

Determining Member Copay Responsibility for Diagnostic Services in 2010 Provider Frequently Asked Questions (FAQs)

Question	Answer
How are copays changing for diagnostic services in 2010?	<p>Effective January 1, 2010, WellCare Medicare members will be responsible for copay amount(s) for certain diagnostic services performed in an outpatient setting. In some instances, the diagnostic copay will be <i>in addition to</i> the facility, or office visit, copay, such as in a Primary Care Physician's office or a Specialist's office.</p> <p>Members may be responsible for a facility copay PLUS up to four additional copays - one copay for <i>each type of diagnostic service</i>.</p>
How are/were copays handled in 2009?	<p>In 2009, the benefit standard is/was to charge one copay, per provider, per date of service.</p> <p>This is often referred to as the "highest of" methodology, since the Member is responsible for the highest co-pay charged by the provider on that date of service.</p>
Will I be paid less as a result of the copay changes for diagnostic services?	<p>No. Providers will not be paid less, however they may receive a lower amount of the total payment from WellCare as a result of the Member's increased copay responsibility. For example purposes only, say a provider's eligible fee is \$100. While the member may be responsible for \$20 and the Plan pays \$80 in 2009; in 2010, the member may be responsible for \$40 while the Plan pays \$60. The total payment to the provider is still \$100.</p>
What types of facilities are eligible for the facility (office visit) copay?	<p>The following facility types are eligible for the office copay, if and only if, a consult or procedure was provided:</p> <ul style="list-style-type: none"> • PCP Office • Specialist Office • Outpatient Hospital • Independent Lab • Diagnostic Center <p>Ambulatory Surgery Center (ASC)</p>
How many copays can providers collect per visit?	<p>In theory, providers could collect up to 5 total copays - 4 different diagnostic service copays PLUS the office visit / facility copay.</p>
What are the 4 diagnostic categories of CPT codes for which copays can be collected on a single date of service, per provider?	<ol style="list-style-type: none"> 1. Tests Basic – such as an allergy test or EKG 2. Tests Advanced – Cardiac Stress Test only 3. Radiology Basic – flat film X-ray only 4. Radiology Advanced (includes Nuclear Medicine) – such as MRI or Ultrasound <p>* Please note that as a benefit to our members, lab services are provided at \$0 copay. * Please review the <i>Determining Member Copay Responsibility</i> Job Aid for further clarification.</p>

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What is the potential impact of the copay changes for diagnostic services?	Because more than one copay may apply for diagnostic services, this may result in increased monetary responsibility for the Member. Providers or their staff may be responsible for collecting more money from the Member up front, based on services rendered.
What are WellCare's expectations of the Provider(s)?	It is crucial for providers to understand the practice of more than one copay for diagnostic services, and when it applies. By collecting the proper amount from Members at the time of service, confusion can later be avoided regarding the collection of eligible copays versus balance billing, which is prohibited.
Are copays different for services within the same category?	No. Copays are the same within the same category. For example purposes only, all CPT codes within the Tests Basic category will have a copay of \$20. <i>* Only one copay can be collected from each diagnostic category (per provider per date of service) regardless of the number of services rendered within that category.</i>
Do the copay changes for diagnostic services apply to inpatient hospitalizations?	No. More than one copay for diagnostic services applies to outpatient services, but <u>NOT</u> to inpatient hospitalization.
What is an example of more than one copay for diagnostic services in 2010?	<ul style="list-style-type: none"> – Member goes to PCP office and has <u>office visit</u> and <u>basic diagnostic test</u> performed and billed by PCP. <ul style="list-style-type: none"> – In 2009, Member Owes <i>Higher</i> of the Two Co-pays – In 2010, Member Owes <i>Sum</i> of the Two Co-pays <ul style="list-style-type: none"> • \$10 PCP Office Visit Co-pay + • \$20 Basic Test Co-pay = • \$30 Member Owes <p>See <i>Determining Member Copay Responsibility</i> Job Aid for more detailed examples.</p>
What if the services require prior authorization?	Prior Authorization rules still apply. Please refer to your Quick Reference Guide (QRG) for information on authorization requests and applicable Place of Service codes.
What information have Members received regarding 2010 benefit changes?	<p>Members received information on 2010 benefits, including more than one copay for diagnostic services, in their Annual Notice of Change (ANOC) and Evidence of Coverage (EOC).</p> <p>Renewing members should have received their ANOC and EOC by October 31, 2009 for benefits effective January 1, 2010.</p> <p>Newly enrolled members will receive their EOC by January 31, 2010 if effective January 1, 2010.</p> <p>Please see the sample ANOC and EOC documents for the exact language used to describe this particular benefit change to members.</p>

Question	Answer
When should I discuss the Member's copay responsibility?	Explain to the Member each copay they are responsible for prior to rendering services. If the Member has additional questions, request that the Member contact the customer service number located on the back of their ID card.
A patient insists I am overcharging them. How do I explain this?	Explain to the Member each copay they are responsible for prior to rendering services. Also explain that this is a change from 2009 and is an industry standard for many commercial health plans. If the Member has additional questions, request the Member contact the customer service telephone number located on the back of their ID card.
How will I know if my office did not collect all applicable copays prior to rendering services?	<p>Review your Explanation of Payment (EOP) thoroughly. Reason codes are provided by line item, and Descriptions are provided at the bottom of the EOP.</p> <p>Reason codes CP001-CP034 indicate Member copay responsibility. Keep in mind that the cost share for dual-eligible members may be the responsibility of a third party payer, such as Medicaid.</p> <p>Please review the <i>Determining Dual-Eligible Cost-Share Job Aid</i> for further clarification.</p>
What should I do if my office did not collect all applicable Member copays prior to rendering services?	You should bill the Member for the unpaid balance if you have determined it is their responsibility, and not the responsibility of WellCare, or a third party payer such as Medicaid.
What is the copay responsibility of dual-eligible Members?	<p>Dual eligible members who are entitled to cost sharing protections have no cost sharing liability. Those who are not protected must pay their applicable copays. Always verify eligibility and benefit information by contacting your State Medicaid office.</p> <p>Please review the <i>Determining Dual-Eligible Cost-Share Job Aid</i> for further clarification.</p>
Who should I contact if I have questions?	Please refer to the customer service telephone number on your Quick Reference Guide (QRG) or log on to www.wellcare.com if you should have additional questions.