

DETERMINING MEMBER CO-PAY RESPONSIBILITY FOR DIAGNOSTIC SERVICES IN 2010

Effective January 1, 2010, WellCare Medicare members will be responsible for co-pay amount(s) for certain diagnostic services performed in an outpatient setting. In some instances, the diagnostic co-pay may be in addition to the facility, or office visit, co-pay, such as in a primary care physician's office or a specialist's office.

- If the member's visit includes a consultation or procedure as well as a diagnostic service or services, you will need to collect the appropriate co-pay amounts for both the facility/office visit and diagnostic service(s). If no consult or procedure was performed, only the diagnostic service(s) co-pay is applicable.
- **As a provider, your overall reimbursement will not be affected.** However, it is important your office staff understands that in certain circumstances more than one co-pay may apply. Your staff should be aware of the eligible diagnostic services to ensure they collect the appropriate co-pay amounts *at the time services are rendered*. Please note that prior authorization rules still apply.
- By collecting the proper amount from members at the time of service, confusion can be avoided later regarding the collection of eligible co-pays versus balance-billing, which is prohibited.
- Members may be responsible for one co-pay within **each of the four categories of eligible diagnostic services** rather than only the highest co-pay of those services per day. Again, members may now owe a sum of co-pays.

See the chart on the back for the types of diagnostic services that may require additional member co-pay responsibility.

If your office did not collect the appropriate co-pay(s) prior to rendering service, review your Explanation of Payment (EOP) thoroughly. Reason codes are provided by line item, and descriptions are provided at the bottom of the EOP. Reason codes CP001–CP034 indicate member co-pay responsibility. Keep in mind that the cost-share for dual-eligible members may be the responsibility of a third-party payer, such as Medicaid. (Please review the Determining Dual-Eligible Member Cost-Share job aid for further clarification.)

Contact Information

Please refer to the Customer Service telephone number located on your Quick Reference Guide if you have any questions.



Please refer to the member's ID card for specific office visit co-pay information. Please call the Customer Service telephone number listed on the back of the ID card to confirm eligibility and to verify benefits.

Facility Visit Co-pays (Examples Only)

Primary Care Physician	\$10
Physician Specialist	\$25
Outpatient Hosp. Non-Surgical	\$100
Outpatient Hosp. Surgical	\$125
Ambulatory Surgical Center	\$75
Diagnostic Center	\$0
Independent Lab	\$0

Diagnostic Category Co-pays*

Basic Radiology (Flat Film X-ray Only)	\$0
Basic Procedures/Tests (e.g., Allergy Test or EKG)	\$20
Advanced Procedures/Tests (e.g., Cardiac Stress Test Only)	\$50
Advanced Radiology (e.g., MRI or Ultrasound)	\$50

*Only one co-pay can be collected from each diagnostic category (per provider per date of service), regardless of the number of services rendered within that category.

*As a benefit to our members, lab services are provided at a \$0 co-pay.

Member Cost-Share Examples:

1) Member goes to PCP's office and has (i) *office visit* and (ii) *basic diagnostic test* performed and billed by PCP.

\$10 PCP Office Visit Co-pay
 + \$20 Basic Test Co-pay
 = **\$30 Member Co-pay**

2) Member goes to an Outpatient Hospital Non-Surgical and has (i) *office visit*, (ii) *basic diagnostic test*, (iii) *advanced radiology test* and (iv) *lab services* performed.

\$100 Outpatient Hospital Non-Surgical Co-pay
 + \$20 Basic Test Co-pay
 + \$50 Advanced Radiology Co-pay
 + \$0 Lab Service Co-pay
 = **\$170 Member Co-pay**

3) Member goes to a Physician Specialist and has (i) *office visit* and (ii) *three separate Advanced Diagnostic tests* performed.

\$25 Physician Specialist Visit Co-pay
 + ONE \$50 Advanced Diagnostic Test Co-pay
 = **\$75 Member Co-pay**

4) Member goes to a Diagnostic Center for (i) *advanced radiology test* with no consult or treatment.

\$50 Advanced Diagnostic Test Co-pay
 = **\$50 Member Co-pay (no office visit co-pay amount due)**

Remember, a facility/office visit co-pay applies only when a consultation or procedure is performed.