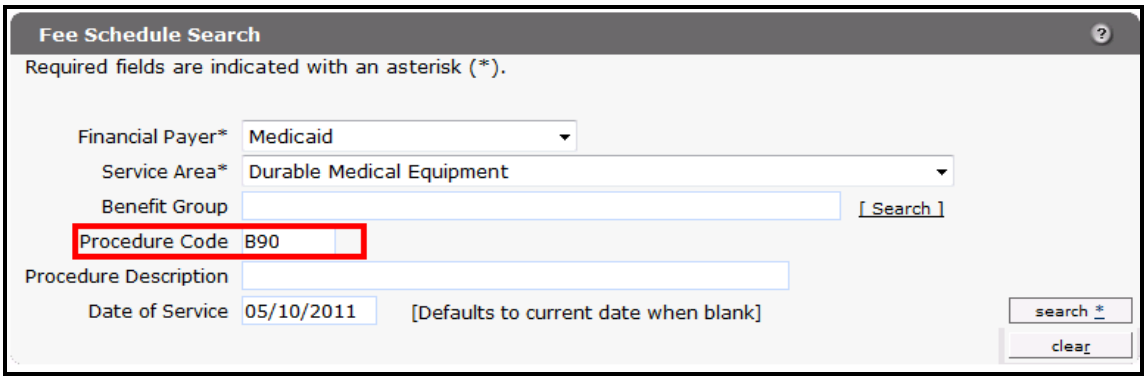
8. Click the applicable code.

   The Max Fee Details page will be displayed. Proceed to *Section 3.2 Max Fee Details Page*.

3.1.2 Search by Procedure Code

Searching by procedure code is the most direct way to search for max fee information.

1. Enter a full or partial procedure code in the Procedure Code field. If entering a partial procedure code, you must enter at least the first three digits of the code.



Procedure Code Field

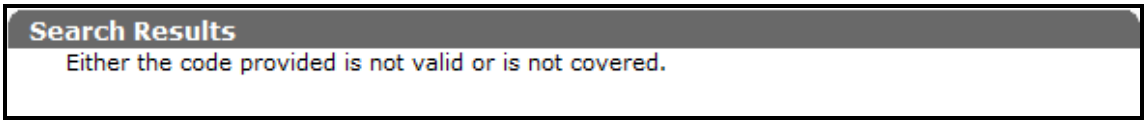
2. Enter the DOS using MM/DD/CCYY format in the Date of Service Field.

The Date of Service field will display the current date if left blank.

3. Click **Search**.

   If you entered a valid procedure code, the Max Fees Details page will be displayed. Proceed to *Section 3.2 Max Fee Details Page*.

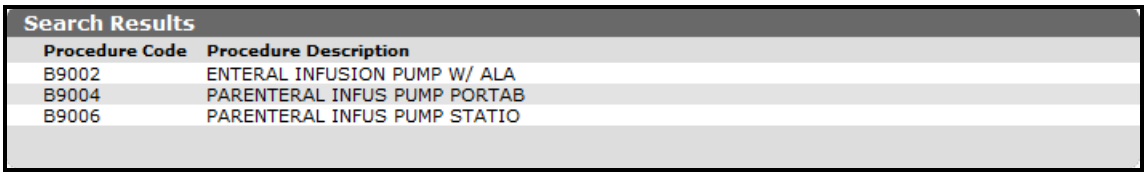
   If no results match the code entered, the Search Results panel will display an error message.



Error Message

If the error message indicates the code is not a reimbursable Wisconsin code, refer to the HCPCS and/or CPT code set for any questions regarding invalid or uncovered codes.

If you entered a partial code, a Search Results panel listing procedure codes will be displayed at the bottom of the page.



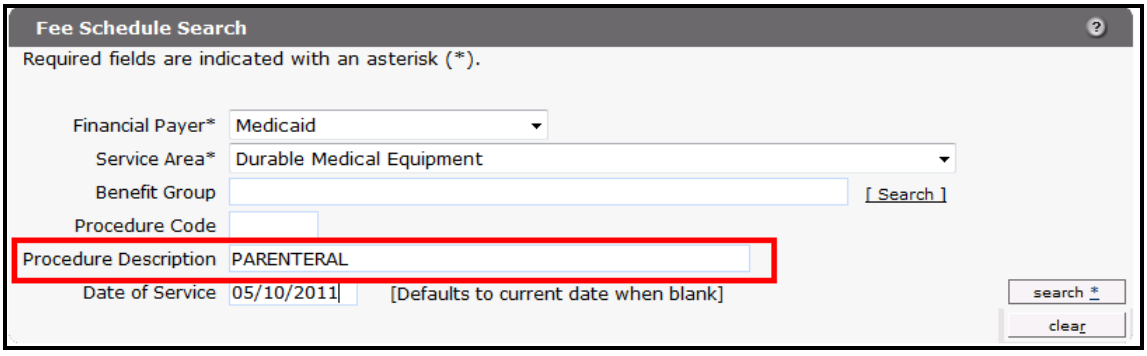
Search Results Panel

- Click the applicable code.
- The Max Fee Details page will be displayed. Proceed to *Section 3.2 Max Fee Details Page*.

3.1.3 Search by Procedure Description

1. Enter a full or partial description of the procedure in the Procedure Description field.

   If entering a partial description, you may enter the first word of the description or as few as the first three letters of the description.



Procedure Description Field

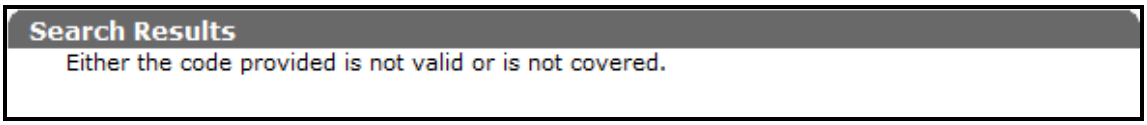
2. Enter the DOS using MM/DD/CCYY format in the Date of Service Field.

   The Date of Service field will display the current date if left blank.

3. Click **Search**.

   If you entered a valid procedure description, the Max Fees Details page will be displayed. Proceed to *Section 3.2 Max Fee Details Page*.

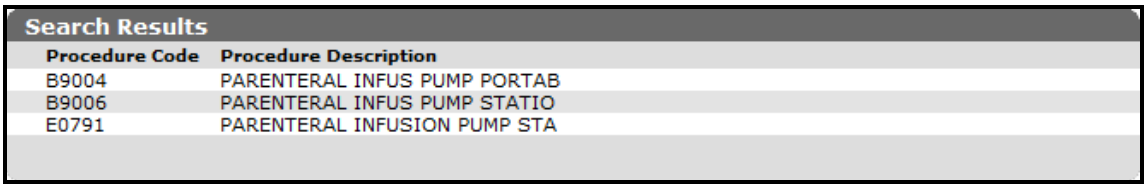
   If no results match the description entered, the Search Results panel will display an error message.



Error Message

If the error message indicates that the code is not a reimbursable Wisconsin code, refer to the HCPCS and/or CPT code set for any questions regarding invalid or uncovered codes.

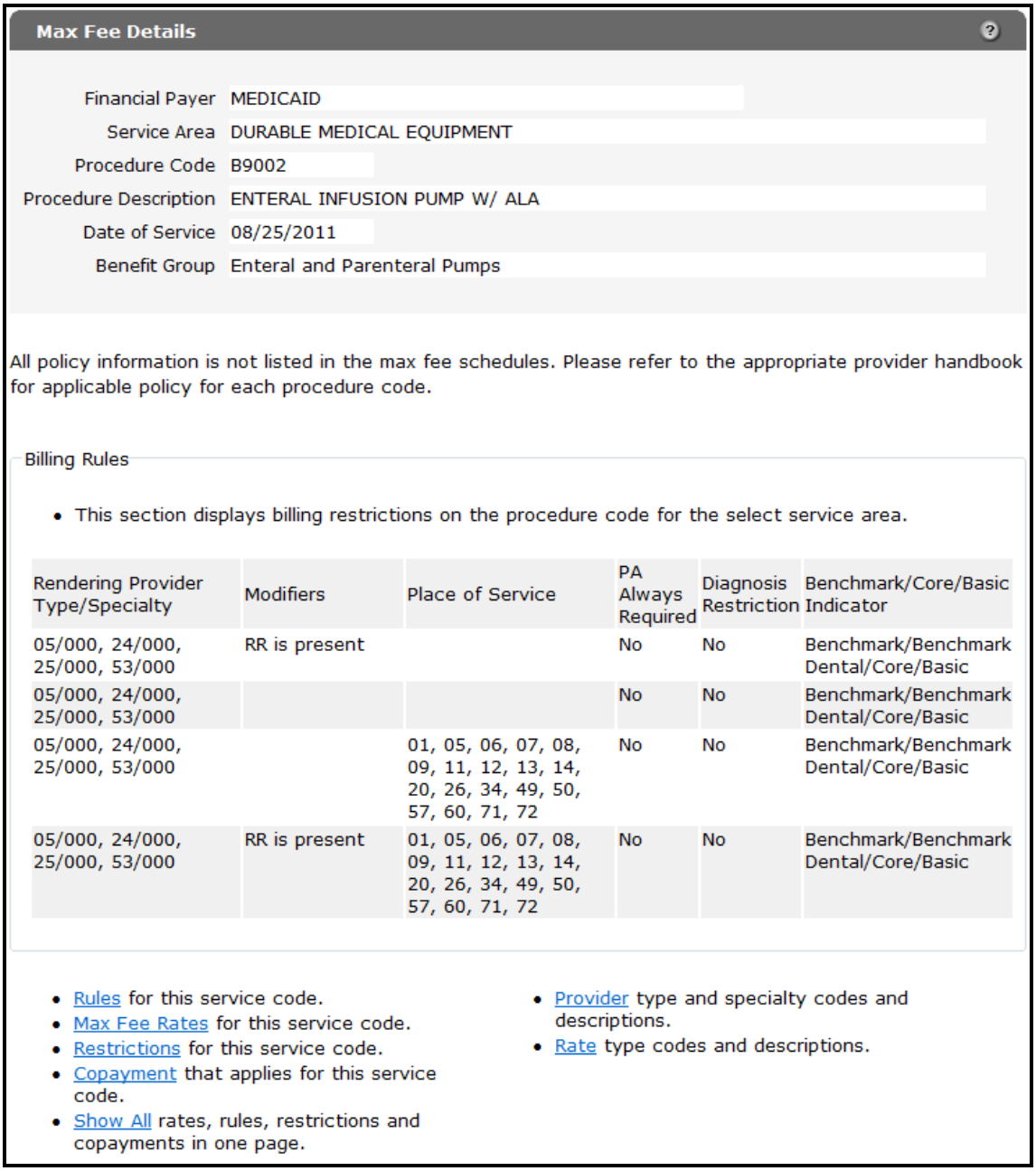
If you entered a partial procedure description, a Search Results panel listing procedure codes will be displayed at the bottom of the page.



Search Results Panel

- Click the desired code.
- The Max Fees Details page will be displayed. Proceed to *Section 3.2 Max Fee Details Page*.

3.2 Max Fee Details Page



Max Fee Details Page

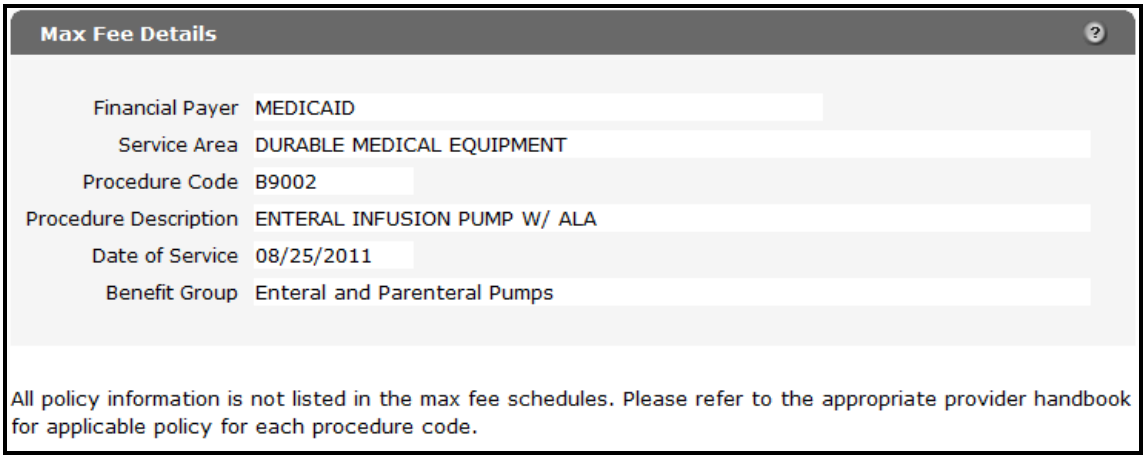
The Max Fee Details page consists of the following:

- The Max Fee Details panel.
- The "Billing Rules" section.
- Links for additional information.

Note: All policy information is not displayed in the fee schedules. Refer to the *ForwardHealth Online Handbook* for applicable policy for each procedure code.

3.2.1 Max Fee Details Panel

The Max Fee Details panel displays the fields from the Fee Schedule Search page. All the fields are populated with basic information for the specific fee schedule.

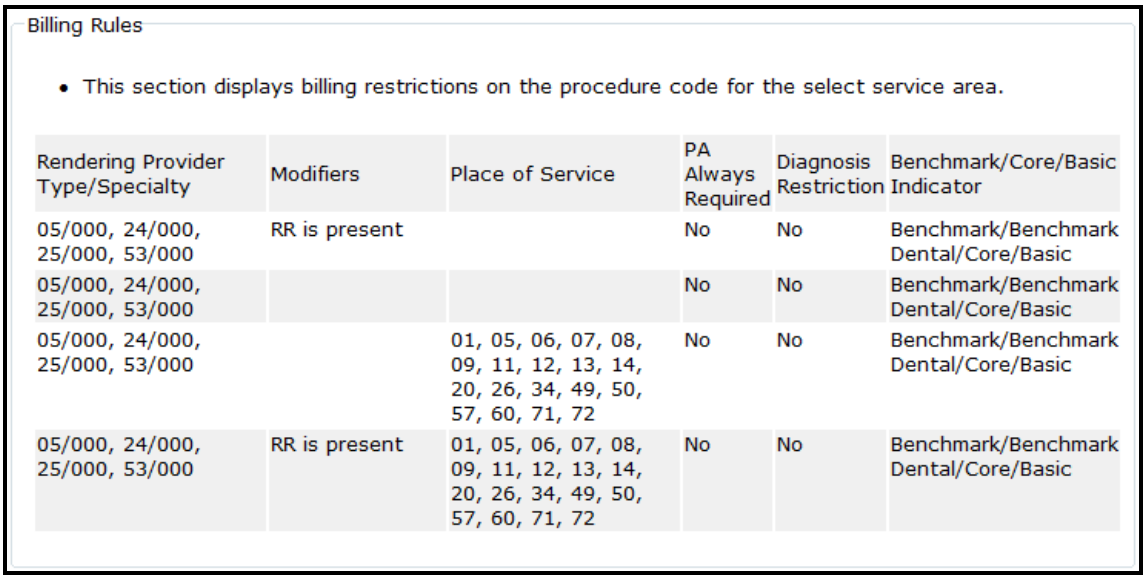


Max Fee Details Panel

3.2.2 Billing Rules Section

The "Billing Rules" section displays any billing restrictions for the procedure code for the selected service area.

Note: Billing rules indicate if the service is payable, not the amount to be paid.



Rendering Provider Type/Specialty	Modifiers	Place of Service	PA Always Required	Diagnosis Restriction	Benchmark/Core/Basic Indicator
05/000, 24/000, 25/000, 53/000	RR is present		No	No	Benchmark/Benchmark Dental/Core/Basic
05/000, 24/000, 25/000, 53/000			No	No	Benchmark/Benchmark Dental/Core/Basic
05/000, 24/000, 25/000, 53/000		01, 05, 06, 07, 08, 09, 11, 12, 13, 14, 20, 26, 34, 49, 50, 57, 60, 71, 72	No	No	Benchmark/Benchmark Dental/Core/Basic
05/000, 24/000, 25/000, 53/000	RR is present	01, 05, 06, 07, 08, 09, 11, 12, 13, 14, 20, 26, 34, 49, 50, 57, 60, 71, 72	No	No	Benchmark/Benchmark Dental/Core/Basic

Billing Rules Section

The following columns are displayed in the "Billing Rules" section:

- The Rendering Provider Type/Specialty column indicates the provider type and specialty of the rendering provider indicated on the claim.
- The Modifiers column displays the modifier or modifiers indicated for the selected procedure code, provider type, provider specialty, and place of service combination.

- The Place of Service column displays the location where services were provided. ForwardHealth uses the national place of service (POS) code set, which are two-digit codes used on claims to indicate the location at which a service was provided.
- The PA Always Required column displays whether or not prior authorization (PA) is required when billing.
- The Diagnosis Restriction column indicates whether or not a defined diagnosis code(s) is required for the selected procedure code, modifier, provider type, provider specialty, and POS combination.
- The Benchmark/Core/Basic Indicator column indicates if the service or procedure is covered under the BadgerCare Plus Benchmark Plan, the BadgerCare Plus Core Plan, and/or the BadgerCare Plus Basic Plan.

Note: The "Billing Rules" section lists several rules for different combinations of provider types and specialties, modifiers, POS, and other billing restrictions. When a restriction is *blank*, the billing rule applies to *any* situation. If a specific restriction is indicated, such as a specific modifier or POS, then the billing rule applies to the restrictions listed.

Billing Rule Examples

The outcome of the billing rules is dependent on the information indicated on the claim, such as the rendering provider type and specialty, POS code, and whether or not a specific modifier is indicated.

Example 1

In Example 1, if the procedure or service is provided by one of the provider types and specialties listed and the procedure code is billed with modifier RR, the following billing restrictions apply regardless of the POS indicated:

- Prior authorization is not always required.

Note: Prior authorization may be required due to other policy considerations. Refer to the ForwardHealth Online Handbook for situations requiring PA.

- There are no diagnosis restrictions; the procedure code can be billed with any diagnosis.
- The code is covered under the BadgerCare Plus Benchmark Plan, the BadgerCare Plus Benchmark Dental Plan, the BadgerCare Plus Core Plan, and the BadgerCare Plus Basic Plan.

Rendering Provider Type/Specialty	Modifiers	Place of Service	PA Always Required	Diagnosis Restriction	Benchmark/Core/Basic Indicator
05/000, 24/000, 25/000, 53/000	RR is present		No	No	Benchmark/Benchmark Dental/Core/Basic

Example 1

Example 2

In Example 2, if the procedure or service is provided by one of the provider types and specialties listed, the following billing restrictions apply regardless of the POS or modifier indicated:

- Prior authorization is not always required.

Note: Prior authorization may be required due to other policy considerations. Refer to the ForwardHealth Online Handbook for situations requiring PA.

- There are no diagnosis restrictions; the procedure code can be billed with any diagnosis.
- The code is covered under the Benchmark Plan, the Benchmark Dental Plan, the Core Plan, and the Basic Plan.

Rendering Provider Type/Specialty	Modifiers	Place of Service	PA Always Required	Diagnosis Restriction	Benchmark/Core/Basic Indicator
11/112, 16/212			No	No	Benchmark/Benchmark Dental/Core/Basic

Example 2

Example 3

In Example 3, if the procedure or service is provided by one of the provider types and specialties listed and the procedure code is billed with modifier TC together with one of the listed POS codes, the following billing restrictions apply:

- Prior authorization is not always required.

Note: Prior authorization may be required due to other policy considerations. Refer to the ForwardHealth Online Handbook for situations requiring PA.

- There are no diagnosis restrictions; the procedure code can be billed with any diagnosis.
- The code is covered under the Benchmark Plan, the Benchmark Dental Plan, the Core Plan, and the Basic Plan.

Rendering Provider Type/Specialty	Modifiers	Place of Service	PA Always Required	Diagnosis Restriction	Benchmark/Core/Basic Indicator
09/000, 10/000, 31/000, 33/000	TC is present	01, 05, 06, 07, 08, 09, 11, 20, 22, 23, 24, 26, 31, 32, 33, 49, 50, 54, 57, 60, 71, 72	No	No	Benchmark/Benchmark Dental/Core/Basic

Example 3

Example 4

In Example 4, if the procedure or service is provided by one of the provider types and specialties listed and the procedure code is billed regardless of modifier, but with one of the listed POS codes, the following billing restrictions apply:

- Prior authorization is not always required.

Note: Prior authorization may be required due to other policy considerations. Refer to the ForwardHealth Online Handbook for situations requiring PA.

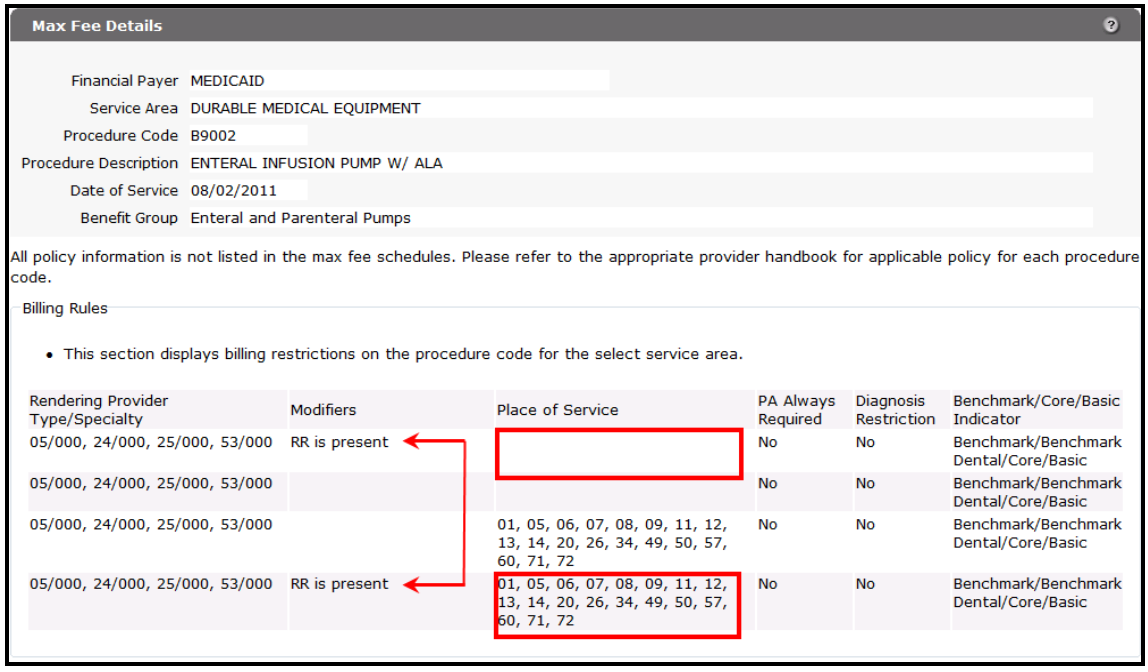
- There are no diagnosis restrictions; the procedure code can be billed with any diagnosis.
- The code is covered under the Benchmark Plan, the Benchmark Dental Plan, the Core Plan and the Basic Plan.

Rendering Provider Type/Specialty	Modifiers	Place of Service	PA Always Required	Diagnosis Restriction	Benchmark/Core/Basic Indicator
01/000, 09/000, 10/000, 28/000, 31/000, 33/000, 58/000, 67/000		01, 03, 04, 05, 06, 07, 08, 09, 11, 15, 20, 26, 49, 50, 56, 57, 60, 71, 72, 81, 99	No	No	Benchmark/Benchmark Dental/Core/Basic

Example 4

Example 5

In some cases, there may appear to be conflicting information in the "Billing Rules" section. In Example 5, lines one and four appear to be similar except for the POS restrictions; however, line one represents a home health claim that *does not* have a POS restriction, and line four represents a professional claim that *does* have a POS restriction.

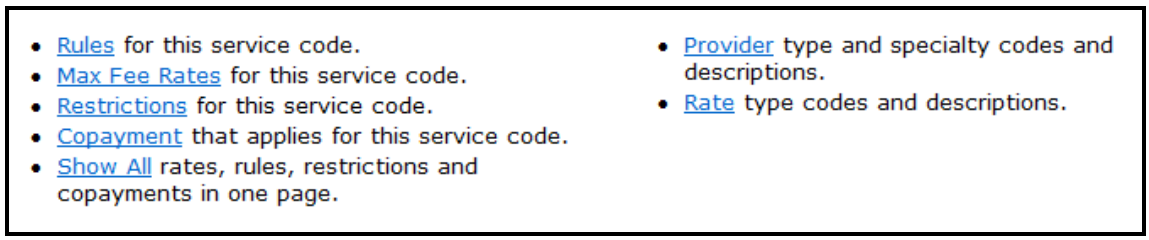


Example 5

The ForwardHealth billing system contains multiple billing rules and max fee rates for different situations based on numerous factors, not all of which are included in the max fee tables available on the ForwardHealth Portal. These factors may include the provider's contract, whether or not the member is enrolled in a Health Professional Shortage Area, or various other pricing adjustments.

If it is not clear from the max fee tables which billing rules apply, refer to the ForwardHealth Online Handbook for applicable policy for each procedure code. For further clarification, call Provider Services at (800) 947-9627.

3.2.3 Links for Additional Information



Additional Information Links

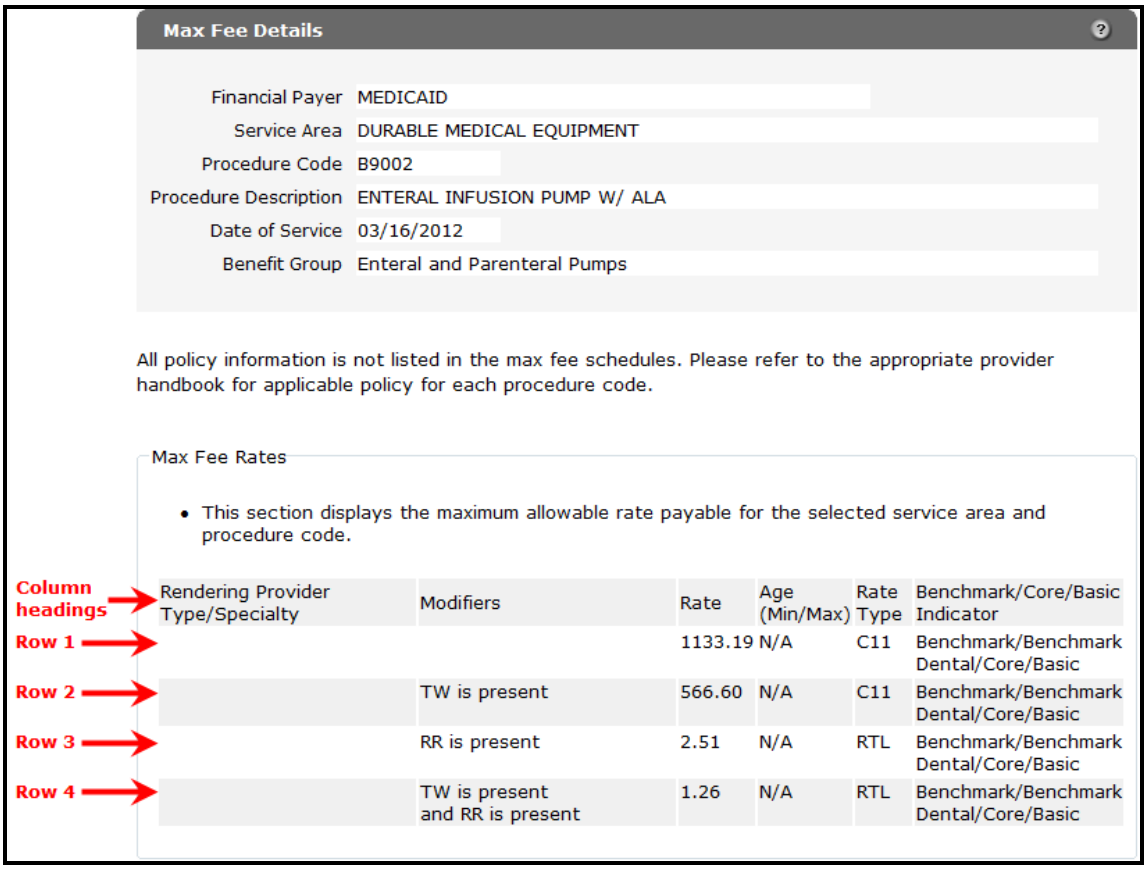
The following links to additional information for the selected procedure code may be displayed at the bottom of the page:

- The Rules link displays the “Billing Rules” section.
- The Max Fee Rates link displays the maximum allowable rate payable for the selected service area and procedure code. For more information, refer to the *Max Fee Rates* section of this user guide.
- The Restrictions link refers to specific limitations on the procedure code for the selected service area. Restriction information is *not* available in the interactive max fee schedule at this time. Refer to the appropriate section of the ForwardHealth Online Handbook for applicable policy.
- The Copayment link displays the amount of copayment for the listed procedure code. The “Copayment” section displays only when a code within the durable medical equipment (DME) service area is selected. For more information, refer to the *Copayment* section of this user guide.
- The Show All link displays all the billing rules, max fee rates, restrictions, and copayment information for the selected procedure code on the Max Fee Details page.
- The Provider link opens a new browser window that displays a list of all provider type and specialty codes.
- The Rate link opens a new browser window that displays a list of all rate type codes and their descriptions.

Max Fee Rates

1. Click **Max Fee Rates**.

   The "Max Fee Rates" section listing the maximum allowable rate payable for the selected service area and procedure code will be displayed.



Max Fee Rates Section

The column headings indicate each individual set of factors affecting the maximum allowable rate payable for the selected service area and procedure code.

- The Rendering Provider Type/Specialty column, if specific provider types and specialties are indicated, applies to only those provider types and specialties. A blank entry indicates that the rate applies to all the provider types and specialties listed in the billing rules.
- The Modifiers column displays the different modifiers that may affect the rate. A blank entry indicates that the rate applies to claims with no modifier indicated.
- The Rate column displays the maximum allowable rate payable for the factors indicated on that row.
- The Age (Min/Max) column displays any age restrictions associated with the selected code.
- The Rate Type column displays the rate type corresponding to the code and modifier (if indicated). For definitions of rate types, click **Rate type codes and descriptions** at the bottom of the Max Fee Details page.

- The Benchmark/Core/Basic Indicator column indicates whether or not the procedure is covered under the Benchmark Plan, the Benchmark Dental Plan, the Core Plan, or the Basic Plan.

In the "Max Fee Rates" section above, rows one and two list the rate dependent on the modifier submitted on claims with rate type C11, which is the DME purchase contract. The rate listed in the Rate column differs if the following are true:

- No modifier is indicated on the claim.
- The TW modifier is indicated.

Rows three and four show the max fee rate for claims with an RTL (DME rental) rate type, which displays when the following are indicated:

- The RR modifier.
- Both the TW and RR modifiers.

Note: A rate of 0.00 would indicate that the procedure *is covered*, but is *manually* priced. For example, if a new procedure code is added before a max fee rate is established, the rate would be listed as 0.00 and the pricing would be determined manually, perhaps as a percentage of the billed amount.

If a service is not covered within a contract, it will not appear in the listing.

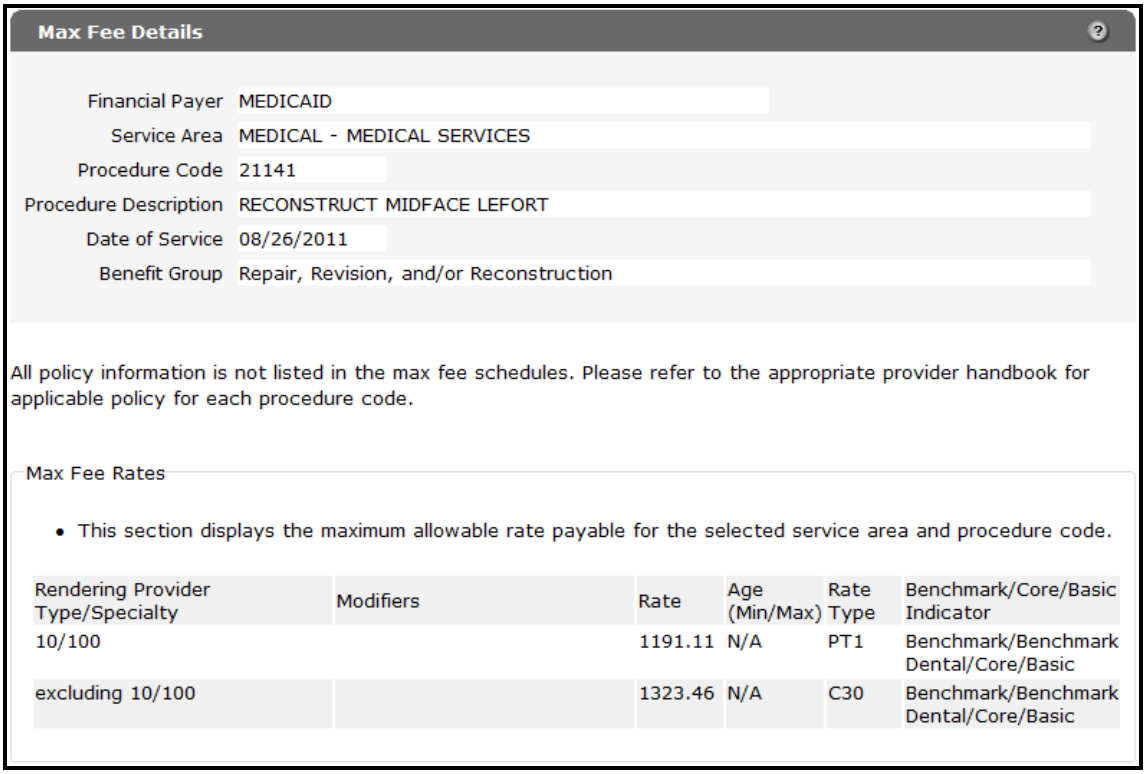
Max Fee Rate Examples

The following are examples of max fee results that may be returned.

Example 1

In Example 1, the rate varies according to the provider type and specialty.

- If the procedure or service is provided by a physician assistant (Provider Type 010/Specialty 100), the rate is $1,191.11.
- If the service is provided by any provider and specialty (excluding physician assistants, 010/100), the rate is $1,323.46.



Max Fee Details

Financial Payer	MEDICAID
Service Area	MEDICAL - MEDICAL SERVICES
Procedure Code	21141
Procedure Description	RECONSTRUCT MIDFACE LEFORT
Date of Service	08/26/2011
Benefit Group	Repair, Revision, and/or Reconstruction

All policy information is not listed in the max fee schedules. Please refer to the appropriate provider handbook for applicable policy for each procedure code.

Max Fee Rates

- This section displays the maximum allowable rate payable for the selected service area and procedure code.

Rendering Provider Type/Specialty	Modifiers	Rate	Age (Min/Max)	Rate Type	Benchmark/Core/Basic Indicator
10/100		1191.11	N/A	PT1	Benchmark/Benchmark Dental/Core/Basic
excluding 10/100		1323.46	N/A	C30	Benchmark/Benchmark Dental/Core/Basic

Example 1

Example 2

In Example 2, the rate varies according to provider type and specialty.

- If the procedure or service is provided by a HealthCheck provider (72/000), the rate is $55.86.
- If the procedure or service is provided by a physician assistant (10/100), the rate is $51.77.
- If the procedure or service is provided by a nurse midwife (16/212), the rate is $51.77.
- If the procedure or service is provided by a nurse practitioner, physician, or institution for mental disease (09/000, 31/000, 33/000, 58/000), the rate is $57.53.
- If the procedure or service is provided by a Family Planning Clinic (71/000), the rate is $56.96.

Max Fee Details

Financial Payer	MEDICAID
Service Area	MEDICAL - MEDICAL SERVICES
Procedure Code	99394
Procedure Description	PREV VISIT EST AGE 12-17
Date of Service	08/26/2011
Benefit Group	Established Patient

All policy information is not listed in the max fee schedules. Please refer to the appropriate provider handbook for applicable policy for each procedure code.

Max Fee Rates

- This section displays the maximum allowable rate payable for the selected service area and procedure code.

Rendering Provider Type/Specialty	Modifiers	Rate	Age (Min/Max)	Rate Type	Benchmark/Core/Basic Indicator
72/000		55.86	N/A	PT1	Benchmark/Benchmark Dental/Core/Basic
10/100		51.77	N/A	PT2	Benchmark/Benchmark Dental/Core/Basic
16/212		51.77	N/A	OTH	Benchmark/Benchmark Dental/Core/Basic
09/000, 31/000, 33/000, 58/000		57.53	N/A	MED	Benchmark/Benchmark Dental/Core/Basic
71/000		56.96	N/A	FAP	Benchmark/Benchmark Dental/Core/Basic

Example 2

Example 3

In Example 3, the rate of $10.95 is payable to any provider listed in the billing rules.

Max Fee Rates

- This section displays the maximum allowable rate payable for the selected service area and procedure code.

Rendering Provider Type/Specialty	Modifiers	Rate	Age (Min/Max)	Rate Type	Benchmark/Core/Basic Indicator
		10.95	N/A	C11	Benchmark/Benchmark Dental/Core/Basic

Example 3

Example 4

In Example 4, the rate varies according to provider and modifier.

- Any provider with modifier UA present has a rate of $19.04.
- Any provider except a physician assistant has a rate of $40.01.
- A physician assistant has a rate of $36.01.

Max Fee Details

Financial Payer	MEDICAID
Service Area	MEDICAL - MEDICAL SERVICES
Procedure Code	99347
Procedure Description	HOME VISIT EST PATIENT
Date of Service	08/26/2011
Benefit Group	Established Patient

All policy information is not listed in the max fee schedules. Please refer to the appropriate provider handbook for applicable policy for each procedure code.

Max Fee Rates

- This section displays the maximum allowable rate payable for the selected service area and procedure code.

Rendering Provider Type/Specialty	Modifiers	Rate	Age (Min/Max)	Rate Type	Benchmark/Core/Basic Indicator
	UA is present	19.04	N/A	OTH	Benchmark/Benchmark Dental/Core/Basic
excluding 10/100		40.01	N/A	MED	Benchmark/Benchmark Dental/Core/Basic
10/100		36.01	N/A	PT1	Benchmark/Benchmark Dental/Core/Basic

Example 4

Example 5

In Example 5, the rate varies according to the age of the member.

- For N/A, the rate of $28.73 applies to any age.
- For 0-18, the rate of $45.90 applies to members 18 years of age and younger.
- For 19-999, the rate of $28.73 applies to members 19 years of age and older.

Note: Other age ranges include 0-1, 0-2, 19-26, blank (any age).

Max Fee Rates

- This section displays the maximum allowable rate payable for the selected service area and procedure code.

Rendering Provider Type/Specialty	Modifiers	Rate	Age (Min/Max)	Rate Type	Benchmark Indicator
71/080, 71/083		28.73	N/A	FAP	Benchmark and Benchmark Dental
71/080, 71/083	AQ, QB, QU one is present and TJ is present	45.90	0 - 18	FAP	Benchmark and Benchmark Dental
71/080, 71/083		28.73	19 - 999	FAP	Benchmark and Benchmark Dental

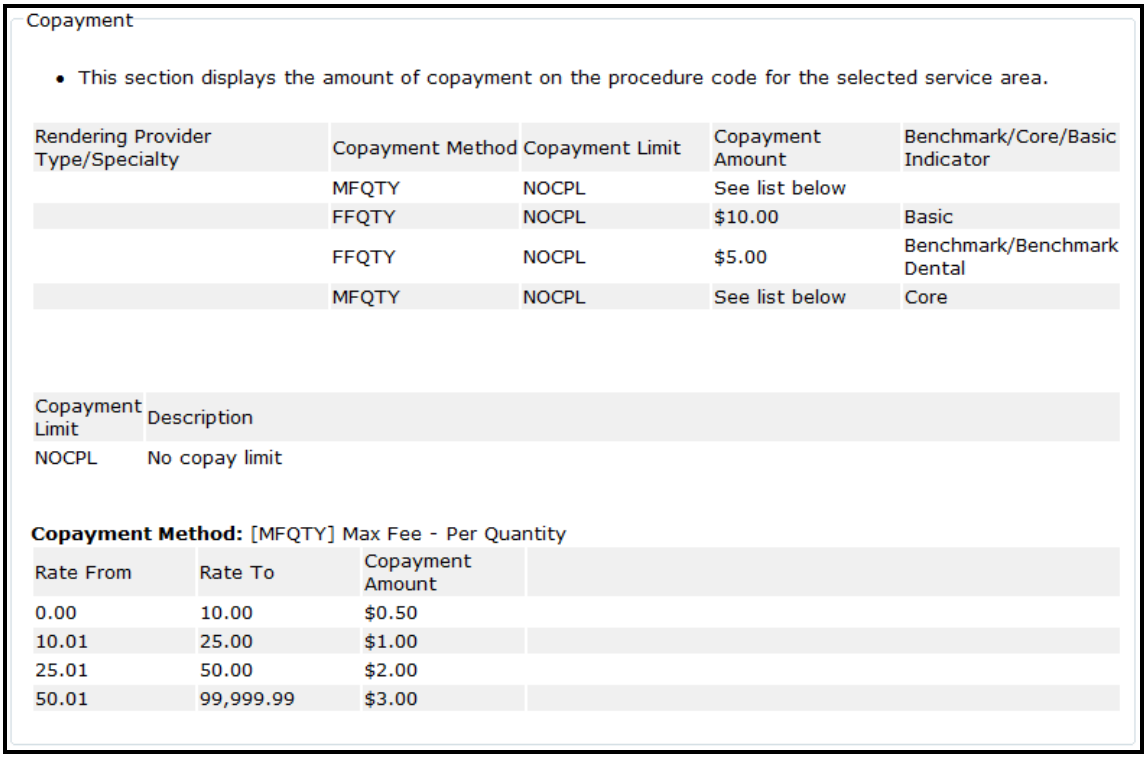
Example 5

Copayment

Note: The Copayment link is displayed only when a code within the DME service area is selected.

1. Click **Copayment** at the bottom of the Max Fee Details page.

   The "Copayment" section will be displayed. The "Copayment" section shows the amount of copayment for a procedure code.



Copayment

- This section displays the amount of copayment on the procedure code for the selected service area.

Rendering Provider Type/Specialty	Copayment Method	Copayment Limit	Copayment Amount	Benchmark/Core/Basic Indicator
	MFQTY	NOCPL	See list below	
	FFQTY	NOCPL	$10.00	Basic
	FFQTY	NOCPL	$5.00	Benchmark/Benchmark Dental
	MFQTY	NOCPL	See list below	Core

Copayment Limit	Description
NOCPL	No copay limit

Copayment Method: [MFQTY] Max Fee - Per Quantity

Rate From	Rate To	Copayment Amount
0.00	10.00	$0.50
10.01	25.00	$1.00
25.01	50.00	$2.00
50.01	99,999.99	$3.00

Copayment Section

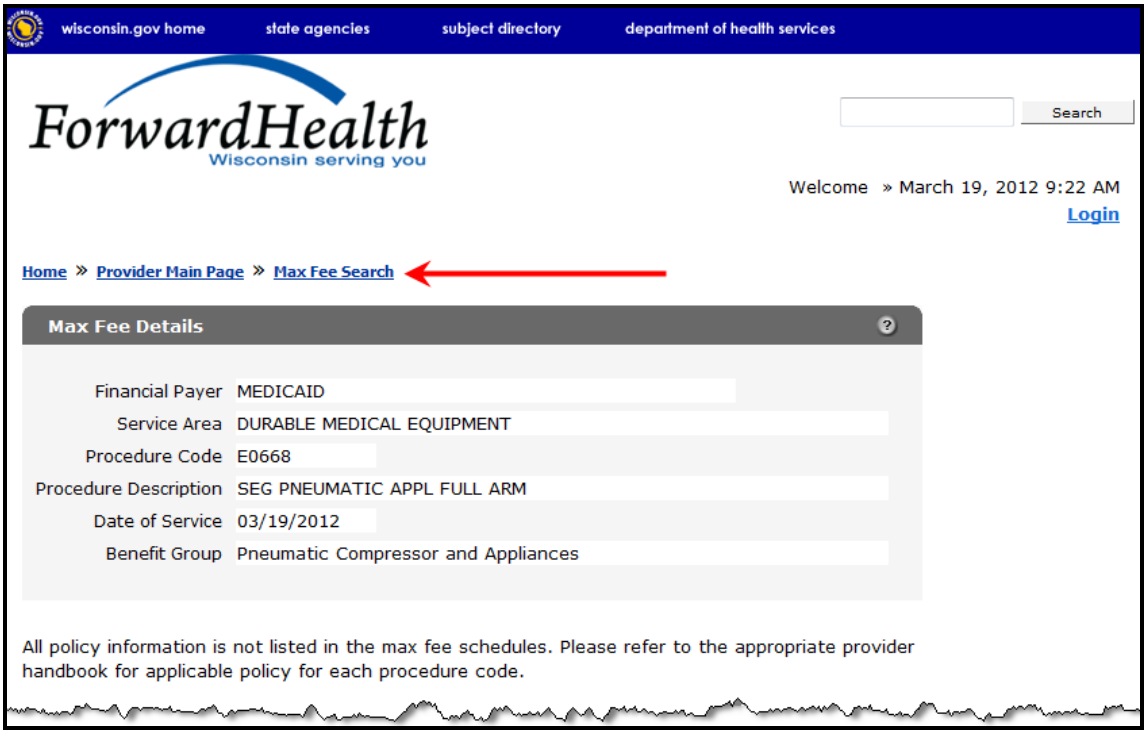
The following columns may be displayed in the "Copayment" section:

- The Copayment Method column indicates how the copayment amount is calculated.
  - MFQTY (Max Fee-Per Quantity) is the copayment amount to be collected from members enrolled in the Standard and Core Plans. The copayment amount is based on the amount billed for the procedure. The rate table is displayed at the bottom of the "Copayment" section.
  - FFQTY (Flat Fee-Per Quantity) is the copayment amount to be collected from members enrolled in the Benchmark, Benchmark Dental, and Basic Plans. The copayment amount is a flat fee, regardless of the amount billed for the procedure. For example, one copayment amount is $5.00.
- The Copayment Limit column displays information about any copayment limits related to the selected procedure code. For example, NOCPL indicates there are no copayment limits.
- The Copayment Amount column displays the amount of copayment required based on the information in the row.

- The Benchmark/Core/Basic Indicator column displays the enrollment plan associated with the information in the row.

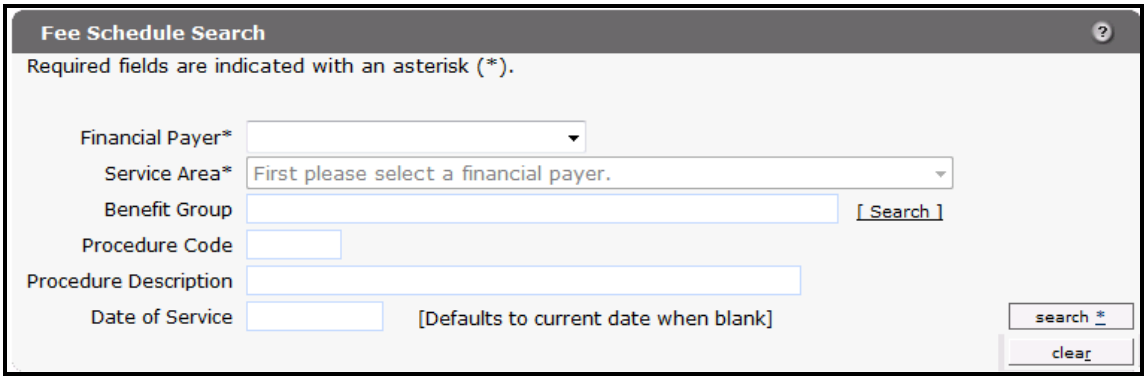
3.2.4 Additional Searches

1. Click **Max Fee Search** in the navigation menu at the top of the page.



Max Fee Search Link

The Fee Schedule Search page will be displayed.



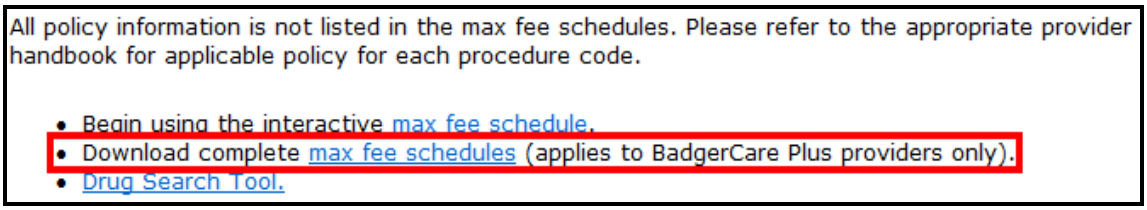
Fee Schedule Search Page

4 Downloadable Fee Schedules

The downloadable fee schedules are updated on the first of each month.

4.1 Accessing Downloadable Fee Schedules

1. Click **Download complete max fee schedules** on the Max Fee Schedules page.



Max Fee Schedules Page

The Downloadable Max Fee Schedules page will be displayed.

Downloadable Max Fee Schedules Page

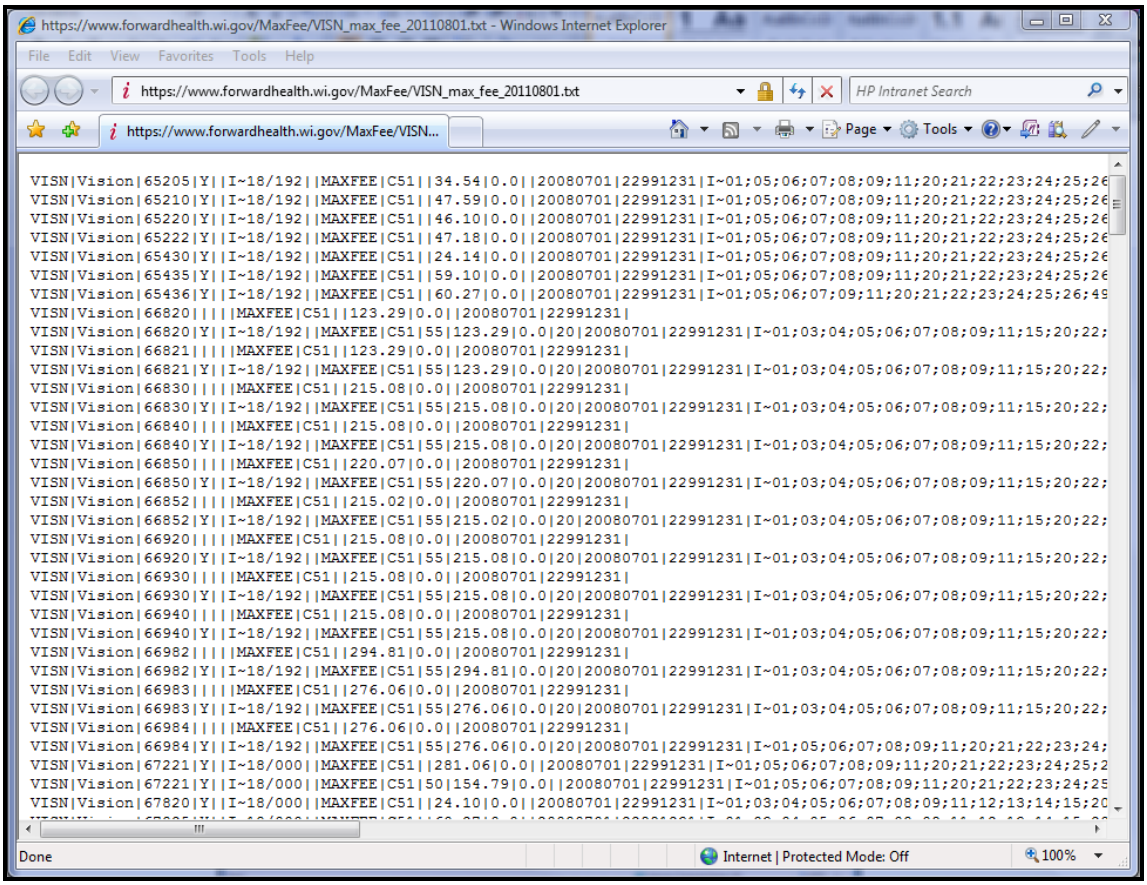
The Downloadable Max Fee Schedules page is divided into two sections. The top section displays links for service areas, and the bottom section displays links to the individual fee schedules within each service area. Some service areas only have one fee schedule, while others may have several.

2. Click a service area.

   The page will jump to the service area.

3. Click the applicable fee schedule.

   The fee schedule will be displayed in a new browser window.



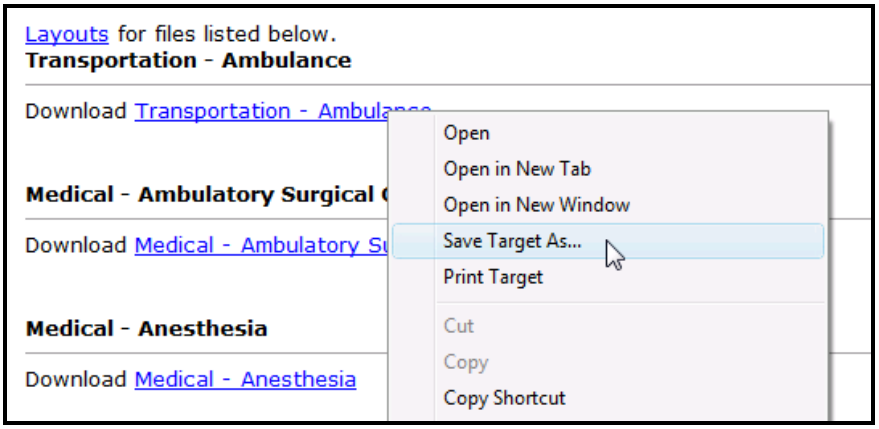
Downloadable Max Fee Schedule in a New Browser Window

The text files can be read in the browser window or downloaded and opened in a text program. For more information on reading the fee schedule text files, refer to *Section 4.2.4 Reading a Fee Schedule*.

4.2 Download a Fee Schedule

1. Right-click the link for the fee schedule you wish to view on the Downloadable Max Fee Schedules page.

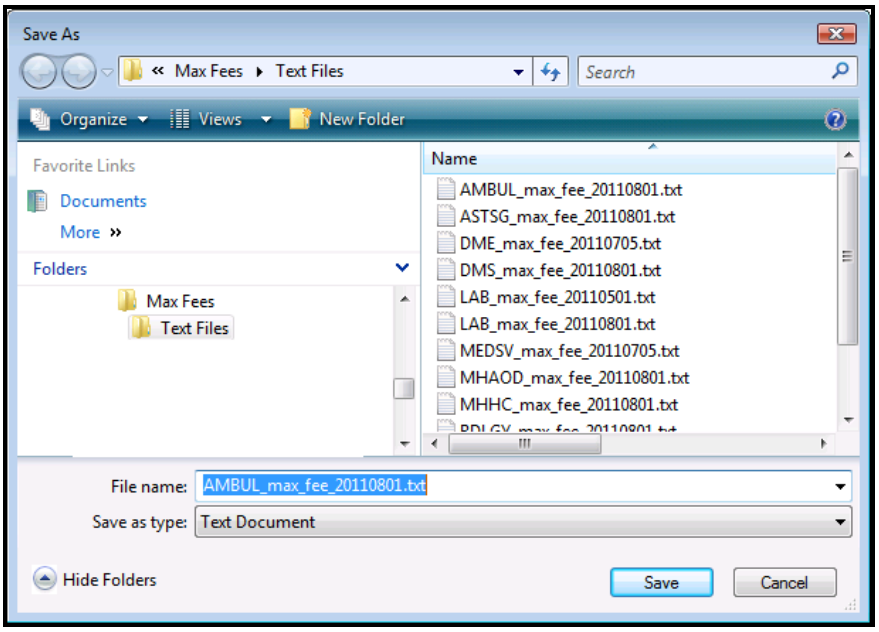
   A drop-down menu will be displayed.



Drop-down Menu

2. Select **Save Target As...**

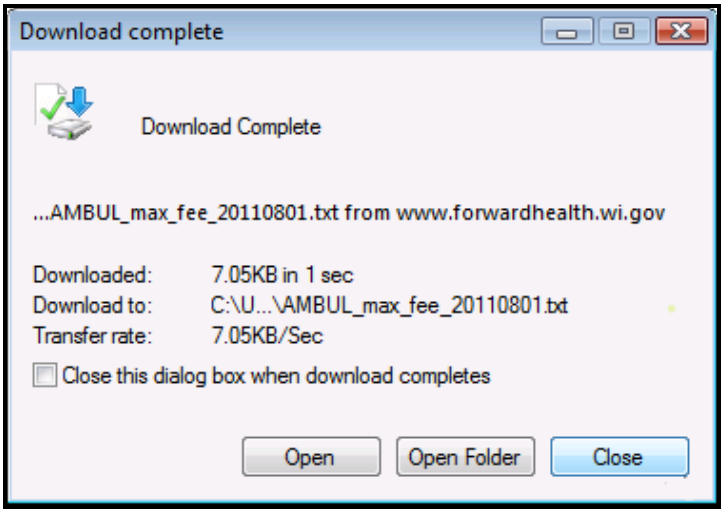
   The Save As window will be displayed.



Save As Window

3. Choose a location on your computer or network to save the file.
4. Click **Save**.

   Once the file is downloaded, the Download Complete window will be displayed.



Download Complete Window

5. Click **Open** to view the file in your computer's default program (usually Notepad).

   To open the file in another program, click **Close**.

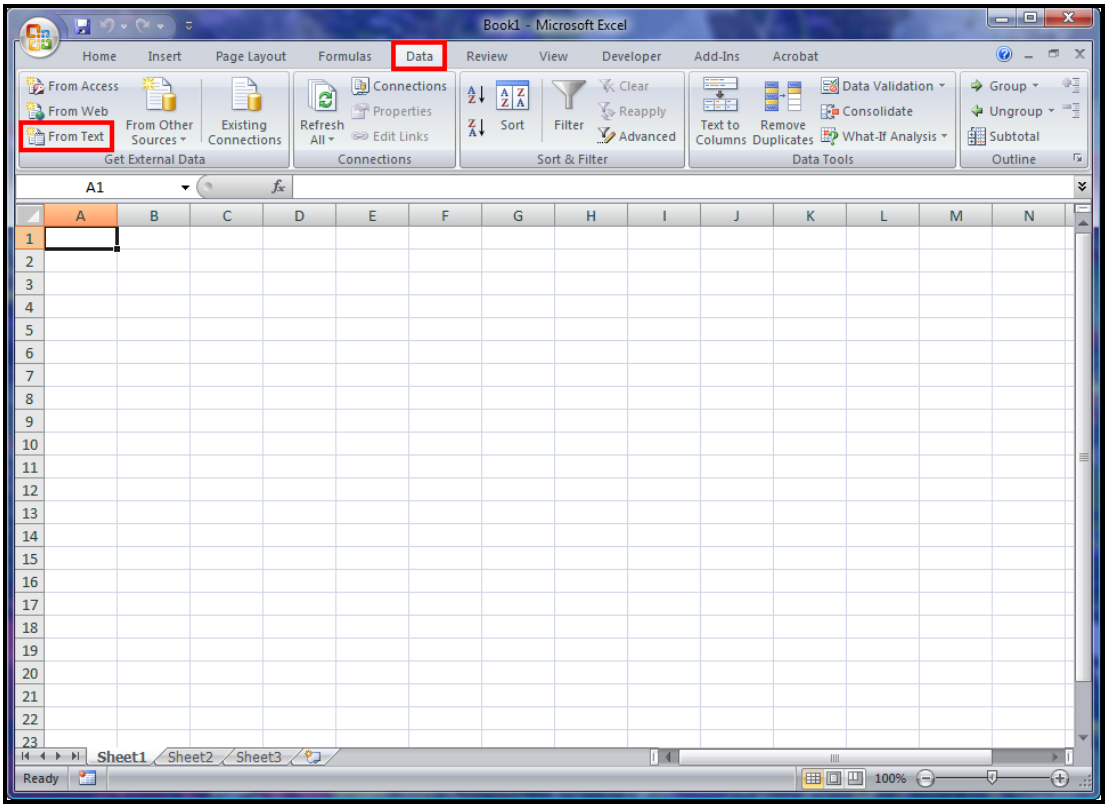
   In most cases, it is easier to view a fee schedule if it is imported into a spreadsheet.

4.2.1 Import to a Spreadsheet

Note: The examples in this user guide use Microsoft® Office Excel 2007. If you are using another program, consult the Help function of your specific program for instructions on how to import the file.

1. Open a blank spreadsheet.
2. Click **Data** in the menu bar at the top of the screen.

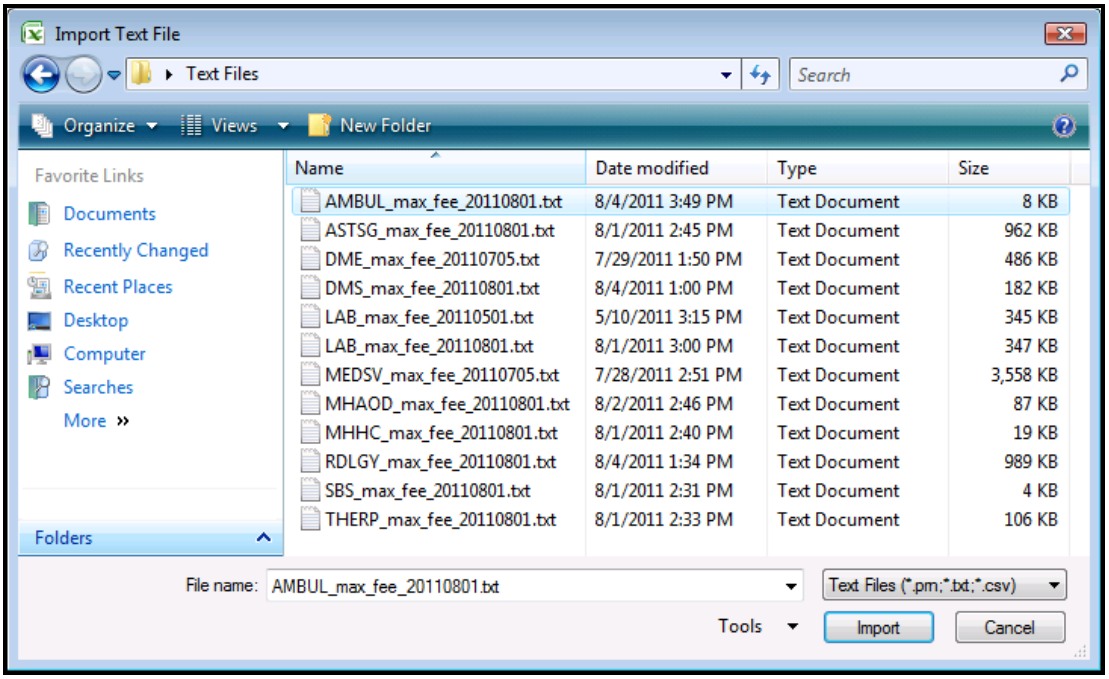
   The Data menu will be displayed.



Blank Spreadsheet

3. Click **From Text**, located on the left side of the Data menu.

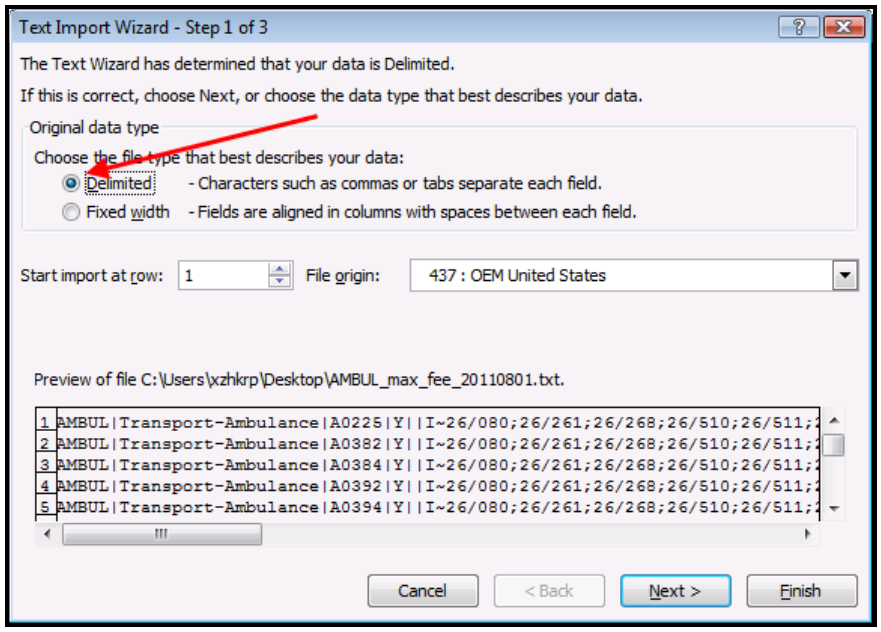
   The Import Text File window will open.



Import Text File Window

4. Navigate to the location where you saved the fee schedule file and select the file.
5. Click **Import**.

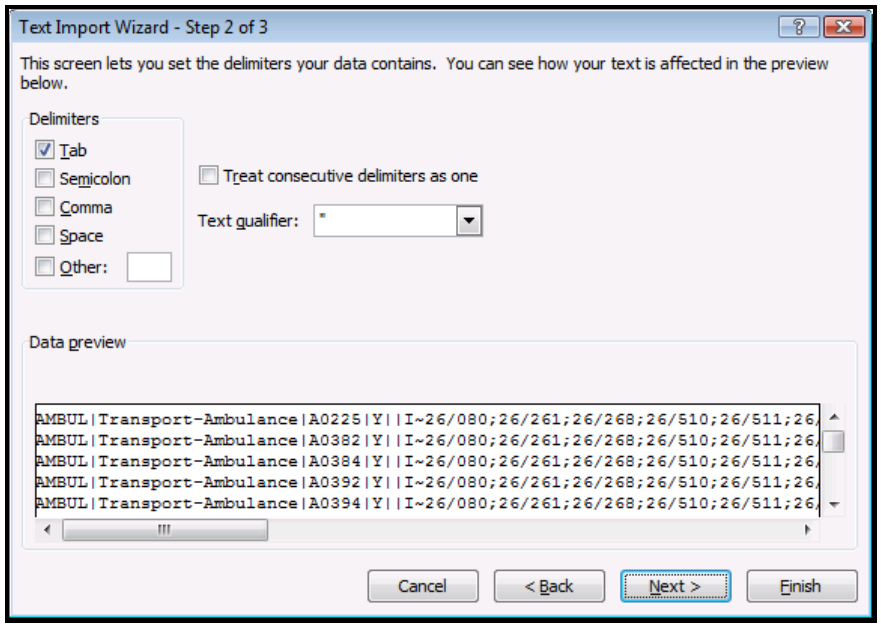
   The Text Import Wizard — Step 1 of 3 window will be displayed.



Text Import Wizard — Step 1 of 3 Window

6. Click **Delimited** in the "Original data type" section.
7. Click **Next**.

   The Text Import Wizard — Step 2 of 3 window will be displayed.

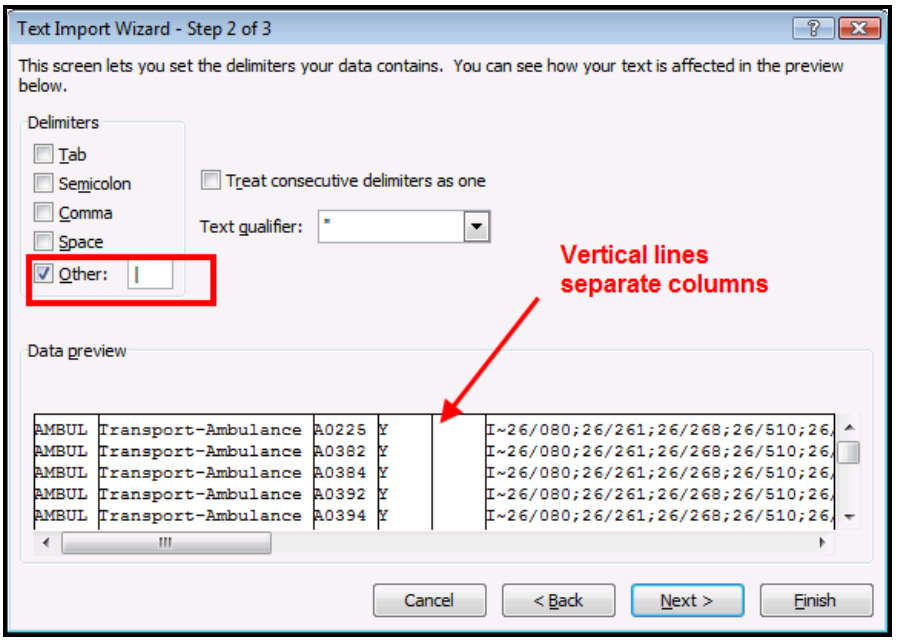


Text Import Wizard — Step 2 of 3 Window

8. Check the **Other** box.

9. Clear any additional boxes that are checked.
10. Type **|** in the free-form box next to Other. (For some computers, the keyboard shortcut for **|** is to hold down the Shift key and the backslash [\] key.)

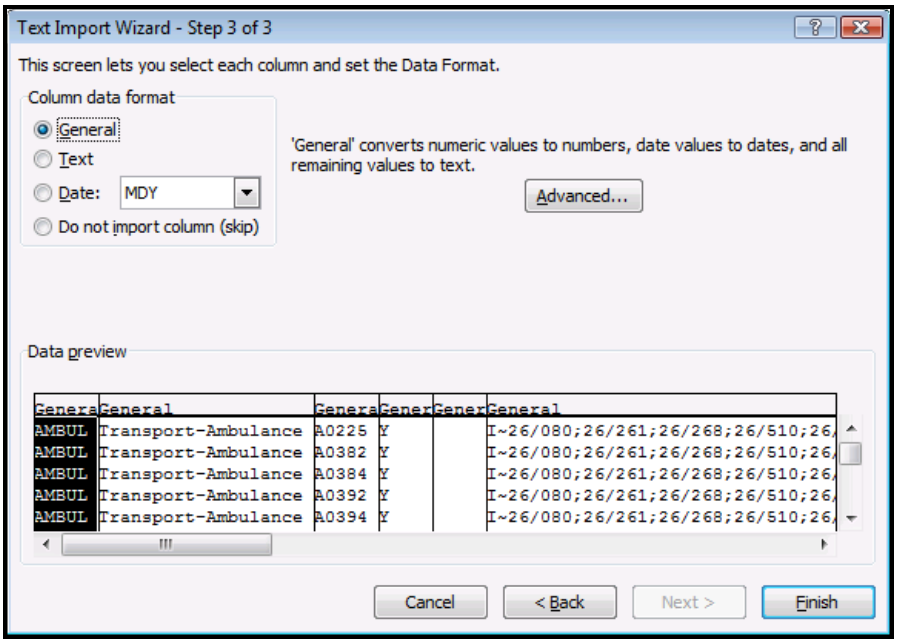
    The "Data preview" section will indicate where columns will be separated by vertical lines in the spreadsheet.



Data Preview Section

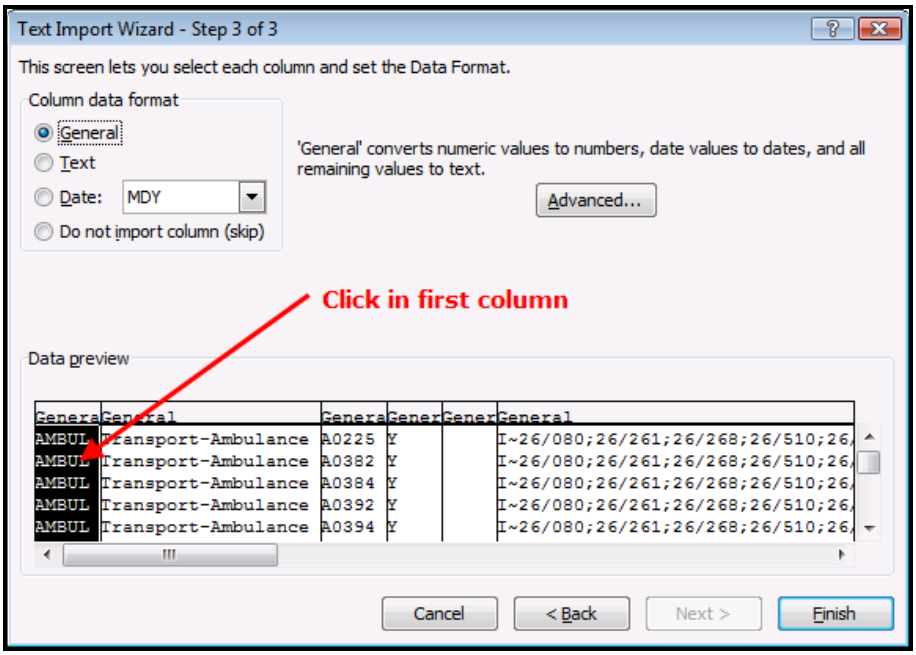
11. Click **Next**.

    The Text Import Wizard — Step 3 of 3 window will be displayed.



Text Import Wizard — Step 3 of 3 Window

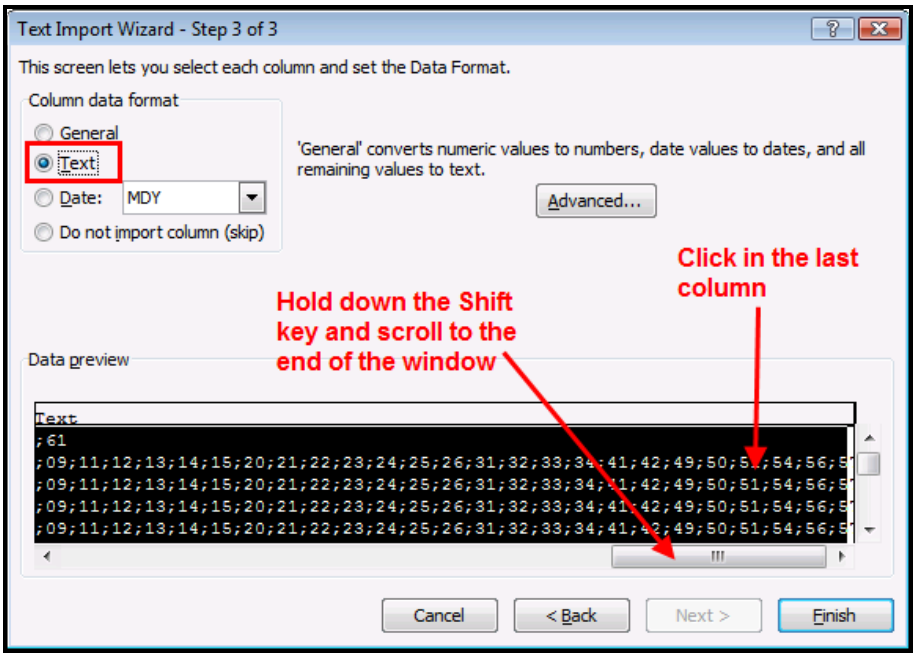
12. Click the first column in the “Data preview” section.



Text Import Wizard — Step 3 of 3 Window

13. Hold down the Shift key.
14. Scroll to the last column while holding down the Shift key.
15. Click the last column.

    All the columns should be selected (highlighted).

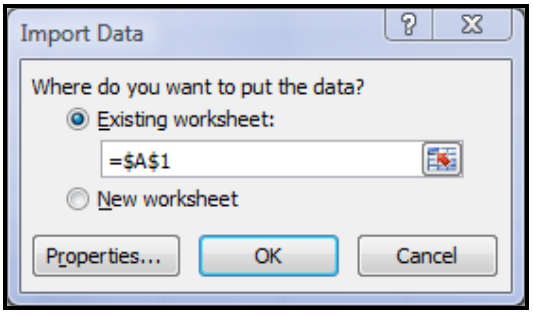


Text Import Wizard — Step 3 of 3 Window with All Columns Selected

16. Select **Text** in the “Column data format” section.

17. Click **Finish**.

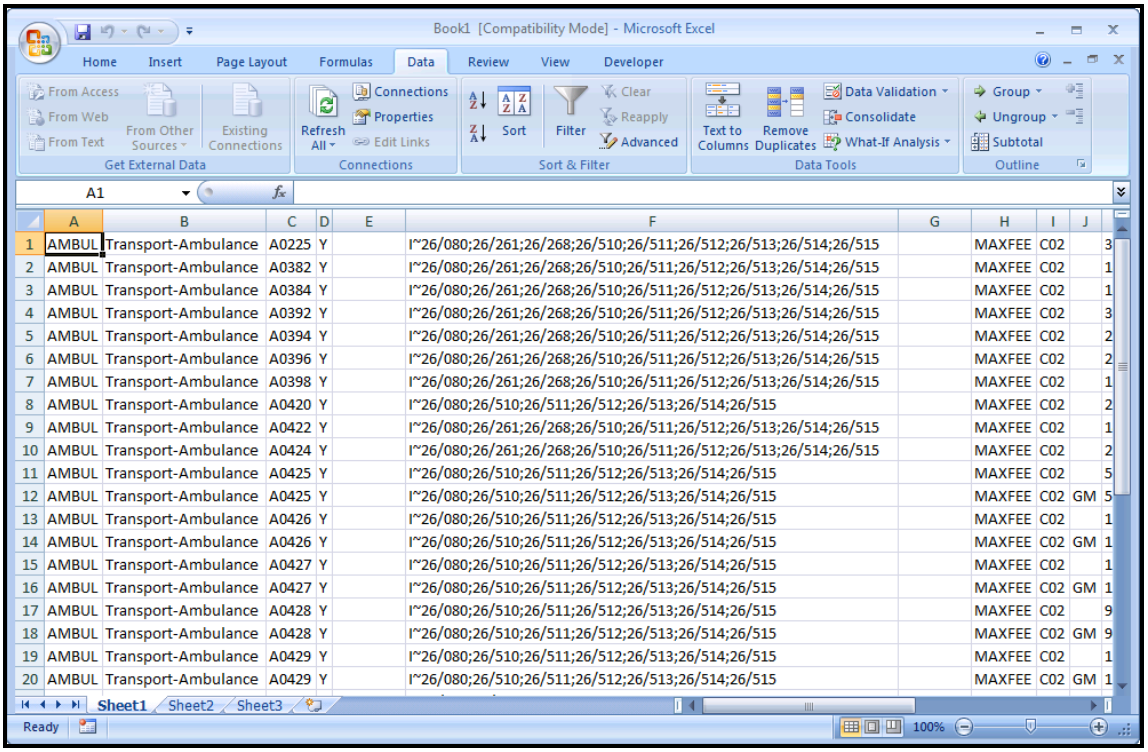
    The Import Data window will be displayed.



Import Data Window

18. Click **Existing worksheet** or **New worksheet**.
19. Click **OK**.

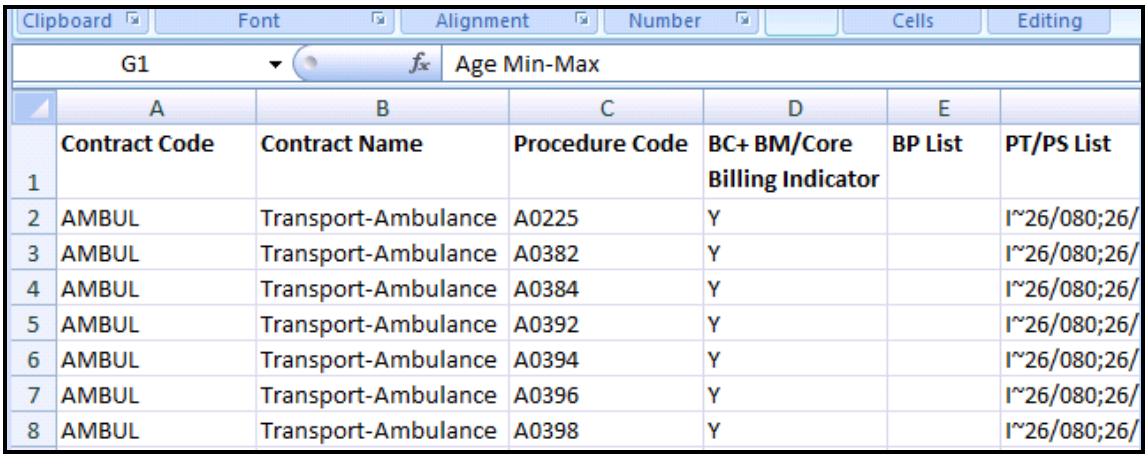
    The fee schedule data will be displayed in the chosen worksheet.



	A	B	C	D	E	F	G	H	I	J	
1	AMBUL	Transport-Ambulance	A0225	Y		I^26/080;26/261;26/268;26/510;26/511;26/512;26/513;26/514;26/515		MAXFEE	C02		3
2	AMBUL	Transport-Ambulance	A0382	Y		I^26/080;26/261;26/268;26/510;26/511;26/512;26/513;26/514;26/515		MAXFEE	C02		1
3	AMBUL	Transport-Ambulance	A0384	Y		I^26/080;26/261;26/268;26/510;26/511;26/512;26/513;26/514;26/515		MAXFEE	C02		1
4	AMBUL	Transport-Ambulance	A0392	Y		I^26/080;26/261;26/268;26/510;26/511;26/512;26/513;26/514;26/515		MAXFEE	C02		3
5	AMBUL	Transport-Ambulance	A0394	Y		I^26/080;26/261;26/268;26/510;26/511;26/512;26/513;26/514;26/515		MAXFEE	C02		2
6	AMBUL	Transport-Ambulance	A0396	Y		I^26/080;26/261;26/268;26/510;26/511;26/512;26/513;26/514;26/515		MAXFEE	C02		2
7	AMBUL	Transport-Ambulance	A0398	Y		I^26/080;26/261;26/268;26/510;26/511;26/512;26/513;26/514;26/515		MAXFEE	C02		1
8	AMBUL	Transport-Ambulance	A0420	Y		I^26/080;26/510;26/511;26/512;26/513;26/514;26/515		MAXFEE	C02		2
9	AMBUL	Transport-Ambulance	A0422	Y		I^26/080;26/261;26/268;26/510;26/511;26/512;26/513;26/514;26/515		MAXFEE	C02		1
10	AMBUL	Transport-Ambulance	A0424	Y		I^26/080;26/261;26/268;26/510;26/511;26/512;26/513;26/514;26/515		MAXFEE	C02		2
11	AMBUL	Transport-Ambulance	A0425	Y		I^26/080;26/510;26/511;26/512;26/513;26/514;26/515		MAXFEE	C02		5
12	AMBUL	Transport-Ambulance	A0425	Y		I^26/080;26/510;26/511;26/512;26/513;26/514;26/515		MAXFEE	C02	GM	5
13	AMBUL	Transport-Ambulance	A0426	Y		I^26/080;26/510;26/511;26/512;26/513;26/514;26/515		MAXFEE	C02		1
14	AMBUL	Transport-Ambulance	A0426	Y		I^26/080;26/510;26/511;26/512;26/513;26/514;26/515		MAXFEE	C02	GM	1
15	AMBUL	Transport-Ambulance	A0427	Y		I^26/080;26/510;26/511;26/512;26/513;26/514;26/515		MAXFEE	C02		1
16	AMBUL	Transport-Ambulance	A0427	Y		I^26/080;26/510;26/511;26/512;26/513;26/514;26/515		MAXFEE	C02	GM	1
17	AMBUL	Transport-Ambulance	A0428	Y		I^26/080;26/510;26/511;26/512;26/513;26/514;26/515		MAXFEE	C02		9
18	AMBUL	Transport-Ambulance	A0428	Y		I^26/080;26/510;26/511;26/512;26/513;26/514;26/515		MAXFEE	C02	GM	9
19	AMBUL	Transport-Ambulance	A0429	Y		I^26/080;26/510;26/511;26/512;26/513;26/514;26/515		MAXFEE	C02		1
20	AMBUL	Transport-Ambulance	A0429	Y		I^26/080;26/510;26/511;26/512;26/513;26/514;26/515		MAXFEE	C02	GM	1

Fee Schedule Data

20. To make the spreadsheet easier to read, you can insert a row at the top and add the column names from the list in *Section 4.2.3 Field Names*.



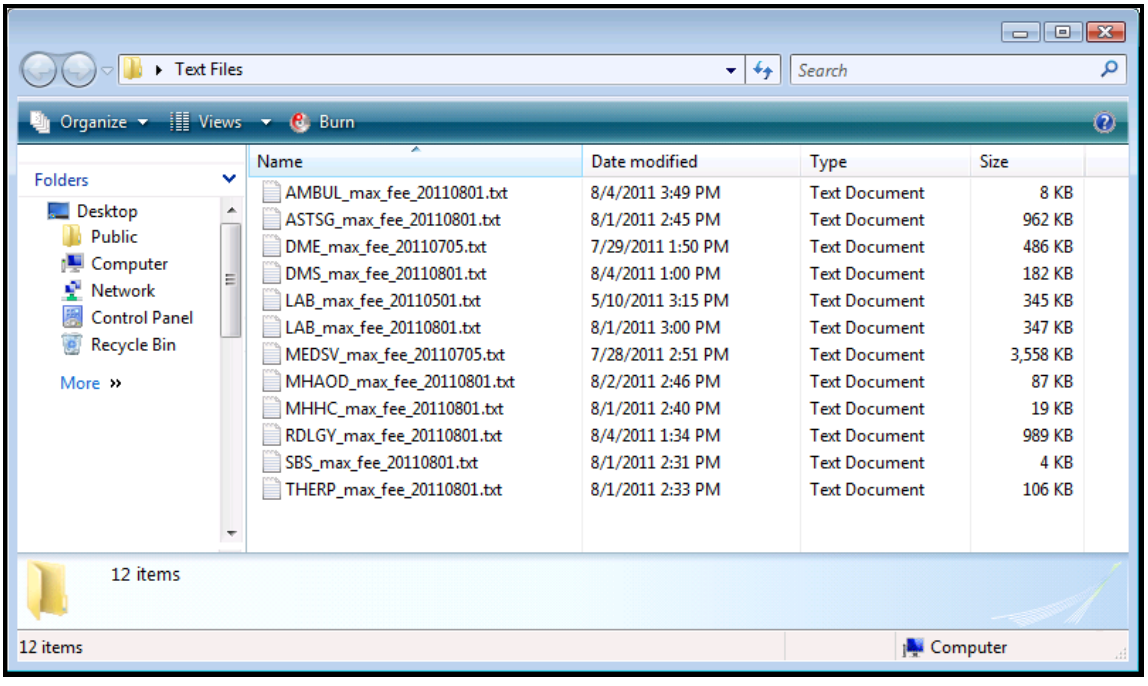
	A	B	C	D	E	
1	**Contract Code**	**Contract Name**	**Procedure Code**	**BC+ BM/Core Billing Indicator**	**BP List**	**PT/PS List**
2	AMBUL	Transport-Ambulance	A0225	Y		I~26/080;26/
3	AMBUL	Transport-Ambulance	A0382	Y		I~26/080;26/
4	AMBUL	Transport-Ambulance	A0384	Y		I~26/080;26/
5	AMBUL	Transport-Ambulance	A0392	Y		I~26/080;26/
6	AMBUL	Transport-Ambulance	A0394	Y		I~26/080;26/
7	AMBUL	Transport-Ambulance	A0396	Y		I~26/080;26/
8	AMBUL	Transport-Ambulance	A0398	Y		I~26/080;26/

Max Fee Schedule Data Spreadsheet with Added Column Names

4.2.2 Open in a Text Program

Note: If you choose to not open the text file in a spreadsheet, you may read the max fee schedule as a text file.

1. After downloading the text file to your computer or network drive, open the folder in which you saved the file.

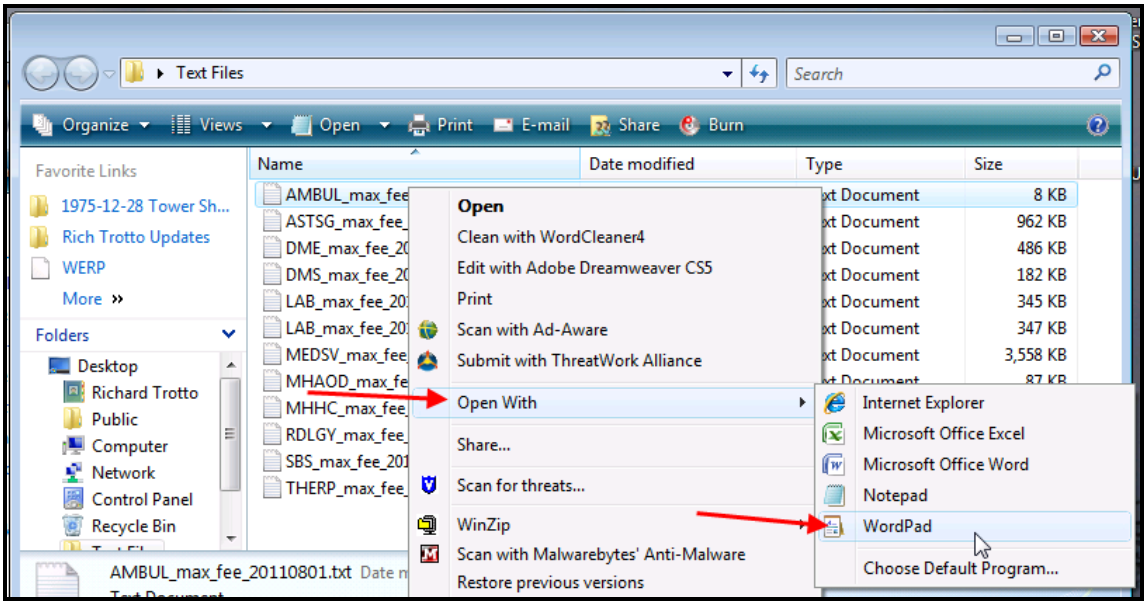


Downloaded Fee Schedule Files

You can open the file by double-clicking it; however, the data is best formatted using a text program such as WordPad.

2. Right-click the file you wish to open.

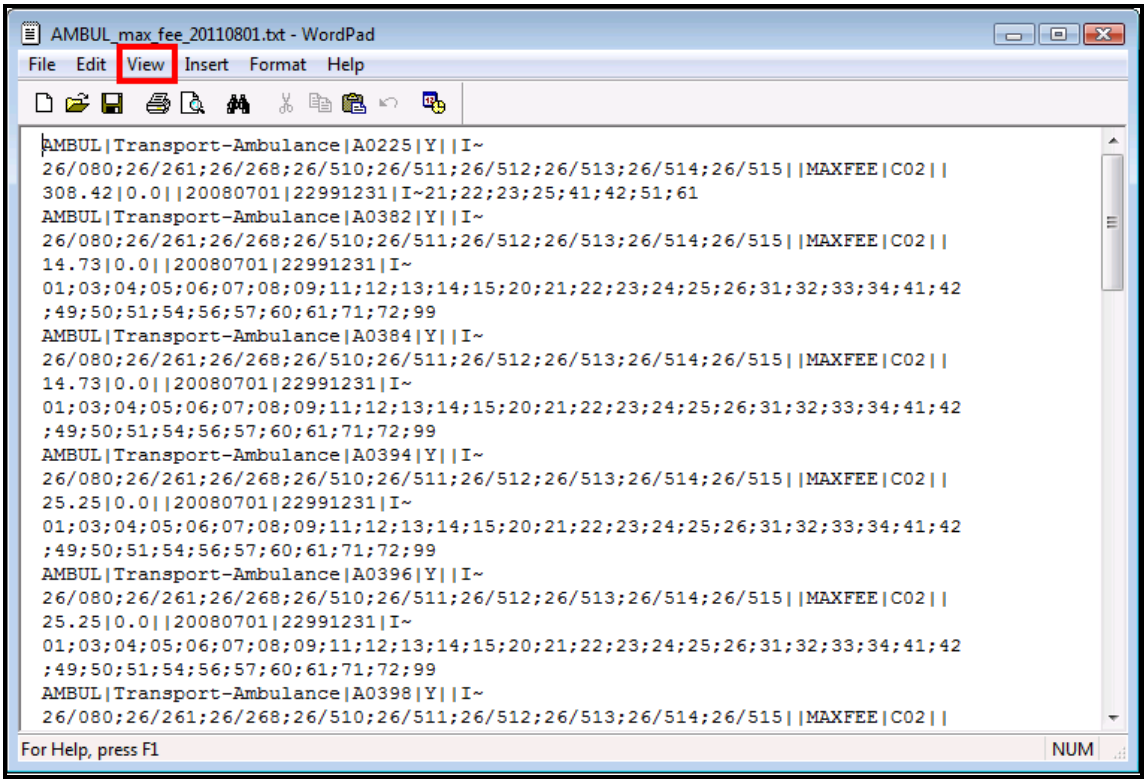
3. Select **WordPad** from the Open With menu.



Open With Menu

Note: If WordPad is not displayed in the Open With menu, click **Choose Default Program** and browse your programs for WordPad.

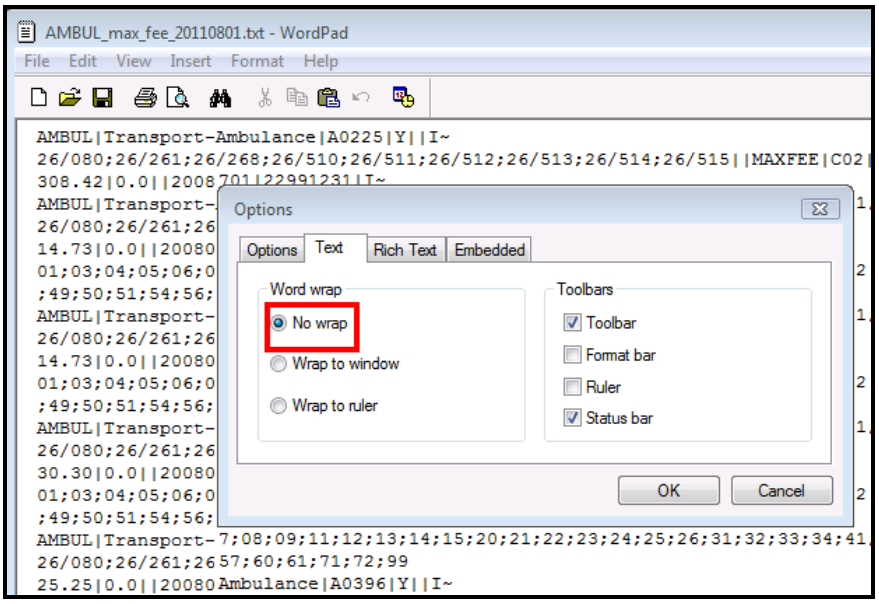
The text file will open in WordPad.



Wrapped Text File in WordPad

4. If the text is wrapped (refer to the example above), click **View** on the menu bar.
5. Select **Options**.

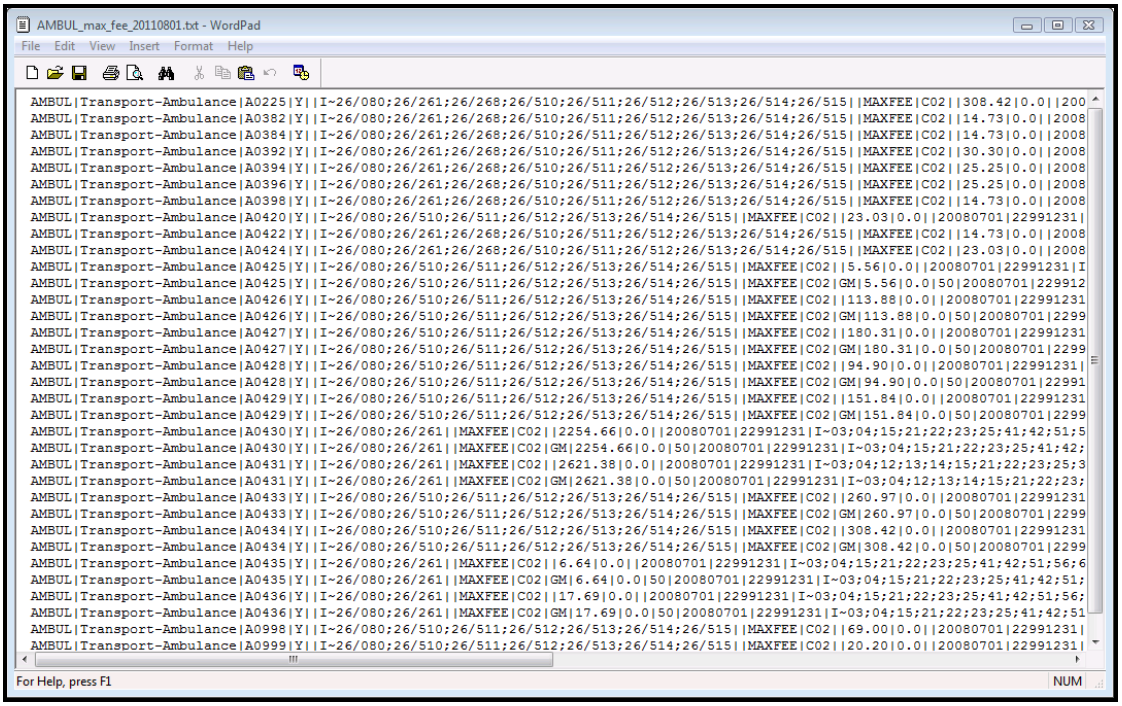
   The Options window will be displayed.



Options Window

6. Under the Text tab, select **No Wrap**.
7. Click **OK**.

   The data will realign and be easier to read.



Unwrapped Text File in WordPad

4.2.3 Field Names

The following table explains the fields in the fee schedule text files. The fields are the same for information displayed in a Web browser or text program. For more information about these fields, refer to *Section 5 Fee Schedule Text File Values and Descriptions*.

Field	Description
1. Contract Code	Code used to uniquely identify a provider contract.
2. Contract Name	Provider contract name.
3. Procedure Code	HCPCS or CPT procedure codes.
4. BC+ BM/Core Billing Indicator (BadgerCare Plus Benchmark/Core Billing Indicator)	Indicates whether the service is billable for the Benchmark Plan and/or the Core Plan. (*Note:* All codes displayed in the text files are billable for Medicaid.) N = Not a billable Benchmark Plan or Core Plan service. Y = Billable Benchmark Plan and Core Plan service. B = Billable Benchmark Plan service only. C = Billable Core Plan service only.
5. BP List (Benefit Plan List)	List of benefit plans that are included or excluded from the reimbursement record, if applicable. Examples: I~BCBP = Includes the Benchmark Plan. E~BCBP = Excludes the Benchmark Plan.
6. PT/PS List (Provider Type/ Provider Specialty List)	List of provider types (PT) and provider specialties (PS) that are applicable to, or excluded from, the reimbursement record. Examples: I~77/000 = Only Providers with PT 77, regardless of specialty. E~77/010 = Any provider except providers with PT 77 and PS 010.
7. Age Min-Max	Reimbursement age restrictions (minimum and maximum). Example: 19-999.
8. Pricing Indicator	Code that identifies the reimbursement/pricing methodology. Examples: ANESTH, MAXFEE, MAXOUT, or SYSMAN.
9. Rate Type	Code that identifies the type of rate.
10. Max Fee Modifiers	Modifier is displayed only if it directly impacts pricing. (Refer to *Section 5.1 Contract Codes and Names* for information on the use of other modifiers.)
11. Rate	Max fee rate for the procedure/service. Format is 9999999.99.
12. RVS Units	Applicable relative value unit. Format is 999.9. This field is only used for the ANESTH pricing method.
13. BAF Codes	Benefit Adjustment Factor (BAF) codes, if applicable.
14. Effective Date	First DOS that the rate is effective. Format is CCYYMMDD.
15. End Date	Last DOS that the rate is effective. Format is CCYYMMDD. Defaults to 22991231.
16. POS List (Place of Service List)	The location where a medical service is provided (e.g., clinic, hospital inpatient, hospital outpatient, nursing facility, home, clinic).

4.2.4 Reading a Fee Schedule

In the example below, the numbers in red above each column correspond to the numbers of the fields in the table in *Section 4.2.3 Field Names*.

When reading the text files, each blank space indicates that there is no information for the corresponding field. In the example below, the three blank spaces between fields 4 and 8 indicate that there is no corresponding restriction or adjustment to the rate indicated for the selected procedure for those fields. The blank fields indicate the following:

- Field 5 — This rate applies to any benefit plan.
- Field 6 — This rate applies to any provider type or specialty.
- Field 7 — This rate applies to any patient age.

```
1    | 2                |3   |4|||| 8    | 9 |10| 11  ||| 14     | 15
MHAOD|Mntl Hlth-MH/AODA|H0022|Y||||MAXFEE|C32|HN|31.96|||20040101|22991231
MHAOD|Mntl Hlth-MH/AODA|H0022|Y||||MAXFEE|C32|HO|55.00|||20040101|22991231
MHAOD|Mntl Hlth-MH/AODA|H0022|Y||||MAXFEE|C32|HP|65.00|||20040101|22991231
MHAOD|Mntl Hlth-MH/AODA|H0022|Y||||MAXFEE|C32|UA|80.13|||20040101|22991231
MHAOD|Mntl Hlth-MH/AODA|H0022|Y||||MAXFEE|C32|UB|31.96|||20040101|22991231
```

Example Text File in WordPad

4.3 Portable Document Format Downloads

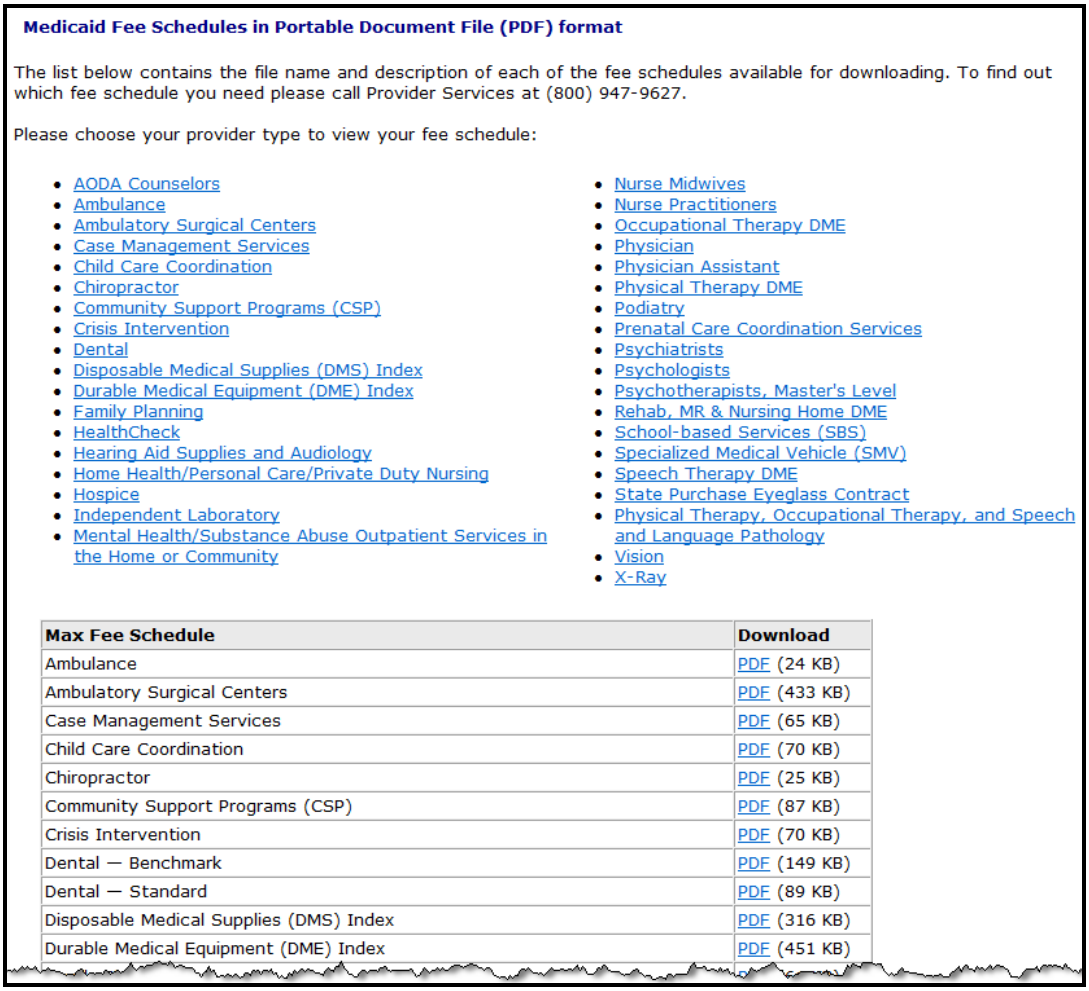
A link to PDF versions of the fee schedules is available on the Downloadable Max Fee Schedules page; however, *these schedules have not been updated since the implementation of ForwardHealth*. The PDF reports are only intended to help users transition to the interactive schedules or the text files.

To access PDF versions of the fee schedules, complete the following steps:

1. On the Downloadable Max Fee Schedules page, click **To view PDF-style reports of the Max Fees**.

Downloadable Max Fee Schedules Page

The Medicaid Fee Schedules in Portable Document File (PDF) format page will be displayed.



Medicaid Fee Schedules in Portable Document File (PDF) format

The list below contains the file name and description of each of the fee schedules available for downloading. To find out which fee schedule you need please call Provider Services at (800) 947-9627.

Please choose your provider type to view your fee schedule:

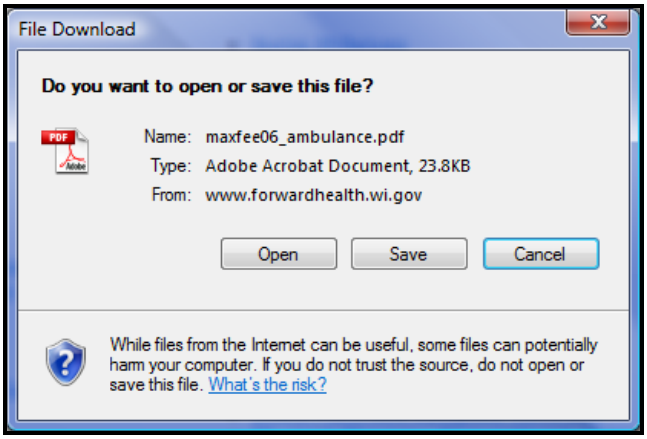
- AODA Counselors
- Ambulance
- Ambulatory Surgical Centers
- Case Management Services
- Child Care Coordination
- Chiropractor
- Community Support Programs (CSP)
- Crisis Intervention
- Dental
- Disposable Medical Supplies (DMS) Index
- Durable Medical Equipment (DME) Index
- Family Planning
- HealthCheck
- Hearing Aid Supplies and Audiology
- Home Health/Personal Care/Private Duty Nursing
- Hospice
- Independent Laboratory
- Mental Health/Substance Abuse Outpatient Services in the Home or Community
- Nurse Midwives
- Nurse Practitioners
- Occupational Therapy DME
- Physician
- Physician Assistant
- Physical Therapy DME
- Podiatry
- Prenatal Care Coordination Services
- Psychiatrists
- Psychologists
- Psychotherapists, Master's Level
- Rehab, MR & Nursing Home DME
- School-based Services (SBS)
- Specialized Medical Vehicle (SMV)
- Speech Therapy DME
- State Purchase Eyeglass Contract
- Physical Therapy, Occupational Therapy, and Speech and Language Pathology
- Vision
- X-Ray

Max Fee Schedule	Download
Ambulance	PDF (24 KB)
Ambulatory Surgical Centers	PDF (433 KB)
Case Management Services	PDF (65 KB)
Child Care Coordination	PDF (70 KB)
Chiropractor	PDF (25 KB)
Community Support Programs (CSP)	PDF (87 KB)
Crisis Intervention	PDF (70 KB)
Dental — Benchmark	PDF (149 KB)
Dental — Standard	PDF (89 KB)
Disposable Medical Supplies (DMS) Index	PDF (316 KB)
Durable Medical Equipment (DME) Index	PDF (451 KB)

Medicaid Fee Schedules in Portable Document File (PDF) Format Page

2. Click a link at the top of the page to jump to the selected provider type in the Max Fee Schedule table or scroll to the applicable provider type.
3. Click **PDF** in the Download column.

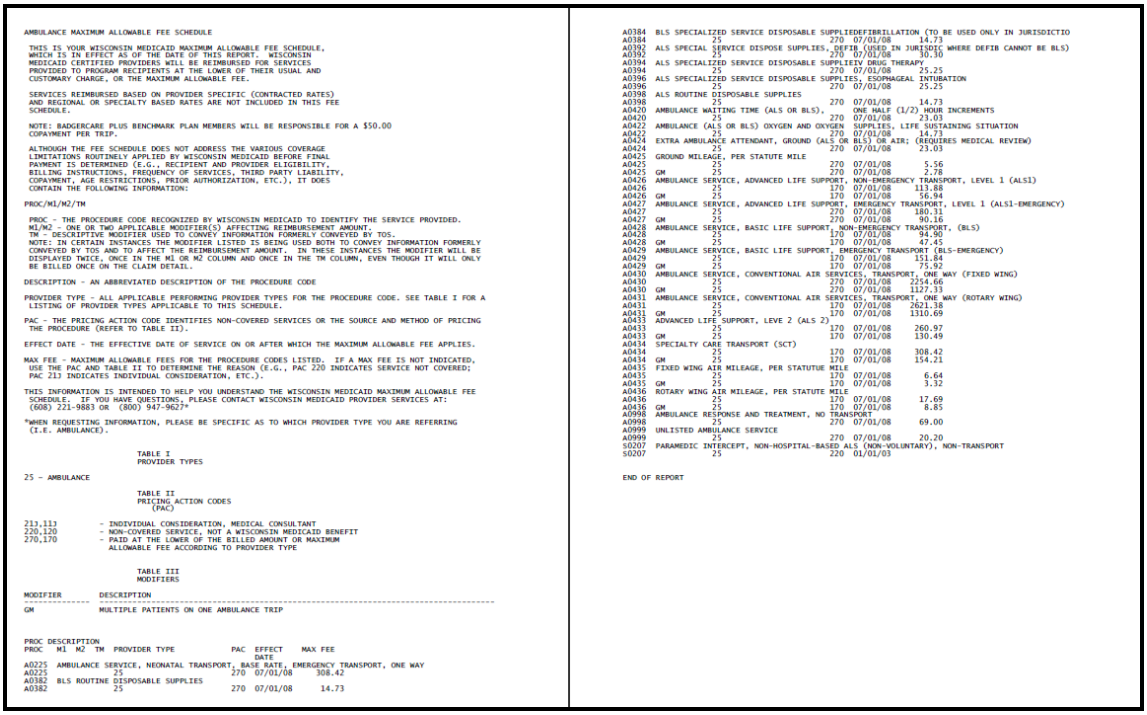
   The File Download window will be displayed.



File Download Window

4. Click **Open**.

   A PDF version of the max fee schedule will open in a new browser window.



AMBULANCE MAXIMUM ALLOWABLE FEE SCHEDULE

THIS IS YOUR WISCONSIN MEDICAID MAXIMUM ALLOWABLE FEE SCHEDULE, WHICH IS IN EFFECT AS OF THE DATE OF THIS REPORT. WISCONSIN MEDICAID CERTIFIED PROVIDERS WILL BE REIMBURSED FOR SERVICES PROVIDED TO PROGRAM RECIPIENTS AT THE LOWER OF THEIR USUAL AND CUSTOMARY CHARGE, OR THE MAXIMUM ALLOWABLE FEE.

SERVICES REIMBURSED BASED ON PROVIDER SPECIFIC (CONTRACTED RATES) AND REGIONAL OR SPECIALTY BASED RATES ARE NOT INCLUDED IN THIS FEE SCHEDULE.

NOTE: BADGERCARE PLUS BENCHMARK PLAN MEMBERS WILL BE RESPONSIBLE FOR A $50.00 COPAYMENT PER TRIP.

ALTHOUGH THE FEE SCHEDULE DOES NOT ADDRESS THE VARIOUS COVERAGE LIMITATIONS ROUTINELY APPLIED BY WISCONSIN MEDICAID BEFORE FINAL PAYMENT IS DETERMINED (E.G., RECIPIENT AND PROVIDER ELIGIBILITY, BILLING INSTRUCTIONS, FREQUENCY OF SERVICES, THIRD PARTY LIABILITY, COPAYMENT, AGE RESTRICTIONS, PRIOR AUTHORIZATION, ETC.), IT DOES CONTAIN THE FOLLOWING INFORMATION:

PROC/M1/M2/TM

PROC - THE PROCEDURE CODE RECOGNIZED BY WISCONSIN MEDICAID TO IDENTIFY THE SERVICE PROVIDED.
M1/M2 - ONE OR TWO APPLICABLE MODIFIER(S) AFFECTING REIMBURSEMENT AMOUNT.
TM - DESCRIPTIVE MODIFIER USED TO CONVEY INFORMATION FORMERLY CONVEYED BY TOS.
NOTE: IN CERTAIN INSTANCES THE MODIFIER LISTED IS BEING USED BOTH TO CONVEY INFORMATION FORMERLY CONVEYED BY TOS AND TO AFFECT THE REIMBURSEMENT AMOUNT. IN THESE INSTANCES THE MODIFIER WILL BE DISPLAYED TWICE, ONCE IN THE M1 OR M2 COLUMN AND ONCE IN THE TM COLUMN, EVEN THOUGH IT WILL ONLY BE BILLED ONCE ON THE CLAIM DETAIL.

DESCRIPTION - AN ABBREVIATED DESCRIPTION OF THE PROCEDURE CODE

PROVIDER TYPE - ALL APPLICABLE PERFORMING PROVIDER TYPES FOR THE PROCEDURE CODE. SEE TABLE I FOR A LISTING OF PROVIDER TYPES APPLICABLE TO THIS SCHEDULE.

PAC - THE PRICING ACTION CODE IDENTIFIES NON-COVERED SERVICES OR THE SOURCE AND METHOD OF PRICING THE PROCEDURE (REFER TO TABLE II).

EFFECT DATE - THE EFFECTIVE DATE OF SERVICE ON OR AFTER WHICH THE MAXIMUM ALLOWABLE FEE APPLIES.

MAX FEE - MAXIMUM ALLOWABLE FEES FOR THE PROCEDURE CODES LISTED. IF A MAX FEE IS NOT INDICATED, USE THE PAC AND TABLE II TO DETERMINE THE REASON (E.G., PAC 220 INDICATES SERVICE NOT COVERED; PAC 213 INDICATES INDIVIDUAL CONSIDERATION, ETC.).

THIS INFORMATION IS INTENDED TO HELP YOU UNDERSTAND THE WISCONSIN MEDICAID MAXIMUM ALLOWABLE FEE SCHEDULE. IF YOU HAVE QUESTIONS, PLEASE CONTACT WISCONSIN MEDICAID PROVIDER SERVICES AT: (608) 221-9883 OR (800) 947-9627*

*WHEN REQUESTING INFORMATION, PLEASE BE SPECIFIC AS TO WHICH PROVIDER TYPE YOU ARE REFERRING (I.E. AMBULANCE).

TABLE I
PROVIDER TYPES

25 - AMBULANCE

TABLE II
PRICING ACTION CODES
(PAC)

213,113 - INDIVIDUAL CONSIDERATION, MEDICAL CONSULTANT
220,120 - NON-COVERED SERVICE, NOT A WISCONSIN MEDICAID BENEFIT
270,170 - PAID AT THE LOWER OF THE BILLED AMOUNT OR MAXIMUM ALLOWABLE FEE ACCORDING TO PROVIDER TYPE

TABLE III
MODIFIERS

MODIFIER	DESCRIPTION
GM	MULTIPLE PATIENTS ON ONE AMBULANCE TRIP

PROC	DESCRIPTION	M1	M2	TM	PROVIDER TYPE	PAC	EFFECT DATE	MAX FEE
A0225	AMBULANCE SERVICE, NEONATAL TRANSPORT, BASE RATE, EMERGENCY TRANSPORT, ONE WAY				25	270	07/01/08	308.42
A0382	BLS ROUTINE DISPOSABLE SUPPLIES				25	270	07/01/08	14.73
A0384	BLS SPECIALIZED SERVICE DISPOSABLE SUPPLIEDEFIBRILLATION (TO BE USED ONLY IN JURISDICTIO				25	270	07/01/08	14.73
A0392	ALS SPECIAL SERVICE DISPOSE SUPPLIES, DEFIB (USED IN JURISDIC WHERE DEFIB CANNOT BE BLS)				25	270	07/01/08	30.30
A0394	ALS SPECIALIZED SERVICE DISPOSABLE SUPPLIEIV DRUG THERAPY				25	270	07/01/08	25.25
A0396	ALS SPECIALIZED SERVICE DISPOSABLE SUPPLIES, ESOPHAGEAL INTUBATION				25	270	07/01/08	25.25
A0398	ALS ROUTINE DISPOSABLE SUPPLIES				25	270	07/01/08	14.73
A0420	AMBULANCE WAITING TIME (ALS OR BLS),				25	270	07/01/08	ONE HALF (1/2) HOUR INCREMENTS 23.03
A0422	AMBULANCE (ALS OR BLS) OXYGEN AND OXYGEN SUPPLIES, LIFE SUSTAINING SITUATION				25	270	07/01/08	14.73
A0424	EXTRA AMBULANCE ATTENDANT, GROUND (ALS OR BLS) OR AIR; (REQUIRES MEDICAL REVIEW)				25	270	07/01/08	23.03
A0425	GROUND MILEAGE, PER STATUTE MILE				25	270	07/01/08	5.56
A0425	GM				25	270	07/01/08	2.78
A0426	AMBULANCE SERVICE, ADVANCED LIFE SUPPORT, NON-EMERGENCY TRANSPORT, LEVEL 1 (ALS1)				25	170	07/01/08	113.88
A0426	GM				25	170	07/01/08	56.94
A0427	AMBULANCE SERVICE, ADVANCED LIFE SUPPORT, EMERGENCY TRANSPORT, LEVEL 1 (ALS1-EMERGENCY)				25	270	07/01/08	180.31
A0427	GM				25	270	07/01/08	90.16
A0428	AMBULANCE SERVICE, BASIC LIFE SUPPORT, NON-EMERGENCY TRANSPORT, (BLS)				25	170	07/01/08	94.90
A0428	GM				25	170	07/01/08	47.45
A0429	AMBULANCE SERVICE, BASIC LIFE SUPPORT, EMERGENCY TRANSPORT (BLS-EMERGENCY)				25	170	07/01/08	151.84
A0429	GM				25	170	07/01/08	75.92
A0430	AMBULANCE SERVICE, CONVENTIONAL AIR SERVICES, TRANSPORT, ONE WAY (FIXED WING)				25	270	07/01/08	2254.66
A0430	GM				25	270	07/01/08	1127.33
A0431	AMBULANCE SERVICE, CONVENTIONAL AIR SERVICES, TRANSPORT, ONE WAY (ROTARY WING)				25	170	07/01/08	2621.38
A0431	GM				25	170	07/01/08	1310.69
A0433	ADVANCED LIFE SUPPORT, LEVE 2 (ALS 2)				25	170	07/01/08	260.97
A0433	GM				25	170	07/01/08	130.49
A0434	SPECIALTY CARE TRANSPORT (SCT)				25	170	07/01/08	308.42
A0434	GM				25	170	07/01/08	154.21
A0435	FIXED WING AIR MILEAGE, PER STATUTE MILE				25	170	07/01/08	6.64
A0435	GM				25	170	07/01/08	3.32
A0436	ROTARY WING AIR MILEAGE, PER STATUTE MILE				25	170	07/01/08	17.69
A0436	GM				25	170	07/01/08	8.85
A0998	AMBULANCE RESPONSE AND TREATMENT, NO TRANSPORT				25	270	07/01/08	69.00
A0999	UNLISTED AMBULANCE SERVICE				25	270	07/01/08	20.20
S0207	PARAMEDIC INTERCEPT, NON-HOSPITAL-BASED ALS (NON-VOLUNTARY), NON-TRANSPORT				25	220	01/01/03	

END OF REPORT

PDF Version of a Max Fee Schedule

The beginning of each PDF explains how to read the report.

5 Fee Schedule Text File Values and Descriptions

This section describes some of the fields in the fee schedule text files and outlines criteria for finding the current maximum fee reimbursement rates. As there are often exceptions to these rules, users should refer to the applicable service area in the *Online Handbook* for specific billing information.

5.1 Contract Codes and Names

The contract codes and names identify the policy area for the displayed record. When a procedure code is present in multiple contracts, the rate data will differ depending on the contract code. When applicable, contract-specific criteria may help determine what contract rate to use.

Note: Not all contract codes are listed.

Provider Contract Code	Contract Name	Contract Criteria		
		PT/PS per Provider Contract Code Applicable as Credentialed if Not Listed	Specific Rate Type or Modifier-Rate Type Combinations Used in Contract*	
PNCCC	Prenatal Child Care Coordination	21/000, 61/000		C43
CSMGT	Case Management	21/000		C09
HOSPC	Hospice	06/000		005-096 and RWI – rates by county
DTAOD	Day Treatment for Alcohol and Other Drug Addiction		HF	C13
DTCHD	Day Treatment for Children		HA	C14
DTMED	Day Treatment Medical		HE	Provider specific rates
DENTL	Dental Services	27/000		C10
HCCM	HealthCheck — Case Management		EP	C17
HCPCC	HealthCheck Other — Pediatric Community Care		59	C19
HCRCC	HealthCheck Other — Residential Care Centers			Provider specific rates

Provider Contract Code	Contract Name	Contract Criteria		
		PT/PS per Provider Contract Code Applicable as Credentialed if Not Listed	Specific Rate Type or Modifier-Rate Type Combinations Used in Contract*	
AUDHA	Hearing Services — Hearing Aid and Audiology			C05
			RR	RNT
HHPC	Home Care — Home Health and Personal Care			C22
		16/000		HPC
HCRS	Home Care — Respiratory Care Services			C21
ANSTH	Medical — Anesthesia		AA, AD, QK, QS, QX, QY, QZ	C03
MEDSV	Medical — Medical Services			C30 (Global surgical codes)
			TC	TEC
			26	PRO
				MED (non-surgical codes)
		10/000		CG1
			TC	TE1
			26	PR1
		71/000		FAP
				GFP
			26	PFP
		72/000		HLK

Provider Contract Code	Contract Name	Contract Criteria		
		PT/PS per Provider Contract Code Applicable as Credentialed if Not Listed	Specific Rate Type or Modifier-Rate Type Combinations Used in Contract*	
ASTSG	Medical — Assistant Surgery		80, 81, 82	C04
		71/000	80, 81, 82	FAP
AMBSR	Medical — Ambulatory Surgical Center	02/000		C01
RDLGY	Medical — Radiology			C44
			TC	TEC
			26	PRO
		10/000		CG1
			TC	TE1
			26	PR1
		71/000	26	PFP
			TC	TFP
LAB	Medical — Laboratory			LA5
			TC	LAT
			26	LAP
		71/000		FAP
				GFP
			26	PFP
			TC	TFP
CHIRO	Medical — Chiropractor	15/000		C07
HCMCR	High Cost Medically Complex Recipients	63/000		C18
MHADC	Mental Health Autism Diagnostic Confirmation			C31
MHCCS	Mental Health — Comprehensive Community Services	80/652, 80/654, 80/655, 80/656		C33
MHCSP	Mental Health — Community Support Program	80/651, 80/653, 80/655, 80/656		C35
MHCI	Mental Health — Crisis Intervention	80/650, 80/653, 80/654, 80/656		C34
MHIHP	Mental Health — In Home Psychotherapy		HA	C37
MHHC	Mental Health — Mental Health and Substance Abuse Services in the Home or Community for Adults		UC	C36

Provider Contract Code	Contract Name	Contract Criteria		
		PT/PS per Provider Contract Code Applicable as Credentialed if Not Listed	Specific Rate Type or Modifier-Rate Type Combinations Used in Contract*	
MHAOD	Mental Health — Mental Health and Mental Health for Alcohol and Other Drug Addictions			C32
MHNTS	Mental Health — Narcotic Treatment Services		HG	C38
SBS	School Based Services	12/000		C46
DME	Durable Medical Equipment			C11
			RR	RTL
DMS	Supplies — Disposable Medical Supplies			C12
THERP	Therapy — Occupational, Physical and Speech Therapy			C49
REHAB	Therapy — Rehabilitation Centers — Occupational, Physical and Speech Therapy	04/000		C45
				Provider-specific rates
AMBUL	Transportation — Ambulance	26/000		C02
SMV	Transportation — Specialized Medical Vehicle	51/000		C47
VISN	Vision Services			C51
SPEC	Vision — State Purchase Eyeglass Program	19/191		C48
			U3	C48
OUTPA	Outpatient Hospital	01/000, 58/000		Not Applicable
MISC	Miscellaneous Codes/Provider Types			C52
		71/000		FAP
MHPW	Mental Health Substance Abuse Screening and Preventive Counseling for Pregnant Women		HE, HF	C53
CCO	COMMUNITY CARE ORGANIZATION	69/000		PT1
				PT2
				PT3
WCDC	Wisconsin Chronic Disease — Adult Cystic Fibrosis			WCD
WCDH	Wisconsin Chronic Disease — Hemophilia HomeCare			WCD
WCDK	Wisconsin Chronic Disease — Renal Disease			WCD
WWWP	Wisconsin Well Woman Program			WWP

* Rate types PT1-PT6 can be used in any contract, and the specific PT/PS listed in the record would be the main criteria for using that rate within the contract for that code.

5.2 Benefit Plan Codes

The Benefit Plan codes identify a rate record specific to the Benchmark Plan or the BadgerCare Plus Core Plan.

Benefit Plan Code	Description
BCBAS	BadgerCare Plus Basic Plan
BCBP	BadgerCare Plus Benchmark Plan
BCBPD	BadgerCare Plus Benchmark Plan and Dental
BCBEE	BadgerCare Plus Benchmark Express Enrollment for Pregnant Women
BCCP	BadgerCare Plus Core Benefit Plan 1
BCCCO	BadgerCare Plus Core Benefit Plan 2

5.3 Provider Type and Specialty Codes

Provider types and specialty codes are listed on the *Provider-specific Resources* page of the ForwardHealth Portal.

5.4 Pricing Indicator Codes

Pricing indicator codes dictate the method used for pricing.

Pricing Indicator Code	Description
ANESTH	The system utilizes the Anesthesia pricing methodology.
MAXFEE	The system utilizes the procedure max fee rate on file.
SYSMAN	The system suspends the claim for manual pricing.

5.5 Rate Type Codes

A rate type, with the pricing indicator and contract, identifies the rate to be used to calculate the allowable amount for the service. The rate type allows the same pricing methodologies, but with varying rates, for the same procedure code. Every contract has specific rate types.

Rate Type	Description
C01	AMB SURG CTR
C02	AMBULANCE
C03	ANSTHESIA
C04	ASSIST SURGY
C05	AUDIO - PURCH AID
HLK	HEALTHCHECK
RNT	RENTAL AID (Modifier RR)
C07	CHIRO
C09	CASEMGT
C10	DENTAL

Rate Type	Description
C11	PURCHASE DME
RTL	RENTAL DME (Modifier RR)
C12	DISP MED SUPPLY
C13	DAY TRTMT AODA
C14	DAY TRTMT CHILD
C15	DAY TRTMT MED
C17	HLTHCK CASE MGT
C18	HGH CST MD CMPLX
C19	HLTHCK PED CAR
C20	HLTHCK RES CAR
C21	RESP CARE
C22	HM HLTH PERS CARE
HPC	PERSONAL CARE
LA5	LAB GLOBAL
LAT	LAB TECH (Modifier TC)
LAP	LAB PROF (Modifier 26)
MED	MEDICAL
OTH	OTHER
TEC	TECHNICAL (Modifier TC)
TE1	PT-TECHNICAL (Modifier TC)
TFP	TECH-FAMILY PLAN (Modifier TC)
PRO	PROFESSIONAL (Modifier 26)
PR1	PT-PROFESSIONAL (Modifier 26)
PFP	PROF-FAMILY PLAN (Modifier 26)
CG1	PT GLOBAL (Not Modifier 26/TC)
GFP	GLOBAL-FAMILY PLANNING
FAP	GEN PT-FAMILY PLANNING
C30	MED SERVICE
C31	MH AUTISM EVAL
C32	MH AODA
C33	MH COMP COMM
C34	MH CRISIS INTVN
C35	MH COMM SUPRT
C36	MH HOME COMM
C37	MH HOME PSYCH
C38	MH NARC TRTMNT
LAC	OUTPATIENT LAB
C43	PN CHLD CARE
C44	RADIOLOGY
C45	REHABILITATION
C46	SCHL BASE SERV
C47	SPECL MED VECH
C48	VISION SPEC
C49	THERAPY
C51	VISION

Rate Type	Description
C52	MISCELANEOUS
C53	MHSA-PREGNANT WMN
005	BROWN CTY
008	CALUMET CTY
009	CHIPPEWA CTY
011	COLUMBIA CTY
013	DANE CTY
016	DOUGLAS CTY
018	EAU CLAIRE CTY
020	FOND DU LAC CTY
025	IOWA CTY
030	KENOSHA CTY
031	KEWAUNEE CTY
032	LA CROSSE CTY
037	MARATHON CTY
040	MILWAUKEE CTY
042	OCONTO CTY
044	OUTAGAMIE CTY
045	OZAUKEE CTY
047	PIERCE CTY
051	RACINE CTY
053	ROCK CTY
055	ST CROIX CTY
059	SHEBOYGAN CTY
066	WASHINGTON CTY
067	WAUKESHA CTY
070	WINNEBAGO CTY
094	ILL BORDER CTYS
095	IOWA BORDER CTYS
096	MICH BORDER CTYS
RWI	RURAL WI CTYS
DEF	DEFAULT
PT1	1 PTPS SPECIFIC
PT2	2 PTPS SPECIFIC
PT3	3 PTPS SPECIFIC
PT4	4 PTPS SPECIFIC
PT5	5 PTPS SPECIFIC
PT6	6 PTPS SPECIFIC
WCD	WI CHRONIC DISEASE
WWP	WI WELL WOMEN PRG
CMC	CROSSOVER MEDICARE

5.6 Benefit Adjustment Factor Codes

Benefit Adjustment Factor codes provide the ability to alter an existing allowed amount by a rate, percentage, or a series of a rate and percentages to increase or reduce the allowed amount. The interactive max fee schedule on the Portal does the calculation for the BAF, but the downloadable extract does not. For additional information about pricing calculations, refer to *Section 6.2 Benefit Adjustment Factor Pricing*.

BAF Code	BAF Description	Rate	Percent in Decimal	Calculate Code (Before / After)
20	Adjustment of 20% **Applicable Contracts:** DENTL Modifier 80, MEDSV and VISN Modifier 55		.200	Before
50	Adjustment of 50% **Applicable Contracts:** AMBUL Modifier GM, DME Modifier TW		.500	Before
80	Adjustment of 80% **Applicable Contracts:** MEDSV Modifier 54		.800	Before
90	Adjustment of 90% **Applicable Contracts:** THERP and REHAB Modifier TF		.900	Before
120	Adjustment of 120% **Applicable Contracts:** MEDSV Modifiers HK, HP		1.200	Before
150	Adjustment of 150% **Applicable Contracts:** MEDSV, ASTSG, RDLGY, VISN Modifiers 50		1.500	Before
207	Adjustment of 207% **Applicable Contracts:** DME Modifier 59		2.070	Before
VACC1	Vaccine Incentive when member is over the age of 18. **Applicable Contracts:** MEDSV	$6.85		Before
VACC2	Vaccine Incentive when member is over the age of 18. **Applicable Contracts:** MEDSV	$12.99		Before
DNTL10414	Dental Incentive when member is under the age of 21.	$104.14		Before
DNTL105	Dental Incentive when member is under the age of 21.	$1.05		Before
DNTL10579	Dental Incentive when member is under the age of 21.	$105.79		Before
DNTL1062	Dental Incentive when member is under the age of 21.	$10.62		Before
DNTL1098	Dental Incentive when member is under the age of 21.	$10.98		Before
DNTL1117	Dental Incentive when member is under the age of 21.	$11.17		Before

BAF Code	BAF Description	Rate	Percent in Decimal	Calculate Code (Before / After)
DNTL115	Dental Incentive when member is under the age of 21.	$1.15		Before
DNTL1181	Dental Incentive when member is under the age of 21.	$11.81		Before
DNTL1198	Dental Incentive when member is under the age of 21.	$11.98		Before
DNTL1215	Dental Incentive when member is under the age of 21.	$12.15		Before
DNTL122	Dental Incentive when member is under the age of 21.	$1.22		Before
DNTL1226	Dental Incentive when member is under the age of 21.	$12.26		Before
DNTL1230	Dental Incentive when member is under the age of 21.	$12.30		Before
DNTL1238	Dental Incentive when member is under the age of 21.	$12.38		Before
DNTL1281	Dental Incentive when member is under the age of 21.	$12.81		Before
DNTL13219	Dental Incentive when member is under the age of 21.	$132.19		Before
DNTL13770	Dental Incentive when member is under the age of 21.	$137.70		Before
DNTL13802	Dental Incentive when member is under the age of 21.	$138.02		Before
DNTL146066	Dental Incentive when member is under the age of 21.	$1,460.66		Before
DNTL14624	Dental Incentive when member is under the age of 21.	$146.24		Before
DNTL1497	Dental Incentive when member is under the age of 21.	$14.97		Before
DNTL14975	Dental Incentive when member is under the age of 21.	$149.75		Before
DNTL154	Dental Incentive when member is under the age of 21.	$1.54		Before
DNTL1568	Dental Incentive when member is under the age of 21.	$15.68		Before
DNTL1616	Dental Incentive when member is under the age of 21.	$16.16		Before
DNTL164	Dental Incentive when member is under the age of 21.	$1.64		Before
DNTL167	Dental Incentive when member is under the age of 21.	$1.67		Before
DNTL170	Dental Incentive when member is under the age of 21.	$1.70		Before
DNTL1741	Dental Incentive when member is under the age of 21.	$17.41		Before

BAF Code	BAF Description	Rate	Percent in Decimal	Calculate Code (Before / After)
DNTL1755	Dental Incentive when member is under the age of 21.	$17.55		Before
DNTL180	Dental Incentive when member is under the age of 21.	$1.80		Before
DNTL1800	Dental Incentive when member is under the age of 21.	$18.00		Before
DNTL1813	Dental Incentive when member is under the age of 21.	$18.13		Before
DNTL1834	Dental Incentive when member is under the age of 21.	$18.34		Before
DNTL18794	Dental Incentive when member is under the age of 21.	$187.94		Before
DNTL188	Dental Incentive when member is under the age of 21.	$1.88		Before
DNTL190	Dental Incentive when member is under the age of 21.	$1.90		Before
DNTL1919	Dental Incentive when member is under the age of 21.	$19.19		Before
DNTL202	Dental Incentive when member is under the age of 21.	$2.02		Before
DNTL2050	Dental Incentive when member is under the age of 21.	$20.50		Before
DNTL2061	Dental Incentive when member is under the age of 21.	$20.61		Before
DNTL2122	Dental Incentive when member is under the age of 21.	$21.22		Before
DNTL2161	Dental Incentive when member is under the age of 21.	$21.61		Before
DNTL218	Dental Incentive when member is under the age of 21.	$2.18		Before
DNTL2183	Dental Incentive when member is under the age of 21.	$21.83		Before
DNTL2324	Dental Incentive when member is under the age of 21.	$23.24		Before
DNTL235	Dental Incentive when member is under the age of 21.	$2.35		Before
DNTL239	Dental Incentive when member is under the age of 21.	$2.39		Before
DNTL246	Dental Incentive when member is under the age of 21.	$2.46		Before
DNTL255	Dental Incentive when member is under the age of 21.	$2.55		Before
DNTL256	Dental Incentive when member is under the age of 21.	$2.56		Before
DNTL2563	Dental Incentive when member is under the age of 21.	$25.63		Before

BAF Code	BAF Description	Rate	Percent in Decimal	Calculate Code (Before / After)
DNTL2607	Dental Incentive when member is under the age of 21.	$26.07		Before
DNTL262	Dental Incentive when member is under the age of 21.	$2.62		Before
DNTL263	Dental Incentive when member is under the age of 21.	$2.63		Before
DNTL266	Dental Incentive when member is under the age of 21.	$2.66		Before
DNTL268	Dental Incentive when member is under the age of 21.	$2.68		Before
DNTL2727	Dental Incentive when member is under the age of 21.	$27.27		Before
DNTL27590	Dental Incentive when member is under the age of 21.	$275.90		Before
DNTL278	Dental Incentive when member is under the age of 21.	$2.78		Before
DNTL279	Dental Incentive when member is under the age of 21.	$2.79		Before
DNTL282	Dental Incentive when member is under the age of 21.	$2.82		Before
DNTL283	Dental Incentive when member is under the age of 21.	$2.83		Before
DNTL3018	Dental Incentive when member is under the age of 21.	$30.18		Before
DNTL304	Dental Incentive when member is under the age of 21.	$3.04		Before
DNTL311	Dental Incentive when member is under the age of 21.	$3.11		Before
DNTL3241	Dental Incentive when member is under the age of 21.	$32.41		Before
DNTL327	Dental Incentive when member is under the age of 21.	$3.27		Before
DNTL328	Dental Incentive when member is under the age of 21.	$3.28		Before
DNTL3400	Dental Incentive when member is under the age of 21.	$34.00		Before
DNTL3416	Dental Incentive when member is under the age of 21.	$34.16		Before
DNTL342	Dental Incentive when member is under the age of 21.	$3.42		Before
DNTL35029	Dental Incentive when member is under the age of 21.	$350.29		Before
DNTL354	Dental Incentive when member is under the age of 21.	$3.54		Before
DNTL358	Dental Incentive when member is under the age of 21.	$3.58		Before

BAF Code	BAF Description	Rate	Percent in Decimal	Calculate Code (Before / After)
DNTL36	Dental Incentive when member is under the age of 21.	$0.36		Before
DNTL360	Dental Incentive when member is under the age of 21.	$3.60		Before
DNTL3655	Dental Incentive when member is under the age of 21.	$36.55		Before
DNTL368	Dental Incentive when member is under the age of 21.	$3.68		Before
DNTL3760	Dental Incentive when member is under the age of 21.	$37.60		Before
DNTL37747	Dental Incentive when member is under the age of 21.	$377.47		Before
DNTL379	Dental Incentive when member is under the age of 21.	$3.79		Before
DNTL3946	Dental Incentive when member is under the age of 21.	$39.46		Before
DNTL397	Dental Incentive when member is under the age of 21.	$3.97		Before
DNTL40074	Dental Incentive when member is under the age of 21.	$400.74		Before
DNTL402	Dental Incentive when member is under the age of 21.	$4.02		Before
DNTL41646	Dental Incentive when member is under the age of 21.	$416.46		Before
DNTL423	Dental Incentive when member is under the age of 21.	$4.23		Before
DNTL429	Dental Incentive when member is under the age of 21.	$4.29		Before
DNTL431	Dental Incentive when member is under the age of 21.	$4.31		Before
DNTL45	Dental Incentive when member is under the age of 21.	$0.45		Before
DNTL45329	Dental Incentive when member is under the age of 21.	$453.29		Before
DNTL4573	Dental Incentive when member is under the age of 21.	$45.73		Before
DNTL4597	Dental Incentive when member is under the age of 21.	$45.97		Before
DNTL4647	Dental Incentive when member is under the age of 21.	$46.47		Before
DNTL467	Dental Incentive when member is under the age of 21.	$4.67		Before
DNTL474	Dental Incentive when member is under the age of 21.	$4.74		Before
DNTL482	Dental Incentive when member is under the age of 21.	$4.82		Before

BAF Code	BAF Description	Rate	Percent in Decimal	Calculate Code (Before / After)
DNTL502	Dental Incentive when member is under the age of 21.	$5.02		Before
DNTL5103	Dental Incentive when member is under the age of 21.	$51.03		Before
DNTL511	Dental Incentive when member is under the age of 21.	$5.11		Before
DNTL5126	Dental Incentive when member is under the age of 21.	$51.26		Before
DNTL516	Dental Incentive when member is under the age of 21.	$5.16		Before
DNTL532	Dental Incentive when member is under the age of 21.	$5.32		Before
DNTL538	Dental Incentive when member is under the age of 21.	$5.38		Before
DNTL571	Dental Incentive when member is under the age of 21.	$5.71		Before
DNTL576	Dental Incentive when member is under the age of 21.	$5.76		Before
DNTL591	Dental Incentive when member is under the age of 21.	$5.91		Before
DNTL603	Dental Incentive when member is under the age of 21.	$6.03		Before
DNTL612	Dental Incentive when member is under the age of 21.	$6.12		Before
DNTL613	Dental Incentive when member is under the age of 21.	$6.13		Before
DNTL6411	Dental Incentive when member is under the age of 21.	$64.11		Before
DNTL647	Dental Incentive when member is under the age of 21.	$6.47		Before
DNTL650	Dental Incentive when member is under the age of 21.	$6.50		Before
DNTL66	Dental Incentive when member is under the age of 21.	$0.66		Before
DNTL6728	Dental Incentive when member is under the age of 21.	$67.28		Before
DNTL683	Dental Incentive when member is under the age of 21.	$6.83		Before
DNTL702	Dental Incentive when member is under the age of 21.	$7.02		Before
DNTL7099	Dental Incentive when member is under the age of 21.	$70.99		Before
DNTL7637	Dental Incentive when member is under the age of 21.	$76.37		Before
DNTL78	Dental Incentive when member is under the age of 21.	$0.78		Before

BAF Code	BAF Description	Rate	Percent in Decimal	Calculate Code (Before / After)
DNTL806	Dental Incentive when member is under the age of 21.	$8.06		Before
DNTL809	Dental Incentive when member is under the age of 21.	$8.09		Before
DNTL8292	Dental Incentive when member is under the age of 21.	$82.92		Before
DNTL8485	Dental Incentive when member is under the age of 21.	$84.85		Before
DNTL862	Dental Incentive when member is under the age of 21.	$8.62		Before
DNTL8626	Dental Incentive when member is under the age of 21.	$86.26		Before
DNTL878	Dental Incentive when member is under the age of 21.	$8.78		Before
DNTL893	Dental Incentive when member is under the age of 21.	$8.93		Before
DNTL90	Dental Incentive when member is under the age of 21.	$0.90		Before
DNTL915	Dental Incentive when member is under the age of 21.	$9.15		Before
DNTL929	Dental Incentive when member is under the age of 21.	$9.29		Before
DNTL9478	Dental Incentive when member is under the age of 21.	$94.78		Before
DNTL952	Dental Incentive when member is under the age of 21.	$9.52		Before
DNTL965	Dental Incentive when member is under the age of 21.	$9.65		Before
DNTL98	Dental Incentive when member is under the age of 21.	$0.98		Before
DNTL984	Dental Incentive when member is under the age of 21.	$9.84		Before
DNTL999	Dental Incentive when member is under the age of 21.	$9.99		Before
BIRTHTO3	Birth to 3 incentive when modifier TL is present. **Applicable Contracts:** THERP and REHAB	$21.50		After
FFPMH5938	Federal share percentage — Mental Health. Date of process from 2008-10-01		.5938	After
FFPCSMG08	Federal share percentage — Case Management (T2023/9). Date of process from 2008-10-01		.5938	Before
FFPCMKID08	Federal share percentage — Case Management (T2023/9). Date of process from 2008-10-01		.5938	Before

BAF Code	BAF Description	Rate	Percent in Decimal	Calculate Code (Before / After)
FFPRCC04	Federal share percentage — Residential Care Center. Date of service from 01/10/2004		.5832	Before
FFPRCC05	Federal share percentage — Residential Care Center. Date of service from 01/01/2005		.5815	Before
FFPRCC06	Federal share percentage — Residential Care Center. Date of service from 01/01/2006		.5761	Before
FFPRCC07	Federal share percentage — Residential Care Center. Date of service from 01/01/2007		.5751	Before
FFPRCC08	Federal share percentage — Residential Care Center. Date of service from 1/1/2008		.5906	Before
FFPSBS60	Federal share percentage — School Based services 60% WI percent. Date of process from 2004-01-01		.60	Before
FFPSBS1029	Federal share percentage — School Based Services add 2.9% Global Insights. Date of process from 07/01/2007		1.029	Before
FFPSBS5938	Federal share percentage — School Based Services 59.38% Federal percent. Date of process from 10/01/2008		.5938	Before
TJ12963	Group, child, and/or adolescent incentive when modifier TJ is present. **Applicable Contracts:** MEDSV		1.2963	Before
TJ13225	Group, child, and/or adolescent incentive when modifier TJ is present. **Applicable Contracts:** MEDSV and CHIRO		1.3225	Before
TJ13342	Group, child, and/or adolescent incentive when modifier TJ is present. **Applicable Contracts:** MEDSV		1.3342	Before
TJ13607	Group, child, and/or adolescent incentive when modifier TJ is present. **Applicable Contracts:** MEDSV		1.3607	Before
TJ14826	Group, child, and/or adolescent incentive when modifier TJ is present. **Applicable Contracts:** MEDSV		1.4826	Before
TJ15126	Group, child, and/or adolescent incentive when modifier TJ is present. **Applicable Contracts:** MEDSV		1.5126	Before
TJ15074	Group, child, and/or adolescent incentive when modifier TJ is present. **Applicable Contracts:** MEDSV		1.5074	Before

BAF Code	BAF Description	Rate	Percent in Decimal	Calculate Code (Before / After)
TJ15374	Group, child, and/or adolescent incentive when modifier TJ is present. **Applicable Contracts:** MEDSV		1.5374	Before
TJ16372	Group, child, and/or adolescent incentive when modifier TJ is present. **Applicable Contracts:** MEDSV		1.6372	Before
TJ16701	Group, child, and/or adolescent incentive when modifier TJ is present. **Applicable Contracts:** MEDSV		1.6701	Before
TJ10767	Group, child, and/or adolescent incentive when modifier TJ is present. **Applicable Contracts:** MEDSV		1.0767	Before
TJ10768	Group, child, and/or adolescent incentive when modifier TJ is present. **Applicable Contracts:** MEDSV		1.0768	Before
TJ10770	Group, child, and/or adolescent incentive when modifier TJ is present. **Applicable Contracts:** MEDSV		1.0770	Before
TJ11950	Group, child, and/or adolescent incentive when modifier TJ is present. **Applicable Contracts:** MEDSV		1.195	Before
TJ10768	Group, child, and/or adolescent incentive when modifier TJ is present. **Applicable Contracts:** MEDSV		1.0768	Before
TJ15977	Group, child, and/or adolescent incentive when modifier TJ is present. **Applicable Contracts:** MEDSV		1.5977	Before
TJ12012	Group, child, and/or adolescent incentive when modifier TJ is present. **Applicable Contracts:** MEDSV		1.2012	Before
TJ20940	Group, child, and/or adolescent incentive when modifier TJ is present. **Applicable Contracts:** MEDSV		2.094	Before
TJ10769	Group, child, and/or adolescent incentive when modifier TJ is present. **Applicable Contracts:** MEDSV		1.0769	Before
TJ18357	Group, child, and/or adolescent incentive when modifier TJ is present. **Applicable Contracts:** MEDSV		1.8357	Before
TJ11330	Group, child, and/or adolescent incentive when modifier TJ is present. **Applicable Contracts:** MEDSV		1.133	Before
TJ13830	Group, child, and/or adolescent incentive when modifier TJ is present. **Applicable Contracts:** MEDSV		1.383	Before
TJ17819	Group, child, and/or adolescent incentive when modifier TJ is present. **Applicable Contracts:** MEDSV		1.7819	Before

BAF Code	BAF Description	Rate	Percent in Decimal	Calculate Code (Before / After)
TJ34128	Group, child, and/or adolescent incentive when modifier TJ is present. **Applicable Contracts:** MEDSV		3.4128	Before
TJ34650	Group, child, and/or adolescent incentive when modifier TJ is present. **Applicable Contracts:** MEDSV		3.4650	Before
HPSA120	HPSA incentive when modifiers AQ, QB, or QU are present.		1.20	Before
HPSA150	HPSA incentive when modifiers AQ, QB, or QU are present.		1.50	Before
HPSA15551	HPSA incentive when modifiers AQ, QB, or QU are present.		1.5551	Before
HPSA15869	HPSA incentive when modifiers AQ, QB, or QU are present.		1.5869	Before
HPSA16015	HPSA incentive when modifiers AQ, QB, or QU are present.		1.6015	Before
HPSA16336	HPSA incentive when modifiers AQ, QB, or QU are present.		1.6336	Before
HPSA17788	HPSA incentive when modifiers AQ, QB, or QU are present.		1.7788	Before
HPSA18149	HPSA incentive when modifiers AQ, QB, or QU are present.		1.8149	Before
HPSA18088	HPSA incentive when modifiers AQ, QB, or QU are present.		1.8088	Before
HPSA18450	HPSA incentive when modifiers AQ, QB, or QU are present.		1.845	Before
HPSA19647	HPSA incentive when modifiers AQ, QB, or QU are present.		1.9647	Before
HPSA20044	HPSA incentive when modifiers AQ, QB, or QU are present.		2.0044	Before
HPSA12926	HPSA incentive when modifiers AQ, QB, or QU are present.		1.2926	Before
HPSA12937	HPSA incentive when modifiers AQ, QB, or QU are present.		1.2937	Before
HPSA12919	HPSA incentive when modifiers AQ, QB, or QU are present.		1.2919	Before
HPSA14978	HPSA incentive when modifiers AQ, QB, or QU are present.		1.4978	Before
HPSA12919	HPSA incentive when modifiers AQ, QB, or QU are present.		1.2919	Before
HPSA19167	HPSA incentive when modifiers AQ, QB, or QU are present.		1.9167	Before
HPSA14381	HPSA incentive when modifiers AQ, QB, or QU are present.		1.4381	Before
HPSA25126	HPSA incentive when modifiers AQ, QB, or QU are present.		2.5126	Before

BAF Code	BAF Description	Rate	Percent in Decimal	Calculate Code (Before / After)
HPSA12923	HPSA incentive when modifiers AQ, QB, or QU are present.		1.2923	Before
HPSA22028	HPSA incentive when modifiers AQ, QB, or QU are present.		2.2028	Before
HPSA13591	HPSA incentive when modifiers AQ, QB, or QU are present.		1.3591	Before
HPSA16595	HPSA incentive when modifiers AQ, QB, or QU are present.		1.6595	Before
HPSA21382	HPSA incentive when modifiers AQ, QB, or QU are present.		2.1382	Before
HPSA40953	HPSA incentive when modifiers AQ, QB, or QU are present.		4.0953	Before
HPSA41581	HPSA incentive when modifiers AQ, QB, or QU are present.		4.1581	Before

6 Professional Pricing

6.1 Maximum Fee Pricing

Maximum Fee Pricing is identified by the pricing indicator MAXFEE. The maximum fee is a standard, statewide maximum rate that can be paid for a procedure. The following calculation is used:

- The allowed amount is calculated:

  Allowed Amount = (Max Fee Rate * Units Allowed).
- The lesser of the billed amount or allowed amount is used:

  Allowed Amount = Lesser of Billed Amount or Allowed Amount.

6.2 Benefit Adjustment Factor Pricing

The BAF can alter an existing allowed amount by a percentage or a series of percentages. The BAF works with pricing methodologies to apply a percentage that either increases or decreases the allowed amount.

The BAFs can also pay additional set amounts that are not service-related. The set amount for a BAF is added or subtracted from the calculated allowed amount after the specific pricing methodology is applied.

BAF pricing can have up to three BAFs applied, which can be a percentage or flat rate. The BAF provides a flag that controls whether the BAF is applied before or after the allowed amount is compared to the billed amount. If the flag is set to *after*, the BAF is applied to the allowed amount after the allowed amount is set to the lesser of the billed or allowed amount, where applicable. The following calculation is used:

- If the BAF Before/After flag is set to *Before*:
  - Allowed Amount = (Max Fee Rate * Units Allowed).
  - Allowed Amount = (Allowed Amount * BAF Percentage) + BAF Incentive Amount.
  - Allowed Amount = Lesser of Billed Amount or Allowed Amount.
- If the BAF Before/After flag is set to *After*:
  - Allowed Amount = (Max Fee Rate * Units Allowed).
  - Allowed Amount = Lesser of Billed Amount or Allowed Amount.
  - Allowed Amount = (Allowed Amount * BAF Percentage) + BAF Incentive Amount.

Note: Each BAF code can only be assigned either a percentage or an incentive amount. The calculation above is used accordingly. For specific situations, additional criteria are outlined below for applying the BAF.

6.2.1 BIRTHTO3 Code

The BAF amount is added to the allowed amount if the modifier TL is billed and the following are true:

- The POS is 04, 12 or 99.
- The PT/PS is 17/000, 74/000, 77/000, 78/000, or 79/000.
- The member is under the age of 3.

  If the member is age 3 or older, the BAF amount is not added to the allowed amount.

6.2.2 HPSA Codes

If the Health Professional Shortage Area (HPSA) modifiers AQ, QB, or QU are billed for specific codes, and the member's or the billing provider's current address is in the list of allowable HPSA ZIP codes, then the HPSA BAFs will apply.

6.3 Anesthesia Pricing

The pricing indicator code is ANESTH. The max fee rate and relative value are used in the Anesthesia Pricing method. The following calculation is used for this method:

- Billed amount is 1 unit = 1 minute.

  Time Units = (Billed Units / 15.00) (Round to the tenth).

  - Allowed Amount = Max Fee Rate * (Relative Value + Time Units).
  - Allowed Amount = Lesser of Billed Amount or Allowed Amount.

6.4 Contracted Rate Pricing

The pricing indicator code is MAXFEE. The contracted max fee allowed amount is always paid, even if it is greater than the billed amount. The following is the calculation used for this pricing:

Allowed Amount = Max Fee Rate * Units Allowed.

This pricing applies to the following contracts:

- MHCSP — Mental Health Community Support Program.
- MHHC — Mental Health — Mental Health and Substance Abuse Services in the Home or Community for Adults.
- CSMGT — Case Management.
- MHCI — Mental Health — Crisis Intervention.
- SBS — School-Based Services.

6.5 Usual and Customary Charge Pricing

For Usual and Customary Charge pricing, the rates will be provided separately to the individual provider. These rates are specific to the provider for specific codes and modifiers and will not be published on the Portal or in the text files.

The following contracts are applicable to this method:

- DTMED — Day Treatment Medical.
- REHAB — Therapy — Rehabilitation Centers — Occupational, Physical, and Speech Therapies.
- MHRCC — HealthCheck Other — Residential Care Centers.

6.6 Manual Pricing

Manual pricing is identified by the pricing indicator code SYSMAN. Manual pricing is used when the procedure code is new or does not have enough charge history to permit determining a reimbursement rate. Manual pricing is also used for "unlisted" procedure codes that are not service-specific and require a review of claim narratives to appropriately reimburse the provider for the services. The following calculation for this method is used:

Allowed Amount = Allowed Amount as determined.

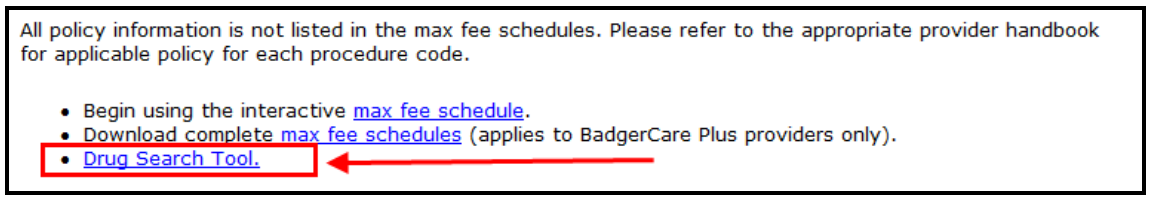
Note: For codes in the Benchmark Plan dental contract, there is a supplemental file for max fees on the Downloadable Max Fee Schedules page; however, this file does not contain all the applicable codes.

7 Drug Search Tool

The drug search tool identifies and calculates ingredient reimbursement rates of drugs covered by Medicaid, BadgerCare Plus, SeniorCare, and the Wisconsin Chronic Disease Program (WCDP).

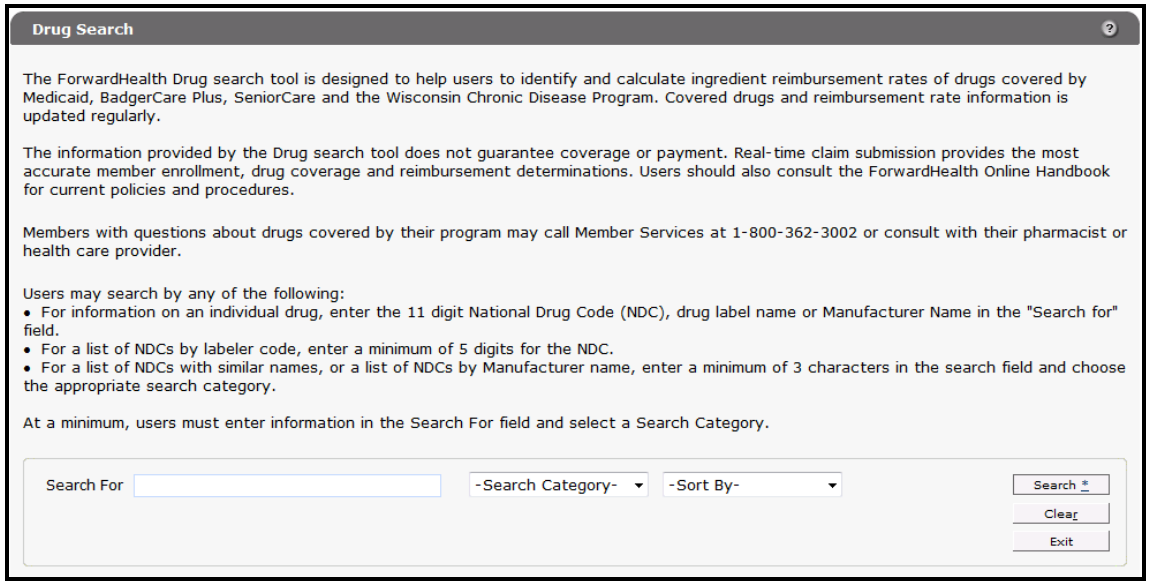
7.1 Access the Drug Search Tool

1. Click **Drug Search Tool** at the bottom of the Max Fee Schedules page.



Drug Search Tool Link

The Drug Search panel will be displayed.



Drug Search Panel

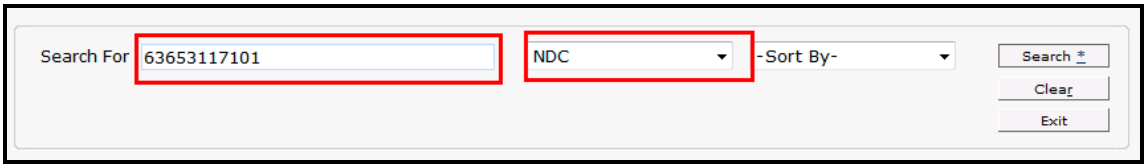
2. Enter information in the Search For field and select a Search Category to conduct a search. The 11-digit National Drug Code (NDC), drug label name, or manufacturer name can be entered in the Search For field to conduct a search.

7.1.1 Search by National Drug Code

Note: The drug search tool only works for drugs billed by an NDC. It does not work for J-code (physician-administered) drugs.

Searching by NDC is most direct way to search for an individual drug.

1. Enter at least the first five numbers of a valid NDC in the Search For field.
2. Select **NDC** from the Search Category drop-down menu.



Search by National Drug Code

3. Click **Search**.

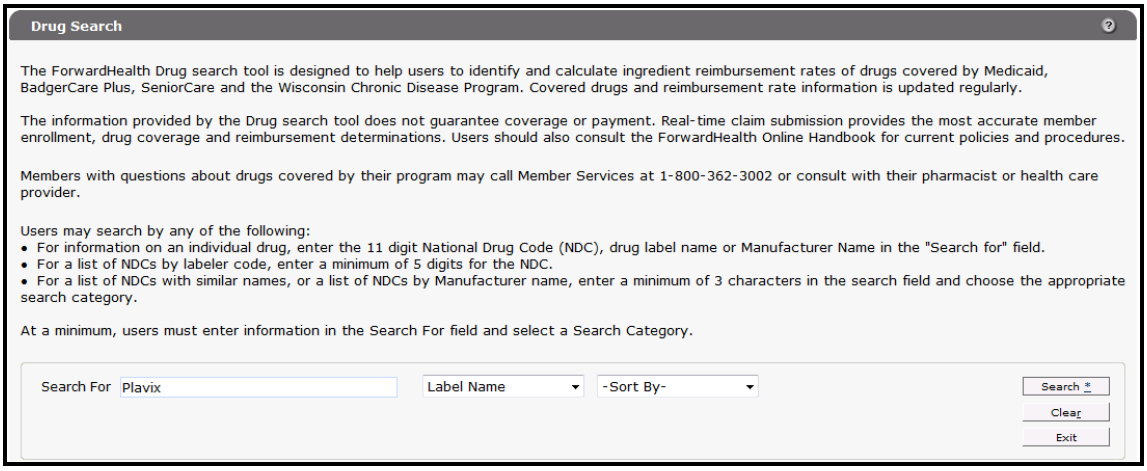
   The Drug Information page will be displayed.

4. Proceed to *Section 7.2 Drug Information Page*.

7.1.2 Search by Label Name — Brand Name

The label name is the combination of the drug name appearing on the package label, the strength description, and the dosage for a specified product; however, it is not necessary to enter all of this information in a search. Entering a full name or at least the first three characters of drug name will yield a list of covered drugs with various strengths and doses.

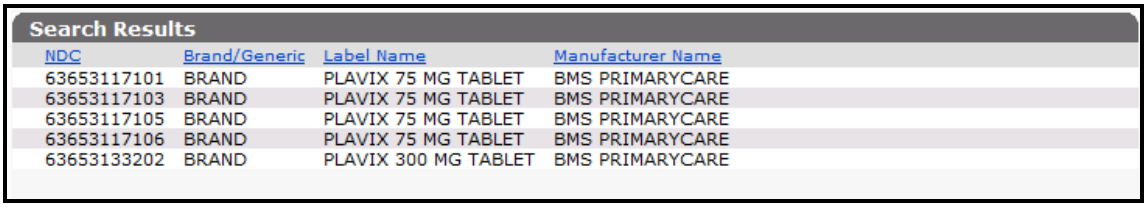
1. Enter at least the first three characters of a label name in the Search For field.



Search by Label Name

2. Select **Label Name** from the Search Category drop-down menu.
3. Click **Search**.

   The Search Results panel will be displayed.



Search Results Panel

Since the search was for a brand-name drug, the Search Results panel will show all covered formulations of the drug. The results will normally be limited to only one

manufacturer unless other manufacturers are licensed to produce the drug under the brand name.

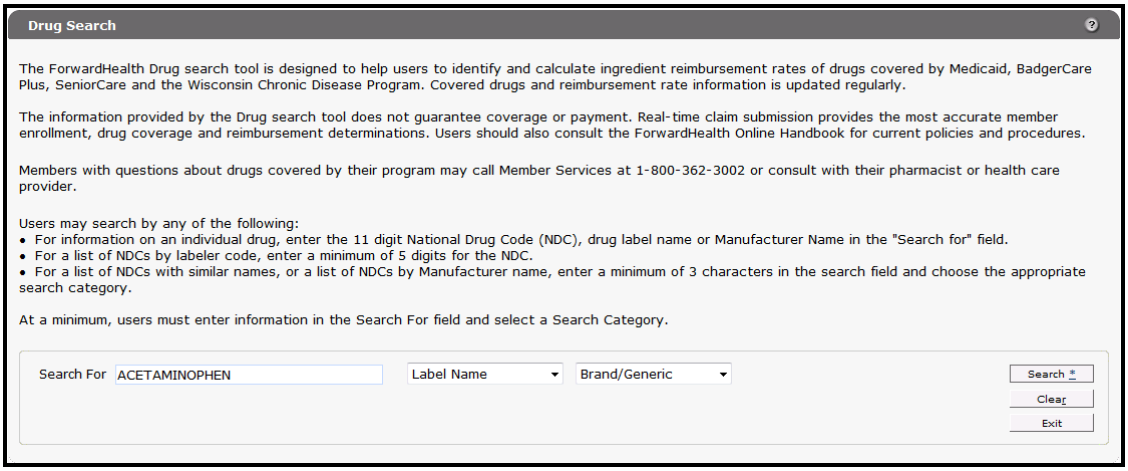
4. Click the applicable record.

   The Drug Information page will be displayed.

5. Proceed to *Section 7.2 Drug Information Page*.

7.1.3 Search by Label Name — Generic

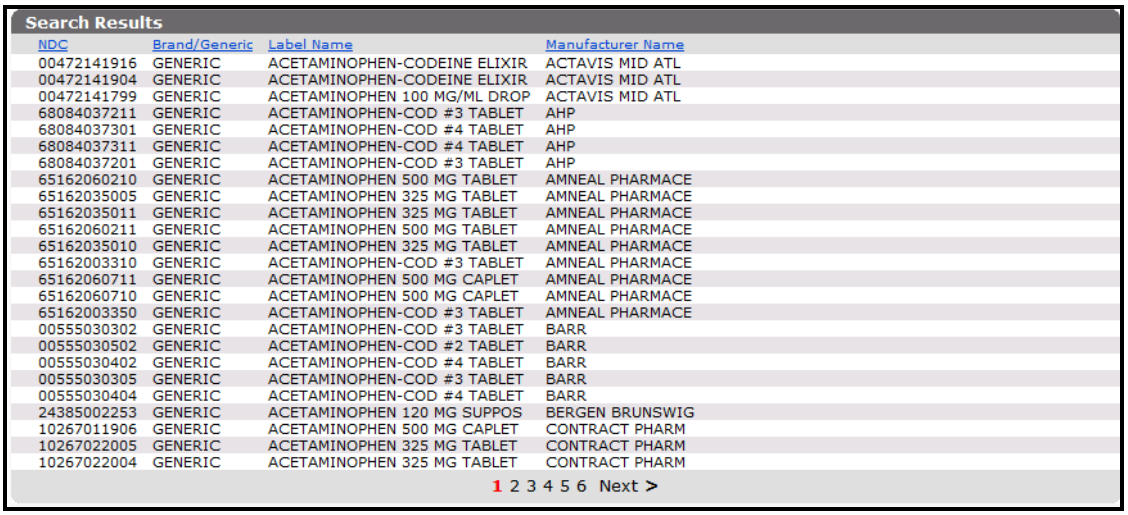
1. Enter at least the first three characters of a label name in the Search For field.



Search by Label Name

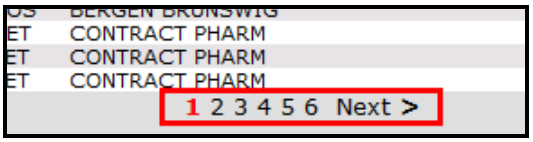
2. Select **Label Name** from the Search Category drop-down menu.
3. If you expect the search to return a large number of results, sort the results by brand or generic name, label name, manufacturer name, or NDC using the Sort By drop-down menu.
4. Click **Search**.

   The Search Results panel will be displayed.



Search Results Panel

5. Scroll through the results by clicking a page number or Next at the bottom of the panel.



Page Numbers and Next Links

6. Click the applicable record.

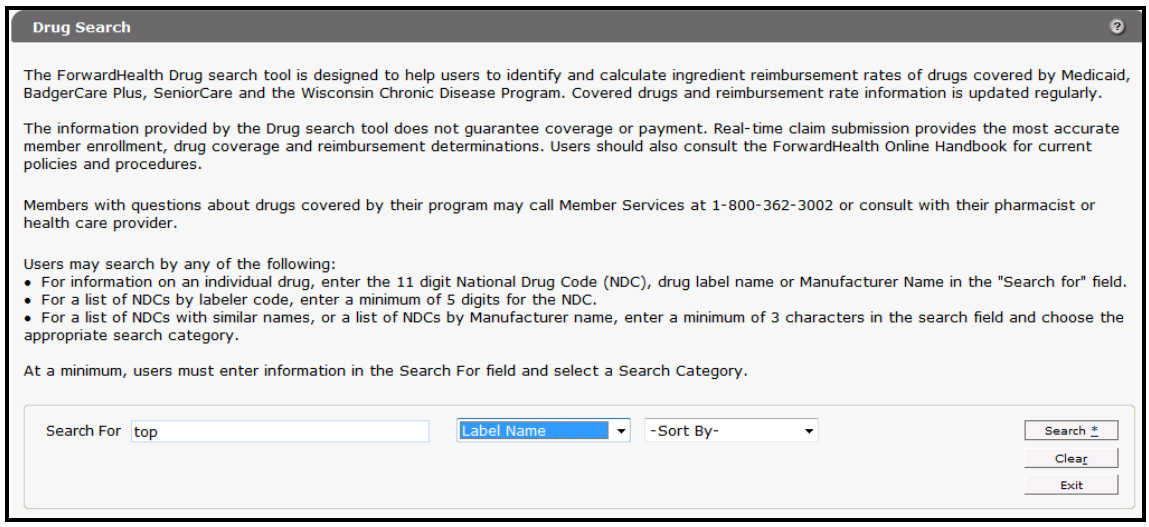
   The Drug Information page will be displayed.

7. Proceed to *Section 7.2 Drug Information Page*.

7.1.4 Search by Partial Name

Partial names can be used to search for label names or manufacturer names.

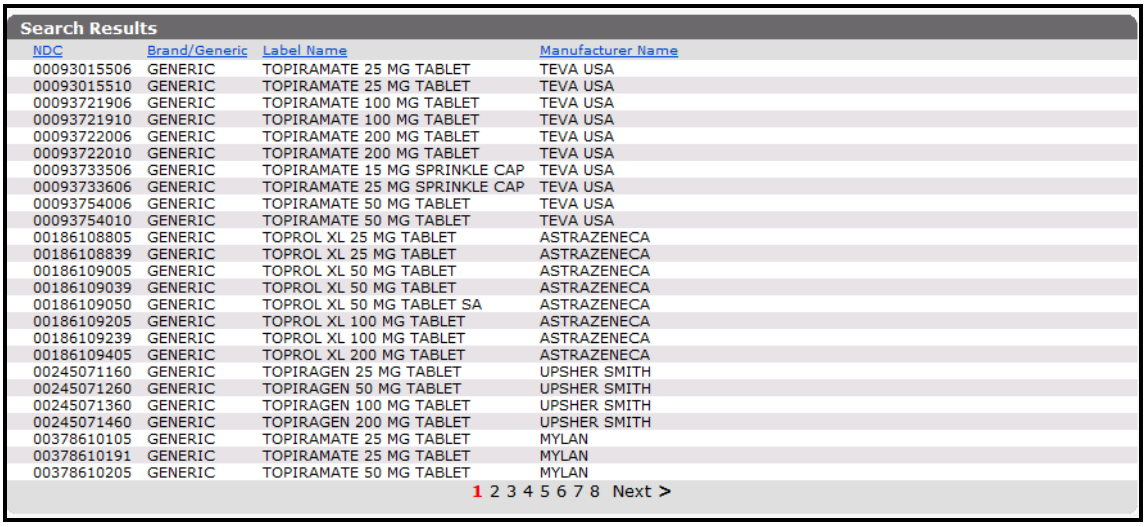
1. Enter at least the first three characters of a label or manufacturer name in the Search For field.



Search by Partial Name

2. Select **Label Name** or **Manufacturer Name** from the Search Category drop-down menu.
3. If you expect the search to return a large number of results, sort the results by brand or generic name, label name, manufacturer name, or NDC from the Sort By drop-down menu.
4. Click **Search**.

   The Search Results panel will be displayed.



Search Results

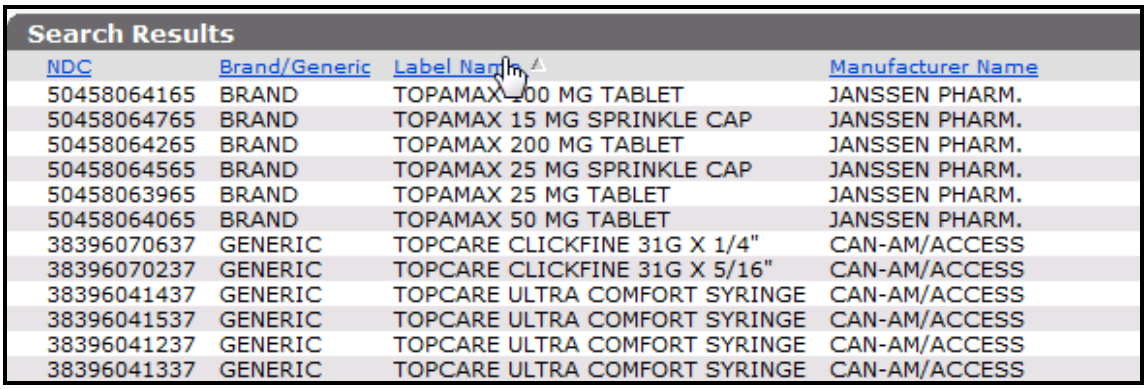
NDC	Brand/Generic	Label Name	Manufacturer Name
00093015506	GENERIC	TOPIRAMATE 25 MG TABLET	TEVA USA
00093015510	GENERIC	TOPIRAMATE 25 MG TABLET	TEVA USA
00093721906	GENERIC	TOPIRAMATE 100 MG TABLET	TEVA USA
00093721910	GENERIC	TOPIRAMATE 100 MG TABLET	TEVA USA
00093722006	GENERIC	TOPIRAMATE 200 MG TABLET	TEVA USA
00093722010	GENERIC	TOPIRAMATE 200 MG TABLET	TEVA USA
00093733506	GENERIC	TOPIRAMATE 15 MG SPRINKLE CAP	TEVA USA
00093733606	GENERIC	TOPIRAMATE 25 MG SPRINKLE CAP	TEVA USA
00093754006	GENERIC	TOPIRAMATE 50 MG TABLET	TEVA USA
00093754010	GENERIC	TOPIRAMATE 50 MG TABLET	TEVA USA
00186108805	GENERIC	TOPROL XL 25 MG TABLET	ASTRAZENECA
00186108839	GENERIC	TOPROL XL 25 MG TABLET	ASTRAZENECA
00186109005	GENERIC	TOPROL XL 50 MG TABLET	ASTRAZENECA
00186109039	GENERIC	TOPROL XL 50 MG TABLET	ASTRAZENECA
00186109050	GENERIC	TOPROL XL 50 MG TABLET SA	ASTRAZENECA
00186109205	GENERIC	TOPROL XL 100 MG TABLET	ASTRAZENECA
00186109239	GENERIC	TOPROL XL 100 MG TABLET	ASTRAZENECA
00186109405	GENERIC	TOPROL XL 200 MG TABLET	ASTRAZENECA
00245071160	GENERIC	TOPIRAGEN 25 MG TABLET	UPSHER SMITH
00245071260	GENERIC	TOPIRAGEN 50 MG TABLET	UPSHER SMITH
00245071360	GENERIC	TOPIRAGEN 100 MG TABLET	UPSHER SMITH
00245071460	GENERIC	TOPIRAGEN 200 MG TABLET	UPSHER SMITH
00378610105	GENERIC	TOPIRAMATE 25 MG TABLET	MYLAN
00378610191	GENERIC	TOPIRAMATE 25 MG TABLET	MYLAN
00378610205	GENERIC	TOPIRAMATE 50 MG TABLET	MYLAN

1 2 3 4 5 6 7 8 Next >

Search Results Panel

The results show all possible label names that begin with the letters entered.

5. Click a column heading to sort the results. Clicking a column heading once will sort the results in ascending order by that column. Clicking the column a second time will sort the results in descending order.



Search Results

NDC	Brand/Generic	Label Name	Manufacturer Name
50458064165	BRAND	TOPAMAX 200 MG TABLET	JANSSEN PHARM.
50458064765	BRAND	TOPAMAX 15 MG SPRINKLE CAP	JANSSEN PHARM.
50458064265	BRAND	TOPAMAX 200 MG TABLET	JANSSEN PHARM.
50458064565	BRAND	TOPAMAX 25 MG SPRINKLE CAP	JANSSEN PHARM.
50458063965	BRAND	TOPAMAX 25 MG TABLET	JANSSEN PHARM.
50458064065	BRAND	TOPAMAX 50 MG TABLET	JANSSEN PHARM.
38396070637	GENERIC	TOPCARE CLICKFINE 31G X 1/4"	CAN-AM/ACCESS
38396070237	GENERIC	TOPCARE CLICKFINE 31G X 5/16"	CAN-AM/ACCESS
38396041437	GENERIC	TOPCARE ULTRA COMFORT SYRINGE	CAN-AM/ACCESS
38396041537	GENERIC	TOPCARE ULTRA COMFORT SYRINGE	CAN-AM/ACCESS
38396041237	GENERIC	TOPCARE ULTRA COMFORT SYRINGE	CAN-AM/ACCESS
38396041337	GENERIC	TOPCARE ULTRA COMFORT SYRINGE	CAN-AM/ACCESS

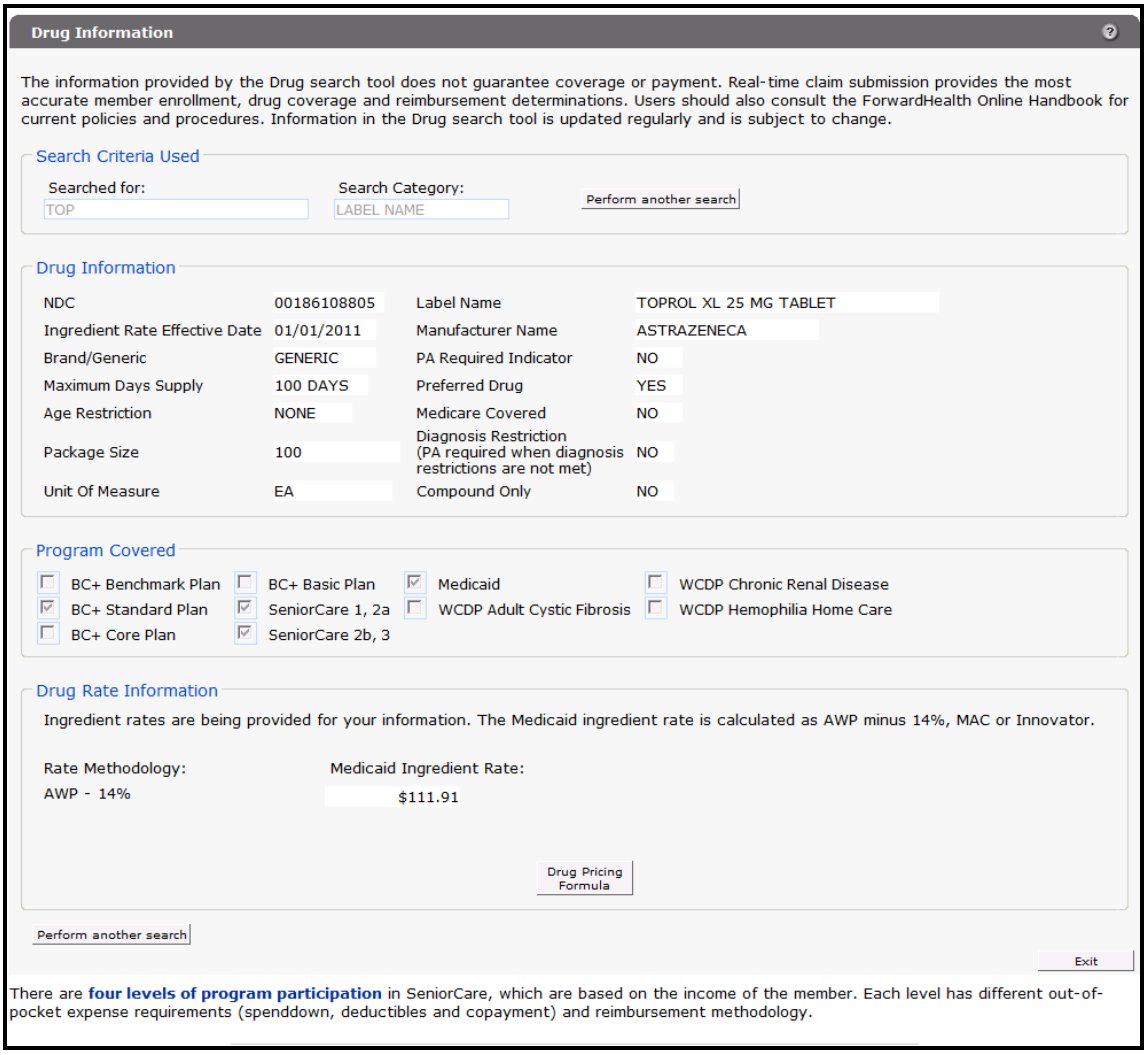
Sort the Results

6. Scroll through the results by clicking a page number or Next at the bottom of the panel.
7. Click the applicable record.

   The Drug Information page will be displayed.
8. Proceed to *Section 7.2 Drug Information Page*.

7.2 Drug Information Page

The Drug Information page helps users identify and calculate ingredient reimbursement rates of drugs covered by Medicaid, BadgerCare Plus, SeniorCare, and WCDP.



Drug Information Page

- The "Drug Information" section may display the following information:
  - The combination of the NDC, label name, and manufacturer name that specifically identifies the drug for which the reimbursement rate applies.
  - The ingredient rate effective date, which indicates when the information for this NDC went into effect.
  - The package size covered by the indicated rate.
  - The maximum days supply covered by the indicated rate.
  - Age restrictions on the drug.
  - If prior authorization is required.
  - If the drug is covered by Medicare.

  - Diagnosis restrictions for the drug.

- The "Program Covered" section indicates the plans under which the drug is covered.
- The "Drug Rate Information" section displays the reimbursement rate information for the selected NDC.
  - The rate methodology indicates how the rate is calculated. In the example above, the rate methodology is AWP – 14% (the Average Wholesale Price minus 14 percent).
  - The Medicaid ingredient rate indicates the reimbursement rate for the package size indicated in the "Drug Information" section.
- The Drug Pricing Formula button gives further information on how reimbursement is determined, as displayed in the following example:

Drug Pricing Formula:

Medicaid Ingredient Rate/Package Size = Unit Price.

Unit Price x Quantity Dispensed + Dispensing Fee = Allowed Amount.

Reimbursement will be based on the lesser of the following amounts:

- Allowed Amount.
- Usual and Customary Charge.

Note: Other factors, such as gender restrictions or age restrictions that may not be detailed in the Drug Information panel, may determine drug reimbursement. If you have any questions regarding coverage for an individual drug, refer to the Pharmacy service area of the *Online Handbook* for policies, procedures, and reimbursement information.