OPTOMETRIST / OPTICIAN
TERMS OF REIMBURSEMENT

The Wisconsin Department of Health Services will establish maximum allowable fees for all covered optometric services and supplies provided to Wisconsin Medicaid members eligible on the date of service. The maximum allowable fees shall be based on various factors, including a review of usual and customary charges submitted to Wisconsin Medicaid, the Wisconsin State Legislature's Medicaid budgetary constraints, and other relevant economic limitations. Maximum allowable fees may be adjusted to reflect reimbursement limits or limits on the availability of federal funding as specified in federal law.

Providers are required to bill their usual and customary charges for services provided. The usual and customary charge is the amount charged by the provider for the same service when provided to non-Medicaid patients, as defined by Wis. Admin. Code § DHS 101.03(181). For providers who have not established usual and customary charges, the charge should be reasonably related to the provider's cost for providing the service.

Wisconsin Medicaid reimbursement, less appropriate copays and payments by other insurers, will be considered payment in full.

Materials not covered under the Vision Care Volume Purchase Plan Contract will be reimbursed at no more than the average wholesale costs of the materials.

The Department of Health Services will adjust payments made to providers to reflect the amounts of any allowable copays that the providers are required to collect pursuant to Wis. Stat. ch. 49.

Payments for deductible and coinsurance payable on an assigned Medicare claim shall be made in accordance with Wis. Stat. § 49.46(2)(c).

In accordance with federal regulations contained in 42 C.F.R. § 447.205, the Department of Health Services will provide public notice in advance of the effective date of any significant proposed change in its methods and standards for setting maximum allowable fees for services.

P-01671 (10/2021)

Wisconsin
Department of Health Services