



**FORWARDHEALTH**

PROVIDER SERVICES  
313 BLETTNER BLVD  
MADISON WI 53784

Scott Walker  
Governor

Telephone: 800-947-9627  
TTY: 711 or 800-947-3529

Kitty Rhoades  
Secretary

**State of Wisconsin**

Department of Health Services

[www.forwardhealth.wi.gov](http://www.forwardhealth.wi.gov)

**OPTOMETRIST / OPTICIAN  
TERMS OF REIMBURSEMENT**

The Department of Health Services (DHS) 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. For providers using a sliding fee scale for specific services, the usual and customary charge is the median of the individual provider's charge for the service when provided to non-Medicaid patients.

Wisconsin Medicaid reimbursement, less appropriate copayments, and payments by other insurers will be considered to be 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 DHS will adjust payments made to providers to reflect the amounts of any allowable copayments that the providers are required to collect pursuant to ch. 49, Wis. Stats.

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

In accordance with federal regulations contained in 42 CFR 447.205, the DHS 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.

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