Certification and Ongoing Responsibilities

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Certification and Ongoing Responsibilities:Certification

Border Status Providers

A provider in a state that borders Wisconsin may be eligible for border-status certification. Border-status providers need to notify ForwardHealth in writing that it is common practice for members in a particular area of Wisconsin to seek their medical services.

Exceptions to this policy include:

- Nursing homes and public entities (e.g., cities, counties) outside Wisconsin are not eligible for border status.
- All out-of-state independent laboratories are eligible to be border-status providers regardless of location in the United States.

Providers who have been denied Medicaid certification in their own state are automatically denied certification by Wisconsin Medicaid unless they were denied because the services they provide are not a covered benefit in their state.

Certified border-status providers are subject to the same program requirements as in-state providers, including coverage of services and PA and claims submission procedures. Reimbursement is made in accordance with ForwardHealth policies.

For more information about out-of-state providers, refer to DHS 105.48, Wis. Admin. Code.

Categories of Certification

Wisconsin Medicaid certifies providers in four billing categories. Each billing category has specific designated uses and restrictions. These categories include the following:

- Billing/rendering provider.
- Rendering provider.
- Group billing that requires a rendering provider.
- Group billing that does not require a rendering provider.

Providers should refer to their certification materials or to service-specific information in the Online Handbook to identify what types of certification categories they may apply for or be assigned.

Billing/Rendering Provider

Certification as billing/rendering provider allows providers to identify themselves on claims (and other forms) as either the provider billing for the services or the provider rendering the services.

Rendering Provider

Certification as a rendering provider is given to those providers who practice under the professional supervision of another provider (e.g., physician assistants). Providers with a rendering provider certification cannot submit claims to ForwardHealth directly, but have reimbursement rates established for their provider type. Claims for services provided by a rendering provider must include the supervising provider or group provider as the billing provider.

Group Billing

Certification as a group billing provider is issued primarily as an accounting convenience. This allows a group billing provider to

receive one reimbursement, one RA, and the 835 transaction for covered services rendered by individual providers within the group.

Group Billing That Requires a Rendering Provider

Individual providers within certain groups are required to be Medicaid certified because these groups are required to identify the provider who rendered the service on claims. Claims indicating these group billing providers that are submitted without a rendering provider are denied.

Group Billing That Does Not Require a Rendering Provider

Other groups (e.g., physician pathology, radiology groups, and rehabilitation agencies) are not required to indicate a rendering provider on claims.

Group billing providers should refer to their certification materials or to service-specific information in the Online Handbook to determine whether or not a rendering provider is required on claims.

Certification Application

To participate in Wisconsin Medicaid, providers are required to be certified by Wisconsin Medicaid as described in DHS 105, Wis. Admin. Code. Providers certified by Wisconsin Medicaid may render services to members enrolled in Wisconsin Medicaid, BadgerCare Plus, and SeniorCare.

Providers interested in becoming certified by Wisconsin Medicaid are required to complete a provider application that consists of the following forms and information:

- General certification information.
- Certification requirements.
- TOR.
- Provider application.
- Provider Agreement and Acknowledgement of Terms of Participation.
- Other forms related to certification.

Providers may submit certification applications by mail or through the ForwardHealth Portal.

General Certification Information

This section of the provider application contains information on contacting ForwardHealth, certification effective dates, notification of certification decisions, provider agreements, and terms of reimbursement.

Certification Requirements

Wisconsin Administrative Code contains requirements that providers must meet in order to be certified with Wisconsin Medicaid; applicable Administrative Code requirements and any special certification materials for the applicant's provider type are included in the certification requirements document.

To become Medicaid certified, providers are required to do the following:

- Meet all certification requirements for their provider type.
- Submit a properly completed provider application, provider agreement, and other forms, as applicable, that are included in the certification packet.

Providers should carefully complete the certification materials and send all applicable documents demonstrating that they meet the

stated Medicaid certification criteria. Providers may call Provider Services for assistance with completing these materials.

Terms of Reimbursement

Wisconsin Medicaid certification materials include Wisconsin Medicaid's TOR, which describes the methodology by which providers are reimbursed for services provided to BadgerCare Plus, Medicaid, and SeniorCare members. Providers should retain a copy of the TOR in their files. TOR are subject to change during a certification period.

Provider Application

A key part of the certification process is the completion of the Wisconsin Medicaid Provider Application. On the provider application, the applicant furnishes contact, address, provider type and specialty, license, and other information needed by Wisconsin Medicaid to make a certification determination.

Provider Agreement and Acknowledgement of Terms of Participation

As part of the application for certification, providers are required to sign a provider agreement with the DHS. Providers applying for certification through the Portal will be required to print, sign and date, and send the provider agreement to Wisconsin Medicaid. Providers who complete a paper provider application will need to sign and date the provider agreement and submit it with the other certification materials.

By signing a provider agreement, the provider certifies that the provider and each person employed by the provider, for the purpose of providing services, holds all licenses or similar entitlements and meets other requirements specified in DHS 101 through DHS 109, Wis. Admin. Code, and required by federal or state statute, regulation, or rule for the provision of the service.

The provider's certification to participate in Wisconsin Medicaid may be terminated by the provider as provided at DHS 106.05, Wis. Admin. Code, or by the DHS upon grounds set forth in DHS 106.06, Wis. Admin. Code.

This provider agreement remains in effect as long as the provider is certified to participate in Wisconsin Medicaid.

Completing Certification Applications

Health care providers are required to include their NPI on the certification application.

Note: Obtaining an NPI does not replace the Wisconsin Medicaid certification process.

Portal Submission

Providers may apply for Medicaid certification directly through the ForwardHealth Portal. Though the provider certification application is available via the public Portal, the data are entered and transmitted through a secure connection to protect personal data. Applying for certification through the Portal offers the following benefits:

- Fewer returned applications. Providers who apply through the Portal are taken through a series of screens that are designed to guide them through the application process. This ensures that required information is captured and therefore reduces the instances of applications returned for missing or incomplete information.
- Instant submission. At the end of the online application process, applicants instantly submit their application to ForwardHealth and are given an ATN to use in tracking the status of their application.
- Indicates documentation requirements. At the end of the online process, applicants are also given detailed instructions about what actions are needed to complete the application process. For example, the applicant will be instructed to print the provider agreement and any additional forms that Wisconsin Medicaid must receive on paper and indicates whether supplemental information (e.g., transcripts, copy of license) is required. Applicants are also able to save a copy of the application for their

records.

Paper Submission

Providers may also submit provider applications on paper. To request a paper provider application, providers should do one of the following:

- Contact Provider Services.
- Click the "Contact Us" link on the Portal and send the request via e-mail.
- Send a request in writing to the following address:

  ForwardHealth
  Provider Maintenance
  6406 Bridge Rd
  Madison WI 53784-0006

Written requests for certification materials must include the following:

- The number of provider applications requested and each applicant's/provider's name, address, and telephone number (a provider application must be completed for each applicant/provider).
- The provider's NPI (for health care providers) that corresponds to the type of application being requested.
- The program for which certification is requested (Wisconsin Medicaid).
- The type of provider (e.g., physician, physician clinic or group, speech-language pathologist, hospital) or the type of services the provider intends to provide.

Paper provider applications are assigned an ATN at the time the materials are requested. As a result, examples of the provider application are available on the Portal for reference purposes only. These examples should not be downloaded and submitted to Wisconsin Medicaid. For the same reason, providers are not able to make copies of a single paper provider application and submit them for multiple applicants. These policies allow Wisconsin Medicaid to efficiently process and track certifications and assign effective dates.

Once completed, providers should mail certification materials to the address indicated on the application cover letter. Sending certification materials to any other Wisconsin Medicaid address may cause a delay.

Effective Date of Medicaid Certification

When assigning an initial effective date, ForwardHealth follows these regulations:

1. The date the provider submits his or her online provider application to ForwardHealth or contacts ForwardHealth for a paper application is the earliest effective date possible and will be the initial effective date if the following are true:
   - The provider meets all applicable licensure, certification, authorization, or other credential requirements as a prerequisite for Wisconsin Medicaid on the date of notification. Providers should not hold their application for pending licensure, Medicare, or other required certification but submit it to ForwardHealth. ForwardHealth will keep the provider's application on file and providers should send ForwardHealth proof of eligibility documents immediately, once available, for continued processing.
   - ForwardHealth received the provider agreement and any supplemental documentation within 30 days of submission of the online provider application.
   - ForwardHealth received the paper application within 30 days of the date the paper application was mailed.
2. If ForwardHealth receives the provider agreement and any applicable supplemental documents more than 30 days after the provider submitted the online application or receives the paper application more than 30 days after the date the paper application was mailed, the provider's effective date will be the date the complete application was received at ForwardHealth.
3. If ForwardHealth receives the provider's application within the 30-day deadline described above and it is incomplete or

unclear, the provider will be granted one 30-day extension to respond to ForwardHealth's request for additional information. ForwardHealth must receive a response to the request for additional information within 30 days from the date on the letter requesting the missing information or item(s). This extension allows the provider additional time to obtain proof of eligibility (such as license verification, transcripts, or other certification).
4. If the provider does not send complete information within the original 30-day deadline or 30-day extension, the initial effective date will be based on the date ForwardHealth receives the complete and accurate application materials.

Group Certification Effective Dates

Group billing certifications are given as a billing convenience. Groups (except providers of mental health services) may submit a written request to obtain group billing certification with a certification effective date back 365 days from the effective date assigned. Providers should mail requests to backdate group billing certification to the following address:

ForwardHealth
Provider Maintenance
6406 Bridge Rd
Madison WI 53784-0006

Request for Change of Effective Date

If providers believe their initial certification effective date is incorrect, they may request a review of the effective date. The request should include documentation that indicates the certification criteria that were incorrectly considered. Requests for changes in certification effective dates should be sent to Provider Maintenance.

Medicare Enrollment

ForwardHealth requires certain types of providers to be enrolled in Medicare as a condition for Medicaid certification. This requirement is specified in the certification materials for these provider groups.

The enrollment process for Medicare is separate from Wisconsin Medicaid's certification process. Providers applying for Medicare enrollment *and* Medicaid certification are encouraged to apply for Wisconsin Medicaid certification at the same time they apply for Medicare enrollment, even though Medicare enrollment must be finalized first. By applying for Medicare enrollment and Medicaid certification simultaneously, it may be possible for ForwardHealth to assign a Medicaid certification effective date that is the same as the Medicare enrollment date.

Materials for New Providers

On an ongoing basis, providers should refer to the Online Handbook for the most current BadgerCare Plus and Medicaid information. Future changes to policies and procedures are published in *Updates*.

Certain providers may opt not to receive these materials by completing the Deletion from Publications Mailing List form in the certification materials. Providers who opt out of receiving publications are still bound by ForwardHealth's rules, policies, and regulations even if they choose not to receive *Updates* on an ongoing basis. *Updates* are available for viewing and downloading on the ForwardHealth Portal.

Multiple Locations

The number of Medicaid certifications allowed or required per location is based on licensure, registration, certification by a state or federal agency, or an accreditation association identified in the Wisconsin Administrative Code. Providers with multiple locations should inquire if multiple applications must be completed when requesting a Medicaid certification application.

Multiple Services

Providers who offer a variety of services may be required to complete a separate Medicaid certification packet for each specified service/provider type.

Health care providers who are federally required to have an NPI are responsible for obtaining the appropriate certification for their NPI.

If a Medicaid-certified provider begins offering a new service *after* he or she has become initially certified, it is recommended that he or she call Provider Services to inquire if another application must be completed.

Noncertified In-State Providers

Wisconsin Medicaid reimburses noncertified in-state providers for providing emergency medical services to a member or providing services to a member during a time designated by the governor as a state of emergency. The emergency situation or the state of emergency must be sufficiently documented on the claim. Reimbursement rates are consistent with rates for Wisconsin Medicaid-certified providers rendering the same service.

Claims from noncertified in-state providers must be submitted with an In-State Emergency Provider Data Sheet. The In-State Emergency Provider Data Sheet provides ForwardHealth with minimal tax and licensure information.

Noncertified in-state providers may call Provider Services with questions.

Notice of Certification Decision

Wisconsin Medicaid will notify the provider of the status of the certification usually within 10 business days, but no longer than 60 days, after receipt of the complete application for certification. Wisconsin Medicaid will either approve the application and issue the certification or deny the application. If the application for certification is denied, Wisconsin Medicaid will give the applicant reasons, in writing, for the denial.

Providers who meet the certification requirements will be sent a welcome letter and a copy of the signed provider agreement. Included with the letter is an attachment with important information such as effective dates, assigned provider type and specialty, and taxonomy code. This information will be used when conducting business with BadgerCare Plus, Medicaid, or SeniorCare (for example, health care providers will need to include their taxonomy code, designated by Wisconsin Medicaid, on claim submissions and requests for PA).

The welcome letter will also notify non-healthcare providers (e.g., SMV providers, personal care agencies, blood banks) of their Medicaid provider number. This number will be used on claim submissions, PA requests, and other communications with ForwardHealth programs.

Out-of-State Providers

Out-of-state providers are limited to those providers who are licensed in the United States (and its territories), Mexico, and Canada. Out-of-state providers are required to be licensed in their own state of practice.

Wisconsin Medicaid reimburses out-of-state providers for providing emergency medical services to a BadgerCare Plus or Medicaid member or providing services to a member during a time designated by the governor as a state of emergency. The emergency situation or the state of emergency must be sufficiently documented on the claim. Reimbursement rates are consistent with rates for Wisconsin Medicaid-certified providers providing the same service.

Out-of-state providers are reimbursed for services provided to eligible BadgerCare Plus or Medicaid members in either of the following situations:

- The service was provided in an emergency situation, as defined in DHS 101.03(52), Wis. Admin. Code.
- PA was obtained from ForwardHealth *before* the nonemergency service was provided.

Claims from noncertified out-of-state providers must be submitted with an Out-of-State Provider Data Sheet. The Out-of-State Provider Data Sheet provides Wisconsin Medicaid with minimal tax and licensure information.

Out-of-state providers may contact Provider Services with questions.

Provider Addresses

ForwardHealth interChange has the capability of storing the following types of addresses and related information, such as contact information and telephone numbers:

- *Practice location address and related information (formally known as physical address).* This address is where the provider's office is physically located and where records are normally kept. Additional information for the practice location includes the provider's office telephone number and telephone number for member's use. With limited exceptions, the practice location and telephone number for member's use are published in a provider directory made available to the public.
- *Mailing address.* This address is where ForwardHealth will mail general information and correspondence. Providers should indicate concise address information to aid in proper mail delivery.
- *PA address.* This address is where ForwardHealth will mail PA information.
- *Financial addresses (formally known as payee address).* Two separate financial addresses are stored in ForwardHealth interChange. The checks address is where Wisconsin Medicaid will mail paper checks. The 1099 mailing address is where Wisconsin Medicaid will mail IRS Form 1099.

Providers may submit additional address information or modify their current information through the ForwardHealth Portal or by using the Provider Change of Address or Status form.

Note: Providers are cautioned that any changes to their practice location on file with ForwardHealth may alter their ZIP+4 code information required on transactions. Providers may verify the ZIP+4 code for their address on the U.S. Postal Service Web site.

Provider addresses are stored separately for each program (i.e., Medicaid, WCDP, and WWWP) for which the provider is certified. Providers should consider this when supplying additional address information and keeping address information current. Providers who are certified for multiple programs and have an address change that applies to more than one program should provide this information for each program. Providers who submit these changes on paper need to submit *one* Provider Change of Address or Status form if changes are applicable for multiple programs.

Provider Type and Specialty Changes

Providers who want to add a certification type or make a change to their certification type should call Provider Services.

Health care providers who are federally required to have an NPI are cautioned that any changes to their provider type and/or specialty information on file with ForwardHealth may alter the applicable taxonomy code for a provider's certification.

Reinstating Certification

Providers whose Medicaid certification has ended for any reason other than sanctions or failure to be recertified may have their certification reinstated as long as all licensure and certification requirements are met. The criteria for reinstating certification vary, depending upon the reason for the cancellation and when the provider's certification ended.

If it has been less than 365 days since a provider's certification has ended, the provider is required to submit a letter or the Provider Change of Address or Status form, stating that he or she wishes to have his or her Medicaid certification reinstated.

If it has been more than 365 days since a provider's certification has ended, the provider is required to submit new certification materials. This can be done by completing them through the ForwardHealth Portal or submitting a paper provider application.

Requirements

For Wisconsin Medicaid and SeniorCare certification for dispensing pharmaceuticals, the provider is required to be licensed by the Wisconsin DR&L in one or both of the following ways:

- As a pharmacy, currently meeting all requirements in chapters 450 and 961, Wis. Stats., chapters Phar 1 through 14 and chapters CSB 1 and 2, Wis. Admin. Code.
- As a physician, currently licensed to practice medicine and surgery according to sections 448.05 and 448.07, Wis. Stats., and ch. Med 1, Med 2, Med 3, Med 4, Med 5, and Med 14, Wis. Admin. Code.

Pharmacies

Any Wisconsin Medicaid or SeniorCare certified pharmacy provider or dispensing physician submitting claims to ForwardHealth for pharmacy services is considered a pharmacy provider.

A pharmacist is an individual licensed as such under ch. 450, Wis. Stats. Wisconsin Medicaid and SeniorCare do not certify individual pharmacists.

Pharmacies that change ownership or locations are required to notify Provider Services of all changes, including a new license number. When pharmacies have multiple locations, each location with a unique license number is required to have its own Medicaid certification and provider number.

In addition to drugs, pharmacies may dispense DME, DMS, and enteral nutrition products without separate certification. The DME service area, the DMS service area, and the Enteral Nutrition Products service area contain information about covered services, PA guidelines, and billing instructions.

Medicare

Pharmacy providers are required to be Medicare certified if they provide a Medicare-covered service to a dual eligible. If the provider is not Medicare certified, the provider should refer the dual eligible to another Medicaid provider who is also Medicare certified.

Dispensing Physicians

A dispensing physician is a physician who dispenses medication to patients and submits claims to ForwardHealth. These medications must be dispensed according to pharmacy dispensing rules. This does not include giving samples.

Dispensing physicians are required to comply with all related limitations and service requirements in the Pharmacy service area.

Tracking Certification Materials

Wisconsin Medicaid allows providers to track the status of their certification application either through the ForwardHealth Portal or by calling Provider Services. Providers who submitted their application through the Portal will receive the ATN upon submission, while providers who request certification materials from Wisconsin Medicaid will receive an ATN on the application cover letter sent

with their provider application. Regardless of how certification materials are submitted, providers may use one of the methods listed to track the status of their certification application.

Note: Providers are required to wait for the Notice of Certification Decision as official notification that certification has been approved. This notice will contain information the provider needs to conduct business with BadgerCare Plus, Medicaid, or SeniorCare; therefore, an approved or enrolled status alone does not mean the provider may begin providing or billing for services.

Tracking Through the Portal

Providers are able to track the status of a certification application through the Portal by entering their ATN. Providers will receive current information on their application, such as whether it's being processed or has been returned for more information.

Tracking Through Provider Services

Providers may also check on the status of their submitted application by contacting Provider Services and giving their ATN.

Documentation

1099 Miscellaneous Forms

ForwardHealth generates the 1099 Miscellaneous form in January of each year for earnings greater than $600.00, per Internal Revenue Service regulations. One 1099 Miscellaneous form per financial payer and per tax identification number is generated, regardless of how many provider IDs or NPIs share the same tax identification number. For example, a provider who conducts business with both Medicaid and WCDP will receive separate 1099 Miscellaneous forms for each program.

The 1099 Miscellaneous forms are sent to the address designated as the "1099 mailing address." The address formerly known as the "payee address" is used as the 1099 mailing address unless a provider has reported a separate address for the 1099 mailing address to ForwardHealth.

Availability of Records to Authorized Personnel

The DHCAA has the right to inspect, review, audit, and reproduce provider records pursuant to DHS 106.02(9)(e), Wis. Admin. Code. The DHCAA periodically requests provider records for compliance audits to match information against ForwardHealth's information on paid claims, PA requests, and enrollment. These records include, but are not limited to, medical/clinical and financial documents. Providers are obligated to ensure that the records are released to an authorized DHCAA staff member(s).

Wisconsin Medicaid reimburses providers $0.06 per page for the cost of reproducing records requested by the DHCAA to conduct a compliance audit. A letter of request for records from the DHCAA will be sent to a provider when records are required.

Reimbursement is not made for other reproduction costs included in the provider agreement between the DHCAA and a provider, such as reproduction costs for submitting PA requests and claims.

Also, state-contracted MCOs, including HMOs and SSI HMOs, are not reimbursed for the reproduction costs covered in their contract with the DHS.

The reproduction of records requested by the PRO under contract with the DHCAA is reimbursed at a rate established by the PRO.

Confidentiality

ForwardHealth supports member rights regarding the confidentiality of health care and other related records, including an applicant or member's billing information or medical claim records. An applicant or member has a right to have this information safeguarded, and the provider is obligated to protect that right. Therefore, use or disclosure of any information concerning applicants and members for any purpose not connected with program administration, including contacts with third-party payers that are necessary for pursuing third-party payment and the release of information as ordered by the court, is prohibited unless authorized by the applicant or member.

To comply with the standards, providers are required to follow the procedures outlined in the Online Handbook to ensure the proper release of this information. ForwardHealth providers, like other health care providers, are also subject to other laws protecting confidentiality of health care information including, but not limited to, the following:

- s. 146.81-146.84, Wis. Stats., Wisconsin health care confidentiality of health care information regulations.
- 42 USC s. 1320d - 1320d-8 (federal HIPAA) and accompanying regulations.

Any person violating this regulation may be fined an amount from $25 up to $500 or imprisoned in the county jail from 10 days up to

one year, or both, for each violation.

A provider is not subject to civil or criminal sanctions when releasing records and information regarding applicants or members if such release is for purposes directly related to administration or if authorized in writing by the applicant or member.

Financial Records

According to DHS 106.02(9)(c), Wis. Admin. Code, a provider is required to maintain certain financial records in written or electronic form.

Medical Records

A dated clinician's signature must be included in all medical notes. According to DHS 106.02(9)(b), Wis. Admin. Code, a provider is required to include certain written documentation in a member's medical record.

Member Access to Records

Providers are required to allow members access to their health care records, including those related to ForwardHealth services, maintained by a provider in accordance with Wisconsin Statutes, excluding billing statements.

Fees for Health Care Records

Per s. 146.83, Wis. Stats., providers may not charge a fee for providing one set of copies of health care records to members who are enrolled in Wisconsin Medicaid or BadgerCare Plus programs on the date of the records request. Members who are enrolled on the date of the records request may obtain one free copy of each document in their record. This applies regardless of the member's enrollment status on the DOS contained within the health care records.

Per s. 146.81(4), Wis. Stats., health care records are all records related to the health of a patient prepared by, or under the supervision of, a health care provider.

For information regarding fees that may be charged to members for health care records, such as paper copies, microfiche, and X-rays beyond the first set of copies, refer to s. 146.83(1f), Wis. Stats.

Fee Refunds

If a provider has collected a fee for the first set of copies of health care records provided to an enrolled member, and the member requests a refund, the provider is required to refund the fee to the member.

Preparation and Maintenance of Records

All providers who receive payment from Wisconsin Medicaid, including state-contracted MCOs, are required to maintain records that fully document the basis of charges upon which all claims for payment are made, according to DHS 106.02(9)(a), Wis. Admin. Code. This required maintenance of records is typically required by any third-party insurance company and is not unique to ForwardHealth.

Record Retention

Providers are required to retain documentation, including medical and financial records, for a period of not less than five years from

the date of payment, except RHCs, who are required to retain records for a minimum of six years from the date of payment.

According to DHS 106.02(9)(d), Wis. Admin. Code, providers are required to retain all evidence of billing information.

Ending participation as a provider does not end a provider's responsibility to retain and provide access to fully maintained records unless an alternative arrangement of record retention and maintenance has been established.

Reviews and Audits

The DHS periodically reviews provider records. The DHS has the right to inspect, review, audit, and photocopy the records. Providers are required to permit access to any requested record(s), whether in written, electronic, or micrographic form.

Records Requests

Requests for billing or medical claim information regarding services reimbursed by BadgerCare Plus may come from a variety of individuals including attorneys, insurance adjusters, and members. Providers are required to notify ForwardHealth by contacting Provider Services when releasing billing information or medical claim records relating to charges for covered services except the following:

- When the member is a dual eligible (i.e., member is eligible for both Medicare and Wisconsin Medicaid or BadgerCare Plus) and is requesting materials pursuant to *Medicare* regulations.
- When the provider is attempting to exhaust all existing health insurance sources prior to submitting claims to BadgerCare Plus.

Request from a Member or Authorized Person

If the request for a member's billing information or medical claim records is from a member or authorized person acting on behalf of the member, the provider should send a copy of the requested billing information or medical claim records, along with the name and address of the requester, to the following address:

Department of Health Services
Casualty/Subrogation Program
PO Box 6243
Madison WI 53791

ForwardHealth will process and forward the requested information to the requester.

Request from an Attorney, Insurance Company, or Power of Attorney

If the request for a member's billing information or medical claim records is from an attorney, insurance company, or power of attorney, the provider should do the following:

1. Obtain a release signed by the member or authorized representative.
2. Furnish the requested material to the requester, marked "BILLED TO FORWARDHEALTH" or "TO BE BILLED TO FORWARDHEALTH," with a copy of the release signed by the member or authorized representative. Approval from ForwardHealth is not necessary.
3. Send a copy of the material furnished to the requestor, along with a copy of their original request and medical authorization release to:

    Wisconsin Casualty Recovery — HMS
    Ste 100
    5615 Highpoint Dr
    Irving TX 75038-9984

Request for Information About a Member Enrolled in a State-Contracted Managed Care Organization

If the request for a member's billing information or medical claim records is for a member enrolled in a state-contracted MCO, the provider is required to do the following:

1. Obtain a release signed by the member or authorized representative.
2. Send a copy of the letter requesting the information, along with the release signed by the member or authorized representative, directly to the MCO.

The MCO makes most benefit payments and is entitled to any recovery that may be available.

Request for a Statement from a Dual Eligible

If the request is for an itemized statement from a dual eligible, pursuant to HR 2015 (Balanced Budget Act of 1997) s. 4311, a dual eligible has the right to request and receive an itemized statement from his or her Medicare-certified health care provider. The Act requires the provider to furnish the requested information to the member. The Act does *not* require the provider to notify ForwardHealth.

Release of Billing Information to Government Agencies

Providers are permitted to release member information without informed consent when a written request is made by the DHS or the federal HHS to perform any function related to program administration, such as auditing, program monitoring, and evaluation.

Providers are authorized under BadgerCare Plus confidentiality regulations to report suspected misuse or abuse of program benefits to the DHS, as well as to provide copies of the corresponding patient health care records.

Ongoing Responsibilities

Accommodating Members with Disabilities

All providers, including ForwardHealth providers, operating an existing public accommodation have requirements under Title III of the Americans with Disabilities Act of 1990 (nondiscrimination).

Change in Ownership

New certification materials, including a provider agreement, must be completed whenever a change in ownership occurs. ForwardHealth defines a "change in ownership" as when a different party purchases (buys out) or otherwise obtains ownership or effective control over a practice or facility. Examples of a change in ownership include the following:

- A sole proprietorship transfers title and property to another party.
- Two or more corporate clinics or centers consolidate and a new corporate entity is created.
- There is an addition, removal, or substitution of a partner in a partnership.
- An incorporated entity merges with another incorporated entity.
- An unincorporated entity (sole proprietorship or partnership) becomes incorporated.

The following provider types require Medicare enrollment and/or DQA certification for Wisconsin Medicaid certification change in ownerships:

- Ambulatory surgery centers.
- ESRD services providers.
- Federally qualified health centers.
- Home health agencies.
- Hospice providers.
- Hospitals (inpatient and outpatient).
- Nursing homes.
- Outpatient rehabilitation facilities.
- Rehabilitation agencies.
- RHCs.

All changes in ownership must be reported in writing to ForwardHealth and new certification materials must be completed *before* the effective date of the change. The affected provider numbers should be noted in the letter. When the change in ownership is complete, the provider(s) will receive written notification of his or her provider number and the new Medicaid certification effective date in the mail.

Providers with questions about change in ownership should call Provider Services.

Repayment Following Change in Ownership

Medicaid-certified providers who sell or otherwise transfer their business or business assets are required to repay ForwardHealth for any erroneous payments or overpayments made to them by Wisconsin Medicaid. If necessary, the provider to whom a transfer of ownership is made will also be held liable by ForwardHealth for repayment. Therefore, prior to final transfer of ownership, the provider acquiring the business is responsible for contacting ForwardHealth to ascertain if he or she is liable under this provision.

The provider acquiring the business is responsible for making payments within 30 days after receiving notice from the DHS that the amount shall be repaid in full.

Providers may send inquiries about the determination of any pending liability on the part of the owner to the following address:

Division of Health Care Access and Accountability
Bureau of Program Integrity
PO Box 309
Madison WI 53701-0309

ForwardHealth has the authority to enforce these provisions within four years following the transfer of a business or business assets. Refer to s. 49.45(21), Wis. Stats., for complete information.

Civil Rights Compliance (Nondiscrimination)

Providers are required to comply with all federal laws relating to Title XIX of the Social Security Act and state laws pertinent to ForwardHealth, including the following:

- Title VI and VII of the Civil Rights Act of 1964.
- The Age Discrimination Act of 1975.
- Section 504 of the Rehabilitation Act of 1973.
- The ADA of 1990.

The previously listed laws require that all health care benefits under ForwardHealth be provided on a nondiscriminatory basis. No applicant or member can be denied participation in ForwardHealth or be denied benefits or otherwise subjected to discrimination in any manner under ForwardHealth on the basis of race, color, national origin or ancestry, sex, religion, age, disability, or association with a person with a disability.

Any of the following actions may be considered discriminatory treatment when based on race, color, national origin, disability, or association with a person with a disability:

- Denial of aid, care, services, or other benefits.
- Segregation or separate treatment.
- Restriction in any way of any advantage or privilege received by others. (There are some program restrictions based on eligibility classifications.)
- Treatment different from that given to others in the determination of eligibility.
- Refusing to provide an oral language interpreter to persons who are considered LEP at no cost to the LEP individual in order to provide meaning access.
- Not providing translation of vital documents to the LEP groups who represent five percent or 1,000, whichever is smaller, in the provider's area of service delivery.

Note: Limiting practice by age is not age discrimination and specializing in certain conditions is not disability discrimination. For further information, see 45 CFR Part 91.

Providers are required to be in compliance with the previously mentioned laws as they are currently in effect or amended. Providers who employ 25 or more employees and receive $25,000 or more annually in Medicaid reimbursement are also required to comply with the DHS Affirmative Action and Civil Rights Compliance Plan requirements. Providers that employ less than 25 employees and receive less than $25,000 annually in Medicaid reimbursement are required to comply by submitting a Letter of Assurance and other appropriate forms.

Providers without Internet access may obtain copies of the DHS Affirmative Action and Civil Rights Compliance Plan (including the Letter of Assurance and other forms) and instructions by calling the Affirmative Action and Civil Rights Compliance Officer at (608) 266-9372. Providers may also write to the following address:

AA/CRC Office

1 W Wilson St Rm 561
PO Box 7850
Madison WI 53707-7850

For more information on the acts protecting members from discrimination, refer to the civil rights compliance information in the Enrollment and Benefits booklet. The booklet is given to new ForwardHealth members by local county or tribal agencies. Potential ForwardHealth members can request the booklet by calling Member Services.

Title VI of the Civil Rights Act of 1964

This act requires that all benefits be provided on a nondiscriminatory basis and that decisions regarding the provision of services be made without regard to race, color, or national origin. Under this act, the following actions are prohibited, if made on the basis of race, color, or national origin:

- Denying services, financial aid, or other benefits that are provided as a part of a provider's program.
- Providing services in a manner different from those provided to others under the program.
- Aggregating or separately treating clients.
- Treating individuals differently in eligibility determination or application for services.
- Selecting a site that has the effect of excluding individuals.
- Denying an individual's participation as a member of a planning or advisory board.
- Any other method or criteria of administering a program that has the effect of treating or affecting individuals in a discriminatory manner.

Title VII of the Civil Rights Act of 1964

This act prohibits differential treatment, based solely on a person's race, color, sex, national origin, or religion, in the terms and conditions of employment. These conditions or terms of employment are failure or refusal to hire or discharge compensation and benefits, privileges of employment, segregation, classification, and the establishment of artificial or arbitrary barriers to employment.

Federal Rehabilitation Act of 1973, Section 504

This act prohibits discrimination in both employment and service delivery based solely on a person's disability.

This act requires the provision of reasonable accommodations where the employer or service provider cannot show that the accommodation would impose an undue hardship in the delivery of the services. A reasonable accommodation is a device or service modification that will allow the disabled person to receive a provider's benefits. An undue hardship is a burden on the program that is not equal to the benefits of allowing that handicapped person's participation.

A handicapped person means any person who has a physical or mental impairment that substantially limits one or more major life activities, has a record of such an impairment, or is regarded as having such an impairment.

In addition, Section 504 requires "program accessibility," which may mean building accessibility, outreach, or other measures that allow for full participation of the handicapped individual. In determining program accessibility, the program or activity will be viewed in its entirety. In choosing a method of meeting accessibility requirements, the provider shall give priority to those methods that offer a person who is disabled services that are provided in the most integrated setting appropriate.

Americans with Disabilities Act of 1990

Under Title III of the ADA of 1990, any provider that operates an existing public accommodation has four specific requirements:

1. Remove barriers to make his or her goods and services available to and usable by people with disabilities to the extent that it is readily achievable to do so (i.e., to the extent that needed changes can be accomplished without much difficulty or expense).

2. Provide auxiliary aids and services so that people with sensory or cognitive disabilities have access to effective means of communication, unless doing so would fundamentally alter the operation or result in undue burdens.
3. Modify any policies, practices, or procedures that may be discriminatory or have a discriminatory effect, unless doing so would fundamentally alter the nature of the goods, services, facilities, or accommodations.
4. Ensure that there are no unnecessary eligibility criteria that tend to screen out or segregate individuals with disabilities or limit their full and equal enjoyment of the place of public accommodation.

Age Discrimination Act of 1975

The Age Discrimination Act of 1975 prohibits discrimination on the basis of age in programs and activities receiving federal financial assistance. The Act, which applies to all ages, permits the use of certain age distinctions and factors other than age that meet the Act's requirements.

Contracted Staff

Under a few circumstances (e.g., personal care, case management services), providers may contract with non-Medicaid certified agencies for services. Providers are legally, programmatically, and fiscally responsible for the services provided by their contractors and their contractor's services.

When contracting services, providers are required to monitor the contracted agency to ensure that the agency is meeting member needs and adhering to ForwardHealth requirements.

Providers are also responsible for informing a contracted agency of ForwardHealth requirements. Providers should refer those with whom they contract for services to ForwardHealth publications for program policies and procedures. ForwardHealth references and publications include, but are not limited to, the following:

- Wisconsin Administrative Code.
- *ForwardHealth Updates*.
- The Online Handbook.

Providers should encourage contracted agencies to visit the ForwardHealth Portal regularly for the most current information.

Examples of Ongoing Responsibilities

Responsibilities for which providers are held accountable are described throughout the Online Handbook. Medicaid-certified providers have responsibilities that include, but are not limited to, the following:

- Providing the same level and quality of care to ForwardHealth members as private-pay patients.
- Complying with all state and federal laws related to ForwardHealth.
- Obtaining PA for services, when required.
- Notifying members in advance if a service is not covered by ForwardHealth and the provider intends to collect payment from the member for the service.
- Maintaining accurate medical and billing records.
- Retaining preparation, maintenance, medical, and financial records, along with other documentation, for a period of not less than five years from the date of payment, except rural health clinic providers who are required to retain records for a minimum of six years from the date of payment.
- Billing only for services that were actually provided.
- Allowing a member access to his or her records.
- Monitoring contracted staff.
- Accepting Medicaid reimbursement as payment in full for covered services.
- Keeping provider information (i.e., address, business name) current.
- Notifying ForwardHealth of changes in ownership.

- Responding to Medicaid recertification notifications.
- Safeguarding member confidentiality.
- Verifying member enrollment.
- Keeping up-to-date with changes in program requirements as announced in ForwardHealth publications.

Keeping Information Current

Types of Changes

Providers are required to notify ForwardHealth of changes, including the following:

- Address(es) — practice location and related information, mailing, PA, and/or financial.
- Telephone number, including area code.
- Business name.
- Contact name.
- Federal Tax ID number (IRS number).
- Group affiliation.
- Licensure.
- Medicare NPI for health care providers or Medicare provider number for providers of *non-healthcare* services.
- Ownership.
- Professional certification.
- Provider specialty.
- Supervisor of nonbilling providers.

Failure to notify ForwardHealth of changes may result in the following:

- Incorrect reimbursement.
- Misdirected payment.
- Claim denial.
- Suspension of payments in the event that provider mail is returned to ForwardHealth for lack of a current address.

Entering new information on a claim form or PA request is *not* adequate notification of change.

Address Changes

Healthcare providers who are federally required to have an NPI are cautioned that changes to their practice location address on file with ForwardHealth may alter their ZIP+4 code information that is required on transactions.

Submitting Changes in Address or Status

Once certified, providers are required to submit changes in address or status as they occur, either through the Portal or on paper.

ForwardHealth Portal Submission

After establishing a provider account on the ForwardHealth Portal, providers may make changes to their demographic information online. Changes made through the Portal instantly update the provider's information in ForwardHealth interChange. In addition, since the provider is allowed to make changes directly to his or her information, the process does not require re-entry by ForwardHealth.

Providers should note, however, that the demographic update function of the Portal limits certain providers from modifying some types of information. Providers who are not able to modify certain information through the Portal may make these changes using the Provider Change of Address or Status form.

Paper Submission

Providers must use the Provider Change of Address or Status form. Copies of old versions of this form will not be accepted and will be returned to the provider so that he or she may complete the current version of the form or submit changes through the Portal.

Change Notification Letter

When a change is made to certain provider information, either through the use of the Provider Change of Address or Status form or through the Portal, ForwardHealth will send a letter notifying the provider of the change(s) made. Providers should carefully review the Provider File Information Change Summary included with the letter. If any information on this summary is incorrect, providers may do one of the following:

- If the provider made an error while submitting information on the Portal, he or she should correct the information through the Portal.
- If the provider submitted incorrect information using the Provider Change of Address or Status form, he or she should either submit a corrected form or correct the information through the Portal.
- If the provider submitted correct information on the Provider Change of Address or Status form and believes an error was made in processing, he or she can contact Provider Services to have the error corrected or submit the correct information via the Portal.

Notify Division of Quality Assurance of Changes

Providers licensed or certified by the DQA are required to notify the DQA of changes to physical address, changes of ownership, and facility closures by calling (608) 266-8481.

Providers licensed or certified by the DQA are required to notify the DQA of these changes *before* notifying ForwardHealth. The DQA will then forward the information to ForwardHealth.

Legal Framework

The following laws and regulations provide the legal framework for BadgerCare Plus, Medicaid, and Wisconsin Well Woman Medicaid:

- Federal Law and Regulation:
  - Law — United States Social Security Act; Title XIX (42 US Code ss. 1396 and following) and Title XXI.
  - Regulation — Title 42 CFR Parts 430-498 and Parts 1000-1008 (Public Health).
- Wisconsin Law and Regulation:
  - Law — Wisconsin Statutes: 49.43-49.499, 49.665, and 49.473.
  - Regulation — Wisconsin Administrative Code, Chapters DHS 101, 102, 103, 104, 105, 106, 107, and 108.

Laws and regulations may be amended or added at any time. Program requirements may not be construed to supersede the provisions of these laws and regulations.

The information included in the ForwardHealth Portal applies to BadgerCare Plus, Medicaid, and Wisconsin Well Woman Medicaid. BadgerCare Plus, Medicaid, and Wisconsin Well Woman Medicaid are administered by the DHS. Within the DHS, the DHCAA is directly responsible for managing these programs.

Prescription

2003 Wisconsin Act 272

2003 Wisconsin Act 272

2003 Wisconsin Act 272 mandates that providers may not disclose a practitioner's federal registration number without consent. Under this act, prescribing providers may decline to authorize the use of their DEA number for claims and PA requests, except when indicated on a prescription for a controlled substance. Violators of the provisions to Wisconsin Act 272 are subject to financial penalties.

DEA numbers, including "default" DEA numbers, are not accepted for the Prescriber ID on POS claims. An NPI is the only identifier accepted in the Prescriber ID field on POS claims. Billing providers are required to make every effort possible to obtain the prescribing provider's NPI. Only when the billing provider is unable to obtain the prescriber's NPI, may the billing provider indicate his or her own NPI in the Prescriber ID field.

Drug Enforcement Agency Number Audits

All prescriptions for controlled substances must indicate the DEA number of the prescriber. DEA numbers are not required on claims or PAs.

Advanced Practice Nurse Prescriber Requirements

Chapter N8, Wis. Admin. Code, authorizes the certification of qualified advanced practice nurses as advanced practice nurse prescribers to issue prescriptions, with certain limitations.

Advanced practice nurse prescribers are encouraged to write their DEA number on all prescriptions for BadgerCare Plus and SeniorCare members.

Prescriber Information for Drug Prescriptions

Most legend and certain OTC drugs are covered. (A legend drug is one whose outside package has the legend or phrase "Caution, federal law prohibits dispensing without a prescription" printed on it.)

Coverage for some drugs may be restricted by one of the following policies:

- PDL.
- PA.
- Brand medically necessary drugs that require PA.
- Diagnosis-restricted drugs.
- Age-restricted and gender-restricted drugs.

Prescribers are encouraged to write prescriptions for drugs that do not have restrictions; however, processes are available to obtain reimbursement for medically necessary drugs that do have restrictions.

For the most current prescription drug information, refer to the Pharmacy Data Tables. Providers may also call Provider Services for more information.

Contraceptives

Contraceptives are covered for females who are 10 through 65 years of age. Quantity limits, age-restrictions, and gender-restrictions apply to contraceptives.

ForwardHealth has adopted the gender restriction coding from First DataBank. The gender restrictions are automatically updated by First DataBank.

Preferred Drug List

Most preferred drugs on the PDL do *not* require PA, although these drugs may have other restrictions (e.g., age, diagnosis); non-preferred drugs *do* require PA. Prescribers are encouraged to write prescriptions for preferred drugs; however, a PA process is available for non-preferred drugs if the drugs are medically necessary. Prescribers are encouraged to try more than one preferred drug, if medically appropriate for the member, before prescribing a non-preferred drug.

Prescriber Responsibilities for Non-preferred Drugs

Prescribers should determine the ForwardHealth benefit plan in which a member is enrolled before writing a prescription. If a member is enrolled in the BadgerCare Plus Standard Plan, Medicaid, or SeniorCare, prescribers are encouraged to write prescriptions for preferred drugs. Prescribers are encouraged to prescribe more than one preferred drug before a non-preferred drug is prescribed.

If a non-preferred drug or a preferred drug that requires clinical PA is medically necessary for a member, the prescriber is required to complete a PA request for the drug. Prescribers are required to complete the appropriate PA form and submit it to the pharmacy provider where the prescription will be filled. When completing the PA form, prescribers are reminded to sign and date the form. PA request forms may be faxed or mailed to the pharmacy provider, or the member may carry the form with the prescription to the pharmacy provider. The pharmacy provider will use the completed form to submit a PA request to ForwardHealth. The prescriber is required to attest on the form that the member meets the clinical criteria for PA approval. Prescribers should not submit PA forms to ForwardHealth.

Prescribers and pharmacy providers are required to retain a completed copy of the PA form.

For BadgerCare Plus Benchmark Plan, BadgerCare Plus Core Plan, and BadgerCare Plus Basic Plan members, prescribers should be aware of drugs covered by the benefit plan and write prescriptions for drugs that are covered by the plan.

If a noncovered drug is medically necessary for a Benchmark Plan, Core Plan, or Basic Plan member, the prescriber should inform the member the drug is not covered by the benefit plan. The prescriber should instruct the member to work with his or her pharmacy provider to determine whether or not the drug is covered by BadgerRx Gold.

Diagnosis-Restricted Drugs

Prescribers are required to include a diagnosis description on prescriptions for those drugs that are diagnosis-restricted.

Prescribing Drugs Manufactured by Companies Who Have Not Signed the Rebate Agreement

By federal law, pharmaceutical manufacturers who participate in state Medicaid programs must sign a rebate agreement with the CMS. BadgerCare Plus, Medicaid, and SeniorCare will cover legend and specific categories of OTC products of manufacturers who have signed a rebate agreement.

Note: SeniorCare does not cover OTC drugs, except insulin.

ForwardHealth has identified drug manufacturers who have signed the rebate agreement. By signing the rebate agreement, the

manufacturer agrees to pay ForwardHealth a rebate equal to a percentage of its "sales" to ForwardHealth.

Drugs of companies choosing not to sign the rebate agreement, with few exceptions, are not covered. A Medicaid-certified pharmacy can confirm for prescribers whether or not a particular drug manufacturer has signed the agreement.

Members Enrolled in the BadgerCare Plus Standard Plan, Medicaid, or SeniorCare (Levels 1 and 2a)

BadgerCare Plus, Medicaid, and SeniorCare levels 1 and 2a may cover certain FDA-approved legend drugs through the PA process even though the drug manufacturers did not sign rebate agreements.

To submit a PA request for a drug without a signed rebate agreement, the prescriber should complete and submit the PA/DGA to the pharmacy where the drug will be dispensed. Pharmacies should complete the PA/RF and submit both forms and any supporting documentation to ForwardHealth. PAs can be submitted by paper, fax, or on the ForwardHealth Portal.

Included with the PA, the prescriber is required to submit documentation of medical necessity and cost-effectiveness that the non-rebated drug is the only available and medically appropriate product for treating the member. The documentation must include the following:

- A copy of the medical record or documentation of the medical history detailing the member's medical condition and previous treatment results.
- Documentation by the prescriber that shows why other drug products have been ruled out as ineffective or unsafe for the member's medical condition.
- Documentation by the prescriber that shows why the non-rebated drug is the most appropriate and cost-effective drug to treat the member's medical condition.

If a PA request for a drug without a signed manufacturer rebate is approved, claims for drugs without a signed rebate agreement must be submitted on paper. Providers should complete and submit the Noncompound Drug Claim indicating the actual NDC of the drug with the Pharmacy Special Handling Request Form.

If a PA request for a drug without a signed manufacturer rebate is denied, the service is considered noncovered.

SeniorCare (Levels 2b and 3)

PA is not available for drugs from manufacturers without a separate, signed SeniorCare rebate agreement for members in levels 2b and 3. PA requests submitted for drugs without a separate, signed SeniorCare rebate agreement for members in levels 2b and 3 will be returned to the providers unprocessed and the service will be noncovered. Members do not have appeal rights regarding returned PA requests for noncovered drugs.

The BadgerCare Plus Benchmark, the BadgerCare Plus Core Plan, and the BadgerCare Plus Basic Plan

PA is not available for drugs that are not included on the BadgerCare Plus Benchmark National Drug Code List, BadgerCare Plus Core Plan National Drug Code List, BadgerCare Plus Basic Plan National Drug Code List, and the BadgerCare Plus Core Plan Brand Name Drugs — Quick Reference. PA requests submitted for noncovered drugs will be returned to providers unprocessed and the services will not be covered. Members do not have appeal rights regarding returned PA requests for noncovered drugs.

Drug Utilization Review System

The federal OBRA (42 CFR Parts 456.703 and 456.705) called for a DUR program for all Medicaid-covered drugs to improve the quality and cost-effectiveness of member care. ForwardHealth's prospective DUR system assists pharmacy providers in screening

certain drug categories for clinically important potential drug therapy problems before the prescription is dispensed to the member. The DUR system checks the member's entire drug history regardless of where the drug was dispensed or by whom it was prescribed.

Diagnoses from medical claims are used to build a medical profile for each member. The prospective DUR system uses this profile to determine whether or not a prescribed drug may be inappropriate or harmful to the member. It is very important that prescribers provide up-to-date medical diagnosis information about members on medical claims to ensure complete and accurate member profiles, particularly in cases of disease or pregnancy.

Note: The prospective DUR system does not dictate which drugs may be dispensed; prescribers and pharmacists must exercise professional judgment.

Prospective Drug Utilization Review's Impact on Prescribers

If a pharmacist receives an alert, a response is required before the drug can be dispensed to the member. This may require the pharmacist to contact the prescriber for additional information to determine if the prescription should be filled as written, modified, or cancelled. Prescribers should respond to inquiries, such as telephone calls or faxes, related to prescribed drugs from pharmacy providers.

Drugs with Three-Month Supply Requirement

ForwardHealth has identified a list of drugs for which pharmacy providers are required to dispense a three-month supply. The same list includes drugs that may be (but are not required to be) dispensed in a three-month supply.

Member Benefits

When it is appropriate for the member's medical condition, a three-month supply of a drug benefits the member in the following ways:

- Aiding compliance in taking prescribed generic, maintenance medications.
- Reducing the cost of member copayments.
- Requiring fewer trips to the pharmacy.
- Allowing the member to obtain a larger quantity of generic, maintenance drugs for chronic conditions (e.g., hypertension).

Prescribers are encouraged to write prescriptions for a three-month supply when appropriate for the member.

Prescription Quantity

A prescriber is required to indicate the appropriate quantity on the prescription to allow the dispensing provider to dispense the maintenance drug in a three-month supply. For example, if the prescription is written for "Hydrochlorothiazide 25 mg, take one tablet daily," the prescriber is required to indicate a quantity of 90 or 100 tablets on the prescription so the pharmacy provider can dispense a three month supply. In certain instances, brand name drugs (e.g., oral contraceptives) may be dispensed in a three-month supply.

Pharmacy providers are not required to contact prescribers to request a new prescription for a three-month supply if a prescription has been written as a one-month supply with multiple or as needed (i.e., PRN) refills.

ForwardHealth will not audit or recoup three-month supply claims if a pharmacy provider changes a prescription written as a one-month supply with refills as long as the total quantity dispensed per prescription does not exceed the total quantity authorized by the prescriber.

Prescription Mail Delivery

Current Wisconsin law permits Wisconsin Medicaid-certified retail pharmacies to deliver prescriptions to members via the mail. Wisconsin Medicaid-certified retail pharmacies may dispense and mail any prescription or OTC medication to a Medicaid fee-for-service member at no additional cost to the member or Wisconsin Medicaid.

Providers are encouraged to use the mail delivery option if requested by the member, particularly for prescriptions filled for a three-month supply.

Noncovered Drugs

The following drugs are not covered:

- Drugs that are identified by the FDA as LTE or identical, related, or similar to LTE drugs.
- Drugs identified on the Wisconsin Negative Formulary.
- Drugs manufactured by companies who have not signed the rebate agreement.
- Drugs to treat the condition of ED. Examples of noncovered drugs for ED are Viagra® and Cialis®.

SeniorCare

SeniorCare is a prescription drug assistance program for Wisconsin residents who are 65 years of age or older and meet eligibility criteria. SeniorCare is modeled after Wisconsin Medicaid in terms of drug coverage and reimbursement, although there are a few differences. Unlike Medicaid, SeniorCare does not cover OTC drugs other than insulin.

ePocrates

Providers may also access the Medicaid, BadgerCare Plus, and SeniorCare PDL through ePocrates. ePocrates' products provide clinical reference information specifically for health care providers to use at the point of care. Prescribers and pharmacy providers (e.g., pharmacies, dispensing physicians, FQHCs, blood banks) who use PDAs can subscribe and download the PDL from the ePocrates' Web site.

Requirements

Except as otherwise indicated in federal or state law, a prescriber is required to write a prescription or a pharmacist is required to accept a prescription verbally or electronically from the prescriber. The prescription must include the following:

- The name, strength, and quantity of the drug or item prescribed.
- The date of issue of the prescription.
- The prescriber's name and address.
- The member's name and address.
- The prescriber's signature (if the prescriber writes the prescription).
- The directions for use of the prescribed drug or item.

If the pharmacist takes the prescription verbally from the prescriber, the pharmacist is required to generate a hard copy. BadgerCare Plus and SeniorCare prescription orders, including prescriber-limited refill prescriptions, are valid for no more than one year from the date of the prescription. Controlled substance and prescriber-limited prescriptions are valid for periods of less than one year.

According to DHS 105.02(4) and 105.02(7), Wis. Admin. Code, and s. 450.11(2), Wis. Stats., pharmacy providers are required to retain hard copies of prescriptions for five years from the DOS. Prescriptions transmitted electronically may be filed and preserved in electronic format, per s. 961.38(2), Wis. Stats. If a pharmacist takes a prescription verbally from the prescriber, the pharmacist is required to generate a hard copy.

Tamper-Resistant Prescription Pad Requirement

Section 7002(b) of the U.S. Troop Readiness, Veterans' Care, Katrina Recovery, and Iraq Accountability Appropriations Act of 2007 imposed a requirement on prescriptions paid for by Medicaid, SeniorCare, or BadgerCare fee-for-service. The law requires

that all written or computer-generated prescriptions that are given to a patient to take to a pharmacy must be written or printed on tamper-resistant prescription pads or tamper-resistant computer paper. This requirement applies to prescriptions for both controlled and noncontrolled substances.

All other Medicaid policies and procedures regarding prescriptions continue to apply.

Required Features for Tamper-Resistant Prescription Pads or Computer Paper

As of October 1, 2008, to be considered tamper-resistant, federal law requires that prescription pads/paper contain all three of the following characteristics:

- One or more industry-recognized features designed to prevent unauthorized copying of a completed or blank prescription form.
- One or more industry-recognized features designed to prevent the erasure or modification of information written on the prescription by the prescriber.
- One or more industry-recognized features designed to prevent the use of counterfeit prescription forms.

Exclusions to Tamper-Resistant Prescription Pad Requirement

The following are exclusions to the tamper-resistant prescription pad requirement:

- Prescriptions faxed directly from the prescriber to the pharmacy.
- Prescriptions electronically transmitted directly from the prescriber to the pharmacy.
- Prescriptions telephoned directly from the prescriber to the pharmacy.
- Prescriptions provided to members in nursing facilities, intermediate care facilities for the mentally retarded, and other specified institutional and clinical settings to the extent that drugs are part of their overall rate. However, written prescriptions filled by a pharmacy outside the walls of the facility are subject to the tamper-resistant requirement.

Obtaining Free Prescription Pads

The Wisconsin DHS has made available a limited supply of free prescription pads through its contracted vendor, Standard Register. Medicaid-certified prescribers may request up to five free prescription pads. There is a limited supply of the free pads available, and they will be distributed as requests are received. Providers are required to pay the shipping costs for the free pads.

Providers are not required to use the state-supplied prescription pads to be compliant with the tamper-resistant prescription pad requirement.

To request the free tamper-resistant prescription pads, providers must complete and submit an order form to Standard Register. The order form is available for download from the Standard Register Web site. Completed orders may be faxed or placed over the telephone to Standard Register at the following numbers:

- Fax — (866) 869-3971.
- Telephone — (866) 741-8488.

72-Hour Grace Period

Prescriptions presented by patients on non-tamper-resistant pads or paper may be dispensed and considered compliant if the pharmacy receives a compliant prescription order within 72 hours.

Coordination of Benefits

The federal law imposing these new requirements applies even when ForwardHealth is the secondary payer.

Retroactive Medicaid Eligibility

If a patient becomes retroactively eligible for ForwardHealth, the federal law presumes that prescriptions retroactively dispensed were compliant. However, prospective refills will require a tamper-resistant prescription.

Penalty for Noncompliance

Payment made to the pharmacy for a claim corresponding to a noncompliant order may be recouped, in full, by ForwardHealth.

Therapeutic Pharmaceutical Agents-Certified Optometrists Requirements

BadgerCare Plus and SeniorCare reimburse for prescriptions written by optometrists with a TPA certificate. However, not every TPA-certified optometrist has a DEA number since it is required only for prescribers that prescribe Schedule III, IV, or V narcotic analgesics as listed in Ch. RL 10.01(10), Wis. Admin. Code.

Optometrists are encouraged to indicate either their DEA number or their eight-digit Medicaid provider number on a prescription for a BadgerCare Plus or SeniorCare member. Pharmacy providers should contact the prescribing optometrist for this number if it is not indicated on the prescription.

If the prescribing optometrist does not have a DEA number, but has a Medicaid provider number, indicate "OD" followed by the first seven digits of the prescriber's eight-digit Medicaid provider number in the DEA number field.

If the prescribing optometrist does not have a DEA number or a Medicaid provider number, pharmacy providers should indicate XX9999991 in the DEA number field.

Provider Numbers

National Provider Identifier

Health care providers are required to indicate an NPI on electronic and paper transactions submitted to ForwardHealth.

The NPI is a 10-digit number obtained through NPPES.

Providers should ensure that they have obtained an appropriate NPI to correspond to their certification.

There are two kinds of NPIs:

- Entity Type 1 NPIs are for individuals who provide health care, such as physicians, dentists, and chiropractors.
- Entity Type 2 NPIs are for organizations that provide health care such as hospitals, group practices, pharmacies, and home health agencies.

It is possible for a provider to qualify for both Entity Type 1 and Entity Type 2 NPIs. For example, an individual physical therapist may also be the owner of a therapy group that is a corporation and have two Wisconsin Medicaid certifications — one certification as an individual physical therapist and the other certification as the physical therapy group. A Type 1 NPI for the individual certification and a Type 2 NPI for the group certification are required.

NPIs and classifications may be viewed on the NPPES Web site. The CMS Web site includes more Type 1 and Type 2 NPI information.

Some providers hold multiple certifications with ForwardHealth. For example, a health care organization may be certified according to the type of services their organization provides (e.g., physician group, therapy group, home health agency) or the organization may have separate certification for each practice location. ForwardHealth maintains a separate provider file for each certification that stores information used for processing electronic and paper transactions (e.g., provider type and specialty, certification begin and end dates). When a single NPI is reported for multiple certifications, ForwardHealth requires additional data to identify the provider and to determine the correct provider file to use when processing transactions.

Either or both of the following additional data is required with NPI when a single NPI corresponds to multiple certifications:

- The ForwardHealth-designated taxonomy code.
- ZIP+4 code (complete, nine digits) that corresponds to the practice location address on file with ForwardHealth.

Omission of the additional required data will cause claims and other transactions to be denied or delayed in processing.

Taxonomy Codes

Taxonomy codes are standard code sets used to provide information about provider type and specialty for the provider's certification. Providers are required to use the taxonomy code designated by ForwardHealth when the NPI reported to ForwardHealth corresponds to multiple certifications and the provider's practice location ZIP+4 code does not uniquely identify the provider.

ForwardHealth designates a taxonomy code as additional data to be used to correctly match NPI to the correct provider file. The designated taxonomy code may be different than the taxonomy code providers originally submitted to NPPES when obtaining their NPI as not all national taxonomy code options are recognized by ForwardHealth. For example, some taxonomy codes may correspond to provider types not certifiable with ForwardHealth, or they may represent services not covered by ForwardHealth.

Omission of a taxonomy code when it is required as additional data to identify the provider or indicating a taxonomy code that is not designated by ForwardHealth will cause claims and other transactions to be denied or delayed in processing.

Refer to the ForwardHealth-designated taxonomy codes for the appropriate taxonomy code for your certification.

Note: The ForwardHealth-designated taxonomy code does not change provider certification or affect reimbursement terms.

ZIP Code

The ZIP+4 code is the ZIP code of a provider's practice location address on file with ForwardHealth. Providers are required to use the ZIP+4 code when the NPI reported to ForwardHealth corresponds to multiple certifications and the designated taxonomy code does not uniquely identify the provider.

Omission of the ZIP+4 code of the provider's practice location address when it is required as additional data to identify the provider will cause claims and other transactions to be denied or delayed in processing.

Providers may verify the ZIP+4 code for their address on the U.S. Postal Service Web site.

Provider Rights

A Comprehensive Overview of Provider Rights

Medicaid-certified providers have certain rights including, but not limited to, the following:

- Limiting the number of members they serve in a nondiscriminatory way.
- Ending participation in Wisconsin Medicaid.
- Applying for a discretionary waiver or variance of certain rules identified in Wisconsin Administrative Code.
- Collecting payment from a member under limited circumstances.
- Refusing services to a member if the member refuses or fails to present a ForwardHealth identification card. However, possession of a ForwardHealth card does not guarantee enrollment (e.g., the member may not be enrolled, may be enrolled only for limited benefits, or the ForwardHealth card may be invalid). Providers may confirm the current enrollment of the member by using one of the EVS methods, including calling Provider Services.

Ending Participation

Providers other than home health agencies and nursing facilities may terminate participation in ForwardHealth according to DHS 106.05, Wis. Admin. Code.

Providers choosing to withdraw should promptly notify their members to give them ample time to find another provider.

When withdrawing, the provider is required to do the following:

- Provide a written notice of the decision at least 30 days in advance of the termination.
- Indicate the effective date of termination.

Providers will not receive reimbursement for nonemergency services provided on and after the effective date of termination. Voluntary termination notices can be sent to the following address:

ForwardHealth
Provider Maintenance
6406 Bridge Rd
Madison WI 53784-0006

If the provider fails to specify an effective date in the notice of termination, ForwardHealth may terminate the provider on the date the notice is received.

Hearing Requests

A provider who wishes to contest a DHS action or inaction for which due process is required under s. 227, Wis. Stats., may request a hearing by writing to the DHA.

A provider who wishes to contest the DHCAA's notice of intent to recover payment (e.g., to recoup for overpayments discovered in an audit by DHCAA) is required to request a hearing on the matter within the time period specified in the notice. The request, which must be in writing, should briefly summarize the provider's basis for contesting the DHS decision to withhold payment.

Refer to DHS 106, Wis. Admin. Code, for detailed instructions on how to file an appeal.

If a timely request for a hearing is not received, the DHS may recover those amounts specified in its original notice from future amounts owed to the provider.

Note: Providers are not entitled to administrative hearings for billing disputes.

Limiting the Number of Members

If providers choose to limit the number of members they see, they cannot accept a member as a private-pay patient. Providers should instead refer the member to another ForwardHealth provider.

Persons applying for or receiving benefits are protected against discrimination based on race, color, national origin, sex, religion, age, disability, or association with a person with a disability.

Requesting Discretionary Waivers and Variances

In rare instances, a provider or member may apply for, and the DHCAA will consider applications for, a discretionary waiver or variance of certain rules in DHS 102, 103, 104, 105, 107, and 108, Wis. Admin. Code. Rules that are not considered for a discretionary waiver or variance are included in DHS 106.13, Wis. Admin. Code.

Waivers and variances are not available to permit coverage of services that are either expressly identified as noncovered or are not expressly mentioned in HFS 107, Wis. Admin. Code.

Requirements

A request for a waiver or variance may be made at any time; however, all applications must be made in writing to the DHCAA. All applications are required to specify the following:

- The rule from which the waiver or variance is requested.
- The time period for which the waiver or variance is requested.
- If the request is for a variance, the specific alternative action proposed by the provider.
- The reasons for the request.
- Justification that all requirements for a discretionary waiver or variance would be satisfied.

The DHCAA may also require additional information from the provider or the member prior to acting on the request.

Application

The DHCAA may grant a discretionary waiver or variance if it finds that all of the following requirements are met:

- The waiver or variance will not adversely affect the health, safety, or welfare of any member.
- Either the strict enforcement of a requirement would result in unreasonable hardship on the provider or on a member, or an alternative to a rule is in the interests of better care or management. An alternative to a rule would include a new concept, method, procedure or technique, new equipment, new personnel qualifications, or the implementation of a pilot project.
- The waiver or variance is consistent with all applicable state and federal statutes and federal regulations.
- Federal financial participation is available for all services under the waiver or variance, consistent with the Medicaid state plan, the federal CMS, and other applicable federal program requirements.
- Services relating to the waiver or variance are medically necessary.

To apply for a discretionary waiver or variance, providers are required to send their application to the following address:

Division of Health Care Access and Accountability

Waivers and Variances
PO Box 309
Madison WI 53701-0309

Recertification

An Overview

Each year approximately one-third of all Medicaid-certified providers undergo recertification. During provider recertification, providers update their information and sign the Wisconsin Medicaid Provider Agreement and Acknowledgement of Terms of Participation. Providers are required to complete the provider recertification process to continue their participation with Wisconsin Medicaid. For most providers, recertification will be conducted online at the ForwardHealth Portal. Providers will be notified when they need to be recertified and will be provided with instructions on how to complete the recertification process.

Checking the Status of a Recertification Application

Providers may check the status of their recertification on the ForwardHealth Portal by entering the ATN from the Provider Recertification Notice and pressing "Search."

Providers will receive one of the following status responses:

- "Approved." ForwardHealth has reviewed the recertification materials and all requirements have been met. ForwardHealth is completing updates to provider files.
- "Awaiting Additional Info." ForwardHealth has reviewed the recertification materials and has requested additional information from the provider. Providers will receive a letter via mail when additional materials or information are required to complete processing of the recertification materials.
- "Awaiting Follow-On Documents." ForwardHealth requires additional paper documents to process the recertification. After the provider has submitted recertification information online via the Portal, the final screen will list additional documents the provider must mail to ForwardHealth. ForwardHealth cannot complete processing until these documents are received. This status is primarily used for SMV provider recertification.
- "Denied." The provider's recertification has been denied.
- "Failure to Recertify." The provider has not recertified by the established recertification deadline.
- "In Process." The recertification materials are in the process of being reviewed by ForwardHealth.
- "Paper Requested." The provider requested a paper recertification application and ForwardHealth has not received the paper application yet.
- "Recert Initiated." The Provider Recertification Notice and PIN letter have been sent to the provider. The provider has not started the recertification process yet.
- "Recertified." The provider has successfully completed recertification. There are no actions necessary by the provider.
- "Referred To DHS." ForwardHealth has referred the provider recertification materials to the State Certification Specialist for recertification determination.

Notification Letters

Providers undergoing recertification will receive two important letters in the mail from ForwardHealth:

- The Provider Recertification Notice. This is the first notice to providers. The Provider Recertification Notice contains identifying information about the provider who is required to complete recertification, the recertification deadline, and the ATN assigned to the provider. The ATN is used when logging in to the ForwardHealth Portal to complete recertification and also serves as the tracking number when checking the status of the provider's recertification.
- The PIN letter. Providers will receive this notice a few days after the Provider Recertification Notice. The PIN letter will contain a recertification PIN and instructions on logging in to the Portal to complete recertification.

The letters are sent to the mailing address on file with Wisconsin Medicaid. Providers should read these letters carefully and keep them for reference. The letters contain information necessary to log in to the secure Recertification area of the Portal to complete recertification. If a provider needs to replace one of the letters, the recertification process will be delayed.

Paper Recertification Applications

Providers who do not have Internet access or who are not able to complete recertification via the ForwardHealth Portal should contact Provider Services to request a paper recertification application. Providers who request a paper application are required to complete the recertification process on paper and not online via the Portal to avoid duplicate recertification submissions.

Recertification Completed by an Authorized Representative

A provider has several options for submitting information to the DHS, including electronic and Web-based submission methodologies that require the input of secure and discrete access codes but not written provider signatures.

The provider has sole responsibility for maintaining the privacy and security of any access code the provider uses to submit information to the DHS, and any individual who submits information using such access code does so on behalf of the provider, regardless of whether the provider gave the access code to the individual or had knowledge that the individual knew the access code or used it to submit information to the DHS.

Recertification on the ForwardHealth Portal

Logging in to the Secure Recertification Area of the Portal

Once a provider has received the Provider Recertification Notice and PIN letter, the provider may log in to the Recertification area of the ForwardHealth Portal to begin the recertification process.

The Recertification area of the Portal is not part of a Provider Portal account. Providers do not need a Provider Portal account to participate in recertification via the Portal. Providers are not able to access the Recertification area of the Portal by logging in to a Provider Portal account; providers must use the ATN from the Provider Recertification Notice and PIN from the PIN letter to log in to the Recertification area of the Portal.

The Portal will guide providers through the recertification process. On each screen, providers are required to complete or verify information.

Completing Recertification

Providers are required to complete all of the recertification screens in a single session. The Portal will not save a provider's partial progress through the recertification screens. If a provider does not complete all of the recertification screens in a single session, the provider will be required to start over when logging in to the Recertification area of the Portal again.

It is important to read the final screen carefully and follow all instructions before exiting the recertification process. After exiting the recertification process, providers will not be able to retrieve the provider recertification documents for their records.

The final screen of the recertification process gives providers the option to print and save a PDF version of the recertification information submitted to ForwardHealth. Providers whose recertification is approved immediately will also be able to print a copy of the approval letter and the Provider Agreement signed by the DHS.

In other cases, the final screen will give providers additional instructions to complete recertification, such as the following:

- The recertification application requires review. Providers are mailed the approval letter and other materials when the application is approved.
- Some providers may be required to send additional paper documentation to ForwardHealth.

Sanctions

Intermediate Sanctions

According to DHS 106.08(3), Wis. Admin. Code, the DHS may impose intermediate sanctions on providers who violate certain requirements. Common examples of sanctions that the DHS may apply include the following:

- Review of the provider's claims before payment.
- Referral to the appropriate peer review organization, licensing authority, or accreditation organization.
- Restricting the provider's participation in BadgerCare Plus.
- Requiring the provider to correct deficiencies identified in a DHS audit.

Prior to imposing any alternative sanction under this section, the DHS will issue a written notice to the provider in accordance with DHS 106.12, Wis. Admin. Code.

Any sanction imposed by the DHS may be appealed by the provider under DHS 106.12, Wis. Admin. Code. Providers may appeal a sanction by writing to the DHA.

Involuntary Termination

The DHS may suspend or terminate the Medicaid certification of any provider according to DHS 106.06, Wis. Admin. Code.

The suspension or termination may occur if both of the following apply:

- The DHS finds that any of the grounds for provider termination are applicable.
- The suspension or termination will not deny members access to services.

Reasonable notice and an opportunity for a hearing within 15 days will be given to each provider whose certification is terminated by the DHS. Refer to DHS 106.07, Wis. Admin. Code, for detailed information regarding possible sanctions.

In cases where Medicare enrollment is required as a condition of certification with Wisconsin Medicaid, termination from Medicare results in automatic termination from Wisconsin Medicaid.

Sanctions for Collecting Payment from Members

Under state and federal laws, if a provider inappropriately collects payment from an enrolled member, or authorized person acting on behalf of the member, that provider may be subject to program sanctions including termination of Medicaid certification. In addition, the provider may also be fined not more than $25,000, or imprisoned not more than five years, or both, pursuant to 42 USC s. 1320a-7b(d) or 49.49(3m), Wis. Stats.

There may be narrow exceptions on when providers may collect payment from members.

Withholding Payments

The DHS may withhold full or partial Medicaid provider payments without prior notification if, as the result of any review or audit, the DHS finds reliable evidence of fraud or willful misrepresentation.

"Reliable evidence" of fraud or willful misrepresentation includes, but is not limited to, the filing of criminal charges by a prosecuting

attorney against the provider or one of the provider's agents or employees.

The DHS is required to send the provider a written notice within five days of taking this action. The notice will generally set forth the allegations without necessarily disclosing specific information about the investigation.

Claims

2

Archive Date:03/01/2011

Claims:Adjustment Requests

Allowed Claim

An allowed claim (or adjustment request) contains at least one service that is reimbursable. Allowed claims display on the Paid Claims Section of the RA with a dollar amount greater than "0" in the allowed amount fields. Only an allowed claim, which is also referred to as a claim in an allowed status, may be adjusted.

Denied Claim

A claim that was completely denied is considered to be in a denied status. To receive reimbursement for a claim that was completely denied, it must be corrected and submitted as a new claim.

Electronic

837 Transaction

Even if the original claim was submitted on paper, providers may submit electronic adjustment requests using an 837 transaction.

Provider Electronic Solutions Software

The DHCAA offers electronic billing software at no cost to providers. The PES software allows providers to submit electronic adjustment requests using an 837 transaction. To obtain PES software, providers may download it from the ForwardHealth Portal. For assistance installing and using PES software, providers may call the EDI Helpdesk.

Portal Claim Adjustments

Providers can submit claim adjustments via the Portal. Providers may use the search function to find the specific claim to adjust. Once found, the provider can alter the claim to reflect the desired change and resubmit it to ForwardHealth. Any claim ForwardHealth has paid can be adjusted and resubmitted on the Portal, regardless of how the claim was originally submitted.

Follow-Up

Providers who believe an error has occurred or their issues have not been satisfactorily resolved have the following options:

- Submit a new adjustment request if the previous adjustment request is in an allowed status.
- Submit a new claim for the services if the adjustment request is in a denied status.
- Contact Provider Services for assistance with paper adjustment requests.
- Contact the EDI Helpdesk for assistance with electronic adjustment requests.

Paper

Paper adjustment requests must be submitted using the Adjustment/Reconsideration Request form.

Providers are required to indicate the actual NDC on the Adjustment/Reconsideration Request form. If the actual NDC is not indicated on the Adjustment/Reconsideration Request form, the claim will be denied and the provider will need to resubmit a new

claim.

Processing

Within 30 days of receipt, ForwardHealth generally reprocesses the original claim with the changes indicated on the adjustment request and responds on ForwardHealth remittance information.

Purpose

After reviewing both the claim and ForwardHealth remittance information, a provider may determine that an allowed claim needs to be adjusted. Providers may file adjustment requests for reasons including the following:

- To correct billing or processing errors.
- To correct inappropriate payments (overpayments and underpayments).
- To add and delete services.
- To supply additional information that may affect the amount of reimbursement.
- To request professional consultant review (e.g., medical, dental).

Providers may initiate reconsideration of an allowed claim by submitting an adjustment request to ForwardHealth.

Submitting Paper Attachments with Electronic Claim Adjustments

Providers may submit paper attachments to accompany electronic claim adjustments. Providers should refer to their companion documents for directions on indicating that a paper attachment will be submitted by mail.

Diabetic Supplies

Claim Adjustments for Diabetic Supplies

Adjustment requests for claims submitted must reflect the manner in which the claim was originally processed. For example, if a provider submitted a claim on April 3, 2010, with a HCPCS procedure code and adjusts the claim on August 4, 2010, the provider should not change the HCPCS procedure code to an NDC.

Transition to National Drug Codes

Providers are required to indicate NDCs on claims for diabetic supplies with two exceptions.

- There is an approved PA currently on file.
- The claim is a Medicare Part B crossover claim.

Claims must be submitted in the NCPDP Telecommunication Standard Formation Version 5.1, using PES software, or on a Noncompound Drug Claim form.

Approved Prior Authorization on File

If a member has an approved PA currently on file with ForwardHealth and the PA was approved with a HCPCS code, providers should continue to submit a professional claim with the approved HCPCS code. For example, if a provider received an approved PA on April 3, 2010, with a HCPCS procedure code and submits a claim on August 4, 2010, the provider should not change the HCPCS procedure code to an NDC.

Drug Utilization Review

Alerts and Alert Hierarchy

The BadgerCare Plus and SeniorCare DUR Board established a hierarchy for the order in which multiple alerts appear if more than one alert is activated for a drug claim. Factors taken into account in determining the hierarchy include the potential for avoidance of adverse consequences, improvement of the quality of care, cost savings, likelihood of a false positive, retrospective DUR experience, and a review of alerts used by other state Medicaid programs for prospective DUR. The clinical drug tables used to establish the alerts are provided to BadgerCare Plus and SeniorCare by First DataBank, Inc.

For information about overriding DUR alerts, providers may refer to the Prospective Drug Utilization Review topic.

BadgerCare Plus and SeniorCare activate alerts that identify the following problems. These alerts are listed in hierarchical order according to the following DUR conflict codes:

- DD — Drug-drug interaction.
- Drug-disease contraindication.
  - MC — reported.
  - DC — inferred.
- TD — Therapeutic duplication.
- PG — Pregnancy alert.
- ER — Overuse.
- AT — Additive toxicity.
- PA — Drug-age precaution.
- LR — Underuse.
- HD — High dose.
- SR — Suboptimal Regimen.
- NS — Insufficient Quantity.

Drug-Drug Interaction

This alert is activated when another drug in claims history interacts with the drug being filled. The system reviews not only the prescriptions at the current pharmacy, but all of the prescriptions reimbursed by Wisconsin Medicaid.

Drug-Disease Contraindication

This alert is activated when a drug is prescribed for a member who has a disease for which the drug is contraindicated. Acute diseases remain in the member's medical profile for a limited period of time, while chronic diseases remain permanently. The disease may have been reported on a medical claim or inferred from a drug in claims history.

Contraindications include the following:

- Reported — The diagnosis is extracted from the member's medical profile. A medical profile includes previously reimbursed claims, including pharmacy claims, where a diagnosis is submitted.
- Inferred — BadgerCare Plus and SeniorCare infer that the member has a disease based on a drug present in claims history. This inference is made if there is one disease indicated for a drug.

Therapeutic Duplication

This alert is activated when another drug is present in claims history that has the same therapeutic effect as the drug being dispensed. The message sent to the provider includes the drug name in claims history that is causing the alert. The therapeutic areas for the duplication alert include:

- ACE inhibitor drugs.
- Antilipidemics.
- Anxiolytics.
- Benzodiazepines.
- Diuretics.
- H-2 antagonists.
- Narcotic analgesics.
- Nonsedating antihistamine drugs.
- NSAIDs.
- Oral antifungals.
- Oral contraceptives.
- Oral glucocorticoids.
- Phenothiazine antipsychotics.
- PPI drugs.
- Sedatives and hypnotics.
- SSRI drugs and other new antidepressants.
- Sulfonylureas.

Pregnancy Alert

This alert is activated when the prescribed drug is contraindicated in pregnancy. This alert is activated when all of the following conditions are met:

- The member is a woman between 12 and 60 years of age.
- ForwardHealth receives a medical or pharmacy claim for a member that indicates pregnancy using an ICD-9-CM diagnosis code.
- A pharmacy claim for a drug that possesses a clinical significance of D, X, or 1 (as assigned by the FDA or First DataBank, Inc.) is submitted for a member.

Clinical Significance Codes	
D	There is positive evidence of human fetal risk based on adverse reaction data from investigational or marketing experience or studies in humans. However, potential benefits may warrant use of the drug in pregnant women despite potential risks if the drug is needed in a life-threatening situation or for a serious disease for which safer drugs cannot be used or are ineffective. This is a FDA-assigned value.
X	Studies in animals or humans have demonstrated fetal abnormalities and/or there is positive evidence of human fetal risk based on adverse reaction data from investigational or marketing experience, and the risks involved in use of the drug in pregnant women clearly outweigh potential benefits. This is an FDA-assigned value.
1	No FDA rating but is contraindicated or not recommended; may have animal and/or human studies or pre- or post-marketing information. This is a First DataBank, Inc.-assigned value.

BadgerCare Plus will deactivate the pregnancy diagnosis from a member's medical profile after 260 days or if an intervening diagnosis indicating delivery or other pregnancy termination is received on a claim.

Overuse Precaution

This alert is activated when a member is requesting an early refill of a prescription. The alert is sent to the provider if a claim is submitted before 80 percent of the previous claim's days' supply for the same drug, drug strength, and dosage form has been taken.

The alert indicates the number of days that should remain on the prescription, not the day that the drug can be refilled without activating the alert. Drugs with up to a 10-day supply are excluded from this alert.

A comprehensive list of drug categories are monitored for the "ER" prospective DUR alert if a member requests a refill before 80 percent of a previous claim's days supply has been taken. Antibiotics, insulins, IV solutions, electrolytes (except potassium, blood components and factors), and diagnostic drugs are excluded.

For claims submitted for DOS prior to January 6, 2010, the overuse precaution alert is activated if a claim is submitted before 75 percent of the previous claim's days supply for the same drug, drug strength, and dosage form has been taken.

Additive Toxicity

This alert is activated when a prescribed drug causes a cumulative effect with other drugs in the claims history. Points accumulate for side effects based on the severity and the frequency of the side effect. Once a defined threshold is reached, an alert is sent to the provider.

The NCPDP 5.1 Telecommunication Standard for Retail Pharmacy Claims field 526 ("Additional Message Information") is used to provide pharmacy providers with additional drug history information when the additive toxicity alert is activated. Up to six drugs from the history that activated the alert are displayed in this field.

Drug-Age Precaution

This alert is activated when a drug should not be dispensed to a member because of age precautions specific to the drug. This alert only applies to members who are 18 years of age and younger (pediatric) or for members who are 65 years and older (geriatric).

Underuse Precaution

This alert is activated when a member is late in obtaining a refill of a maintenance drug. The alert is sent to the provider when a drug is refilled and exceeds 125 percent of the days' supply on the same drug in history. The number of days late is calculated as the days after the prescription should have been refilled. Drugs with up to a 10-day supply are excluded from this alert. This alert applies, but is not limited to, the following therapeutic categories:

- ACE inhibitor drugs.
- Alpha-blockers.
- Antilipidemics.
- Angiotensin-2 receptor antagonists.
- Anti-arrhythmics.
- Anticonvulsants.
- Antidepressants.
- Antipsychotics.
- Beta-blockers.
- Calcium channel blockers.
- Digoxin.
- Diuretics.
- Oral hypoglycemics.

High Dose

Providers receive the high dose prospective DUR alert on claims for drugs listed in the table below if the dose exceeds daily limit indicated.

Drug	Daily Limit

Acetaminophen	Greater than 4,000 mg/day, for all members
Alprazolam	Greater than 2 mg/day, for members 65 or older
Amitriptyline	Greater than 150 mg/day, for all members
Cyclobenzaprine	Greater than 30 mg/day, for all members
Escitalopram	Greater than 30 mg/day, for all members
Tramadol	Greater than 300 mg/day, for members 65 or older
Zolpidem	Greater than 10 mg/day for members 65 or older

Suboptimal Regimen

This alert is activated on claims for drugs with the potential for dose consolidation or tablet splitting. Claims will be denied and the provider will be required to respond to the message by overriding the alert and resubmitting the claim or by submitting a new claim that indicates the dose consolidation or tablet splitting.

For claim responses where the "SR" (Suboptimal Regimen) DUR alert is received, "Tablet splitting opportunity" or "Dose consolidation opportunity," displays in an NCPDP field.

Dose consolidation and tablet splitting may only be completed if a provider contacts the prescriber to authorize a new prescription to consolidate a dose or dispense half tablets. A discussion between the provider and the prescriber will determine if dose consolidation or tablet splitting are appropriate for a member.

Insufficient Quantity

For drugs that may be dispensed in a three-month supply, but are not required to be, pharmacy providers may determine whether or not it is clinically appropriate to dispense a three-month supply. Claims for these drugs will be denied with the "NS" prospective DUR alert and providers will be required to respond to the alert and resubmit the claim in the POS system to obtain reimbursement from ForwardHealth.

For claims where the "NS" (Insufficient Quantity) DUR alert is received, "100-day supply opportunity," displays in an NCPDP field.

Dose Consolidation and Tablet Splitting

The dose consolidation and tablet splitting strategies encourage providers to prescribe the most cost-effective form of a medication. Provider participation in these strategies is voluntary, but reimbursement is available through PC if this service is provided.

When a claim is submitted for a drug with the potential for dose consolidation or tablet splitting, ForwardHealth may respond with a prospective DUR alert to notify the pharmacy provider of a dose consolidation or tablet splitting opportunity. ForwardHealth encourages pharmacy providers who receive prescription orders with the potential for dose consolidation, tablet splitting, or a DUR alert to contact the prescriber and ask if the dose may be consolidated or tablets split when appropriate for the member.

Dose consolidation and tablet splitting may only be completed if a pharmacy provider contacts the prescriber to authorize a new prescription for a consolidated dose or for half-tablets. A discussion between the pharmacy provider and the prescriber will determine if dose consolidation or tablet splitting is clinically appropriate for the member.

Dose Consolidation

The dose consolidation policy encourages pharmacy providers to dispense one larger strength of a brand name drug rather than two smaller strengths (e.g., thirty tablets of Norvasc 10 mg are dispensed instead of sixty tablets of Norvasc 5 mg).

A member may receive the following benefits with dose consolidation:

- A reduction in the number of tablets taken per day, thereby simplifying the member's drug regimen.
- A decrease in the chance of missing a dose.

Tablet Splitting

Tablet splitting allows providers to halve a single higher-strength tablet of a brand-name drug to create two half tablets of equal dosage. Tablet splitting is allowed when a half tablet of a higher strength tablet provides the same dose of medication as the prescriber ordered in a lower-strength tablet.

For example, when a pharmacy provider receives a prescription that states, "Lipitor 10 mg; One tablet daily;" the provider may contact the prescriber to recommend tablet splitting to one-half tablet daily of Lipitor 20 mg.

Requests for Dose Consolidation or Tablet Splitting

If the pharmacy provider is unable to contact the prescriber at the POS, he or she may contact the prescriber to request dose consolidation or tablet splitting when the member requests a refill. Pharmacy providers should indicate in the DUR response the action that was taken if they were unable to contact the prescriber.

If approval is given, the prescriber should document the change in the member's medical record. After the prescriber agrees that dose consolidation can occur or that tablets can be safely split, the pharmacy provider may submit a claim to PC to receive reimbursement for dose consolidation or tablet splitting.

Pharmacy providers will not receive DUR alerts of every opportunity; however, the pharmacy provider is required to respond to DUR alerts when received.

Pharmacists should evaluate each opportunity and consider the clinical appropriateness for the member. When an opportunity exists and the prescriber has authorized dose consolidation or tablet splitting, the pharmacy provider may submit a claim for PC for that prescription.

Alerts

Claims for drugs with the potential for dose consolidation or tablet splitting will be denied and the pharmacy provider will be required to respond to the message by overriding the alert and resubmitting the claim or by submitting a new claim that indicates the dose consolidation or tablet splitting.

Pharmacy providers will receive an alert conflict code in NCPDP field 439 and an explanation of the alert in NCPDP field 544. The alert conflict code for dose consolidation and tablet splitting is "SR." The explanation of the alert will contain one of the following messages:

- "Dose consolidation opportunity."
- "Tablet splitting opportunity."

Copayments for SeniorCare Members

When a claim is submitted for a SeniorCare member and the provider responds to a DUR message to acknowledge that tablets have been split, the member's copayment will be half of the brand name copayment.

Drug Utilization Review and Pharmaceutical Care

When pharmacy providers submit real-time noncompound drug claims or reversals with a response to a DUR alert and PC dispensing fee in the same transaction, BadgerCare Plus and SeniorCare require the following NCPDP transaction fields:

NCPDP Field	NCPDP Field Name
473-7E	DUR/PPS Code Counter
439-E4	Reason for Service Code
440-E5	Professional Service Code
441-E6	Result of Service Code
474-8E	DUR/PPS Level of Effort

The DUR/PPS level of effort is only required on PC reimbursement claim submissions.

Pharmacy providers may send one set of DUR fields if the 439-E4, "Reason for Service Code," field for DUR and PC are the same.

Providers are required to have NCPDP field 473-7E, "DUR/PPS Code Counter," present. BadgerCare Plus and SeniorCare monitor this field for claims submitted as real-time compound or noncompound drug transactions.

For real-time compound drug claims, providers are required to indicate DUR/PPS level of effort code to determine the compound drug dispensing fee reimbursement.

Drug Utilization Review and Pharmaceutical Care Claim Submission Examples

The following tables indicate the specific fields that providers are required to submit to ForwardHealth for DUR and PC claims. The "X" denotes a required field with a DUR or PC claim submission.

Policy Requirements	DUR/PPS Code Counter	Reason for Service Code	Professional Service Code	Result of Service Code	DUR/PPS LOE
Compound Drug	X				X
PC	X	X	X	X	X
DUR Override	X	X	X	X	
DUR and PC	X	X	X	X	X

The following table provides additional DUR and PC service claim submission examples for when providers submit responses to the DUR alerts *and* a PC services in the same transaction.

Example	DUR/PPS Code Counter (473-7E)	Reason for Service Code (439-E4)	Professional Service Code (440-E5)	Result of Service Code (441-E6)	DUR/PPS LOE (474-8E)	DUR or PC
A	1	AT	M0	1E	15	DUR *and* PC
B	1	AT	RE	1E	Blank	DUR
C	1	AT	RE	1E	Not sent	DUR
D	1	AT	RE	1E	Blank	DUR
	2	SR	M0	1F	11	PC
E	1	AT	RE	1E	11	PC
	2	SR	M0	1F	11	Not applicable

F	1	AT	RE	1E	Blank	DUR
	2	SR	M0	1F	Blank	Not applicable

Edits and Audits

The claims processing system includes certain edits and audits. Edits check the validity of data on each individual claim. For example, a claim with an invalid NDC will be denied with an edit. In contrast, audits review claim history. For example, if the same claim is filed at two different pharmacies on the same day, the claim at the second pharmacy will be denied with an audit.

Only payable claims that are not denied by an edit or audit are submitted to prospective DUR. Prospective DUR alerts inform providers of potential drug therapy problems. With the exception of the overuse precaution ("ER") alert, providers can override any of these alerts.

Educational Programming

A number of educational programs are generated by the DUR program. One of the primary means of education is the distribution of educational newsletters to prescribers and pharmacists. Topics for newsletters include:

- Current treatment protocols.
- How to best use the information received in the intervention letter.
- New drug-drug interactions.
- Utilization and cost data for selected therapeutic classes of drugs.
- Comparison of efficacy and cost of drugs within a therapeutic class.

In addition, the intervention letters sent out generate additional calls to the DUR pharmacy staff that provide an opportunity for a one-on-one educational activity with the prescriber.

Level of Effort

When submitting claims to ForwardHealth for a compound drug, information in three fields is required to ensure that the claim is processed as a compound drug claim. Indicate the following information in these fields:

- Indicate a level of effortin the DUR/PPS field.
- Indicate a "2" in the Compound code field in the claim segment.
- Indicate an "8" in the Submission Clarification code field in the claim segment.

The following codes should not be indicated in the DUR/PPS segment when the provider submits a claim for a compound drug. If these fields are submitted, compound drug preparation time will not be reimbursed:

- Reason for service code.
- Professional service code.
- Result of service code.

These fields are necessary for PC service claims and prospective DUR references. If these fields are submitted to ForwardHealth, providers will receive an EOB.

National Council for Prescription Drug Programs

Required Fields

The provider is required to respond to DUR alerts to obtain reimbursement from Wisconsin Medicaid. To respond, providers are required to have access to all prospective DUR database fields within the NCPDP 5.1 Telecommunication Standard Format for Retail Pharmacy Claims. Providers are strongly encouraged to contact their software vendors to ensure that they have access to these fields. Providers may also refer to companion documents for information about NCPDP transactions.

The following table lists the NCPDP fields a provider is required to respond to in order to obtain reimbursement. Prospective DUR allows pre-overrides if a drug in claims history will activate an alert for a drug that will be dispensed from the same pharmacy. Providers may not pre-override claims for certain drugs for which the overuse precaution ("ER") DUR alert will activate.

Action	NCPDP Field Number	Field Name	Description
Submitting claims	418	LOE	Only needed for compounding and PC reimbursement.
	439	DUR Conflict Code	DD = Drug-Drug MC = Drug-Disease (Reported) DC = Drug-Disease (Inferred) TD = Therapeutic Duplication PG = Drug-Pregnancy ER = Overuse AT = Additive Toxicity PR = Drug-Age LR = Under use HD = High Dose SR = Suboptimal Regimen NS = Insufficient Quantity
	440	DUR Intervention Code	Refer to the DUR Service Codes.
	441	DUR Outcome Code	Refer to the DUR Service Codes.
Receiving responses — Up to three alerts may be received.	439	DUR Conflict Code	See 439 above.
	526	Additional Message Information	Use to supply information pertaining to AT alert.
	528	Clinical Significance Code	1 = Major 2 = Moderate 3 = Minor

	529	Other Pharmacy Indicator	0 = Alert set is based on current claim only 1 = Your pharmacy 3 = Other pharmacy
	530	Previous Date of Fill	YYYMMDD = This field is zero-filled if the alert is set based on data on the current claim only. Otherwise, it contains the DOS from the other claim or history claim causing the alert to set.
	531	Quantity of Previous Fill	999.99 = This field is zero-filled if the alert is set based on data on the current claim only. This field is also zero-filled when the other claim or profile record causing the alert to set has spaces in the quantity field. Otherwise, this field contains the quantity from the other claim or history claim.
	532	Database Indicator	1 = FDB
	533	Other Prescriber Indicator	0 = Not specified 1 = Same prescriber 2 = Other prescriber
	535	DUR Overflow Indicator	0 = Not specified 2 = More than 3 alerts
	544	Free Text	DUR alert message

Conflict Code, Free Text, and Overflow Indicator Fields

Prospective DUR alerts are returned to pharmacy providers as a conflict code in NCPDP 5.1 Telecommunication Standard for Retail Pharmacy Claims field 439. The explanation of the alert is in NCPDP 5.1 field 544. When more than three alerts are activated by one claim, the system indicates this in the DUR overflow indicator, NCPDP 5.1 field 535. Providers may call Provider Services to find out additional information about alerts or refer to the table below for conflict names, codes, and explanations for each of the prospective DUR alerts.

Conflict Code	Conflict Name	Message
AT	Additive Toxicity	"(ICD-9-CM code from history claim indicating side effect)/(history drug name)."
DC	Drug-Disease (Inferred)	"(Disease description of contraindication)."
DD	Drug-Drug Interaction	"(Brand name of drug in history causing alert)."
ER	Overutilization	"XX days of RX remaining"
HD	High Dose	"Maximum recommended dose is XXX"
LR	Underutilization	"Refill is XX days late"
MC	Drug-Disease (Reported)	"(Disease description of contraindication)."
NS	Insufficient Quantity	"100 day supply opportunity"
PA	Drug-Age	"Age warning/contradiction"
PG	Drug Pregnancy	"Pregnancy contradiction"
SR	Suboptimal Regimen	Either "tablet splitting opportunity" or "dose consolidation opportunity."

TD	Therapeutic Duplication	"(Name of most recent history drug - trade or generic)."

Omnibus Budget Reconciliation Act of 1990 Requirements

The federal OBRA '90 established program requirements regarding several aspects of pharmacy practice. One of the requirements of OBRA '90 was a DUR program for BadgerCare Plus and SeniorCare members to improve the quality and cost-effectiveness of care.

The OBRA '90 requires that BadgerCare Plus and SeniorCare DUR program includes all of the following:

- Prospective DUR.
- Retrospective DUR.
- An educational program using DUR program data on common drug therapy.

SeniorCare uses both prospective and retrospective DUR.

Individual pharmacies are responsible for prospective DUR, while BadgerCare Plus and SeniorCare are responsible for retrospective DUR and educational programming. Additional differences between prospective and retrospective DUR can be found in the following table.

Prospective Versus Retrospective DUR	
Prospective DUR	Retrospective DUR
• Performed before a drug is dispensed • Identifies a potential problem before it occurs • Provides real-time response to a potential problem • Has preventive and corrective action	• Performed after a drug is dispensed • Warns when a potential problem has occurred • Useful for detecting patterns and designing targets for intervention • Has corrective action

The DUR Board, required by federal law, consists of three physicians, five pharmacists, and one nurse practitioner. The DUR Board and the DHS review and approve all DUR criteria and establish a hierarchy of alerts for prospective and retrospective DUR.

Providers should refer to Phar. 7.01(1)(e) and 7.08, Wis. Admin. Code, and 450.01(16)(i), Wis. Stats., for additional information about DUR program requirements.

Pharmacy Services Lock-In Program and Retrospective Drug Utilization Review

The purpose of the Pharmacy Services Lock-In Program is to coordinate the provision of health care services for members who abuse or misuse Medicaid, BadgerCare Plus, or SeniorCare benefits by seeking duplicate or medically unnecessary services, particularly for controlled substances.

Coordination of member health care services is intended to:

- Curb the abuse or misuse of controlled substance medications.
- Improve the quality of care for a member.

- Reduce unnecessary physician utilization.

The Pharmacy Services Lock-In Program focuses on the abuse or misuse of prescription benefits for controlled substances. Abuse or misuse is defined under Recipient Duties in DHS 104.02, Wis. Admin. Code. The abuse and misuse definition includes:

- Not duplicating or altering prescriptions.
- Not feigning illness, using false pretense, providing incorrect enrollment status, or providing false information to obtain service.
- Not seeking duplicate care from more than one provider for the same or similar condition.
- Not seeking medical care that is excessive or not medically necessary.

Referrals of members as candidates for lock-in are received from retrospective DUR, physicians, pharmacists, other providers, and through automated surveillance methods. Once a referral is received, six months of pharmacy claims and diagnoses data are reviewed. A recommendation for one of the following courses of action is then made:

- No further action.
- Send an intervention letter to the physician.
- Send a warning letter to the member.
- Enroll the member in the Pharmacy Services Lock-In Program.

Medicaid, BadgerCare Plus, and SeniorCare members who are candidates for enrollment in the Pharmacy Services Lock-In Program are sent a letter of intent, which explains the restriction that will be applied, how to designate a primary prescriber and a pharmacy, and how to request a hearing if they wish to contest the decision for enrollment (i.e., due process). If a member fails to designate providers, the Pharmacy Services Lock-In Program may assign providers based on claims' history. In the letter of intent, members are also informed that access to emergency care is not restricted.

Letters of notification are sent to the member and to the lock-in primary prescriber and pharmacy. Providers may designate alternate prescribers or pharmacies for restricted medications, as appropriate. Members remain in the Pharmacy Services Lock-In Program for two years. The primary lock-in prescriber and pharmacy may make referrals for specialist care or for care that they are otherwise unable to provide (e.g., home infusion services). The member's utilization of services is reviewed prior to release from the Pharmacy Services Lock-In Program, and lock-in providers are notified of the member's release date.

Designated Lock-In Pharmacies

Information for DOS on and after April 1, 2011, is available.

A pharmacy designated as the lock-in pharmacy for Pharmacy Services Lock-In Program-enrolled members may fill prescriptions from any prescriber, specifically those from emergency care visits or referral physicians, as long as the prescription appears to be appropriate (e.g., it does not overlap with other prescriptions of the same drug class). For prescriptions for nonemergency care, the pharmacist may call the lock-in primary care provider as identified in the most current letter of notification or the Pharmacy Services Lock-In Program, to determine whether or not a referral is in place for the provider issuing the prescription.

Prospective Drug Utilization Review

To help individual pharmacies comply with their prospective DUR responsibility, BadgerCare Plus and SeniorCare developed a prospective DUR system. The system screens certain drug categories for clinically significant potential drug therapy problems before a drug is dispensed to a member. Prospective DUR enhances clinical quality and cost-effective drug use.

Prospective DUR is applied to all BadgerCare Plus and SeniorCare real-time POS claims submitted to ForwardHealth. (Paper claims are excluded from prospective DUR.)

Although the prospective DUR system alerts pharmacy providers to a variety of potential problems, it is not intended to replace pharmacists' professional judgment. Potential drug therapy problems may exist which do not trigger the prospective DUR system.

Prospective DUR remains the responsibility of the pharmacy, as required by federal and state law. The system is an additional tool to assist pharmacists in meeting this requirement.

Claims Reviewed by the Prospective Drug Utilization Review System

Under the prospective DUR system, only reimbursable claims for BadgerCare Plus and SeniorCare members submitted through the real-time pharmacy POS system are reviewed. Although paper claims and compound drug claims are not reviewed by the prospective DUR system, pharmacy providers are still required under provisions of OBRA '90 to perform prospective DUR independently.

Claims for Nursing Home Members

Real-time claims for nursing home members are reviewed through the prospective DUR system; however, they do not require a response to obtain reimbursement since claims submission for these members does not always occur at the same time the drug is dispensed. The nursing home pharmacist consultant is responsible for prospective DUR. Though nursing home claims are exempt from denial, an informational alert will be received for claims with selected drugs exceeding a daily maximum dose.

Overriding Drug Utilization Review Alerts

When a claim is processed for a drug that has the potential to cause problems for a member, BadgerCare Plus or SeniorCare return an alert to inform the pharmacy provider about the potential problem. The provider is then required to respond to the alert to obtain reimbursement. For certain drugs, providers may override the claim in the POS system. The provider is required to resubmit the claim and include information about the action taken and the resulting outcome.

For other drugs, pharmacy providers are required to call the DAPO Center to request authorization.

If a provider receives a prospective DUR alert and subsequently receives an override through DAPO Center, the DUR alert pre-override is not required on the resubmitted claim. If multiple DUR alerts are received for a claim and an override from the DAPO Center is obtained for one DUR alert, the provider may be required to pre-override/override the additional prospective DUR alerts, as appropriate.

Early Refill Prospective Drug Utilization Review Overrides

Examples of when an early refill override request may be approved through the DAPO Center include, but are not limited to, the following:

- If the member has an appropriate medical need (e.g., the member's medications were lost or stolen, the member has requested a vacation supply).
- A member has been taking too much of a medication because he or she misunderstood the directions for administration from the prescriber.
- A prescriber changed the directions for administration of the drug and did not inform the pharmacy provider.

Pharmacy providers should call prescribers to verify the directions for use or to determine whether or not the directions for use changed.

If the pharmacist determines that it is not appropriate to refill the drug early, the pharmacy may instruct the member to return to the pharmacy to pick up the refill after 80 percent of the previous claim's days supply has been taken. Providers may refer to NCPDP field 544-FY (DUR Free Text Message) to determine the date the member may pick up the refill of a drug.

ForwardHealth does not allow emergency medication dispensing to override an "ER" DUR alert. Emergency medication dispensing is intended to ensure members receive medically necessary medications while a PA request is being adjudicated.

Reason, Action, and Result Codes

The following tables include DUR reason, action, and result codes.

Providers may refer to companion documents for information about reason, action, and result codes.

Reason Codes

Dosing/Limits	Drug Conflict
ER — Overuse	AT — Additive Toxicity
LR — Underuse	DC — Drug-Disease (Inferred)
HD — High Dose	DC — Drug-Drug Interaction
SR — Suboptimal Regimen	MC — Drug-Disease (Reported)
NS — Insufficient Quantity	PA — Drug-Age
	PG — Drug-Pregnancy
	TD — Therapeutic Duplication

Action Codes

Administrative	
00	No Intervention
FE	Formulary Enforcement
GP	Generic Product Selection
PH	Patient Medication History
TC	Payer/Processor Consulted
TH	Therapeutic Product Interchange
SW	Literature Search/Review

Patient Care	
AS	Patient Assessment
CC	Coordination of Care
M0	Prescriber Consulted
MR	Medication Review
P0	Patient Consulted
PE	Patient Education/Instruction
PF	Patient Referral
PM	Patient Monitoring
PT	Perform Laboratory Test
R0	Pharmacy Consulted Other

	Source
RT	Recommended Laboratory Test
SC	Self-Care Consultation

Result Codes

Dispensed	Not Dispensed	Patient Care
00 — Not specified 01 — Filled as is; False Positive Clarified 1B — Filled Prescription as is 1C — Filled, With Different Dose 1D — Filled, With Different Directions 1E — Filled, With Different Drug Acknowledged 1F — Filled, With Different Quantity 1G — Filled, With Prescriber 1H — Brand-to-Generic Change 1J — Rx-to-OTC change	2A — Prescription Not Filled 2B — Not Filled, Directions Clarified	3A — Recommendation Accepted 3B — Recommendation Not Accepted, Clarified 3C — Discontinued Drug 3D — Regimen Changed 3E — Therapy Changed 3F — Therapy Changed, Cost Increase Acknowledged 3G — Drug Therapy Unchanged 3H — Follow-Up Report

Outcome codes that begin with "1" indicate that dispensing ultimately did occur. Outcome codes that begin with "2" indicate that dispensing was avoided. Outcome codes that begin with "3," or patient care types of Result codes, may or may not be involved with the dispensing of a medication.

Retrospective Drug Utilization Review

Retrospective DURs are performed by BadgerCare Plus and SeniorCare on a monthly basis. Review of drug claims against DUR Board-approved criteria generates patient profiles that are individually reviewed for clinical significance.

Each month, all BadgerCare Plus and SeniorCare pharmacy claims are examined by a software program for potential adverse drug concerns. Criteria are developed by BadgerCare Plus and SeniorCare and are reviewed and approved by the DUR Board. Problems that are reviewed include drug-drug interactions, overuse (i.e., early refill), drug-disease contraindications, duplicate therapy, high dose, and drug pregnancy contraindication.

If a potential drug problem is discovered, intervention letters are sent to all prescribers who ordered a drug relevant to an identified problem. Also included with an intervention letter is a response form for the prescriber to complete, a pre-addressed return envelope, and a patient drug profile.

Good Faith Claims

Definition

A good faith claim may be submitted when a claim is denied due to a discrepancy between the member's enrollment information in the claims processing system and the member's actual enrollment. If a member presents a temporary card or an EE card, BadgerCare Plus encourages providers to check the member's enrollment and, if the enrollment is not on file yet, make a photocopy of the member's temporary card or EE card. If Wisconsin's EVS indicates that the member is not enrolled in BadgerCare Plus, providers should check enrollment again in two days or wait one week to submit a claim to ForwardHealth. If the EVS indicates that the member still is not enrolled after two days, or if the claim is denied with an enrollment-related EOB code, providers should contact Provider Services for assistance.

Pharmacy providers who submit real-time claims should only send a copy of the member enrollment information the provider received at the time of service.

Overpayments

Adjustment Request vs. Cash Refund

Except for nursing home and hospital providers, cash refunds may be submitted to ForwardHealth in lieu of an adjustment request. However, whenever possible, providers should submit an adjustment request for returning overpayments since both of the following are true:

- A cash refund does not provide documentation for provider records as an adjustment request does. (Providers may be required to submit proof of the refund at a later time.)
- Providers are not able to further adjust the claim after a cash refund is done if an additional reason for adjustment is determined.

Adjustment Requests

When correcting an overpayment through an adjustment request, providers may submit the adjustment request electronically or on paper. Providers should not submit provider-based billing claims through adjustment processing channels.

ForwardHealth processes an adjustment request if the provider is all of the following:

- Medicaid certified on the DOS.
- Not currently under investigation for Medicaid fraud or abuse.
- Not subject to any intermediate sanctions under DHS 106.08, Wis. Admin. Code.
- Claiming and receiving ForwardHealth reimbursement in sufficient amounts to allow the recovery of the overpayment within a very limited period of time. The period of time is usually no more than 60 days.

Electronic Adjustment Requests

ForwardHealth will deduct the overpayment when the electronic adjustment request is processed. Providers should use the companion document for the appropriate 837 transaction when submitting adjustment requests.

Paper Adjustment Requests

For paper adjustment requests, providers are required to do the following:

- Submit an Adjustment/Reconsideration Request form through normal processing channels (not Timely Filing), regardless of the DOS.
- Indicate the reason for the overpayment, such as a duplicate reimbursement or an error in the quantity indicated on the claim.

After the paper adjustment request is processed, ForwardHealth will deduct the overpayment from future reimbursement amounts.

Cash Refunds

When submitting a personal check to ForwardHealth for an overpayment, providers should include a copy of the RA for the claim to be adjusted and highlight the affected claim on the RA. If a copy of the RA is not available, providers should indicate the ICN, the NPI (if applicable), and the payee ID from the RA for the claim to be adjusted. The check should be sent to the following address:

ForwardHealth

Financial Services Cash Unit
6406 Bridge Rd
Madison WI 53784-0004

ForwardHealth-Initiated Adjustments

ForwardHealth may initiate an adjustment when a retroactive rate increase occurs or when an improper or excess payment has been made. ForwardHealth has the right to pursue overpayments resulting from computer or clerical errors that occurred during claims processing.

If ForwardHealth initiates an adjustment to recover overpayments, ForwardHealth remittance information will include details of the adjustment in the Claims Adjusted Section of the paper RA.

Requirements

As stated in DHS 106.04(5), Wis. Admin. Code, the provider is required to refund the overpayment within 30 days of the date of the overpayment if a provider receives overpayment for a claim because of duplicate reimbursement from ForwardHealth or other health insurance sources.

In the case of all other overpayments (e.g., incorrect claims processing, incorrect maximum allowable fee paid), providers are required to return the overpayment within 30 days of the date of discovery.

The return of overpayments may occur through one of the following methods:

- Return of overpayment through the adjustment request process.
- Return of overpayment with a cash refund.
- Return of overpayment with a voided claim.
- ForwardHealth-initiated adjustments.

Note: Nursing home and hospital providers may not return an overpayment with a cash refund. These providers routinely receive retroactive rate adjustments, requiring ForwardHealth to reprocess previously paid claims to reflect a new rate. This is not possible after a cash refund is done.

Reversing Claims

Providers may reverse (or void) claims on the ForwardHealth Portal to return overpayments. This way of returning overpayments may be a more efficient and timely way for providers as a reversed claim is a complete recoupment of that claim payment. Once a claim has been reversed, the claim can no longer be adjusted; however, the services provided and indicated on the reversed claim may be resubmitted on a new claim.

If a provider returns an overpayment by mail, reversed claims will have ICNs beginning with "67." Overpayments that are adjusted on the Portal will have ICNs that begin with "59."

Responses

An Overview of the Remittance Advice

The RA provides important information about the processing of claims and adjustment requests as well as additional financial transactions such as refunds or recoupment amounts withheld. ForwardHealth provides electronic RAs to providers on their secure ForwardHealth Portal accounts when at least one claim, adjustment request, or financial transaction is processed. RAs are generated from the appropriate ForwardHealth program when at least one claim, adjustment request, or financial transaction is processed. An RA is generated regardless of how a claim or adjustment is submitted (electronically or on paper). Generally, payment information is released and an RA is generated by ForwardHealth no sooner than the first state business day following the financial cycle.

Providers are required to access their secure ForwardHealth provider Portal account to obtain their RA.

RAs are accessible to providers in a TXT format via the secure Provider area of the Portal. Providers are also able to download the RA from their secure provider Portal account in a new CSV format.

National Provider Identifier on the Remittance Advice

Providers who have a single NPI that is used for multiple certifications will receive an RA for each certification with the same NPI reported on each of the RAs. For instance, if a hospital has obtained a single NPI and the hospital has a clinic, a lab, and a pharmacy that are all certified by Medicaid, the clinic, the lab, and the pharmacy will submit separate claims that indicate the same NPI as the hospital. Separate RAs will be generated for the hospital, the clinic, the lab, and the pharmacy.

Calculating Totals on the Remittance Advice for Adjusted and Paid Claims

The total amounts for all adjusted or paid claims reported on the RA appear at the end of the adjusted claims and paid claims sections in the TXT file. Pay-out amounts are in the Financial Transactions section in the CSV. ForwardHealth calculates the total by adding the amounts for all of the claims; cutback amounts are subtracted from the allowed amount to reach the total reimbursement for the claims.

Note: Some cutbacks that are reported in detail lines will appear as EOB codes and will not display an exact dollar amount.

Claim Number

Each claim or adjustment request received by ForwardHealth is assigned a unique claim number (also known as the ICN). However, denied claims submitted using the NCPDP 5.1 transaction are not assigned an ICN.

Interpreting Claim Numbers

The ICN consists of 13 digits that identify valuable information (e.g., the date the claim was received by ForwardHealth, how the claim was submitted) about the claim or adjustment request.

Claim Status

ForwardHealth generally processes claims and adjustment requests within 30 days of receipt. Providers may check the status of a

claim or adjustment request using the AVR system or the 276/277 transaction.

If a claim or adjustment request does not appear in claim status within 45 days of the date of submission, a copy of the original claim or adjustment request should be resubmitted through normal processing channels.

Cutback Fields on the Remittance Advice for Adjusted and Paid Claims

Cutback fields indicate amounts that reduce the allowed amount of the claim. Examples of cutbacks include other insurance, member copayment, spenddown amounts, deductibles, or patient liability amounts. Amounts indicated in a cutback field are subtracted from the total allowed reimbursement.

Providers should note that cutback amounts indicated in the header of an adjusted or paid claim section apply only to the header. Not all cutback fields that apply to a detail line (such as copayments or spenddowns) will be indicated on the RA; the detail line EOB codes inform providers that an amount was deducted from the total reimbursement but may not indicate the exact amount.

Note: Providers who receive 835 transactions will be able to see all deducted amounts on paid and adjusted claims.

Electronic Remittance Information

Providers are required to access their secure ForwardHealth provider Portal account to obtain their RAs. Electronic RAs on the Portal are not available to the following providers because these providers are not allowed to establish Portal accounts by their Provider Agreements:

- In-state emergency providers.
- Out-of-state providers.
- Out-of-country providers.

RAs are accessible to providers in a TXT format or from a CSV file via the secure Provider area of the Portal.

Text File

The TXT format file is generated by financial payer and listed by RA number and RA date on the secure provider Portal account under the new "View Remittance Advices" menu. RAs from the last 97 days are available in the TXT format. When a user clicks on an RA, a pop-up window displays asking if the user would like to "Open" or "Save" the file. If "Open" is chosen, the document opens based on the user's application associated with opening text documents. If "Save" is chosen, the "Save As" window will open. The user can then browse to a location on their computer or network to save the document.

Users should be aware that "Word Wrap" must be turned off in the Notepad application. If it is not, it will cause distorted formatting. Also, users may need to resize the Notepad window in order to view all of the data. Providers wanting to print their files must ensure that the "Page Setup" application is set to the "Landscape" setting; otherwise the printed document will not contain all the information.

Comma-Separated Values Downloadable File

A CSV file is a file format accepted by a wide range of computer software programs. Downloadable CSV-formatted RAs allow users the benefits of building a customized RA specific to their use and saving the file to their computer. The CSV file on a provider's Portal appears as linear text separated by commas until it is downloaded into a compatible software program. Once downloaded, the file may be saved to a user's computer and the data manipulated, as desired.

To access the CSV file, providers should select the new "View Remittance Advices" menu at the top of the provider's Portal home

page.

The CSV files are generated per financial payer and listed by RA number and RA date. A separate CSV file is listed for the last 10 RAs. Providers can select specific sections of the RA by date to download making the information easy to read and organize.

The CSV file may be downloaded into a Microsoft Office Excel spreadsheet or into another compatible software program, such as Microsoft Office Access or OpenOffice 2.2.1. OpenOffice is a free software program obtainable from the Internet. Google Docs and ZDNet also offer free spreadsheet applications. Microsoft Office Excel, a widely used program, is a spreadsheet application for Microsoft Windows and Mac OS X. For maximum file capabilities when downloading the CSV file, the 1995 Office Excel for Windows (Version 7.0) included in Office 95 or a newer version is recommended. Earlier versions of Microsoft Office Excel will work with the CSV file; however, files exceeding 65,000 lines may need to be split into smaller files when downloading using earlier versions. Microsoft Office Access can manage larger data files.

The CSV User Guide includes instructions about Microsoft Office Excel functions that can be used to manipulate RA data downloaded from the CSV file.

835

Electronic remittance information may be obtained using the 835 transaction. It provides useful information regarding the processing of claims and adjustment requests, which includes the status or action taken on a claim, claim detail, adjustment, or adjustment detail for all claims and adjustments processed that week, regardless of whether they are reimbursed or denied. However, a claim submitted by a pharmacy using the NCPDP 5.1 transaction will not appear on remittance information if the claim is denied by ForwardHealth. ForwardHealth releases payment information to the 835 no sooner than on the first state business day following the financial cycle.

Provider Electronic Solutions Software

The DHCAA offers electronic billing software at no cost to the provider. The PES software allows providers to download the 835 transaction. To obtain PES software, providers may download it from the ForwardHealth Portal. For assistance installing and using PES software, providers may call the EDI Helpdesk.

Explanation of Benefit Codes in the Claim Header and in the Detail Lines

EOB codes are four-digit numeric codes specific to ForwardHealth that correspond to a printed message about the status or action taken on a claim, claim detail, adjustment, or adjustment detail.

The claim processing sections of the RA report EOBs for the claim header information and detail lines, as appropriate. Header information is a summary of the information from the claim, such as the DOS that the claim covers or the total amount paid for the claim. Detail lines report information from the claim details, such as specific procedure codes or revenue codes, the amount billed for each code, and the amount paid for a detail line item.

Header EOBs are listed below the claim header information and pertain only to the header information. Detail line EOBs are listed after each detail line and pertain only to the detail line.

TEXT File

EOB codes and descriptions are listed in the RA information in the TXT file.

CSV File

EOB codes are listed in the RA information from the CSV file; however, the printed message corresponding to the codes do not appear in the file. The EOB Code Listing matching standard EOB codes to explanation text are available on the Portal for reference.

Explanation of Benefits

An EOB code corresponds to a printed message about the status or action taken on a claim, claim detail, adjustment, or adjustment detail. EOB codes may be periodically revised. Providers should occasionally check the Explanation of Benefits Code Listing for revisions.

Explanation of Benefits Monthly Reports

ForwardHealth publishes two monthly reports titled, "EOBs on Paid Claims for Month CCYY" and "EOBs on Denied Claims for Month CCYY". These reports allow providers to see common denial reasons and research the policies and procedures to educate their staff on covered services.

The data tables will be posted by the 10th of every month on the pharmacy page of the ForwardHealth Portal. Previous monthly reports will be maintained in the "Archived Data Tables" section on the pharmacy page of the ForwardHealth Portal.

Identifying the Claims Reported on the Remittance Advice

The RA reports the first 12 characters of the MRN and/or a PCN, also referred to as Patient Account Number, submitted on the original claims. The MRN and PCN fields are located beneath the member's name on any section of the RA that reports claims processing information.

Providers are strongly encouraged to enter these numbers on claims. Entering the MRN and/or the PCN on claims may assist providers in identifying the claims reported on the RA.

Note: Claims processing sections for dental and drug claims do not include the MRN or the PCN.

Obtaining the Remittance Advice

Providers are required to access their secure ForwardHealth provider Portal account to obtain RAs. The secure Portal allows providers to conduct business and exchange electronic transactions with ForwardHealth. A separate Portal account is required for each financial payer.

Providers who do not have a ForwardHealth provider Portal account may request one.

RAs are accessible to providers in a TXT format via the secure provider Portal account. The TXT format file is generated per financial payer and listed by RA number and RA date on the secure provider Portal account under "View Remittance Advices" menu at the top of the provider's Portal home page. RAs from the last 97 days are available in the TXT format.

Providers can also access RAs in a CSV format from their secure provider Portal account. The CSV files are generated per financial payer and listed by RA number and RA date on the secure provider Portal account under "View Remittance Advices" menu at the top of the provider's Portal home page. A separate CSV file is listed for the last 10 RAs.

Overview of Claims Processing Information on the Remittance Advice

The claims processing sections of the RA includes information submitted on claims and the status of the claims. The claim status

designations are paid, adjusted, or denied. The RA also supplies information about why the claim was adjusted or denied or how the reimbursement was calculated for the payment.

The claims processing information in the RA is grouped by the type of claim and the status of the claim. Providers receive claims processing sections that correspond to the types of claims that have been finalized during the current financial cycle.

The claims processing sections reflect the types of claims submitted, such as the following:

- Compound drug claims.
- Dental claims.
- Drug claims.
- Inpatient claims.
- Long term care claims.
- Medicare crossover institutional claims.
- Medicare crossover professional claims.
- Outpatient claims.
- Professional claims.

The claims processing sections are divided into the following status designations:

- Adjusted claims.
- Denied claims.
- Paid claims.

Payment Variance Edit

All electronic and paper pharmacy claims submitted to ForwardHealth will be reviewed by a payment variance edit. The variance edit verifies claims data and ensures correct claims reimbursement. The variance edit compares the program-allowed amount for a drug to the dispensing provider's billed amount. If the billed amount is 60 percent greater than or less than the allowed amount, the claim will be denied because there was likely a billing error on the quantity or billed amount. Providers will receive EOB code 0509 (Claim denied. Please verify the units and dollars billed. If correct, refer to Pharmacy Handbook for special handling instructions.) and NCPDP reject code 84 (Claim has not been paid/captured.) when the variance is exceeded.

Remittance Information

Denied claims will appear on the RA with an EOB code that requires the provider to verify the quantity and charge for the claim. If the quantity or charge were submitted incorrectly for an electronic or paper claim, the provider should complete one of the following:

- If the claim was partially paid, submit an Adjustment/Reconsideration Request.
- If the claim was denied, correct and resubmit the claim.

Prior Authorization Number on the Remittance Advice

The RA reports PA numbers used to process the claim. PA numbers appear in the detail lines of claims processing information.

Reading Non-Claims Processing Sections of the Remittance Advice

Address Page

In the TXT file, the Address page displays the provider name and "Pay to" address of the provider.

Banner Messages

The Banner Messages section of the RA contains important, time-sensitive messages for providers. For example, banner messages might inform providers of claim adjustments initiated by ForwardHealth, claim submission deadlines, and dates of upcoming training sessions. It is possible for each RA to include different messages, therefore providers who receive multiple RAs should read all of their banner messages.

Banner messages appear on the TXT file, but not on the CSV file. Banner messages are posted in the "View Remittance Advices" menu on the provider's secure Portal account.

Explanation of Benefits Code Descriptions

EOB Code Descriptions are listed in the RA information in the TXT file.

EOBs are listed in the RA information from the CSV file; however, the printed message corresponding to the codes does not appear in the file. The EOB listing matches standard EOB codes to explanation text is available on the Portal for reference.

Financial Transactions Page

The Financial Transactions section details the provider's weekly financial activity. Financial transactions reported on the RA include payouts, refunds, accounts receivable, and payments for claims.

Payouts are payments made to the provider by ForwardHealth that do not correspond to a specific claim (i.e., nursing home assessment reimbursement).

Refunds are payments made to providers for overpayments.

The Accounts Receivable section displays the accounts receivable for amounts owed by providers. The accounts receivable is set to automatically recover any outstanding balance so that money owed is automatically recouped from the provider. If the full amount cannot be recouped during the current financial cycle, an outstanding balance will appear under "Accounts Receivable." The "Total Recoupment" field lists the cumulative amount recovered for the accounts receivable.

Every financial transaction that results in the creation of an accounts receivable is assigned an identification number called the "adjustment ICN." The adjustment ICN for an adjusted claim matches the original ICN assigned to the adjusted claim. For other financial transactions, the adjustment ICN is determined by the following formula.

Type of Character and Description	Applicable Characters and Description
Transaction — The first character indicates the type of financial transaction that created the accounts receivable.	V — Capitation adjustment 1 — OBRA Level 1 screening void request 2 — OBRA Nurse Aide Training/Testing void request
Identifier — 10 additional numbers are assigned to complete the Adjustment ICN.	The identifier is used internally by ForwardHealth.

Service Code Descriptions

The Service Code Descriptions section lists all the service codes (i.e., procedure codes or revenue codes) reported on the RA with their corresponding descriptions.

Summary

The Summary section reviews the provider's claim activity and financial transactions with the payer (Medicaid, WCDP, or WWWP) for the current financial cycle, the month-to-date, and the year-to-date, if applicable.

Under the "Claims Data" heading, providers can review the total number of claims that have been paid, adjusted, or denied along with the total amount reimbursed for all paid and adjusted claims. Only WWWP providers will see amounts reported for "Claims in Process." Other providers will always see zeroes in these fields.

Under the "Earnings Data" heading, providers will see total reimbursement amounts for other financial transactions, such as reimbursement for OBRA Level 1 screening, reimbursement for OBRA Nurse Aid Training/Testing, and capitation payments.

Note: HMOs should note that capitation payments are only reported in the Summary section of the RA. HMOs receive supplemental reports of their financial transactions from ForwardHealth.

The "Earnings Data" portion also summarizes refunds and voids and reports the net payment for the current financial cycle, the month-to-date, and the year-to-date, if applicable.

Providers should note that the Summary section will include outstanding checks 90 days after issuance and/or payments made to lien holders, if applicable.

Reading the Claim Adjustments Section of the Remittance Advice

Providers receive a Claim Adjustments section in the RA if any of their claims were adjusted during the current financial cycle. A claim may be adjusted because one of the following occurred:

- An adjustment request was submitted by the provider.
- ForwardHealth initiated an adjustment.
- A cash refund was submitted to ForwardHealth.

In a claim adjustments section, the original claim information in the claim header is surrounded by parentheses. Information about the adjusted claim appears directly below the original claim header information. Providers should check the Adjustment EOB code(s) for a summary of why the claim was adjusted; other header EOBs will provide additional information.

The claim adjustments section lists detail lines only for the adjusted claim with detail line EOBs. Details from the original claim will not be reported on the adjusted claims sections of the RA.

Note: For adjusted drug claims, only the compound drug sections include detail lines.

Below the claim header and the detail information will be located one of three possible responses with a corresponding dollar amount: "additional payment," "overpayment to be withheld," or "refund amount applied."

An amount appears for "additional payment" if ForwardHealth owes additional monies to the provider after the claim has been adjusted. This amount will be added to the provider's total reimbursable amount for the RA.

An amount appears for "overpayment to be withheld" if ForwardHealth determines, as the result of an adjustment to the original claim, that the provider owes ForwardHealth monies. ForwardHealth automatically withholds this amount from payments made to the

provider during the same financial cycle or during subsequent financial cycles, if necessary. This amount also appears in the Financial Transactions section as an outstanding balance under "Accounts Receivable."

An amount appears for "refund amount applied" if ForwardHealth makes a payment to refund a cash receipt to a provider.

Reading the Claims Denied Section of the Remittance Advice

Providers receive a Claims Denied section in the RA if any of their claims were denied during the current financial cycle.

In the denied claims section, providers will see the original claim header information reported along with EOB codes for the claim header and the detail lines, as applicable. Providers should refer to the EOB Code Description section of the RA to determine why the claim was denied.

Reading the Claims Paid Section of the Remittance Advice

Providers receive a Claims Paid section in the RA if any of their claims were determined payable during the current financial cycle.

In a paid claims section, providers will see the original claim information reported along with EOB codes for both the header and the detail lines, if applicable. Providers should refer to the EOB Code Description section of the RA for more information about how the reimbursement amount was determined.

Remittance Advice Financial Cycles

Each financial payer (Medicaid, WCDP, and WWWP) has separate financial cycles that occur on different days of the week. RAs are generated and posted to secure provider Portal accounts after each financial cycle is completed. Therefore, RAs may be generated and posted to secure provider Portal accounts from different payers on different days of the week.

Certain financial transactions may run on a daily basis, including non-claim related payouts and stop payment reissues. Providers may have access to the RAs generated and posted to secure provider Portal accounts for these financial transactions at any time during the week.

Remittance Advice Generated by Payer and by Provider Certification

RAs are generated and posted to secure provider Portal accounts from one or more of the following ForwardHealth financial payers:

- Wisconsin Medicaid (Wisconsin Medicaid is the financial payer for the Medicaid, BadgerCare Plus, and SeniorCare programs).
- WCDP.
- WWWP.

A separate Portal account is required for each financial payer.

Note: Each of the three payers generate separate RAs for the claims, adjustment requests, or other financial transactions submitted to the payer. A provider who submits claims, adjustment requests, or other financial transactions to more than one of these payers may receive several RAs.

The RA is generated per provider certification. Providers who have a single NPI that is used for multiple certifications should be aware that an RA will be generated for each certification, but the same NPI will be reported on each of the RAs.

For instance, a hospital has obtained a single NPI. The hospital has a clinic, a lab, and a pharmacy that are all certified with ForwardHealth. The clinic, the lab, and the pharmacy submit separate claims that indicate the same NPI as the hospital. Separate RAs will be generated for the hospital, the clinic, the lab, and the pharmacy.

Reporting a Lost Check

To report a lost check to ForwardHealth, providers are required to mail or fax a letter to ForwardHealth Financial Services. Providers are required to include the following information in the letter:

- Provider's name and address, including the ZIP+4 code.
- Provider's identification number.
  - For healthcare providers, include the NPI and ForwardHealth-issued taxonomy code.
  - For non-healthcare providers, include the provider identification number.
- Check number, check date, and check amount. (This should be recorded on the RA.)
- A written request to stop payment and reissue the check.
- The signature of an authorized financial representative. (An individual provider is considered his or her own authorized financial representative.)

Fax the letter to ForwardHealth at (608) 221-4567 or mail it to the following address:

ForwardHealth
Financial Services
6406 Bridge Rd
Madison WI 53784-0005

Searching for and Viewing All Claims on the Portal

All claims, including pharmacy and dental claims, are available for viewing on the ForwardHealth Portal.

To search and view claims on the Portal, providers may do the following:

- Go to the ForwardHealth Portal.
- Log in to the secure Provider area of the Portal.
- The most recent claims processed by ForwardHealth will be viewable on the provider's home page or the provider may select "claim search" and enter the applicable information to search for additional claims.
- Select the claim the provider wants to view.

Sections of the Remittance Advice

The RA information in the TXT file includes the following sections:

- Address page.
- Banner messages.
- Paper check information, if applicable.
- Claims processing information.
- EOB code descriptions.
- Financial transactions.
- Service code descriptions.

- Summary.

The RA information in the CSV file includes the following sections:

- Payment.
- Payment hold.
- Service codes and descriptions.
- Financial transactions.
- Summary.
- Inpatient claims.
- Outpatient claims.
- Professional claims.
- Medicare crossovers — Professional.
- Medicare crossovers — Institutional.
- Compound Drug Claims.
- Drug claims.
- Dental claims.
- Long term care claims.
- Financial transactions.
- Summary.

Providers can select specific sections of the RA in the CSV file within each RA date to be downloaded making the information easy to read and to organize.

Remittance Advice Header Information

The first page of each section of the RA (except the address page of the TXT file) displays the same RA header information.

The following fields are on the left-hand side of the header:

- The technical name of the RA section (e.g., CRA-TRAN-R), which is an internal ForwardHealth designation.
- The RA number, which is a unique number assigned to each RA that is generated.
- The name of the payer (Medicaid, WCDP, or WWWP).
- The "Pay to" address of the provider. The "Pay to" address is used for mailing purposes.

The following information is in the middle of the header:

- A description of the financial cycle.
- The name of the RA section (e.g., "Financial Transactions" or "Professional Services Claims Paid").

The right-hand side of the header reports the following information:

- The date of the financial cycle and date the RA was generated.
- The page number.
- The "Payee ID" of the provider. A payee ID is defined as the identification number of a unique entity receiving payment for goods and/or services from ForwardHealth. The payee ID is up to 15 characters long and may be based on a pre-existing identification number, such as the Medicaid provider number. The payee ID is an internal ForwardHealth designation. The Medicaid provider number will display in this field for providers who do not have an NPI.
- The NPI of the provider, if applicable. This field will be blank for those providers who do not have an NPI.
- The number of the check issued for the RA, if applicable. The date of payment on the check, if applicable.

Verifying Accuracy of Claims Processing

After obtaining ForwardHealth remittance information, providers should compare it to the claims or adjustment requests to verify that ForwardHealth processed elements of the claims or adjustment requests as submitted. To ensure correct reimbursement, providers should do the following:

- Identify and correct any discrepancy that affected the way a claim processed.
- Correct and resubmit claims that are denied.
- Submit an adjustment request for allowed claims that require a change or correction.

When posting a payment or denial to a member's account, providers should note the date on the ForwardHealth remittance information that indicates that the claim or adjustment has finalized. Providers are required to supply this information if further follow-up actions are necessary.

Responsibilities

Accuracy of Claims

The provider is responsible for the accuracy, truthfulness, and completeness of all claims submitted whether prepared or submitted by the provider or by an outside billing service or clearinghouse.

Providers may submit claims only *after* the service is provided.

A provider may not seek reimbursement from ForwardHealth for a noncovered service by charging ForwardHealth for a covered service that was not actually provided to the member and then applying the reimbursement toward the noncovered service. In addition, a provider may not seek reimbursement for two separate covered services to receive additional reimbursement over the maximum allowed amount for the one service that was provided. Such actions are considered fraudulent.

Copayment Amounts

Copayment amounts collected from members should not be deducted from the charges submitted on claims. Providers should indicate their usual and customary charges for all services provided.

In addition, copayment amounts should not be included when indicating the amount paid by other health insurance sources.

The appropriate copayment amount is automatically deducted from allowed payments. Remittance information reflects the automatic deduction of applicable copayment amounts.

Exceptions to the Submission Deadline

State and federal laws provide eight exceptions to the submission deadline. According to federal regulations and DHS 106.03, Wis. Admin. Code, ForwardHealth may consider exceptions to the submission deadline only in the following circumstances:

- Change in a nursing home resident's level of care or liability amount.
- Decision made by a court order, fair hearing, or the DHS.
- Denial due to discrepancy between the member's enrollment information in ForwardHealth interChange and the member's actual enrollment.
- Reconsideration or recoupment.
- Retroactive enrollment for persons on GR.
- Medicare denial occurs after ForwardHealth's submission deadline.
- Refund request from an other health insurance source.
- Retroactive member enrollment.

ForwardHealth has no authority to approve any other exceptions to the submission deadline.

Claims or adjustment requests that meet one of the exceptions to the submission deadline may be submitted to Timely Filing.

Submission Deadline

ForwardHealth recommends that providers submit claims at least on a monthly basis. Billing on a monthly basis allows the maximum time available for filing and refiling before the mandatory submission deadline.

With few exceptions, state and federal laws require that providers submit correctly completed claims before the submission deadline.

Providers are responsible for resolving claims. Members are not responsible for resolving claims. To resolve claims before the submission deadline, ForwardHealth encourages providers to use all available resources.

Claims

To receive reimbursement, claims and adjustment requests must be received within 365 days of the DOS. This deadline applies to claims, corrected claims, and adjustments to claims.

Crossover Claims

To receive reimbursement for services that are allowed by Medicare, claims and adjustment requests for coinsurance, copayment, and deductible must be received within 365 days of the DOS or within 90 days of the Medicare processing date, whichever is later. This deadline applies to all claims, corrected claims, and adjustments to claims. Providers should submit these claims through normal processing channels (not timely filing).

Usual and Customary Charges

For most services, providers are required to indicate their usual and customary charge when submitting claims. The usual and customary charge is the provider's charge for providing the same service to persons not entitled to the program's benefits. For providers using a sliding fee scale, the usual and customary charge is the median of the individual provider's charge for the service when provided to non-program patients. 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.

Providers may not discriminate against BadgerCare Plus or Medicaid members by charging a higher fee for the same service than that charged to a private-pay patient.

For services requiring a member copayment, providers should still indicate their usual and customary charge. The copayment amount collected from the member should not be deducted from the charge submitted. When applicable, BadgerCare Plus automatically deducts the copayment amount.

For most services, BadgerCare Plus reimburses the lesser of the provider's usual and customary charge or the maximum allowable fee established.

Submission

Accuracy in Pharmacy Claims Submission

BadgerCare Plus and SeniorCare monitor pharmacy claims for accuracy. Fields monitored may include:

- Unit dose.
- Days' supply.
- Prescription number.
- Quantity.
- Amount billed.
- DAW.
- Brand medically necessary.
- PC code.

A post-pay review of these fields may result in an audit by BadgerCare Plus or SeniorCare.

Attached Documentation

Providers should not submit additional documentation with a claim *unless* specifically requested.

Claim Reversals

ForwardHealth is unable to electronically reverse claims at a provider's request. Providers can electronically reverse claims up to 365 days from the date of service or submit an Adjustment/Reconsideration Request form.

Claim Submission for Non-Preferred Drugs

Pharmacy providers who submit real-time pharmacy claims for non-preferred drugs will receive an EOB code and an NCPDP reject code indicating a denial in the claim response.

For non-real-time pharmacy claims, providers will receive an EOB code on their RA and an NCPDP reject code on the 835 transaction.

Claims for Diagnosis-Restricted Drugs

Pharmacy providers are required to indicate diagnosis codes on claims for diagnosis-restricted drugs. Claims using diagnosis codes are monitored by DHCAA auditors.

All diagnosis codes indicated on claims (and PA requests when applicable) must be the most specific ICD-9-CM diagnosis code. Providers are responsible for keeping current with diagnosis code changes. E&M codes may not be used as a primary diagnosis.

The required use of valid diagnosis codes includes the use of the most specific diagnosis code. Valid, most specific diagnosis codes may have up to five digits. Claims submitted with three- or four-digit codes where four- and five-digit codes are available may be denied.

When a claim is submitted with a missing or invalid diagnosis code, or with a code that is not an allowed diagnosis code, providers

will receive an EOB code.

If an EOB response is received because the provider did not submit an allowable diagnosis code, a paper PA request with supporting documentation should be submitted to ForwardHealth.

Documentation Requirements

A provider is expected to have reasonable, readily retrievable documentation to verify the accuracy of the diagnosis for the original prescription. This documentation must show the diagnosis was indicated on the prescription, or provided by someone in the prescriber's office. If a diagnosis code is not indicated on the prescription, pharmacy providers should contact prescribers to obtain the diagnosis code or diagnosis description.

Claims with Medicare-Paid Amounts

BadgerCare Plus and SeniorCare providers should submit drug claims to Medicare prior to sending them to ForwardHealth. Wisconsin Medicaid will consider reimbursing drug crossover claims for BadgerCare Plus and SeniorCare members. Pharmacy providers are required to send drug claims to any entity, including Medicare, using NCPDP Telecommunication Standard 5.1 for Retail Pharmacy Claims standards and NDCs. Medicare-paid drug claims will automatically cross over to ForwardHealth.

SeniorCare claims with Medicare paid amounts will *not* automatically cross over to SeniorCare. For SeniorCare members, pharmacy providers may submit a straight SeniorCare claim (real-time NCPDP 5.1 B1 billing transaction or paper drug claim). Pharmacies should indicate the appropriate NDC and enter the Medicare-paid amount in the "Other Coverage Amount" field for paper claims or the "Other Payer Amount Paid" field for real-time claims. If commercial health insurance is the member's primary insurance and Medicare is the secondary, providers are required to enter the total paid amounts from commercial health insurance *and* Medicare in the "Other Coverage Amount" field.

Providers should submit their Medicare remittance information containing the Medicare-paid amounts with paper claims. BadgerCare Plus and SeniorCare process the Medicare-paid amount like payment from commercial health insurance.

Claims Submission

BadgerCare Plus and Wisconsin Medicaid reimburse a single fee for clozapine management services provided either once per calendar week (i.e., Sunday through Saturday) or once per two calendar weeks. Providers indicate a quantity of 1.0 for each billing period. For members who have weekly WBC counts, providers will only be allowed to bill clozapine management once (up to 4.0 units) per week, regardless of the number of services provided during a week. For those members who have WBC counts taken every other week, providers will only be allowed to bill clozapine management once (up to 4.0 units) every two weeks.

A quantity of no more than four 15-minute time units per DOS may be indicated on the claim. Providers may submit claims for clozapine management only as often as a member's WBC count and ANC are tested, even if clozapine is dispensed more frequently. Documentation must support the actual time spent on clozapine management services.

Providers submit claims for clozapine management services using the 837P transaction or paper 1500 Health Insurance Claim Form. For each billing period, only one provider per member may be reimbursed for clozapine management with procedure code H0034 (Medication training and support, per 15 minutes) and modifier "UD" (clozapine management).

Billing Units for Clozapine Management Services	
Quantity	**Time**
1.0	1-15 minutes
2.0	16-30 minutes
3.0	31-45 minutes

4.0	46-60 minutes

Place of Service Codes

Allowable POS codes for clozapine management services are listed in the following table.

Place of Service Code	Description
03	School
04	Homeless Shelter
05	Indian Health Service Free-Standing Facility
06	Indian Health Service Provider-Based Facility
07	Tribal 638 Free-Standing Facility
08	Tribal 638 Provider-Based Facility
11	Office
12	Home
22	Outpatient Hospital
34	Hospice
71	State or Local Public Health Clinic
99	Other Place of Service

Compound Drugs

Providers should submit claims for compound drugs through the real-time POS system using the NCPDP 5.1 Telecommunication Standard for Retail Pharmacy Claims or on a Compound Drug Claim form. Providers are required to indicate an NDC for each component on claims for compound drugs. Claims for injectible drugs (IV, IM, subcutaneous, TPN solution, and lipids) with more than one component should be submitted as compound drugs.

NDCs of bulk chemicals are on file for reimbursement where there is a signed rebate agreement with BadgerCare Plus or SeniorCare. Claims for these NDCs may be submitted only as part of a compound drug.

Compound Drug Preparation Time

Providers should indicate time spent preparing a compound drug on a claim. BadgerCare Plus and SeniorCare note the time indicated and, as a result, are better able to price the compound drug when an unusual amount of time is required to prepare the compound drug.

Providers are required to indicate the time (in minutes) to compound the prescription by using a level of effort code. The maximum amount of time that BadgerCare Plus or SeniorCare will reimburse is 30 minutes. Providers may indicate level of effort codes 14 and 15 to indicate that compounding the drug took more than 30 minutes, but they will only be reimbursed for up to 30 minutes. In calculating level of effort, providers should not include non-professional staff time, set-up time, or clean-up time in the total.

The usual and customary charge should include both the dispensing fee and the cost of the drug ingredients. On paper claims, indicate the usual and customary charge in the "Total Billed Amount" field. On real-time and PES claims, include the dispensing fee and the cost of the drug ingredients in both the "Usual and Customary Charge" field and in the "Gross Amount Due" field.

Billing Compound Drug Ingredients

All of the ingredients of a compound drug must be billed as one compound drug. Claims for individual items of a compound drug may not be submitted separately with an accompanying dispensing fee for each ingredient. The quantity field should be the total number of units that are dispensed. This number is not the total number of units for each individual ingredient.

When submitting real-time claims for compound drugs, pharmacy providers should enter NCPDP compound drug indicator "2" in the compound drug indicator field. This alerts the POS system that the NDCs indicated comprise a single compound drug.

Billing Options When Compound Drug Ingredients Are Not on File

If one or more of the ingredients in a compound drug are not present on the drug file, the provider may choose not to bill the ingredient(s) not on file. The provider should submit the remaining ingredients on the Compound Drug Claim form using the previously defined billing instructions.

If a compound drug has any noncovered ingredients, payment for those ingredients will be denied, but the rest of the ingredients will be covered, assuming other conditions are met.

The BadgerCare Plus Standard Plan, Medicaid, and SeniorCare do not cover compounded medications in dosage forms that have no proven therapeutic effect.

Compound drugs are not covered by the BadgerCare Plus Benchmark Plan or the BadgerCare Plus Core Plan.

Correct Errors on Claims and Resubmit to ForwardHealth on the Portal

Providers can view EOB codes and descriptions for any claim submitted to ForwardHealth on the ForwardHealth Portal. The EOBs help providers determine why a claim did not process successfully, so providers may correct the error online and resubmit the claim. The EOB appears on the bottom of the screen and references the applicable claim header or detail.

Compound and Noncompound Drug Claims

For example, the provider might see on his or her RA the detail for a noncompound drug claim was denied with the EOB code indicating that the detail on the claim was not processed due to an error. The provider may then correct the error on the claim via the Portal online screen application and resubmit the claim to ForwardHealth.

Direct Data Entry of Professional and Institutional Claims on the Portal

Providers can submit the following claims to ForwardHealth via DDE on the ForwardHealth Portal:

- Professional claims.
- Institutional claims.
- Dental claims.
- Compound drug claims.
- Noncompound drug claims.

DDE is an online application that allows providers to submit claims directly to ForwardHealth.

When submitting claims via DDE, required fields are indicated with an asterisk next to the field. If a required field is left blank, the claim will not be submitted and a message will appear prompting the provider to complete the specific required field(s). Portal help is

available for each online application screen. In addition, search functions accompany certain fields so providers do not need to look up the following information in secondary resources.

On professional claim forms, providers may search for and select the following:

- Procedure codes.
- Modifiers.
- Diagnosis codes.
- POS codes.

On institutional claim forms, providers may search for and select the following:

- Type of bill.
- Patient status.
- Admission source.
- Admission type.
- Diagnosis codes.
- Revenue codes.
- Procedure codes.
- Modifiers.

On dental claims, providers may search for and select the following:

- Procedure codes.
- Rendering providers.
- Area of the oral cavity.
- POS.

On compound and noncompound drug claims, providers may search for and select the following:

- Diagnosis codes.
- NDCs.
- Patient location codes.
- Professional service codes.
- Reason for service codes.
- Result of service codes.

Using DDE, providers may submit claims for compound drugs and single-entity drugs. Any provider, including a provider of DME or of DMS who submits noncompound drug claims, may submit these claims via DDE. All claims, including POS claims, are viewable via DDE.

Dispense As Written Code

Dispense As Written Code "5"

Pharmacy providers are allowed to indicate DAW code "5" (Substitution Allowed; Brand Drug Dispensed As Generic) on claims for drugs on the Legend Drug MAC List. This will allow a provider who purchases brand name drugs below the MAC rate to dispense these drugs to a member without brand medically necessary policy restrictions.

If a pharmacy provider receives a prescription for a brand name drug on the MAC List and "brand medically necessary" is *not* handwritten on the prescription, DAW code "5" may be indicated on the claim. The provider will be reimbursed the MAC rate for the brand name drug and may collect the generic copayment from the member. The provider is not required to obtain brand medically

necessary PA when submitting a claim for a brand name drug with DAW code "5."

PA is required for prescriptions for brand name drugs on the MAC List if "brand medically necessary" is handwritten on the prescription.

Providers are required to submit claims to BadgerCare Plus and SeniorCare for their usual and customary charge for services provided.

Dispense As Written Code "6"

Information is available for DOS before March 1, 2010.

Pharmacy providers may indicate NCPDP DAW code "6" (Override) on claims for drugs excluded from brand medically necessary PA requirements.

Providers receive brand reimbursement for the innovator drug and generic reimbursement for the non-innovator drug. Drugs may be excluded from brand medically necessary PA policy when, due to federal and supplemental rebates, their generic equivalents are more costly for ForwardHealth than their brand name counterparts.

Prescribers do not need to indicate "Brand Medically Necessary" on prescriptions for preferred, brand name drugs excluded from brand medically necessary PA requirements. In addition, if a prescription is written for a generic drug, pharmacy providers may dispense the brand name drug without contacting the prescriber, unless there is a clinically appropriate reason not to dispense the brand name drug.

Members pay the generic drug copayment, not the brand-name copayment for drugs for which ForwardHealth has indicated that a preferred brand name drug is less costly than its non-preferred generic counterpart and DAW code "6" is indicated on claims. Providers are required to refund to the member any copayment amount that may have been overcharged.

Brand Name Drugs for Which Generic Copayment Applies

Information is available for DOS before January 1, 2010.

To assist providers with the brand name drugs with generic copayment policy, ForwardHealth has added to the PDL Quick Reference an indicator for preferred brand name drugs for which generic copayments apply.

Electronic Claims Submission

Providers are encouraged to submit claims electronically. Electronic claims submission does the following:

- Adapts to existing systems.
- Allows flexible submission methods.
- Improves cash flow.
- Offers efficient and timely payments.
- Reduces billing and processing errors.
- Reduces clerical effort.

Point-of-Sale Claims

BadgerCare Plus, Medicaid, and SeniorCare use a voluntary pharmacy POS electronic claims management system for fee-for-service and SeniorCare members. The POS system enables providers to submit electronic pharmacy claims for legend and OTC drugs in an online, real-time environment.

The pharmacy system verifies member enrollment and monitors pharmacy policy. Within seconds of submitting a real-time claim, these processes are completed and the provider receives an electronic response indicating payment or denial.

National Council for Prescription Drug Programs 5.1 Telecommunications Standard Claims

BadgerCare Plus, Medicaid, and SeniorCare use the NCPDP Telecommunication Standard Formation Version 5.1. Using this format, providers are able to complete the following:

- Initiate new claims and reverse and resubmit previously paid real-time claims.
- Submit individual claims or a batch of claims for the same member within one electronic transmission.
- Submit claims for PC.
- Submit claims for compound drugs.

National Provider Identifier On National Council for Prescription Drug Programs 5.1 Telecommunications Standard Claims

An NPI is required on NCPDP 5.1 transactions. There are no data elements for other NPI-related data, taxonomy code, or ZIP+4 code on the NCPDP 5.1 transaction. Providers who do not have a unique NPI for each certification are required to select one certification as the "default" certification. Claims will be processed using the provider file information from the default certification.

An NPI only is accepted in the Prescriber ID field of NCPDP 5.1 transactions. Billing providers may indicate the prescriber's NPI or the pharmacy's NPI.

Prescriber ID and Prescriber ID Qualifier

An NPI is the only identifier accepted in the Prescriber ID field on pharmacy claims, including paper claims. Billing providers are required to make every effort possible to obtain the prescribing provider's NPI. Only in instances when the billing provider is unable to obtain the prescriber's NPI, may the billing provider indicate his or her own NPI in the Prescriber ID field. DEA numbers, including "default" DEA numbers, are not accepted for the Prescriber ID on pharmacy claims.

The Prescriber ID Qualifier value "01" is the only value accepted for the Prescriber ID Qualifier. A value of "01" in the Prescriber ID Qualifier field (466-EZ) indicates that the Prescriber ID field (411-DB) contains an NPI for the prescribing provider. Real-time and PES claims submitted without "01" are denied.

Claim Submission Requirements

Information is available for claims processed before March 1, 2010.

When submitting claims for other insurance to ForwardHealth, providers are required to include specific COB information based on the results of the claim submission to other insurance sources. Some or all of the information below may be automatically populated by the pharmacy software; however, if the software does not automatically populate this information, pharmacy providers are required to enter the information before submitting the claim.

If a service is covered by other insurance and payment is collected, providers are required to indicate a value of "2" in NCPDP field 308-C8 (Other Coverage Code) and information in the following NCPDP fields for each other insurance source:

- 338-5C (Other Payer Coverage Type).
- 340-7C (Other Payer ID).
- 339-6C (Other Payer ID Qualifier) with a value of "99."
- 443-E8 (Other Payer Date) with the payment date, denial date, or the date the claim was submitted to other insurance sources.
- 431-DV (Other Payer Amount Paid) with amount paid by other insurance sources.

- 342-HC (Other Payer Amount Paid Qualifier) with a value of "08."

If a service is not covered by other insurance or if payment is not collected, providers are required to indicate the appropriate value in NCPDP field 308-C8 (Other Coverage Code) and information in the following NCPDP fields for each other insurance source:

- 338-5C (Other Payer Coverage Type).
- 340-7C (Other Payer ID).
- 339-6C (Other Payer ID Qualifier) with a value of "99."
- 443-E8 (Other Payer Date) with the payment date, denial date, or the date the claim was submitted to other insurance sources.
- 471-5E (Other Payer Reject Count) with the number of reject codes to follow.
- 511-FB (Reject Code) with the error code provided by the other insurance source.

Lists of common COB errors and resolutions and COB examples are available.

Other Payer Date

ForwardHealth enforces the submission of an other payer date in NCPDP field 443-E8 (Other Payer Date) when the COB segment is present. A valid date not greater than the submission date must be indicated in this field. The field cannot be left blank. Letters are not accepted in the field.

On claims where an invalid date is indicated in the Other Payer Date field, providers will receive EOB codes and a reject code.

Other Coverage Codes and Reject Codes

When submitting claims to ForwardHealth, providers are required to indicate specific COB information based on the results of the claim submission to other insurance sources. Two fields used for COB are the other coverage code and reject code. Providers are required to use these indicators and reject codes as applicable on claims submitted for members with other health insurance, including Medicare.

Other Payer Reject Code

ForwardHealth enforces the use of valid NCPDP reject codes in the Other Payer Reject Code field (472-6E). Claims will be denied if a valid other payer reject code(s) is not indicated in this field. Pharmacy providers are encouraged to work closely with their software vendors to ensure their software is compliant with NCPDP standards.

On claims where an invalid other payer reject code(s) is indicated in the Other Payer Reject Code field, providers will receive an EOB code and a reject code.

Reject Codes

Effective for DOS on and after March 1, 2010, claims are denied if reject codes indicated are invalid or not reasonable for the service provided (e.g., provider errors in billing the member's primary insurance).

Direct Data Entry of Claims on the Portal

Claims for compound drugs and noncompound drugs may be submitted to ForwardHealth using DDE on the ForwardHealth Portal. DDE is an online application that allows providers to submit claims directly to ForwardHealth.

When submitting claims via DDE, required fields are indicated with an asterisk next to the field. If a required field is left blank, the claim will not be submitted and a message will appear prompting the provider to complete the specific required field(s). Portal help is available for each online application screen. In addition, search functions accompany certain fields so providers do not need to look up the following information in secondary resources.

On compound and noncompound drug claims, providers may search for and select the following:

- Diagnosis codes.
- NDCs.
- Patient location codes.
- Professional service codes.
- Reason for service codes.
- Result of service codes.

Using DDE, providers may submit claims for compound drugs and single-entity drugs. Any provider, including a provider of DME or of DMS who submits noncompound drug claims, may submit these claims via DDE. All claims, including POS claims, are viewable via DDE.

Provider Electronic Solutions Software

ForwardHealth offers electronic billing software at no cost to providers. The PES software allows providers to submit NCPDP 1.1 batch format pharmacy transactions, reverse claims, and check claim status. To obtain PES software, providers may download it from the ForwardHealth Portal. For assistance installing and using PES software, providers may call the EDI Helpdesk.

Extraordinary Claims

Extraordinary claims are claims that have been denied by a BadgerCare Plus HMO or SSI HMO and should be submitted to fee-for-service.

HIPAA-Compliant Data Requirements

Procedure Codes

All fields submitted on paper and electronic claims are edited to ensure HIPAA compliance before being processed. Compliant code sets include CPT and HCPCS procedure codes entered into all fields, including those fields that are "Not Required" or "Optional."

If the information in all fields is not valid and recognized by ForwardHealth, the claim will be denied.

Provider Numbers

For health care providers, NPIs are required in all provider number fields on paper claims and 837 transactions, including rendering, billing, referring, prescribing, attending, and "Other" provider fields.

Non-healthcare providers, including personal care providers, SMV providers, blood banks, and CCOs should enter valid provider numbers into fields that require a provider number.

Managed Care Organizations

Claims for services that are covered in a member's state-contracted MCO should be submitted to that MCO.

Noncertified Providers

Claims from noncertified in-state providers must meet additional requirements.

Noncompound Drug Claims

Claims for noncompound drugs may be submitted on the Noncompound Drug Claim form.

Note Field for Most Claims Submitted Electronically

In some instances, ForwardHealth requires providers to include a description of a service identified by an unlisted, or NOC, procedure code. Providers submitting claims electronically should include a description of a NOC procedure code in a "Notes" field, if required. The Notes field allows providers to enter up to 80 characters. In some cases, the Notes field allows providers to submit NOC procedure code information on a claim electronically instead of on a paper claim or with a paper attachment to an electronic claim.

The Notes field should only be used for NOC procedure codes that do not require prior authorization.

Claims Submitted Via the ForwardHealth Portal Direct Data Entry or Provider Electronic Solutions

A Notes field is available on the ForwardHealth Portal DDE and PES software when providers submit the following types of claims:

- Institutional.
- Professional.
- Dental.

On the Professional and Dental forms, a Notes field is available on each detail. On the Institutional form, the Notes field is only available on the header.

Claims Submitted Via the 837 Health Care Claim Transaction

ForwardHealth accepts and utilizes information submitted by providers about NOC procedure codes in the following loop/segments on the 837 transactions:

- Loop 2300, segment NTE for 837 Health Care Claim: Institutional.
- Loop 2400, segment NTE for 837 Health Care Claim: Professional.
- Loop 2400, segment NTE for 837 Health Care Claim: Dental.

Other Health Insurance

When a member has other commercial health insurance coverage and a claim does not reflect the outcome of the other health insurance in the "Other Coverage code" fields, providers will receive an EOB code with each claim submission.

Members may be covered by multiple other insurance sources that are primary to BadgerCare Plus, Medicaid, or SeniorCare. A claim must be submitted to each other insurance source before it is submitted to BadgerCare Plus, Medicaid, or SeniorCare. Providers may submit COB information on real-time claims for up to nine other insurance sources to BadgerCare Plus, Medicaid, and SeniorCare. Claims submitted to BadgerCare Plus, Medicaid, or SeniorCare should include the amount paid or the reason for denial by other insurance sources.

Paper Claims Submission

Providers may submit paper claims for pharmacy services to BadgerCare Plus and SeniorCare. Paper claims are processed through

the pharmacy system but do not furnish real-time claim responses. Providers who submit paper claims will receive claim status on a provider's remittance information. To submit paper claims to BadgerCare Plus or SeniorCare, pharmacy providers should complete either the Noncompound Drug Claim form or a Compound Drug Claim form. Both forms accommodate NCPDP 5.1.

Submit completed paper claim forms for payment to the following address:

ForwardHealth
Claims and Adjustments
6406 Bridge Road
Madison WI 53784-0002

To order paper claim forms, providers may call Provider Services, or write to the following address:

ForwardHealth
Form Reorder
6406 Bridge Road
Madison, WI 53784-0003

Providers should indicate the number of forms needed in their written request.

Pharmacy Special Handling Requests

A Pharmacy Special Handling Request form must accompany any paper claims submitted by a pharmacy provider that require special handling and cannot be processed as normal claims. Only one Pharmacy Special Handling Request form is required for each set of similar problem claims. Providers may also prepare their own form to request special handling, but that form should include all the elements in ForwardHealth's Pharmacy Special Handling Request form.

A fiscal agent pharmacist consultant reviews claims for compound drugs while a state pharmacist consultant reviews all other claims.

Prior Authorization Numbers on Claims

Providers are not required to indicate a PA number on claims. ForwardHealth interChange matches the claim with the appropriate approved PA request. ForwardHealth's RA and the 835 report to the provider the PA number used to process a claim. If a PA number is indicated on a claim, it will not be used and it will have no effect on processing the claim.

When a PA requirement is added to the list of drugs requiring PA and the effective date of a PA falls in the middle of a billing period, two separate claims that coincide with the presence of PA for the drug must be submitted to ForwardHealth.

Provider-Administered Drugs

Deficit Reduction Act of 2005

Providers are required to comply with requirements of the federal DRA of 2005 and submit NDCs with HCPCS procedure codes on claims for provider-administered drugs. Section 1927(a)(7)(B) of the Social Security Act requires NDCs to be indicated on all claims submitted to ForwardHealth, including Medicare crossover claims.

ForwardHealth requires that NDCs be indicated on claims for all provider-administered drugs to identify the drugs and invoice a manufacturer for rebates, track utilization, and receive federal funds. States that do not collect NDCs with HCPCS procedure codes on claims for provider-administered drugs will not receive federal funds for those claims. ForwardHealth cannot claim a rebate or federal funds if the NDC submitted on a claim is incorrect or invalid or if an NDC is not indicated.

If an NDC is not indicated on a claim submitted to ForwardHealth, or if the NDC indicated is invalid, the claim will be denied.

Radiopharmaceuticals are included in the DRA requirements. Providers will be required to indicate NDCs with HCPCS procedure codes on claims for radiopharmaceuticals.

Note: Vaccines are exempt from the DRA requirements. Providers who receive reimbursement under a bundled rate are not subject to the DRA requirements.

Less-Than-Effective Drugs

ForwardHealth will deny provider-administered drug claims for LTE or identical, related, or similar drugs for ForwardHealth members.

Medicare Crossover Claims

To be considered for reimbursement, NDCs and a HCPCS procedure code must be indicated on Medicare crossover claims for provider-administered drugs. NDCs must be indicated on claims where Medicare is the primary payer. Medicare claims with an NDC present should automatically cross over to ForwardHealth.

ForwardHealth will deny crossover claims if an NDC was not submitted to Medicare.

340B Providers

Providers who participate in the 340B Drug Pricing Program are required to indicate an NDC on claims for provider-administered drugs. The 340B Drug Pricing Program allows certain federally funded grantees and other health care providers to purchase prescription drugs at significantly reduced prices. When submitting the 340B billed amount, they are also required to indicate the actual acquisition cost plus a reasonable dispensing fee.

Explanation of Benefits Codes on Claims for Provider-Administered Drugs

Providers will receive an EOB code on claims with a denied detail for a provider-administered drug if the claim does not comply with the standards of the DRA. If a provider receives an EOB code on a claim for a provider-administered drug, he or she should correct and resubmit the claim for reimbursement.

Provider-Administered Claim Denials

If a clinic's professional claim with a HCPCS code is received by ForwardHealth and a subsequent claim for the same drug is received from a pharmacy, having a DOS within seven days of the clinic's DOS, then the pharmacy's claim will be denied as a duplicate claim.

Reconsideration of the denied drug claim may occur if the claim was denied with EOB code 1309 and the drug therapy was due to the treatment for an acute condition. To submit a claim that was originally denied as a duplicate, pharmacies should complete and submit the Noncompound Drug Claim form along with the Pharmacy Special Handling Request form indicating the EOB code and requesting an override.

Provider-Administered Drugs and Administration Codes Reimbursed by Managed Care Organizations

For Dates of Service On and After January 1, 2009

For DOS on and after January 1, 2009, for members enrolled in BadgerCare Plus HMOs, Medicaid SSI HMOs, and most special

managed care programs, BadgerCare Plus and Medicaid fee-for-service, not the member's MCO, reimburse providers for the following if the service is covered by BadgerCare Plus and Medicaid:

- All "J" codes.
- Drug-related "Q" codes.
- A limited number of related administration codes.

This policy is known as the provider-administered drugs carve out policy. For members enrolled in BadgerCare Plus HMOs, Medicaid SSI HMOs, and most special managed care programs, claims for "J" codes, drug-related "Q" codes, and administration code services should be submitted to BadgerCare Plus and Medicaid fee-for-service.

Claims for dual eligibles should be submitted to Medicare first before they are submitted to ForwardHealth. Providers should continue to submit claims for other services to the member's MCO.

Provider-administered drugs and related services for members enrolled in the PACE and the Family Care Partnership are provided and reimbursed by the special managed care program.

Exemptions

Claims for drugs included in the cost of the procedure (e.g., a claim for a dental visit where lidocaine is administered) should be submitted to the member's MCO.

Vaccines and their administration fees are reimbursed by a member's MCO.

Providers who receive reimbursement under a bundled rate are reimbursed by a member's MCO.

Providers who were reimbursed a bundled rate by the member's MCO for certain services (e.g., hydration, catheter maintenance, TPN) for DOS prior to January 1, 2009, should continue to be reimbursed by the member's MCO. Provider should work with the member's MCO in these situations.

Additional Information

Additional information about the DRA and claim submission requirements, can be located on the following Web sites:

- CMS DRA information page.
- NUBC.
- NUCC.

For information about NDCs, providers may refer to the following Web sites:

- The FDA Web site.
- The Drug Search Tool. (Providers may verify if an NDC and its segments are valid using this Web site.)
- The Noridian Administrative Services NDC to HCPCS crosswalk.

Claims from Prescribers

Claims for provider-administered drugs may be submitted to ForwardHealth via the following:

- A 1500 Health Insurance Claim Form.
- The 837P transaction.
- The DDE on ForwardHealth Portal.
- The PES software.

1500 Health Insurance Claim Form

NDCs for provider-administered drugs must be indicated in the shaded area of Elements 24A-24G on the 1500 Health Insurance Claim Form. The NDC must be accompanied by an NDC qualifier, unit qualifier, and units. To indicate an NDC, providers should do the following:

- Indicate the NDC qualifier "N4," followed by the 11-digit NDC of the drug dispensed, with no space in between.
- Indicate one space between the NDC and the unit qualifier.
- Indicate one unit qualifier (F2 [International unit], GR [Gram], ML [Milliliter], or UN [Unit]), followed by the NDC units, with no space in between.

N412345678901 UN1234.567 is an example of what may be indicated in Elements 24A-24G of the 1500 Health Insurance Claim Form.

Providers should indicate the appropriate NDC of the drug that was dispensed that corresponds to the HCPCS procedure code on claims for provider-administered drugs. If an NDC is not indicated on the claim, or if the NDC indicated is invalid, the claim will be denied.

837 Health Care Claim: Professional Transactions

Providers may refer to the NUCC Web site for information about indicating NDCs on provider-administered drug claims submitted using the 837P transaction.

Direct Data Entry on the ForwardHealth Portal

The following must be indicated on provider-administered drug claims submitted using DDE on the Portal:

- The NDC of the drug dispensed.
- Quantity unit.
- Unit of measure.

Note: The "N4" NDC qualifier is not required on claims submitted on the Portal.

Provider Electronic Solutions Software

ForwardHealth offers electronic billing software at no cost to providers. The PES software allows providers to submit 837P transactions, adjust claims, and check claim status. To obtain PES software, providers may download it from the ForwardHealth Portal. For assistance installing and using PES software, providers may call the EDI Helpdesk.

Quantity Limits

Generally, ForwardHealth follows FDA labeled dose and administration guidelines to establish quantity limits. The quantity limit allowed for a specific drug and drug strength is established to encourage prescribing and dispensing of the most cost effective strength and quantity of a drug.

When a claim is submitted with a quantity that exceeds the limit, providers will receive an EOB and an NCPDP reject code.

Quantity Limit Policy Overrides

The pharmacy provider should contact the prescriber to determine whether or not it is medically appropriate for a member to exceed the quantity limits. If it is medically appropriate for a member to exceed a quantity limit, pharmacy providers may request a quantity limit policy override by calling the DAPO Center.

Providers may dispense up to the allowed quantity of a drug without contacting the DAPO Center. Pharmacy providers cannot obtain a PC dispensing fee for calling the DAPO Center.

Pharmacy providers may request a quantity limit policy override for members enrolled in the BadgerCare Plus Standard Plan, the BadgerCare Plus Benchmark Plan, the BadgerCare Plus Core Plan, the BadgerCare Plus Basic Plan, Medicaid, and SeniorCare.

Examples of when a quantity limit override request may be approved through the DAPO Center include, but are not limited to, the following:

- If the member has an appropriate medical need (e.g., the member's medications were lost or stolen, the member has requested a vacation supply).
- If the member has been taking too much of a medication because he or she misunderstood the directions for administration by the prescriber.
- If the prescriber changed the directions for administration of the drug and did not inform the pharmacy provider.

Pharmacy providers may dispense up to a 96-hour supply of a drug to a member when the DAPO Center is closed and a policy override to exceed a quantity limit must be obtained. If the DAPO Center grants a policy override to exceed a quantity limit, the policy override will be retroactive and the pharmacy provider may submit a claim for the drug using the Point-of-Sale system or on paper. If the claim for a 96-hour supply is submitted on paper, the pharmacy provider will be required to complete and submit a Pharmacy Special Handling Request. Providers should check Element 6 (Pharmacy Consultant Review) and provide an explanation of the review needed (e.g., 96-hour policy override for quantity limits) in the space provided.

If the DAPO Center denies the policy override, ForwardHealth will reimburse the provider for the 96-hour supply. A claim must be submitted on paper with the Pharmacy Special Handling Request. Providers should check Element 6 (Pharmacy Consultant Review) and provide an explanation of the review needed (e.g., 96-hour policy override for quantity limit) in the space provided.

Service Limitations

If an override of the service limitation, such as a quantity limit override, is requested and the request does not meet service limitation override criteria, the override will be denied and the service will be a noncovered service. Members do not have appeal rights for noncovered drugs or services.

Reimbursement Reduction for Most Paper Claims

As a result of the Medicaid Rate Reform project, ForwardHealth will reduce reimbursement on most claims submitted to ForwardHealth on paper. Most paper claims will be subject up to a $1.10 reimbursement reduction per claim.

For each claim that a reimbursement reduction was applied, providers will receive an EOB to notify them of the payment reduction. For claims with reimbursement reductions, the EOB will state the following, "This claim is eligible for electronic submission. Up to a $1.10 reduction has been applied to this claim payment."

If a paid claim's total reimbursement amount is less than $1.10, ForwardHealth will reduce the payment up to a $1.10. The claim will show on the Remittance Advice as paid but with a $0 paid amount.

The reimbursement reduction applies to the following paper claims:

- 1500 Health Insurance Claim Form.
- UB-04 (CMS 1450) Claim Form.
- Compound Drug Claim Form.
- Noncompound Drug Claim Form.

Exceptions to Paper Claim Reimbursement Reduction

The reimbursement reduction will not affect the following providers or claims:

- In-state emergency providers.
- Out-of-state providers.
- Medicare Crossover Claims.
- Any claims that ForwardHealth requires additional supporting information to be submitted on paper. For example:
  - Hysterectomy claims must be submitted along with a paper Acknowledgement of Receipt of Hysterectomy Information Form.
  - Sterilization claims must be submitted along with a paper Consent for Sterilization Form.
  - Claims submitted to Timely Filing appeals must be submitted on paper with a Timely Filing Appeals Request form.
  - In certain circumstances, drug claims must be submitted on paper with a Pharmacy Special Handling Request.

Repackaging

Pharmacy providers dispensing medications using member compliance aid packaging (e.g., Pill Minder, blister packaging) are required to relabel unused quantities when the drug regimen is changed.

When submitting claims for repackaging of medications, pharmacy providers are required to indicate the appropriate code in the "Submission Clarification Code" field.

Submission Options

Pharmacy providers may submit claims to ForwardHealth via the following:

- Using the real-time POS system.
- Using DDE.
- Using PES software.
- On paper by fax or mail.

Pharmacy providers may submit claims for DMS and DME via the following:

- On the 1500 Health Insurance Claim Form.
- On an 837P transaction.
- Using DDE.
- Using PES software.

Provider-administered drugs and related services for members enrolled in PACE and the Family Care Partnership Program should be provided and reimbursed by the special managed care program.

Submitting Paper Attachments with Electronic Claims

Providers may submit paper attachments to accompany electronic claims and electronic claim adjustments. Providers should refer to their companion documents for directions on indicating that a paper attachment will be submitted by mail.

Paper attachments that go with electronic claim transactions must be submitted with the Claim Form Attachment Cover Page. Providers are required to indicate an ACN for paper attachment(s) submitted with electronic claims. (The ACN is an alphanumeric entry between 2 and 80 digits assigned by the provider to identify the attachment.) The ACN must be indicated on the cover page so that ForwardHealth can match the paper attachment(s) to the correct electronic claim.

ForwardHealth will hold an electronic claim transaction or a paper attachment(s) for up to 30 calendar days to find a match. If a

match cannot be made within 30 days, the claim will be processed without the attachment and will be denied if an attachment is required. When such a claim is denied, both the paper attachment(s) and the electronic claim will need to be resubmitted.

Providers are required to send paper attachments relating to electronic claim transactions to the following address:

ForwardHealth
Claims and Adjustments
6406 Bridge Rd
Madison WI 53784-0002

This does not apply to pharmacy claims.

Switch Vendors

Pharmacy providers who submit real-time claims are required to submit electronic transactions for pharmacy services using an approved switch vendor. For transmission problems, providers may contact the following sources:

- Emdeon.
- RelayHealth — (866) 735.2963.
- QS/1 Data Systems — (800) 231-7776.

Synagis

Synagis® (palivizumab), a monoclonal antibody, is used to prevent lower respiratory tract diseases caused by RSV in premature, high-risk infants. The prevalence for RSV is from October through April and the treatment season in the northern hemisphere is generally from November through March. The general recommendation for treatment with Synagis during a treatment season is to administer the first dose in November and the last dose in March.

PA is required for Synagis®.

Synagis® is not part of the provider-administered drugs carve-out policy; therefore, a member's MCO should reimburse providers for Synagis®.

Professional Claim Submission

Information is available for DOS before October 15, 2009.

Claims for Synagis® must be submitted using the 837P transaction or on the 1500 Health Insurance Claim Form. Prescribers and pharmacy providers are required to indicate CPT procedure code 90378 (Respiratory syncytial virus immune globulin [RSV-IgIM], for intramuscular use, 50 mg, each) and the appropriate unit(s) on each claim submission. To comply with the requirements of the DRA, the NDC of the drug dispensed, the quantity, qualifier, and unit dispensed must also be indicated on claims for Synagis®.

Pharmacy providers should indicate modifier "U1" on claims for Synagis® to obtain reimbursement for the dispensing fee.

For Synagis®, one unit equals 50 mg. The dose should be indicated on claims as the number of 50 mg vials administered. Providers should obtain the dose from the appropriately sized vial of Synagis® and indicate the corresponding NDC on claims. For example, a 155 mg calculated dose is equal to four units of Synagis®.

Dosage Criteria

The following table lists weight-based criteria for Synagis®.

Weight Range (in kg)	Synagis® Calculated Dose	Number of Units*
Up to 3.6 kg	0 - 54 mg	1
3.7 to 6.9 kg	55 mg - 104 mg	2
7.0 to 10.2 kg	105 mg - 154 mg	3
10.3 to 13.6 kg	155 mg - 204 mg	4
13.7 to 16.9 kg	205 mg - 254 mg	5
17.0 to 20.3 kg	255 mg - 304 mg	6

* Units are a 50 mg dose.

Total Parenteral Nutrition and Lipids

For members enrolled in the BadgerCare Plus Standard Plan, Medicaid, and SeniorCare, TPN solution and TPN lipids are reimbursed using NDCs from each item used to prepare and administer the TPN. Claims for these NDCs may be submitted using the NCPDP 5.1, on the Compound Drug Claim form, or using PES software.

Providers should submit claims for DMS and DME associated with TPNs separately using the 1500 Health Insurance Claim Form or the 837P transaction.

Unacceptable Practices

Based on the claims submission requirements in DHS 106.03(3), Wis. Admin. Code, and the definition of covered services in DHS 107.10, Wis. Admin. Code, the following are examples of unacceptable and, in some cases, fraudulent practices:

- Billing BadgerCare Plus or Wisconsin SeniorCare for a quantity of a drug that is greater than the quantity prescribed.
- Billing BadgerCare Plus or Wisconsin SeniorCare for a higher-priced drug when a lower-priced drug was prescribed and dispensed to the member.
- Dispensing a brand-name drug, billing for the generic, and then charging the member for the difference.
- Billing for a drug quantity greater than the quantity dispensed to the member (i.e., prescription shorting).
- Dispensing a smaller quantity than was prescribed in order to collect more than one professional dispensing fee (i.e., prescription splitting).
- Charging a drug price greater than the price usually charged to the general public.
- Billing for a legend or OTC drug without a prescription.
- Submitting a claim with an NDC other than the NDC on the package from which the drug was dispensed.
- Providing unit-dose carts and member drug regimen review without charge. Lease arrangements for carts and other services must reflect fair market value.
- Dispensing and billing a medication of lesser strength than prescribed to obtain more than one dispensing fee.
- Billing more than once per month for maintenance drugs for nursing facility members.

This limitation does not apply to treatment medications (e.g., topical preparations) or drugs ordered with a stop date of less than 30 days.

BadgerCare Plus or Wisconsin SeniorCare may suspend or terminate a provider's Medicaid certification for violations of these or other restrictions that constitute fraud or billing abuses. Refer to DHS 106.06 and DHS 106.08, Wis. Admin. Code, for information about provider sanctions.

Unlisted Procedure Codes

According to the HCPCS code book, if a service is provided that is not accurately described by other HCPCS/CPT procedure codes, the service should be reported using an unlisted procedure code.

Before considering using an unlisted, or NOC, procedure code, a provider should determine if there is another more specific code that could be indicated to describe the procedure or service being performed/provided. If there is no more specific code available, the provider is required to submit the appropriate documentation, which could include a PA request, to justify use of the unlisted procedure code and to describe the procedure or service rendered. Submitting the proper documentation, which could include a PA request, may result in more timely claims processing.

Unlisted procedure codes should not be used to request adjusted reimbursement for a procedure for which there is a more specific code available.

Unlisted Codes That Do Not Require Prior Authorization or Additional Supporting Documentation

For a limited group of unlisted procedure codes, ForwardHealth has established specific policies for their use and associated reimbursement. These codes do not require PA or additional documentation to be submitted with the claim. Providers should refer to their service-specific area of the Online Handbook on the ForwardHealth Portal for details about these unlisted codes.

For most unlisted codes, ForwardHealth requires additional documentation.

Unlisted Codes That Require Prior Authorization

Certain unlisted procedure codes require PA. Providers should follow their service-specific PA instructions and documentation requirements for requesting PA. For a list of procedure codes for which ForwardHealth requires PA, refer to the service-specific interactive maximum allowable fee schedules.

In addition to a properly completed PA request, documentation submitted on the service-specific PA attachment or as additional supporting documentation with the PA request should provide the following information:

- Specifically identify or describe the name of the procedure/service being performed or billed under the unlisted code.
- List/justify why other codes are not appropriate.
- Include only relevant documentation.
- Include all required clinical/supporting documentation.

For most situations, once the provider has an approved PA request for the unlisted procedure code, there is no need to submit additional documentation along with the claim.

Unlisted Codes That Do Not Require Prior Authorization

If an unlisted procedure code does not require PA, documentation submitted with the claim to justify use of the unlisted code and to describe the procedure/service rendered must be sufficient to allow ForwardHealth to determine the nature and scope of the procedure and to determine whether or not the procedure is covered and was medically necessary, as defined in Wisconsin Administrative Code.

The documentation submitted should provide the following information related to the unlisted code:

- Specifically identify or describe the name of the procedure/service being performed or billed under the unlisted code.
- List/justify why other codes are not appropriate.
- Include only relevant documentation.

How to Submit Claims and Related Documentation

Claims including an unlisted procedure code and supporting documentation may be submitted to ForwardHealth in the following ways:

- On paper with supporting information/description included in Element 19 of the 1500 Health Insurance Claim Form.
- On paper with supporting documentation submitted on paper. This option should be used if Element 19 does not allow enough space for the description or when billing multiple unlisted procedure codes. Providers should indicate "See Attachment" in Element 19 of the paper claim and send the supporting documentation along with the paper claim.
- Electronically, either using Direct Data Entry through the ForwardHealth Portal, PES transactions, or 837 Health Care Claim electronic transactions, with supporting documentation included electronically in the Notes field. The Notes field is limited to 80 characters.
- Electronically with an indication that supporting documentation will be submitted separately on paper. This option should be used if the Notes field does not allow enough space for the description or when billing multiple unlisted procedure codes. Providers should indicate "See Attachment" in the Notes field of the electronic transaction and submit the supporting documentation on paper.

Timely Filing Appeals Requests

Requirements

When a claim or adjustment request meets one of the exceptions to the submission deadline, the provider is required to submit a Timely Filing Appeals Request form with a paper claim or an Adjustment/Reconsideration Request form to override the submission deadline.

DOS that are beyond the submission deadline should be submitted separately from DOS that are within the deadline. Claims or adjustment requests received that contain both current and late DOS are processed through normal channels without review by Timely Filing and late DOS will be denied.

Resubmission

Decisions on Timely Filing Appeals Requests cannot be appealed. Providers may resubmit the claim to Timely Filing if both of the following occur:

- The provider submits additional documentation as requested.
- ForwardHealth receives the documentation before the specified deadline for the exception to the submission deadline.

Submission

To receive consideration for an exception to the submission deadline, providers are required to submit the following:

- A properly completed Timely Filing Appeals Request form.
- A legible claim or adjustment request.
- All required documentation as specified for the exception to the submission deadline.

To receive consideration, a Timely Filing Appeals Request must be received before the deadline specified for the exception to the submission deadline.

When completing the claim or adjustment request, providers are required to indicate the procedure code, diagnosis code, POS code, etc., as effective for the DOS. However, providers should use the current claim form and instructions or adjustment request form and instructions. Reimbursement for Timely Filing Appeals Requests is contingent upon the claim or adjustment request meeting program requirements for the DOS.

The following table lists the filing deadlines and documentation requirements as they correspond to each of the eight allowable exceptions.

Change in Nursing Home Resident's Level of Care or Liability Amount		
Description of the Exception	**Documentation Requirements**	**Submission Address**
This exception occurs when a nursing home claim is initially received within the submission deadline and reimbursed incorrectly due to a change in the member's authorized level of care or liability amount.	To receive consideration, the request must be submitted within 455 days from the DOS and the correct liability amount or level of care must be indicated on the Adjustment/Reconsideration Request form. The most recent claim number (also known as the ICN)	ForwardHealth Timely Filing Ste 50 6406 Bridge Rd Madison WI 53784-0050

	must be indicated on the Adjustment/Reconsideration Request form. This number may be the result of a ForwardHealth-initiated adjustment.	

Decision Made by a Court, Fair Hearing, or the Department of Health Services		
Description of the Exception	**Documentation Requirements**	**Submission Address**
This exception occurs when a decision is made by a court, fair hearing, or the DHS.	To receive consideration, the request must be submitted within 90 days from the date of the decision of the hearing. A complete copy of the notice received from the court, fair hearing, or DHS must be submitted with the request.	ForwardHealth Timely Filing Ste 50 6406 Bridge Rd Madison WI 53784-0050

Denial Due to Discrepancy Between the Member's Enrollment Information in ForwardHealth interChange and the Member's Actual Enrollment		
Description of the Exception	**Documentation Requirements**	**Submission Address**
This exception occurs when a claim is initially received by the deadline but is denied due to a discrepancy between the member's enrollment information in ForwardHealth interChange and the member's actual enrollment.	To receive consideration, the following documentation must be submitted within 455 days from the DOS: • A copy of remittance information showing the claim was submitted in a timely manner and denied with a qualifying enrollment-related explanation. • A photocopy of one of the following indicating enrollment on the DOS: ○ White paper BadgerCare Plus EE for pregnant women or children identification card. ○ Green paper temporary identification card. ○ White paper TE for Family Planning Only Services identification card. ○ The response received through the EVS from a commercial eligibility vendor. ○ The transaction log number received through WiCall.	ForwardHealth Good Faith/Timely Filing Ste 50 6406 Bridge Rd Madison WI 53784-0050

ForwardHealth Reconsideration or Recoupment		
Description of the Exception	**Documentation Requirements**	**Submission Address**
This exception occurs when ForwardHealth reconsiders a previously processed claim. ForwardHealth will initiate an adjustment on a previously paid claim.	If a subsequent provider submission is required, the request must be submitted within 90 days from the date of the RA message. A copy of the RA message that shows the ForwardHealth-initiated adjustment must be submitted with the request.	ForwardHealth Timely Filing Ste 50 6406 Bridge Rd Madison WI 53784-0050

Retroactive Enrollment for Persons on General Relief		
Description of the Exception	**Documentation Requirements**	**Submission Address**

This exception occurs when the local county or tribal agency requests a return of a GR payment from the provider because a member has become retroactively enrolled for Wisconsin Medicaid or BadgerCare Plus.	To receive consideration, the request must be submitted within 180 days from the date the backdated enrollment was added to the member's enrollment information. The request must be submitted with one of the following: • "GR retroactive enrollment" indicated on the claim. • A copy of the letter received from the local county or tribal agency.	ForwardHealth GR Retro Eligibility Ste 50 6406 Bridge Rd Madison WI 53784-0050

Medicare Denial Occurs After the Submission Deadline		
Description of the Exception	**Documentation Requirements**	**Submission Address**
This exception occurs when claims submitted to Medicare (within 365 days of the DOS) are denied by Medicare after the 365-day submission deadline. A waiver of the submission deadline will not be granted when Medicare denies a claim for one of the following reasons: • The charges were previously submitted to Medicare. • The member name and identification number do not match. • The services were previously denied by Medicare. • The provider retroactively applied for Medicare enrollment and did not become enrolled.	To receive consideration, the following must be submitted within 90 days of the Medicare processing date: • A copy of the Medicare remittance information. • The appropriate Medicare disclaimer code must be indicated on the claim.	ForwardHealth Timely Filing Ste 50 6406 Bridge Rd Madison WI 53784-0050

Refund Request from an Other Health Insurance Source		
Description of the Exception	**Documentation Requirements**	**Submission Address**
This exception occurs when an other health insurance source reviews a previously paid claim and determines that reimbursement was inappropriate.	To receive consideration, the following documentation must be submitted within 90 days from the date of recoupment notification: • A copy of the commercial health insurance remittance information. • A copy of the remittance information showing recoupment for crossover claims when Medicare is recouping payment.	ForwardHealth Timely Filing Ste 50 6406 Bridge Rd Madison WI 53784-0050

Retroactive Member Enrollment		
Description of the Exception	**Documentation Requirements**	**Submission Address**
This exception occurs when a claim cannot be submitted within the submission deadline due to a delay in the determination of a member's retroactive	To receive consideration, the request must be submitted within 180 days from the date the backdated enrollment was added to the member's enrollment information. In addition, "retroactive enrollment" must be indicated on the	ForwardHealth Timely Filing Ste 50 6406 Bridge Rd

enrollment.	claim.	Madison WI 53784-0050

Coordination of Benefits

3

Archive Date:03/01/2011

Coordination of Benefits:Commercial Health Insurance

Assignment of Insurance Benefits

Assignment of insurance benefits is the process by which a specified party (e.g., provider or policyholder) becomes entitled to receive payment for claims in accordance with the insurance company policies.

Commercial health insurance companies may permit reimbursement to the provider or member. Providers should verify whether commercial health insurance benefits may be assigned to the provider. As indicated by the commercial health insurance, providers may be required to obtain approval from the member for this assignment of benefits.

If the provider is assigned benefits, providers should bill the commercial health insurance.

If the member is assigned insurance benefits, it is appropriate to submit a claim to ForwardHealth without billing the commercial health insurance. In this instance providers should indicate the appropriate other insurance indicator. ForwardHealth will bill the commercial health insurance.

Claims for Services Denied by Commercial Health Insurance

If commercial health insurance denies or recoups payment for services that are covered, the provider may submit a claim for those services. To allow payment in this situation, providers are encouraged to follow the requirements (e.g., request PA before providing the service for covered services that require PA). If the requirements are followed, BadgerCare Plus may reimburse for the service up to the allowed amount (less any payments made by other health insurance sources).

Commercial Fee-for-Service

Fee-for-service commercial health insurance is the traditional health care payment system under which providers receive a payment for each unit of service provided rather than a capitation payment for each member. Such insurance usually does not restrict health care to a particular network of providers.

Commercial Managed Care

A commercial managed care plan provides coverage through a specified group of providers in a particular service area. The providers may be under contract with the commercial health insurance and receive payment based on the number of patients seen (i.e., capitation payment).

Commercial managed care plans require members to use a designated network of providers. Non-network providers (i.e., providers who do not have a contract with the member's commercial managed care plan) will be reimbursed by the commercial managed care plan *only* if they obtain a referral or provide an emergency service.

Except for emergency services and covered services that are not covered under the commercial managed care plan, members enrolled in both a commercial managed care plan and BadgerCare Plus (i.e., state-contracted MCO, fee-for-service) are required to receive services from providers affiliated with the commercial managed care plan. In this situation, providers are required to refer the members to commercial managed care providers. This is necessary because commercial health insurance is always primary to BadgerCare Plus.

BadgerCare Plus will *not* reimburse the provider if the commercial managed care plan denied or would deny payment because a service otherwise covered under the commercial managed care plan was performed by a provider outside the plan. In addition, if a member receives a covered service outside his or her commercial managed care plan, the provider cannot collect payment from the member.

Definition of Commercial Health Insurance

Commericial health insurance is defined as any type of health benefit not obtained from Medicare or Wisconsin Medicaid and BadgerCare Plus. The insurance may be employer-sponsored or privately purchased. Commercial health insurance may be provided on a fee-for-service basis or through a managed care plan.

Discounted Rates

Providers of services that are discounted by commercial health insurance should include the following on claims submitted:

- Their usual and customary charge.
- The appropriate other insurance indicator.
- The amount, if any, actually received from commercial health insurance as the amount paid by commercial health insurance.

Exhausting Commercial Health Insurance Sources

Providers are required to exhaust commercial health insurance sources before submitting claims to ForwardHealth. This is accomplished by following the process indicated in the following steps. Providers are required to prepare complete and accurate documentation of efforts to bill commercial health insurance to substantiate other insurance indicators used on any claim.

Step 1. Determine if the Member Has Commercial Health Insurance
If Wisconsin's EVS does not indicate that the member has commercial health insurance, the provider may submit a claim to ForwardHealth unless the provider is otherwise aware of commercial health insurance coverage. **If the member disputes the information as it is indicated in the EVS,** the provider should submit a completed Other Coverage Discrepancy Report form. Unless the service does not require other health insurance billing, the provider should allow at least two weeks before proceeding to Step 2.
Step 2. Determine if the Service Requires Other Health Insurance Billing
If the service requires other health insurance billing, the provider should proceed to Step 3. **If the service does not require other health insurance billing,** the provider should proceed in one of the following ways: • The provider is encouraged to bill commercial health insurance if he or she believes that benefits are available. Reimbursement from commercial health insurance may be greater than the BadgerCare Plus-allowed amount. If billing commercial health insurance first, the provider should proceed to Step 3. • The provider may submit a claim without indicating an other insurance indicator on the claim. The provider may not bill BadgerCare Plus and commercial health insurance simultaneously. Simultaneous billing may constitute fraud and interferes with BadgerCare Plus's ability to recover prior payments.
Step 3. Identify Assignment of Commercial Health Insurance Benefits
The provider should verify whether commercial health insurance benefits may be assigned to the provider. (As indicated by commercial health insurance, the provider may be required to obtain approval from the member for this assignment of benefits.) The provider should proceed in one of the following ways:

- **If the provider is assigned benefits,** the provider should bill commercial health insurance and proceed to Step 4.
- **If the member is assigned insurance benefits,** the provider may submit a claim (without billing commercial health insurance) using the appropriate other insurance indicator.

If the commercial health insurance reimburses the member, the provider may collect the payment from the member. If the provider receives reimbursement from BadgerCare Plus and the member, the provider is required to return the lesser amount to BadgerCare Plus.

Step 4. Bill Commercial Health Insurance and Follow Up
If commercial health insurance denies or partially reimburses the provider for the claim, the provider may proceed to Step 5. **If commercial health insurance does not respond within 45 days,** the provider should follow up the original claim with an inquiry to commercial health insurance to determine the disposition of the claim. If commercial health insurance does not respond within 30 days of the inquiry, the provider may proceed to Step 5.

Step 5. Submit Claim to ForwardHealth
If only partial reimbursement is received, if the correct and complete claim is denied by commercial health insurance, or if commercial health insurance does not respond to the original and follow-up claims, the provider may submit a claim to ForwardHealth using the appropriate other insurance indicator. Commercial remittance information should not be attached to the claim.

Pharmacy Providers

Pharmacy providers are required to bill all commercial health insurance carriers prior to ForwardHealth when a member has verified drug coverage through commercial health insurance. Pharmacies are required to bill private HMOs, all commercial health insurance, and Medicare prior to billing ForwardHealth.

Members Unable to Obtain Services Under Managed Care Plan

Sometimes a member's enrollment file shows commercial managed care coverage, but the member is unable to receive services from the managed care plan. Examples of such situations include the following:

- Children enrolled in a commercial managed care plan by a noncustodial parent if the custodial parent refuses to use the coverage.
- Members enrolled in a commercial managed care plan who reside outside the service area of the managed care plan.
- Members enrolled in a commercial managed care plan who enter a nursing facility that limits the member's access to managed care providers.

In these situations, BadgerCare Plus will pay for services covered by both BadgerCare Plus and the commercial managed care plan even though the services are obtained from providers outside the plan.

When submitting claims for these members, providers should do one of the following:

- Indicate "OI-Y" on paper claims.
- Refer to the Wisconsin Provider Electronic Solutions Manual or the appropriate 837 companion document to determine the appropriate other insurance indicator for electronic claims.

Non-Reimbursable Commercial Managed Care Services

Providers are not reimbursed for the following:

- Services covered by a commercial managed care plan, except for coinsurance, copayment, or deductible.
- Services for which providers contract with a commercial managed care plan to receive a capitation payment for services.

Other Insurance Indicators

Other insurance indicators are used to report results of commercial health insurance billing and to report when existing insurance was not billed. Providers are required to use these indicators as applicable on claims submitted for members with commercial health insurance. The intentional misuse of other insurance indicators to obtain inappropriate reimbursement constitutes fraud.

Other insurance indicators identify the status and availability of commercial health insurance. The indicators allow providers to be reimbursed correctly when the following occur:

- Commercial health insurance exists, does not apply, or when, for some valid reason, the provider is unable to obtain such reimbursement by reasonable means.
- Commercial health insurance does not cover the service provided.
- Full or partial payment was made by commercial health insurance.

Providers should not use other insurance indicators when the following occur:

- Wisconsin's EVS indicates no commercial health insurance for the DOS.
- The service does not require other health insurance billing.
- Claim denials from other payers relating to NPI and related data should be resolved with that payer and not submitted to ForwardHealth. Payments made in these situations may be recouped.

Documentation Requirements

Providers are required to prepare and maintain truthful, accurate, complete, legible, and concise documentation of efforts to bill commercial health insurance sources to substantiate other insurance indicators used on any claim, according to DHS 106.02(9)(a), Wis. Admin. Code.

Preferred Drug List Coordination of Benefits

Providers are required to follow BadgerCare Plus and SeniorCare PA policies even if a member's commercial health insurance has a different policy. Therefore, pharmacy providers and dispensing physicians are required to obtain PA for non-preferred drugs, regardless of other commercial health insurance coverage.

Services Not Requiring Commercial Health Insurance Billing

Providers are not required to bill commercial health insurance sources before submitting claims for the following:

- Case management services.
- CRS.
- Family planning services.
- PNCC services.
- Preventive pediatric services.
- SMV services.

Services Requiring Commercial Health Insurance Billing

If the EVS indicates the code **"DEN"** for "Other Coverage," the provider is required to bill dental services to commercial health insurance before submitting claims to ForwardHealth.

If the EVS indicates that the member has Wausau Health Protection Plan (**"HPP"**), BlueCross & BlueShield (**"BLU"**), Wisconsin Physicians Service (**"WPS"**), TriCare (**"CHA"**), or some other (**"OTH"**) commercial health insurance, the provider is required to bill the following services to commercial health insurance before submitting claims to ForwardHealth:

- Ambulance services, if provided as emergency services.
- Anesthetist services.
- Audiology services, unless provided in a nursing home or SNF.
- Blood bank services.
- Chiropractic services.
- CSP services.
- Dental services.
- DME (rental or purchase), prosthetics, and hearing aids if the billed amount is over $10.00 per item.
- Home health services (excluding PC services).
- Hospice services.
- Hospital services, including inpatient or outpatient.
- Independent nurse, nurse practitioner, or nurse midwife services.
- Laboratory services.
- Medicare-covered services for members who have Medicare and commercial health insurance.
- Mental health/substance abuse services, including services delivered by providers other than physicians, regardless of POS.
- PT, OT, and SLP services, unless provided in a nursing home or SNF.
- Physician assistant services.
- Physician services, including surgery, surgical assistance, anesthesiology, or any service to a hospital inpatient. However, physician services provided to a woman whose primary diagnosis indicates a high-risk pregnancy do not require commercial health insurance billing.
- Pharmacy services for members with verified drug coverage.
- Podiatry services.
- PDN services for ventilator-dependent members.
- Radiology services.
- RHC services.
- Skilled nursing home care, if any DOS is within 30 days of the date of admission. If benefits greater than 30 days are available, the nursing home is required to continue to bill for them until those benefits are exhausted.
- Vision services over $50, unless provided in a home, nursing home, or SNF.

If the EVS indicates the code **"VIS"** for "Other Coverage", the provider is required to bill the following services to commercial health insurance before submitting claims to ForwardHealth:

- Ophthalmology services.
- Optometrist services.

If the EVS indicates the code **"HMO"** for "Other Coverage," the provider is required to bill the following services to commercial health insurance before submitting claims to ForwardHealth:

- Ambulance services, if provided as emergency services.
- Anesthetist services.
- Audiology services, unless provided in a nursing home or SNF.
- Blood bank services.
- Chiropractic services.

- CSP services.
- Dental services.
- DME (rental or purchase), prosthetics, and hearing aids if the billed amount is over $10.00 per item.
- Home health services (excluding PC services).
- Hospice services.
- Hospital services, including inpatient or outpatient regardless of the type of hospital.
- Independent nurse, nurse practitioner, or nurse midwife services.
- Laboratory services.
- Medicare-covered services billed for a member who has both Medicare and commercial health insurance.
- Mental health/substance abuse services, including services delivered by providers other than physicians, regardless of POS.
- Pharmacy services for members with verified drug coverage.
- PT, OT, and SLP services, unless provided in a nursing home or SNF.
- Physician and physician assistant services.
- Podiatry services.
- PDN services for ventilator-dependent members.
- Radiology services.
- RHC services.
- Skilled nursing home care, if any DOS is within 30 days of the date of admission. If benefits greater than 30 days are available, the nursing home is required to continue to bill for them until those benefits are exhausted.
- Vision services over $50, unless provided in a home, nursing home, or SNF.

If the EVS indicates Medicare Supplemental Plan Coverage (**"SUP"**), the provider is required to bill the following services to commercial health insurance before submitting claims to ForwardHealth:

- Alcohol, betadine, and/or iodine provided by a pharmacy or medical vendor.
- Ambulance services.
- Ambulatory service center services.
- Breast reconstruction services.
- Chiropractic services.
- Dental anesthesia services.
- Home health services (excluding PC services).
- Hospital services, including inpatient or outpatient.
- Medicare-covered services.
- Osteopath services.
- Physician services.
- Skilled nursing home care, if any DOS is within 100 days of the date of admission. If benefits greater than 100 days are available, the nursing home is required to continue to bill for them until those benefits are exhausted.

BadgerCare Plus has identified services requiring Medicare billing.

Medicare

Acceptance of Assignment

In Medicare, "assignment" is a process through which a provider agrees to accept the Medicare-allowed amount as payment in full. A provider who agrees to this amount is said to "accept assignment."

A Medicare-enrolled provider performing a Medicare-covered service for a dual eligible or QMB-Only member is required to accept assignment of the member's Medicare Part B benefits. Therefore, total payment for the service (i.e., any amount paid by other health insurance sources, any copayment or spenddown amounts paid by the member, and any amount paid by Wisconsin Medicaid) may not exceed the Medicare-allowed amount.

Claims Denied for Errors

Medicare claims that were denied for provider billing errors must be corrected and resubmitted to Medicare before the claim may be submitted to ForwardHealth.

Claims Processed by Commercial Insurance That Is Secondary to Medicare

If a crossover claim is also processed by commercial health insurance that is secondary to Medicare (e.g., Medicare supplemental), the claim will not be forwarded to ForwardHealth. After the claim has been processed by the commercial health insurance, the provider should submit a provider-submitted crossover claim to ForwardHealth with the appropriate other insurance indicator.

Claims That Do Not Require Medicare Billing

For services provided to dual eligibles, claims should be submitted to ForwardHealth without first submitting them to Medicare in the following situations:

- The provider cannot be enrolled in Medicare.
- The service is not allowed by Medicare under any circumstance. Providers should note that claims are denied for services that Medicare has determined are not medically necessary.

In these situations, providers should not indicate a Medicare disclaimer code on the claim.

Claims That Fail to Cross Over

ForwardHealth must be able to identify the billing provider in order to report paid or denied Medicare crossover claims information on the RA. Claims with an NPI that fails to appear on the provider's RA are an indication that there is a problem with the matching and identification of the billing provider and the claims were denied.

ForwardHealth is not able to identify the billing provider on automatic crossover claims submitted by health care providers in the following situations:

- The billing provider's NPI has not been reported to ForwardHealth.
- The taxonomy code designated by ForwardHealth is required to identify the billing provider and is not indicated on the

automatic crossover claim.
- The billing provider's practice location ZIP+4 code on file with ForwardHealth is required to identify the provider and is not indicated on the automatic crossover claim.

If automatic crossover claims do not appear on the RA after 30 days of the Medicare processing date, providers are required to resubmit the claim directly to ForwardHealth using the NPI that was reported to ForwardHealth as the primary NPI. Additionally, the taxonomy code designated by ForwardHealth and the ZIP+4 code of the practice location on file with ForwardHealth are required when additional data is needed to identify the provider.

Claims for Services Denied by Medicare

If Medicare denies or recoups payment for services provided to dual eligibles that are covered by BadgerCare Plus, the provider may submit a claim for those services directly to ForwardHealth. To allow payment by Wisconsin Medicaid in this situation, providers are encouraged to follow BadgerCare Plus requirements (e.g., request PA before providing the service for covered services that require PA). If the requirements are followed, Wisconsin Medicaid may reimburse for the service up to the allowed amount (less any payments made by other health insurance sources).

Crossover Claims

A Medicare crossover claim is a Medicare-allowed claim for a dual eligible or QMB-Only member sent to ForwardHealth for payment of coinsurance, copayment, and deductible.

Submit Medicare claims first, as appropriate, to one of the following:

- Medicare Part A fiscal intermediary.
- Medicare Part B carrier.
- Medicare DME regional carrier.
- Medicare Advantage Plan.
- Railroad Retirement Board carrier (also known as the Railroad Medicare carrier).

There are two types of crossover claims based on who submits them:

- Automatic crossover claims.
- Provider-submitted crossover claims.

Automatic Crossover Claims

An automatic crossover claim is a claim that Medicare automatically forwards to ForwardHealth by the COBC.

Claims will be forwarded if the following occur:

- Medicare has identified that the services were provided to a dual eligible or a QMB-Only member.
- The claim is for a member who is not enrolled in a Medicare Advantage Plan.

Provider-Submitted Crossover Claims

A provider-submitted crossover claim is a Medicare-allowed claim that a provider directly submits to ForwardHealth when the Medicare claim did not automatically cross over. Providers should submit a provider-submitted crossover claim in the following situations:

- The automatic crossover claim does not appear on the ForwardHealth RA within 30 days of the Medicare processing date.

- The automatic crossover claim is denied and additional information may allow payment.
- The claim is for a member who is enrolled in Medicare and commercial health insurance that is secondary to Medicare (e.g., Medicare Supplemental).
- The claim is for a member who was not enrolled in BadgerCare Plus at the time the service was submitted to Medicare for payment, but the member was retroactively determined enrolled in BadgerCare Plus.
- The claim is for a member who is enrolled in a Medicare Advantage Plan.

When submitting crossover claims directly, the following additional data may be required on the claim to identify the billing and rendering provider:

- The NPI that ForwardHealth has on file for the provider.
- Taxonomy code that is required by ForwardHealth.
- The ZIP+4 code that corresponds to the practice location address on file with ForwardHealth.

Providers may initiate a provider-submitted claim in one of the following ways:

- DDE through the ForwardHealth Provider Portal.
- 837I transaction, as applicable.
- 837P transaction, as applicable.
- PES software.
- Paper claim form.

Crossover Claims for Diabetic Supplies

Medicare Part B

Claims for dual eligibles enrolled in the BadgerCare Plus Standard Plan and Medicaid should first be submitted to Medicare Part B. Claims that are reimbursed by Medicare Part B should automatically cross over to ForwardHealth. Claims that are reimbursed by Medicare Part B that fail to cross over to ForwardHealth must be submitted on the 1500 Health Insurance Claim form with the appropriate HCPCS procedure code.

As a reminder, if Medicare Part B denies a claim for diabetic supplies provided to a member who is covered by the Standard Plan or Medicaid, the provider may submit a claim for those services to ForwardHealth. Medicare Part B-denied crossover claims must be submitted to ForwardHealth electronically, on a Compound Drug Claim form, or a Noncompound Drug Claim form with an NDC, and the appropriate other coverage code.

Medicare Part D

Diabetic supplies associated with the administration of insulin may be covered for members with Medicare Part D. Providers should contact the member's Medicare Part D PDP for information about the PDP's diabetic supply policy.

Definition of Medicare

Medicare is a health insurance program for people 65 years of age or older, for certain people with disabilities under age 65, and for people with ESRD. Medicare is a federal government program created under Title XVIII of the Social Security Act.

Medicare coverage is divided into four parts:

- Part A (i.e., Hospital Insurance). Part A helps to pay for medically necessary services, including inpatient hospital services, services provided in critical access hospitals (i.e., small facilities that give limited inpatient services and outpatient services to beneficiaries who reside in rural areas), services provided in skilled nursing facilities, hospice services, and some home health

services.
- Part B (i.e., Supplemental Medical Insurance). Part B helps to pay for medically necessary services, including physician services, outpatient hospital services, and some other services that Part A does not cover (such as PT services, OT services, and some home health services).
- Part C (i.e., Medicare Advantage).
- Part D (i.e., drug benefit).

Dual Eligibles

Dual eligibles are members who are eligible for coverage from Medicare (either Medicare Part A, Part B, or both) *and* Wisconsin Medicaid or BadgerCare Plus.

Dual eligibles may receive coverage for the following:

- Medicare monthly premiums for Part A, Part B, or both.
- Coinsurance, copayment, and deductible for Medicare-allowed services.
- BadgerCare Plus-covered services, even those that are not allowed by Medicare.

Exhausting Medicare Coverage

Providers are required to exhaust Medicare coverage before submitting claims to ForwardHealth. This is accomplished by following these instructions. Providers are required to prepare complete and accurate documentation of efforts to bill Medicare to substantiate Medicare disclaimer codes used on any claim.

Adjustment Request for Crossover Claim
The provider may submit a paper or electronic adjustment request. If submitting a paper Adjustment/Reconsideration Request form, the provider should attach a copy of Medicare remittance information. (If this is a Medicare reconsideration, copies of the original and subsequent Medicare remittance information should be attached.)

Provider-Submitted Crossover Claim

The provider may submit a provider-submitted crossover claim in the following situations:

- The claim is for a member who is enrolled in a Medicare Advantage Plan.
- The automatic crossover claim is not processed by ForwardHealth within 30 days of the Medicare processing date.
- ForwardHealth denied the automatic crossover claim and additional information may allow payment.
- The claim is for a member who is enrolled in Medicare and commercial health insurance that is secondary to Medicare (e.g., Medicare Supplemental).
- The claim is for a member who was not enrolled in BadgerCare Plus at the time the service was submitted to Medicare for payment, but the member was retroactively enrolled.*

When submitting provider-submitted crossover claims, the provider is required to follow all claims submission requirements in addition to the following:

- For electronic claims, indicate the Medicare payment.
- For paper claims, the provider is required to the do the following:
  - Attach Medicare's remittance information and refrain from indicating the Medicare payment.
  - Indicate "MMC" in the upper right corner of the claim for services provided to members enrolled in a Medicare Advantage Plan.

When submitting provider-submitted crossover claims for members enrolled in Medicare and commercial health insurance that is

secondary to Medicare, the provider is also required to do the following:

- Refrain from submitting the claim to ForwardHealth until after the claim has been processed by the commercial health insurance.
- Indicate the appropriate other insurance indicator.

* In this situation, a timely filing appeals request may be submitted if the services provided are beyond the claims submission deadline. The provider is required to indicate "retroactive enrollment" on the provider-submitted crossover claim and submit the claim with the Timely Filing Appeals Request form. The provider is required to submit the timely filing appeals request within 180 days from the date the backdated enrollment was added to the member's file.

Claim for Services Denied by Medicare
When Medicare denies payment for a service provided to a dual eligible that is covered by BadgerCare Plus, the provider may proceed as follows: • Bill commercial health insurance, if applicable. • Submit a claim to ForwardHealth using the appropriate Medicare disclaimer code. If applicable, the provider should indicate the appropriate other insurance indicator. A copy of Medicare remittance information should not be attached to the claim.

Crossover Claim Previously Reimbursed
A crossover claim may have been previously reimbursed by Wisconsin Medicaid when one of the following has occured: • Medicare reconsiders services that were previously not allowed. • Medicare retroactively determines a member eligible. In these situations, the provider should proceed as follows: • Refund or adjust Medicaid payments for services previously reimbursed by Wisconsin Medicaid. • Bill Medicare for the services and follow BadgerCare Plus's procedures for submitting crossover claims.

Medicare Advantage

Medicare services may be provided to dual eligibles or QMB-Only members on a fee-for-service basis or through a Medicare Advantage Plan. Medicare Advantage was formerly known as Medicare Managed Care (MMC), Medicare + Choice (MPC), or Medicare Cost (Cost). Medicare Advantage Plans have a special arrangement with the federal CMS and agree to provide all Medicare benefits to Medicare beneficiaries for a fee. Providers may contact Medicare for a list of Medicare Advantage Plans in Wisconsin and the insurance companies with which they are associated.

Paper Crossover Claims

Providers are required to indicate "MMC" in the upper right corner of provider-submitted crossover claims for services provided to members enrolled in a Medicare Advantage Plan. The claim must be submitted with a copy of the Medicare EOMB. This is necessary in order for ForwardHealth to distinguish whether the claim has been processed as commercial managed care or Medicare managed care.

Crossover claims for Medicare Part B covered drugs for members enrolled in the Standard Plan, Medicaid, or SeniorCare with a Medicare Advantage plan will deny due to the Medicare Advantage plan being on the member's file. To be reimbursed, providers are required to submit a Pharmacy Special Handling Request and a Noncompound Drug Claim. Providers should indicate the member is enrolled in a Medicare Advantage plan and indicate the Medicare Part B covered drug on the Pharmacy Special Handling Request.

Reimbursement Limits

Reimbursement limits on Medicare Part B services are applied to all Medicare Advantage Plan copayment amounts in accordance with federal law. This may reduce reimbursement amounts in some cases.

Medicare Disclaimer Codes

Medicare disclaimer codes are used to ensure consistent reporting of common billing situations for dual eligibles. Refer to claim instructions for Medicare disclaimer codes and their descriptions. The intentional misuse of Medicare disclaimer codes to obtain inappropriate reimbursement from Wisconsin Medicaid constitutes fraud.

Medicare disclaimer codes identify the status and availability of Medicare benefits. The code allows a provider to be reimbursed correctly by Wisconsin Medicaid when Medicare benefits exist or when, for some valid reason, the provider is unable to obtain such benefits by reasonable means.

When submitting a claim for a covered service that was denied by Medicare, providers should resubmit the claim *directly* to ForwardHealth using the appropriate Medicare disclaimer code.

Documentation Requirements

Providers are required to prepare and maintain truthful, accurate, complete, legible, and concise documentation of efforts to bill Medicare to substantiate Medicare disclaimer codes used on any claim, according to DHS 106.02(9)(a), Wis. Admin. Code.

Medicare Enrollment

Some providers may become retroactively enrolled in Medicare. Providers should contact Medicare for more information about retroactive enrollment.

Services for Dual Eligibles

As stated in DHS 106.03(6) and 106.03(7)(b), Wis. Admin. Code, a provider is required to be enrolled in Medicare if both of the following are true:

- He or she provides a Medicare Part B service to a dual eligible.
- He or she can be enrolled in Medicare.

If a provider can be enrolled in Medicare but chooses *not* to be, the provider is required to refer dual eligibles to another certified provider who is enrolled in Medicare.

To receive Medicaid reimbursement for a Medicare Part B service provided to a dual eligible, a provider who is not enrolled in Medicare but can be is required to apply for retroactive enrollment.

Services for Qualified Medicare Beneficiary-Only Members

Because QMB-Only members receive coverage from Wisconsin Medicaid only for services allowed by Medicare, providers who are not enrolled in Medicare are required to refer QMB-Only members to another certified provider who is enrolled in Medicare.

Medicare Late Fees

Medicare assesses a late fee when providers submit a claim after Medicare's claim submission deadline has passed. Claims that cross over to ForwardHealth with a Medicare late fee are denied for being out of balance. To identify these claims, providers should reference the Medicare remittance information and check for ANSI code B4 (Late filing penalty), which indicates a late fee amount deducted by Medicare.

ForwardHealth considers a late fee part of Medicare's paid amount for the claim because Medicare would have paid the additional amount if the claim had been submitted before the Medicare claim submission deadline. ForwardHealth will not reimburse providers for late fees assessed by Medicare.

Resubmitting Medicare Crossover Claims with Late Fees

Providers may resubmit to ForwardHealth crossover claims denied because the claim was out of balance due to a Medicare late fee. The claim may be submitted on paper, submitted electronically using the ForwardHealth Portal, or submitted as an 837 transaction.

Paper Claim Submissions

When resubmitting a crossover claim on paper, include a copy of the Medicare remittance information so ForwardHealth can determine the amount of the late fee and apply the correct reimbursement amount.

Electronic Claim Submissions

When resubmitting a claim via the Portal or an electronic 837 transaction (including PES software submissions), providers are required to balance the claim's paid amount to reflect the amount Medicare would have paid before Medicare subtracted a late fee. This is the amount that ForwardHealth considers when adjudicating the claim. To balance the claim's paid amount, add the late fee to the paid amount reported by Medicare. Enter this amount in the Medicare paid amount field.

For example, the Medicare remittance information reports the following amounts for a crossover claim:

- Billed Amount: $110.00.
- Allowed Amount: $100.00.
- Coinsurance: $20.00.
- Late Fee: $5.00.
- Paid Amount: $75.00.

Since ForwardHealth considers the late fee part of the paid amount, providers should add the late fee to the paid amount reported on the Medicare remittance. In the example above, add the late fee of $5.00 to the paid amount of $75.00 for a total of $80.00. The claim should report the Medicare paid amount as $80.00.

Medicare Part D Benefits for Dual Eligibles

Providers may verify Medicare Part D enrollment for a dual eligible through Wisconsin's EVS, the AVR system, or through WellPoint. The EVS or AVR will state only that a dual eligible is in a Medicare Part D PDP. It will not indicate the name of the specific PDP.

To determine the specific PDP in which a dual eligible is enrolled, providers should first check with the individual. If the individual does not know the PDP in which he or she is enrolled, providers may send an online enrollment transaction through Medicare's E1 query. If the E1 transaction does not return Medicare Part D plan information, providers may call the Medicare Pharmacy Hotline, available 24 hours a day, seven days a week, at (866) 835-7595. Providers may also call Provider Services to determine the PDP in which a dual eligible is enrolled.

Pharmacy providers are required to be Medicare certified if they provide a Medicare-covered service to a dual eligible. If the provider is not Medicare certified, the provider should refer the dual eligible to another Medicaid-certified provider who is also

Medicare certified.

Medicare Part D Claim Submission

ForwardHealth will deny claims for Medicare Part D-covered drugs for dual eligibles. Claims and PA requests for Medicare Part D-covered drugs for dual eligibles must be submitted to the appropriate Medicare Part D PDP. For dual eligibles enrolled in a PDP, providers may *only* submit claims to ForwardHealth for excluded Medicare Part D drugs. All other claims will be denied and the pharmacy provider will be instructed to submit the claim to the Medicare Part D PDP. Providers will receive an EOB code for this denial.

Medicare Part D-excluded drugs include barbiturates, benzodiazepines, OTC drugs, agents that are used for the symptomatic relief of cough and cold, prescription vitamins and mineral products (*except* prenatal vitamins and fluoride), and weight loss agents.

A PA request for drugs covered by Medicare Part D will be denied because these drugs will be covered by a Medicare Part D PDP.

State-Contacted Managed Care Organizations or HMOs

Drug claims for dual eligibles enrolled in state-contracted MCOs or HMOs should be handled in the same way as claims for dual eligibles who receive drug coverage from BadgerCare Plus fee-for-service. Claims for barbiturates, benzodiazepines, OTC drugs, agents that are used for the symptomatic relief of cough and cold, and prescription vitamins and mineral products (*except* prenatal vitamins and fluoride), and weight loss agents may be submitted to BadgerCare Plus fee-for-service for dual eligible MCO or HMO enrollees.

Drug claims for members who are *not* dual eligibles should be submitted to the state-contracted MCO or HMO.

Medicare Part D Payment Recoupment

ForwardHealth initiates a monthly process of recouping payment for claims for members enrolled in Medicare Part D. Providers will receive adjustments for previously paid claims. Providers may not bill members for services that are adjusted and should seek reimbursement from the member's Medicare Part D PDP.

Prior to submitting claims to SeniorCare, providers are required to submit claims to Medicare Part D for SeniorCare members who are enrolled in a Medicare Part D PDP. A PDP includes not only the stand-alone Medicare Part D PDPs, but also Medicare Advantage PDPs. Under certain circumstances, claims may have been reimbursed by ForwardHealth without reimbursement having been obtained from a Medicare Part D PDP.

Claim Responses

Providers may identify claims adjusted for Medicare Part D eligibility if they receive an informational EOB code on adjustments to previously paid claims.

Drugs Excluded from Coverage by Medicare Part D

BadgerCare Plus and Medicaid Members Enrolled in Medicare Part D

Providers may submit claims for drugs that are covered by BadgerCare Plus and Medicaid but are excluded from coverage by Medicare Part D.

SeniorCare

Because SeniorCare coordinates benefits with Medicare Part D, SeniorCare covers Medicare Part D excluded drugs and accepts PA requests for drugs for SeniorCare members in all levels of participation who are enrolled in a Medicare Part D PDP.

Medicare Retroactive Eligibility

If a member becomes retroactively eligible for Medicare, the provider is required to refund or adjust any Medicaid payments for the retroactive period. The provider is required to then bill Medicare for the services and follow ForwardHealth's procedures for submitting crossover claims. Claims found to be in conflict with this program requirement will be recouped.

Modifier for Catastrophe/Disaster-Related Crossover Claims

ForwardHealth accepts modifier "CR" (Catastrophe/disaster related) on Medicare crossover claims (both 837P transactions and 1500 Health Care Claim Forms) to accommodate the emergency health care needs of dual eligibles and QMB-Only members affected by disasters. The CMS Web site contains more information.

National Provider Identifier and Related Data on Crossover Claims

An NPI and related data are required on crossover claims, in most instances. However, in some cases the taxonomy code designated by ForwardHealth may not be indicated on automatic crossover claims received from Medicare.

Secondary NPI

Medicare requires that certain subparts of an organization obtain separate NPIs and use the NPI for billing Medicare (e.g., hospital psychiatric unit). If an organization has identified subparts for the purpose of submitting claims to Medicare, and the NPIs appear on automatic crossover claims to ForwardHealth, ForwardHealth considers the NPIs submitted to Medicare to be secondary NPIs. ForwardHealth will process automatic crossover claims using secondary NPIs in cases where the provider has reported a secondary NPI to ForwardHealth. Along with the NPI, providers should also indicate the taxonomy and ZIP+4 code information.

Taxonomy Code Designated by ForwardHealth

The taxonomy code indicated on automatic crossover claims received from Medicare may be different than the taxonomy designated by ForwardHealth. Providers should resubmit the claim to ForwardHealth when the taxonomy code designated by ForwardHealth is required to identify the provider and is not indicated on the crossover claim received from Medicare.

Qualified Medicare Beneficiary-Only Members

QMB-Only members are a limited benefit category of Medicaid members. They are eligible for coverage from Medicare (either Part A, Part B, or both) *and* limited coverage from Wisconsin Medicaid. QMB-Only members receive Medicaid coverage for the following:

- Medicare monthly premiums for Part A, Part B, or both.
- Coinsurance, copayment, and deductible for Medicare-allowed services.

QMB-Only members do not receive coverage from Wisconsin Medicaid for services not allowed by Medicare. Therefore, Wisconsin Medicaid will not reimburse for services if either of the following occur:

- Medicare does not cover the service.

- The provider is not enrolled in Medicare.

Reimbursement for Crossover Claims

Professional Crossover Claims

State law limits reimbursement for coinsurance and copayment of Medicare Part B services provided to dual eligibles and QMB-Only members.

Total payment for a Medicare Part B service (i.e., any amount paid by other health insurance sources, any copayment or spenddown amounts paid by the member, and any amount paid by Wisconsin Medicaid) may not exceed the Medicare-allowed amount. Therefore, Medicaid reimbursement for coinsurance or copayment of a Medicare Part B service is the lesser of the following:

- The *Medicare*-allowed amount less any amount paid by other health insurance sources and any copayment or spenddown amounts paid by the member.
- The *Medicaid*-allowed amount less any amount paid by other health insurance sources and any copayment or spenddown amounts paid by the member.

The following table provides examples of how the limitations are applied.

Reimbursement for Coinsurance or Copayment of Medicare Part B Services			
Explanation	Example		
	1	2	3
Provider's billed amount	$120	$120	$120
Medicare-allowed amount	$100	$100	$100
Medicaid-allowed amount (e.g., maximum allowable fee, rate-per-visit)	$90	$110	$75
Medicare payment	$80	$80	$80
Medicaid payment	$10	$20	$0

Outpatient Hospital Crossover Claims

Detail-level information is used to calculate pricing for all outpatient hospital crossover claims and adjustments. Details that Medicare paid in full or that Medicare denied in full will not be considered when pricing outpatient hospital crossover claims. Medicare deductibles are paid in full.

Providers may use the following steps to determine how reimbursement was calculated:

1. Sum all of the detail Medicare paid amounts to establish the Claim Medicare paid amount.
2. Sum all of the detail Medicare coinsurance or copayment amounts to establish the Claim Medicare coinsurance or copayment amount.
3. Multiply the number of DOS by the provider's rate-per-visit. For example, $100 (rate-per-visit) x 3 (DOS) = $300. This is the Medicaid gross allowed amount.
4. Compare the Medicaid gross allowed amount calculated in step 3 to the Claim Medicare paid amount calculated in step 1. If the Medicaid gross allowed amount is less than or equal to the Medicare paid amount, Wisconsin Medicaid will make no further payment to the provider for the claim. If the Medicaid gross allowed amount is greater than the Medicare paid amount, the difference establishes the Medicaid net allowed amount.
5. Compare the Medicaid net allowed amount calculated in step 4 and the Medicare coinsurance or copayment amount calculated in step 2. Wisconsin Medicaid reimburses the lower of the two amounts.

Services Requiring Medicare Billing

If the EVS indicates Medicare + Choice (**"MPC"**) for "Medicare Managed Care Coverage," the provider is required to bill the following services to the Medicare Advantage Plan before submitting claims to ForwardHealth:

- Ambulance services.
- Ambulatory service center services.
- Chiropractic services.
- Dental anesthesia services.
- Home health services (excluding PC services).
- Hospital services, including inpatient or outpatient.
- Medicare-covered services.
- Osteopath services.
- Physician services.

If the EVS indicates Medicare Cost (**"MCC"**) for "Medicare Managed Care Coverage," the provider is required to bill the following services to the Medicare Advantage Plan before submitting claims to ForwardHealth:

- Ambulance services.
- Home health services (excluding PC services).
- Medicare-covered services.

ForwardHealth has identified services requiring commercial health insurance billing.

Other Coverage Information

AIDS/HIV Drug Assistance Members Enrolled Either in the Core Plan or the Basic Plan

The BadgerCare Plus Core Plan and the BadgerCare Plus Basic Plan do not cover drugs in the antiretroviral drug class for members enrolled in the Core Plan or the Basic Plan. Claims for antiretroviral drugs for Core Plan members and Basic Plan members who are also enrolled in the Wisconsin ADAP should be submitted to ADAP. For all other drugs, providers should submit claims first to the Core Plan or the Basic Plan, then to ADAP, and then to BadgerRx Gold.

Providers with questions may call ADAP at (800) 991-5532.

After Reporting Discrepancies

After receiving an Other Coverage Discrepancy Report, ForwardHealth confirms the information and updates the member files.

It may take up to two weeks to process and update the member's enrollment information. During that time, ForwardHealth verifies the insurance information submitted and adds, changes, or removes the member's other coverage information as appropriate. If verification contradicts the provider's information, a written explanation is sent to the provider. The provider should wait to submit claims until one of the following occurs:

- The provider verifies through Wisconsin's EVS that the member's other coverage information has been updated.
- The provider receives a written explanation.

Coverage Discrepancies

Maintaining complete and accurate insurance information may result in fewer claim denials. Providers are an important source of other coverage information as they are frequently the first to identify coverage discrepancies.

HIRSP Members Enrolled in the Core Plan

BadgerCare Plus Core Plan members may also be enrolled in the HIRSP as long as members meet the eligibility requirements for the Core Plan and HIRSP. For Core Plan members who are also enrolled in HIRSP, providers should submit claims for all Core Plan covered services to the Core Plan. For services not covered by the Core Plan, providers should submit claims to HIRSP. HIRSP is always the payer of last resort.

For pharmacy services, providers should first submit claims to the Core Plan if drugs are covered by the Core Plan. After a response is received from the Core Plan, claims should be submitted to HIRSP if drugs are covered by HIRSP. Finally, claims should be submitted to BadgerRx Gold if appropriate.

Note: HIRSP will only cover noncovered Core Plan services if the services are covered under the HIRSP benefit.

Insurance Disclosure Program

ForwardHealth receives policyholder files from most major commercial health insurance companies on a monthly basis. ForwardHealth then compares this information with member enrollment files. If a member has commercial health insurance,

ForwardHealth revises the member's enrollment file with the most current information.

The insurance company is solely responsible for the accuracy of this data. If the insurance company provides information that is not current, ForwardHealth's files may be inaccurate.

Maintaining Accurate and Current Records

ForwardHealth uses many sources of information to keep accurate and current records of a member's other coverage, including the following:

- Insurance Disclosure program.
- Providers who submit an Other Coverage Discrepancy Report form.
- Member certifying agencies.
- Members.

The information about a member's other health insurance coverage in the member files may be incomplete or incorrect if ForwardHealth received inaccurate information from the other health insurance source or the member's certifying agency.

Reporting Discrepancies

Providers are encouraged to report discrepancies to ForwardHealth by submitting the Other Coverage Discrepancy Report form. Providers are asked to complete the form in the following situations:

- The provider is aware of other coverage information that is not indicated by Wisconsin's EVS.
- The provider received other coverage information that contradicts the information indicated by the EVS.
- A claim is denied because the EVS indicates commercial managed care coverage but the coverage is not available to the member (e.g., the member does not live in the plan's service area).

Providers should not use the Other Coverage Discrepancy Report form to update any information regarding a member's coverage in a state-contracted MCO.

When reporting discrepancies, providers should include photocopies of current insurance cards and any available documentation, such as remittance information and benefit coverage dates or denials.

Provider-Based Billing

Purpose of Provider-Based Billing

The purpose of provider-based billing is to reduce costs by ensuring that providers receive maximum reimbursement from other health insurance sources that are primary to BadgerCare Plus. For example, a provider-based billing claim is created when BadgerCare Plus pays a claim and later discovers that other coverage exists or was made retroactive. Since BadgerCare Plus benefits are secondary to those provided by most other health insurance sources, providers are required to seek reimbursement from the primary payer, as stated in DHS 106.03(7), Wis. Admin. Code.

Questions About Provider-Based Billing

For questions about provider-based billing claims that are within the 120-day limit, providers may call the Coordination of Benefits Unit at (608) 221-4746. Providers may fax the corresponding Provider-Based Billing Summary to (608) 221-4567 at the time of the telephone call.

For questions about provider-based billing claims that are *not* within the 120-day limit, providers may call Provider Services.

Receiving Notification

When a provider-based billing claim is created, the provider will receive the following:

- A notification letter.
- A Provider-Based Billing Summary. The Summary lists each claim from which a provider-based billing claim was created. The summary also indicates the corresponding primary payer for each claim.
- Provider-based billing claim(s). For each claim indicated on the Provider-Based Billing Summary, the provider will receive a prepared provider-based billing claim. This claim may be used to bill the other health insurance source; the claim includes all of the other health insurance source's information that is available.

If a member has coverage through multiple other health insurance sources, the provider may receive additional Provider-Based Billing Summaries and provider-based billing claims for each other health insurance source that is on file.

Responding to ForwardHealth After 120 Days

If a response is not received within 120 days, the amount originally paid by BadgerCare Plus will be withheld from future payments. This is not a final action. To receive payment after the original payment has been withheld, providers are required to submit the required documentation to the appropriate address as indicated in the following tables. For DOS that are within claims submission deadlines, providers should refer to the first table. For DOS that are beyond claims submission deadlines, providers should refer to the second table.

Within Claims Submission Deadlines		
Scenario	**Documentation Requirement**	**Submission Address**
The provider discovers through the EVS that ForwardHealth has removed or enddated the other health insurance coverage from the member's file.	A claim according to normal claims submission procedures (do *not* use the prepared provider-based billing claim).	ForwardHealth Claims and Adjustments 6406 Bridge Rd Madison WI 53784-0002

The provider discovers that the member's other coverage information (i.e., enrollment dates) reported by the EVS is invalid.	• An Other Coverage Discrepancy Report form. • A claim according to normal claims submission procedures after verifying that the member's other coverage information has been updated by using the EVS (do *not* use the prepared provider-based billing claim).	Send the Other Coverage Discrepancy Report form to the address indicated on the form. Send the claim to the following address: ForwardHealth Claims and Adjustments 6406 Bridge Rd Madison WI 53784-0002
The other health insurance source reimburses or partially reimburses the provider-based billing claim.	• A claim according to normal claims submission procedures (do *not* use the prepared provider-based billing claim). • The appropriate other insurance indicator. • The amount received from the other health insurance source.	ForwardHealth Claims and Adjustments 6406 Bridge Rd Madison WI 53784-0002
The other health insurance source denies the provider-based billing claim.	• A claim according to normal claims submission procedures (do *not* use the prepared provider-based billing claim). • The appropriate other insurance indicator or Medicare disclaimer code.	ForwardHealth Claims and Adjustments 6406 Bridge Rd Madison WI 53784-0002
The commercial health insurance carrier does not respond to an initial *and* follow-up provider-based billing claim.	• A claim according to normal claims submission procedures (do *not* use the prepared provider-based billing claim). • The appropriate other insurance indicator.	ForwardHealth Claims and Adjustments 6406 Bridge Rd Madison WI 53784-0002

Beyond Claims Submission Deadlines		
Scenario	**Documentation Requirement**	**Submission Address**
The provider discovers through the EVS that ForwardHealth has removed or enddated the other health insurance coverage from the member's file.	• A claim (do *not* use the prepared provider-based billing claim). • A Timely Filing Appeals Request form according to normal timely filing appeals procedures.	ForwardHealth Timely Filing Ste 50 6406 Bridge Rd Madison WI 53784-0050

The provider discovers that the member's other coverage information (i.e., enrollment dates) reported by the EVS is invalid.	• An Other Coverage Discrepancy Report form.
	• *After* using the EVS to verify that the member's other coverage information has been updated, include both of the following:
	  ○ A claim (do *not* use the prepared provider-based billing claim.)
	  ○ A Timely Filing Appeals Request form according to normal timely filing appeals procedures.
		Send the Other Coverage Discrepancy Report form to the address indicated on the form.
		
		Send the timely filing appeals request to the following address:
		
		ForwardHealth
		Timely Filing
		Ste 50
		6406 Bridge Rd
		Madison WI 53784-0050

The commercial health insurance	• A claim (do *not* use the prepared provider-based	ForwardHealth

carrier reimburses or partially reimburses the provider-based billing claim.	billing claim). • Indicate the appropriate other insurance indicator. • Indicate the amount received from the commercial insurance. • A Timely Filing Appeals Request form according to normal timely filing appeals procedures.	Timely Filing Ste 50 6406 Bridge Rd Madison WI 53784-0050

The other health insurance source denies the provider-based billing claim.	• A claim (do *not* use the prepared provider-based billing claim).
	• The appropriate other insurance indicator or Medicare disclaimer code.
	• A Timely Filing Appeals Request form according to normal timely filing appeals procedures.
	• The Provider-Based Billing Summary.
	• Documentation of the denial, including any of the following:
	    ○ Remittance information from the other health insurance source.
	    ○ A written statement from the other health insurance source identifying the reason for denial.
	    ○ A letter from the other health insurance source indicating a policy termination date that proves that the other health insurance source paid the member.
	    ○ A copy of the insurance card or other documentation from the other health insurance source that indicates that the policy provides limited coverage such as pharmacy, dental, or Medicare supplemental coverage only.
	• The DOS, other health insurance source, billed amount, and procedure code indicated on the documentation must match the information on the Provider-Based Billing Summary.
		ForwardHealth
		Timely Filing
		Ste 50
		6406 Bridge Rd
		Madison WI 53784-0050

The commercial health insurance carrier does not respond to an initial and follow-up provider-based billing claim.	• A claim (do *not* use the prepared provider-based billing claim). • The appropriate other insurance indicator. • A Timely Filing Appeals Request form according to normal timely filing appeals procedures.	ForwardHealth Timely Filing Ste 50 6406 Bridge Rd Madison WI 53784-0050

Responding to ForwardHealth Within 120 Days

Within 120 days of the date on the Provider-Based Billing Summary, the Provider-Based Billing Unit must receive documentation verifying that one of the following occurred:

- The provider discovers through the EVS that ForwardHealth has removed or enddated the other health insurance coverage from the member's file.
- The provider verifies that the member's other coverage information reported by ForwardHealth is invalid.
- The other health insurance source reimbursed or partially reimbursed the provider-based billing claim.

- The other health insurance source denied the provider-based billing claim.
- The other health insurance source failed to respond to an initial *and* follow-up provider-based billing claim.

When responding to ForwardHealth within 120 days, providers are required to submit the required documentation to the appropriate address as indicated in the following table. If the provider's response to ForwardHealth does not include all of the required documentation, the information will be returned to the provider. The provider is required to send the complete information within the original 120-day limit.

<table>
<tr><th>Scenario</th><th>Documentation Requirement</th><th>Submission Address</th></tr>
<tr><td>The provider discovers through the EVS that ForwardHealth has removed or enddated the other health insurance coverage from the member's file.</td><td>The Provider-Based Billing Summary.
Indication that the EVS no longer reports the member's other coverage.</td><td>ForwardHealth
Provider-Based Billing
PO Box 6220
Madison WI 53716-0220
Fax (608) 221-4567</td></tr>
<tr><td>The provider discovers that the member's other coverage information (i.e., enrollment dates) reported by the EVS is invalid.</td><td>The Provider-Based Billing Summary.
One of the following:
The name of the person with whom the provider spoke and the member's correct other coverage information.
A printed page from an enrollment Web site containing the member's correct other coverage information.</td><td>ForwardHealth
Provider-Based Billing
PO Box 6220
Madison WI 53716-0220
Fax (608) 221-4567</td></tr>
<tr><td>The other health insurance source reimburses or partially reimburses the provider-based billing claim.</td><td>The Provider-Based Billing Summary.
A copy of the remittance information received from the other health insurance source.
The DOS, other health insurance source, billed amount, and procedure code indicated on the other insurer's remittance information must match the information on the Provider-Based Billing Summary.
Note: In this situation, ForwardHealth will initiate an adjustment if the amount of the other health insurance payment does not exceed the allowed amount (even though an adjustment request should not be submitted). However, providers (except nursing home and hospital providers) may issue a cash refund. Providers who choose this option should include a refund check but should not use the Claim Refund form.</td><td>ForwardHealth
Provider-Based Billing
PO Box 6220
Madison WI 53716-0220
Fax (608) 221-4567</td></tr>
<tr><td>The other health insurance source denies the provider-based billing claim.</td><td>The Provider-Based Billing Summary.
Documentation of the denial, including any of the following:
Remittance information from the other health insurance source.
A letter from the other health insurance source indicating a policy termination date that precedes the DOS.
Documentation indicating that the other health insurance source paid the member.
A copy of the insurance card or other documentation from the other health insurance source that indicates the policy provides limited coverage such as pharmacy, dental, or Medicare supplemental coverage.
The DOS, other health insurance source, billed amount, and procedure code indicated on the documentation must match the information on the Provider-Based Billing Summary.</td><td>ForwardHealth
Provider-Based Billing
PO Box 6220
Madison WI 53716-0220
Fax (608) 221-4567</td></tr>
</table>

The other health insurance source fails to respond to the initial *and* follow-up provider-based billing claim.	• The Provider-Based Billing Summary. • Indication that no response was received by the other health insurance source. • Indication of the dates that the initial and follow-up provider-based billing claims were submitted to the other health insurance source.	ForwardHealth Provider-Based Billing PO Box 6220 Madison WI 53716-0220 Fax (608) 221-4567

Submitting Provider-Based Billing Claims

For each provider-based billing claim, the provider is required to send a claim to the appropriate other health insurance source. The provider may use the claim prepared by ForwardHealth or produce his or her own claim. If the other health insurance source requires information beyond what is indicated on the prepared claim, the provider should add that information to the claim. The providers should also attach additional documentation (e.g., Medicare's remittance information) if required by the other health insurance source.

Reimbursement for Services Provided for Accident Victims

Billing Options

Providers may choose to seek payment from either of the following:

- Civil liabilities (e.g., injuries from an automobile accident).
- Worker's compensation.

However, as stated in DHS 106.03(8), Wis. Admin. Code, BadgerCare Plus will not reimburse providers if they receive payment from either of these sources.

The provider may choose a different option for each DOS. For example, the decision to submit one claim to ForwardHealth does not mean that all claims pertaining to the member's accident must be submitted to ForwardHealth.

Points of Consideration

Providers should consider the time and costs involved when choosing whether to submit a claim to ForwardHealth or seek payment from a settlement.

Time

Providers are not required to seek payment from worker's compensation or civil liabilities, rather than seeking reimbursement from BadgerCare Plus, because of the time involved to settle these cases. While some worker's compensation cases and certain civil liability cases may be settled quickly, others may take several years before settlement is reached.

Costs

Providers may receive more than the allowed amount from the settlement; however, in some cases the settlement may not be enough to cover all costs involved.

Seeking Payment from Settlement

After choosing to seek payment from a settlement, the provider may *instead* submit the claim to ForwardHealth as long as it is submitted before the claims submission deadline. For example, the provider may instead choose to submit the claim to ForwardHealth because no reimbursement was received from the liability settlement or because a settlement has not yet been reached.

Submitting Claims to ForwardHealth

If the provider chooses to submit a claim to ForwardHealth, he or she may not seek further payment for that claim in any liability settlement that may follow. Once a claim is submitted to ForwardHealth, the provider may not decide to seek reimbursement for that claim in a liability settlement. Refunding payment and then seeking payment from a settlement may constitute a felony. If a settlement occurs, ForwardHealth retains the sole right to recover medical costs.

Providers are required to indicate when services are provided to an accident victim on claims submitted to ForwardHealth. If the member has other health insurance coverage, the provider is required to exhaust the other health insurance sources before submitting the claim to ForwardHealth.

Covered and Noncovered Services

4

Archive Date:03/01/2011

Covered and Noncovered Services:Codes

Administration Procedure Codes for Provider-Administered Drugs

For provider-administered drugs administered to members enrolled in BadgerCare Plus HMOs, Medicaid SSI HMOs, and most special MCOs, the CPT administration procedure codes below should be indicated on claims submitted for reimbursement to BadgerCare Plus and Medicaid fee-for-service, not the member's MCO. Claims for administration procedure codes not indicated on the table below should be submitted to the member's MCO for reimbursement. Only services that are covered by ForwardHealth are reimbursed.

Code	Description
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular
96373	intra-arterial
96374	intravenous push, single or initial substance/drug
96375	each additional sequential intravenous push of a new substance/drug
96376	each additional sequential intravenous push of the same substance/drug provided in a facility
96379	Unlisted therapeutic, prophylactic, or diagnostic intravenous or intra-arterial injection or infusion

Contraceptive Supply Procedure Codes

Pharmacies are required to use the 11-digit NDC on the drug package or a procedure code for all drugs dispensed when submitting pharmacy claims.

Providers are required to submit claims for condoms using the paper 1500 Health Insurance Claim Form or 837P transaction using the following HCPCS codes:

- A4267 (Contraceptive supply, condom, male, each).
- A4268 (Contraceptive supply, condom, female, each).

Diagnosis Codes

All diagnosis codes indicated on claims (and PA requests when applicable) must be the most specific ICD-9-CM diagnosis code. Providers are responsible for keeping current with diagnosis code changes. Etiology and manifestation codes may not be used as a primary diagnosis.

The required use of valid diagnosis codes includes the use of the most specific diagnosis code. Valid, most specific diagnosis codes may have up to five digits. Claims submitted with three- or four-digit codes where four- and five-digit codes are available may be denied.

Pharmaceutical Care Diagnosis Code

Information is available for DOS on and after November 1, 2010.

Valid ICD-9-CM diagnosis codes are required on the claim submitted for each PC intervention. Providers are required to make a

reasonable effort to report an ICD-9-CM code that identifies the medical condition most closely related to the drug and PC intervention performed.

The diagnosis and associated ICD-9-CM code should be determined and reported to the level of specificity the provider believes is necessary to perform the intervention. The ICD-9-CM diagnosis code must be the most specific diagnosis code. Valid, most specific diagnosis codes may have up to five digits. Claims submitted with three- or four-digit codes where four- and five-digit codes are available may be denied. In some situations, a general knowledge of the disease state(s) is necessary; in other instances, a more precise determination is necessary to determine if an intervention is appropriate.

Diagnosis-Restricted Drugs Pharmacy Data Table

The Diagnosis Restricted Drugs pharmacy data table lists diagnosis-restricted drug categories and the corresponding diagnosis codes and disease descriptions. PA is required for a diagnosis outside approved diagnosis restrictions, except for Benchmark Plan, Core Plan, and Basic Plan members because, under the Benchmark, Core, and Basic Plans, drugs used for treatment outside approved diagnoses are considered noncovered services. Diagnosis-restricted drugs do not require PA if they are used to treat certain diagnoses listed on the diagnosis restricted drugs table. If providers use an unapproved diagnosis code for a drug, the claim will be denied and providers will receive a message that a paper PA request is required. If the claim was submitted on paper, a message will appear in the provider's remittance information.

Some drugs do not require PA when claims are submitted with certain valid diagnoses. Reimbursement for these drugs is restricted by an acceptable and valid ICD-9-CM diagnosis code.

Submission of peer-reviewed medical literature to support the proven efficacy of the requested use of the drug is required for PA outside the diagnosis restriction.

Submitting Prior Authorization Requests

PA requests for drugs outside approved diagnoses must be submitted on paper using a PA/RF and a PA/DGA. The prescriber is required to complete the PA/DGA and submit peer-reviewed medical literature to support the proven efficacy of the requested use of the drug to the pharmacy where the prescription will be filled. The pharmacy provider is required to complete a PA/RF and submit the forms and supporting documentation to ForwardHealth.

National Drug Codes

BadgerCare Plus and SeniorCare cover FDA-approved NDCs for drugs in which the manufacturer has signed a rebate agreement.

The FDA assigns NDCs for drugs that have received FDA approval. The NDC is an 11-digit, three-segment number for a drug.

The NDC is divided into the following segments:

- The first segment, a five-digit labeler code that identifies any firm that manufactures, repacks, or distributes the drug. (Repackaged drugs are covered.)
- The second segment, a four-digit code that identifies the drug's strength, dose, and formulation.
- The third segment, a two-digit code that identifies the package size.

In most cases, if an NDC is 10 digits or less, providers are required to indicate a preceding zero in the segment(s) with less than the required number of digits. If the labeler code begins with a number that is greater than or equal to one, the preceding zero may need to be indicated in the second or third segment. In other cases, providers may need to indicate a zero at the end of a segment.

Providers may use the Drug Search Tool to verify the arrangement of the segments of a specific NDC. Providers may also contact Provider Services or refer to the Noridian Administrative Services NDC to HCPCS crosswalk. (This Web site contains a crosswalk of J codes and NDCs to HCPCS and select CPT procedure codes.)

Providers are required to indicate an appropriate NDC on PA requests.

New National Drug Codes

BadgerCare Plus and SeniorCare automatically add an NDC of a new drug to the BadgerCare Plus and SeniorCare drug file if it meets program guidelines and is produced by a manufacturer participating in the drug rebate program.

Patient Location Codes

Certain two-digit NCPDP patient location codes must be used on all claims and PA requests, including PA requests submitted in the STAT-PA system and on STAT-PA worksheets.

Patient location codes include the following:

Code	Description
00	Not specified
01	Home (IV-IM Services Only)
04	Long Term/Extended Care
07	Skilled Care Facility
10	Outpatient

Procedure Codes for Injectible Antipsychotic Drugs and Hemophilia Products for Core Plan Members

The following HCPCS procedure codes are allowable on claims for BadgerCare Plus Core Plan members for injectible antipsychotic drugs and hemophilia products.

Mental Health Drug Procedure Codes	
Code	**Description**
J0400	Injection, aripiprazole, intramuscular, 0.25 mg
J1630	Injection, haloperidol, up to 5 mg
J1631	Injection, haloperidol decanoate, per 50 mg
J2680	Injection, fluphenazine deconoate, [Prolixin Deconoate], up to 25mg
J2794	Injection, risperidone, long acting, 0.5 Mg
J3486	Injection, ziprasidone mesylate, 10 mg
J3490*	Unclassified drugs

* Pharmacy providers may indicate procedure code J3490 only on claims for intramuscular olanzapine.

Hemophilia Drug Procedure Codes	
Code	**Description**
J7186	Injection, antihemophilic factor VIII/von Willebrand factor complex (human), per factor VIII IU
J7187	Injection, von willebrand factor complex (Humate-p), per IU VWF:RCO

J7189	Factor VIIA (antihemophilic factor, recombinant), per 1 microgram
J7190	Factor VIII (antihemophilic factor, human), per IU
J7192	Factor VIII (antihemophilic factor, recombinant), per IU
J7193	Factor IX (antihemophilic factor, purified, non-recombinant) per IU
J7194	Factor IX, complex, per IU
J7195	Factor IX (antihemophilic factor, recombinant) per IU
J7197	Antithrombin III (human), per IU
J7198	Anti-inhibitor, per IU
Q2023	Injection, factor VIII (antihemophilic factor, recombinant) (xyntha), per IU

Covered Services and Requirements

Age- and Gender-Restricted Drugs

The drugs in the tables below are age- or gender-restricted by BadgerCare Plus, Medicaid, and SeniorCare.

The tables include the most current information and may be updated periodically.

Age-Restricted Drugs	
Product	**Allowable Ages**
Certain HealthCheck "Other Services" (e.g., iron supplements, multivitamins)	Under 21 years of age
Iron Products	Under 60 years of age

Age- and Gender-Restricted Drugs		
Product	**Allowable Members**	**Allowable Ages**
Oral Contraceptives	Females	10 to 60 years of age
Prenatal Vitamins	Females	12 to 60 years of age

ForwardHealth has adopted the gender restriction coding from First DataBank. The gender restrictions are automatically updated by First DataBank.

Alpha Hydroxprogesterone (17P) Caproate Compound Injection

The 17P caproate compound injection is covered for members enrolled in the BadgerCare Plus Standard Plan, the BadgerCare Plus Benchmark Plan, and Medicaid. The compound is available through and only reimbursable for sterile compounding pharmacies.

The 17P compound must be injected by a medical professional. Members may not self-administer the 17P injection.

The following is clinical criteria for coverage of the 17P injection:

- The pregnancy must be a singleton pregnancy.
- The member must have had a previous pre-term delivery (i.e., a spontaneous birth before 37 weeks gestation).
- The 17P injection must be administered beginning at 16 weeks gestation through 37 weeks gestation or delivery, whichever is first.

Claim Submission

Information is available for DOS before May 31, 2010.

Claims for the17P injection must be submitted on paper on the 1500 Health Insurance Claim Form with the new Attestation to Administer Alpha Hydroxyprogesterone (17P) Caproate Injections as an attachment to the claim. Claims for the 17P injection can only be submitted on paper.

On the Attestation to Administer Alpha Hydroxyprogesterone (17P) Caproate Injections, providers are required to sign and date that they have communicated to the member the criteria for coverage of the 17P injection and that the drug is not an FDA-approved drug. Providers should keep a copy of the signed and completed Attestation to Administer Alpha Hydroxyprogesterone (17P) Caproate Injections in the member's medical record in addition to sending the completed form to ForwardHealth. The provider is required to sign and date a new Attestation to Administer Alpha Hydroxyprogesterone (17P) Caproate Injections each time an injection is administered.

To be reimbursed for the 17P injection, the following must be indicated on the claim according to the completion instructions for the 1500 Health Insurance Claim Form:

- A quantity of 250 mg.
- Procedure code J3490 (Unclassified drugs). (*Note:* Procedure code J3490 may also be indicated on claims for other injections.)
- The NDC and description from the bulk powder used to compound the 17P injection.
- The name of the person who administered the injection on the same detail line as procedure code J3490.

The 17P injection is a diagnosis-restricted drug. Diagnosis code V23.41 (Pregnancy with history of pre-term labor) is the only diagnosis code that is allowable on claims for the 17P injection. Claims with other diagnosis codes indicated will be denied.

The claim for the 17P injection may be submitted to ForwardHealth by mail. The provider's usual and customary charge should be indicated on the claim.

Reimbursement

The maximum allowable rate for the 17P injection is $22.66 per injection, which does not include reimbursement for the administration of the drug.

Providers may be reimbursed for the administration of the 17P injection by indicating procedure code 96372 (Therapeutic, prophylactic, or diagnostic injection [specify substance or drug]; subcutaneous or intramuscular) on the claim.

The rate for administering the 17P injection is $3.31.

BadgerRx Gold Program for Benchmark Plan, Core Plan, and Basic Plan Members

All BadgerCare Plus Benchmark Plan, BadgerCare Plus Core Plan, and BadgerCare Plus Basic Plan members are automatically enrolled in the BadgerRx Gold Program.

Drugs that are not covered by the Benchmark Plan, the Core Plan, or the Basic Plan may be available to members through the BadgerRx Gold Program. The BadgerRx Gold Program is a prescription drug program administered by Navitus Health Solutions that offers certain drugs at a lower cost.

Members are responsible for the full price of drugs that are not covered by the BadgerRx Gold Program, the Benchmark Plan, the Core Plan, or the Basic Plan.

The BadgerRx Gold Program provides members with select drugs at a lower cost; however, the cost of a drug covered by the BadgerRx Gold Program may be greater than a typical copayment amount under the Benchmark Plan, the Core Plan, or the Basic Plan. Members will have a greater financial responsibility for drugs purchased through the BadgerRx Gold Program.

The formulary for the BadgerRx Gold Program is available through the BadgerRx Gold Web site. Additional questions may be directed to the toll-free BadgerRx Gold hotline at (866) 809-9382.

Claim Submission

Providers should submit claims to the BadgerRx Gold Program for drugs not covered by the Benchmark Plan, the Core Plan, or the Basic Plan. BadgerCare Plus does not coordinate benefits with BadgerRx Gold for members enrolled in the Benchmark Plan, the Core Plan, or the Basic Plan.

Claims submitted for noncovered drugs for members enrolled in the Benchmark Plan, the Core Plan, and the Basic Plan will be returned to providers with an EOB code and an NCPDP reject code.

Basic Plan Covered Pharmacy Services

The BadgerCare Plus Basic Plan has a closed drug formulary. The following drugs are on the Basic Plan formulary:

- Certain generic drugs.
- A limited number of OTC drugs.
- Humalog insulin.
- Humalog Mix insulin.
- Lantus insulin.
- Tamiflu.
- Relenza.

Providers may refer to the BadgerCare Plus Basic Plan National Drug Code List for a list of drugs covered by the Basic Plan.

Family planning services, including oral contraceptives, are covered for Basic Plan members enrolled in Family Planning Only Services.

Diagnosis-Restricted Drugs

Drugs used for treatment outside approved diagnoses are considered noncovered services under the Basic Plan. Providers will receive an EOB code on claims submitted with diagnosis codes outside approved diagnoses. Claims for diagnosis-restricted drugs for use outside approved diagnoses may be submitted to BadgerRx Gold.

Providers should not submit a PA request for a diagnosis-restricted drug for use outside approved diagnoses. PA requests for drugs with a diagnosis outside approved diagnoses will be returned to the provider with a message stating, "The services requested are not covered under the BadgerCare Plus Basic Plan. Providers are reminded that they must adhere to the service limitations specified by the BadgerCare Plus Basic Plan."

For diagnosis-restricted drugs, allowable diagnoses for the Basic Plan are the same as the BadgerCare Plus Standard Plan.

Service Limitations

The Basic Plan covers a maximum of 10 pharmacy claims per member, per calendar month, regardless of provider. Any prescription beyond the 10 claims allowed in a calendar month will be denied as noncovered services. A provider may collect payment from a member for noncovered services. However, before the service is provided, the provider should inform the member that the service is noncovered.

Claims submissions for diabetic supplies do not count towards the 10 pharmacy claims per member, per calendar month limit.

Note: For drugs for which a three-month supply can be dispensed, dispensing of the drug counts towards the 10 prescription per calendar month maximum only in the month the prescription is filled.

Members enrolled in the Basic Plan may be dispensed up to the allowed quantity of a drug. If an override of the quantity limit service limitation is requested and the request does not meet service limitation override criteria, it will be a noncovered service.

Service limitation policies apply to the early refill DUR and three-month supply initiatives.

Benchmark Plan Covered Pharmacy Services

The BadgerCare Plus Benchmark Plan covers a broad list of generic drugs and a limited number of OTC drugs. The PC dispensing fee and the repackaging allowance are also covered by the Benchmark Plan.

The Benchmark Plan only covers drugs listed on the BadgerCare Plus Benchmark Plan and Core Plan National Drug Code List.

Certain generic drugs that are non-preferred under the BadgerCare Plus Standard Plan, Medicaid, or SeniorCare may be covered by the Benchmark Plan (e.g., fentanyl transdermal patches).

For those drugs that are covered by the Benchmark Plan, policies and procedures are the same as they are under the Standard Plan.

Brand name drugs may be available to Benchmark Plan members through BadgerRx Gold. All Benchmark Plan members are automatically enrolled in BadgerRx Gold.

Certain drugs are not covered by the Benchmark Plan.

Compound Drugs

The BadgerCare Plus Standard Plan, Medicaid, and SeniorCare cover a compound drug only when the compound drug prescription:

- Contains more than one ingredient (each ingredient is separately billed on a compound claim).
- Contains at least one drug that is covered by the Standard Plan, Medicaid, or SeniorCare.
- Does not contain any drug listed on the Less-Than-Effective/Identical, Related, or Similar Drugs list, or any equivalent or similar drug.
- Does not result in drug combinations that the FDA considers less-than-effective. For example, a topical compound drug is considered less-than-effective if it combines any two of the following: a steroid, an antibiotic, or an antifungal agent.

If one component of the compound drug requires PA, the compound drug requires PA. If one component of the compound drug has a diagnosis restriction, the compound drug has the same diagnosis restriction.

If a compound drug has one noncovered component, payment for that component will be denied, but the rest of the components will be covered, assuming the other conditions are met.

The Standard Plan, Medicaid, and SeniorCare do not cover a compound drug prescription intended for a therapeutic use if the FDA does not approve the therapeutic use of the combination.

Compound drugs are *not* covered by the BadgerCare Plus Benchmark Plan, BadgerCare Plus Core Plan, or BadgerCare Plus Basic Plan.

Preferred Drug List

Compound drugs are excluded from PDL requirements. Prescribers are not required to complete a PA/PDL form, and pharmacy providers are not required to obtain PA for non-preferred products that are included in a compound drug.

Claims

Providers should indicate the actual NDC of the ingredients in a compound and submit claims through the POS system, using PES claims submission software, or on the Compound Drug Claim form.

Providers may also submit real-time claims for compound drugs with the actual NDCs for bulk chemicals.

Core Plan Covered Pharmacy Services

The BadgerCare Plus Core Plan has a closed drug formulary. The Core Plan covers certain generic and OTC drugs and certain brand name drugs in specific drugs classes for all Core Plan members. The BadgerCare Plus Core Plan — Quick Reference lists specific drugs in certain classes for which brand name drugs will be covered for all Core Plan members.

Family planning services, including oral contraceptives, may be covered for Core Plan members enrolled in Family Planning Only Services.

For a complete list of generic and OTC drugs covered by the Core Plan, providers may access the regularly revised BadgerCare Plus Core Plan National Drug Code List. The Core Plan Brand Name Drug Quick Reference, which includes the Core Plan formulary, is available on the Portal and on the ePocrates Web site. Providers may also refer to the Drug Search Tool to search for specific drugs covered by the Core Plan.

The PC dispensing fee and the repackaging allowance are covered by the Core Plan.

If a member has not been transitioned from GAMP or GA medical programs, the member will not be grandfathered on drugs he or she is currently taking. Grandfathered drugs for transtioned Core Plan members are indicated on the BadgerCare Plus Core Plan — Quick Reference.

Diagnosis-Restricted Drugs

Drugs used for treatment outside approved diagnoses are considered noncovered services under the Core Plan. Providers will receive an EOB code on claims submitted with diagnosis codes outside approved diagnoses. Claims for diagnosis-restricted drugs submitted for use outside approved diagnoses may be submitted to BadgerRx Gold.

Providers should not submit a PA request for a diagnosis-restricted drug for use outside approved diagnoses. PA requests for drugs with a diagnosis outside approved diagnoses will be returned to the provider with a message stating, "The services requested are not covered under the BadgerCare Plus Core Plan." Providers are reminded that they must adhere to the service limitations specified by the Core Plan.

For diagnosis-restricted drugs allowable diagnoses for the Core Plan are the same as the BadgerCare Plus Standard Plan, with the exception of diagnoses for Provigil®, Suboxone®, and Subutex.

Quantity Limits

ForwardHealth has established quantity limits for Provigil®, Suboxone®, and Subutex.

ForwardHealth allows a maximum of 200 mg per day of Provigil® and 32 mg per day of Suboxone® or Subutex. To adhere to established quantity limits, members may be dispensed two 100 mg tablets per day or one 200 mg tablet per day of Provigil®. For Suboxone® and Subutex, members may be dispensed any combination of two- or eight-milligram tablets, not to exceed the 32-mg dose per day limit.

Any dose that exceeds the quantity limits previously described is a noncovered service.

Core Plan Covered Pharmacy Services Exceptions for Transitioned Members

Covered Drugs

Generally, covered pharmacy services and the policies and procedures for BadgerCare Plus Core Plan members transitioned from GAMP and GA medical programs are the same as those for members enrolled in the Core Plan on and after July 15, 2009, with a few exceptions indicated below.

Oral antiretroviral drugs are not covered by ForwardHealth for transitioned Core Plan members. In addition, ForwardHealth enddated reimbursement by NDC for injectible antipsychotic drugs and hemophilia products for transitioned members on June 30, 2009.

Grandfathering of Mental Health Drugs for Transitioned Members

Transitioned members who are currently taking mental health drugs in the following classes are grandfathered on all drugs in these classes as long as the member is enrolled in the Core Plan *and* until a generic equivalent is available:

- Atypical antipsychotic drugs.
- Alzheimer's agents.

Transitioned members will be grandfathered on the specific drugs they are currently taking in the following classes as long as the member is enrolled in the Core Plan *and* until a generic equivalent is available:

- Anticonvulsants.
- Antidepressants, other.
- Antidepressants, SSRI.
- Antiparkinson's agents.
- Stimulants and related agents.

PA is not required for transitioned members for a grandfathered drug or class, except when a generic equivalent drug becomes available for a brand name drug. Other policies (e.g., diagnosis restrictions) for these drugs and drug classes may apply. For classes grandfathered by drug, if a member must be switched to different drugs in these classes, generic drugs are covered. Other non-preferred brand name drugs are not covered by the Core Plan, but may be covered by BadgerRx Gold. PA is not available for other drugs (i.e., a drug the member is not taking) in the previously listed classes.

Brand Medically Necessary Prior Authorization for Mental Health Drugs for Grandfathered Transitioned Members

Transitioned members taking brand name drugs in any mental health drug class will not be grandfathered on the drug or in the class if the drug was considered a brand medically necessary drug before July 1, 2009. For example, members taking Prozac® for DOS before July 1, 2009, will not be grandfathered on Prozac® and instead must be dispensed fluoxetine or another generic antidepressant for DOS on and after July 1, 2009.

Brand medically necessary PA requests may be submitted only for the mental health drug or class for which the transitioned member has been grandfathered. If a brand name mental health drug is available in a generic equivalent, the transitioned member should receive the generic equivalent unless it is medically necessary for the member to receive the brand name drug. Brand medically necessary PA requests may be submitted only for the mental health drug or class for which the member is grandfathered.

If a member is currently grandfathered on a brand name drug and a generic equivalent is released, grandfathering of the brand name

drug for the member will be discontinued when the brand name drug is added to the Brand Medically Necessary Drugs That Require Prior Authorization.

For example, in the antidepressants, SSRI drug class, if a member is currently grandfathered on Lexapro® and a generic equivalent is released, the prescriber should switch the member to the generic equivalent or to another generic drug in the antidepressant drug classes. If the generic equivalent does not work for the member and the brand name drug is medically necessary, the prescriber must submit a PA/BMNA to the pharmacy where the prescription will be filled. The pharmacy provider is required to submit the PA/BMNA, along with a completed PA/RF to ForwardHealth. The PA will be adjudicated using current BadgerCare Plus Standard Plan brand medically necessary policy.

ePocrates

The list of covered NDCs for the BadgerCare Plus Benchmark Plan and the Core Plan is not available on ePocrates' Web site.

Definition of Covered Services

A covered service is a service, item, or supply for which reimbursement is available when *all* program requirements are met. DHS 101.03(35) and 107, Wis. Admin. Code, contain more information about covered services.

Drugs with Signed Manufacturer Rebate Agreements

In accordance with the OBRA of 1990, also known as the Medicaid Drug Rebate Program, drug manufacturers who choose to participate in BadgerCare Plus and Medicaid are required to sign a rebate agreement with the federal government.

BadgerCare Plus and SeniorCare cover only the legend drugs of manufacturers who have signed rebate agreements. Non-participating manufacturers may sign rebate agreements that are effective the following quarter.

Manufacturer rebates are based on Medicaid claims data showing the quantity of each NDC dispensed to ForwardHealth program members. Manufacturers may dispute the payment of drug rebates if they believe the utilization data reported to them is inaccurate. To resolve disputes, ForwardHealth verifies utilization data by having individual providers check the accuracy of claims information they submit.

A signed national drug rebate agreement is required for payment of a manufacturer's drugs. Claims for provider-administered drugs that do not have a signed manufacturer rebate agreement on file are denied.

Drugs with a Three-Month Supply Maximum

For three-month supply drugs, the following apply:

- Certain drugs are required to be dispensed in a three-month supply.
- Additional drugs may be dispensed in a three-month supply.
- All other drugs shall be dispensed in the full amount prescribed, up to a 34-day supply.

Dispensing a three-month supply of drugs streamlines the prescription filling process for pharmacy providers, encourages the use of generic, maintenance drugs when medically appropriate for a member, and results in savings to ForwardHealth programs.

Drugs Required to Be Dispensed in a Three-Month Supply

ForwardHealth has identified a list of drugs for which pharmacy providers will be required to dispense a three-month supply.

Claims for drugs required to be dispensed in a three-month supply will be denied with an EOB code and an NCPDP reject code.

Pharmacy providers will be required to call the DAPO Center to request a policy override to dispense less than a three-month supply. ForwardHealth may authorize dispensing of less than a three-month supply for up to one year. Pharmacy providers may request an override to dispense less than a three-month supply for members enrolled in the BadgerCare Plus Standard Plan, the BadgerCare Plus Benchmark Plan, the BadgerCare Plus Core Plan, the BadgerCare Plus Basic Plan, Medicaid, and SeniorCare.

Examples of when a request for a policy override to dispense less than a three-month supply may be approved include, but are not limited to, the following:

- The member's primary insurance does not allow a three-month supply.
- The prescriber or pharmacist is concerned about dispensing a three-month supply to a member.

ForwardHealth may authorize dispensing of less than a three-month supply for up to one year.

Pharmacy providers may dispense up to a 96-hour supply of a drug to a member when the DAPO Center is closed and a policy override to dispense less than a three-month supply must be obtained. If the DAPO Center grants a policy override for less than a three-month supply, the policy override will be retroactive and the pharmacy provider may submit a claim for the drug using the POS system or on paper. If the claim for a 96-hour supply is submitted on paper, the pharmacy provider will be required to complete and submit a Pharmacy Special Handling Request. Providers should check Element 6 (Pharmacy Consultant Review) and provide this statement in the space provided: 96-hour policy override for a three-month supply.

If the DAPO Center denies the policy override, ForwardHealth will reimburse the provider for the 96-hour supply. A claim must be submitted on paper with the Pharmacy Special Handling Request. Providers should check Element 6 (Pharmacy Consultant Review) and provide an explanation of the review needed (e.g., 96-hour policy override for early refill) in the space provided.

The 14-day emergency medication dispensing policy does not apply to the three-month supply initiative.

Drugs That May Be Dispensed in a Three-Month Supply

For drugs that may be dispensed in a three-month supply, but are not required to be, pharmacy providers should work with the member and the prescriber to determine whether or not it is clinically appropriate to dispense a three-month supply. Claims for these drugs will be denied with the "NS" prospective DUR alert and providers will be required to respond to the alert and resubmit the claim in the POS system to obtain reimbursement from ForwardHealth. Providers will receive an EOB code on claims for these drugs.

Note: Claims for some drugs previously denied with the "NS" prospective DUR alert and an EOB code that did not require a three-month supply may now be denied with an EOB code indicating a three-month supply is required.

Pharmacy providers will receive the "NS" prospective DUR alert on claims with less than a three-month supply indicated for drugs that may be dispensed in a three-month supply. Pharmacy providers are encouraged to work with the member and prescriber to determine whether or not the prescription should be dispensed in a three-month supply. If the prescription is updated, pharmacy providers do not need to override the DUR alert. If the prescription is not dispensed in a three-month supply, pharmacy providers will need to override the DUR alert.

Note: When DUR alerts are returned to providers, the NCPDP DUR Free Text Message field (544-FY) states that a 100-day supply may be dispensed. A 100-day supply is equivalent to a three-month supply.

Prescriber Responsibilities for Three-Month Supply Drugs

For drugs that are required to be dispensed in a three-month supply, prescribers must indicate a three-month supply (e.g., a quantity of 90 or 100) on the prescription to allow the pharmacy provider to dispense maintenance drugs in quantities up to a three-month supply. For example, if the prescription is written for "Hydrochlorothiazide 25 mg, take one tablet daily," the prescriber is required to

indicate a quantity of 90 or 100 tablets on the prescription so the pharmacy provider can dispense a three month supply. In certain instances, brand name drugs (e.g., oral contraceptives) may be dispensed in a three-month supply.

For drugs required to be dispensed in a three-month supply, once a member has been stabilized on a drug as evidenced by use of the same drug strength and dosage form for 90 days of the past 120 days, refills of the same drug strength and dosage form must be dispensed in a three-month supply. If the member previously has been dispensed a three-month supply of a drug of the same strength and dosage form, a three-month supply must be dispensed.

If a member has not previously been dispensed a three-month supply of a drug of the same strength and dosage form, but has been stabilized on that drug, the prescriber must write a prescription so the pharmacy provider can dispense a three-month supply of the drug.

Pharmacy Responsibilities for Three-Month Supply Drugs

According to DHS 107.10(3)(e), Wis. Admin. Code, providers are required to dispense all legend drugs in the full quantity prescribed, not to exceed a 34-day supply, except for drugs that may be dispensed in a three-month supply and those required to be dispensed in a three-month supply.

When appropriate, pharmacy providers are required to contact prescribers to request a new prescription for a three-month supply if a prescription has been written as a one-month supply with multiple or as needed (i.e., PRN) refills.

If a prescription for a drug that is required to be dispensed in a three-month supply was not ordered with a three-month supply, pharmacy providers should determine if the member has been stabilized on the drug. If the member has not been stabilized on the drug, a quantity not to exceed a 34-day supply should be dispensed. If the member has been stabilized on the drug, the pharmacy provider must work with the prescriber to obtain a prescription for a three-month supply or obtain a policy override to dispense less than a three-month supply.

Prescription Quantity

A prescriber must indicate the appropriate quantity on the prescription to allow the pharmacy provider to dispense the maintenance drug in quantities up to a three-month supply. For example, if the prescription is written for "Phenytoin 100mg, take one capsule three times daily," the pharmacy provider may dispense up to 300 capsules as long as the prescriber has indicated a three-month supply quantity on the prescription.

Pharmacy providers are not required to contact prescribers to request a new prescription for a three-month supply if a prescription has been written as a one-month supply with multiple or as needed (i.e., PRN) refills.

ForwardHealth will not audit or recoup three-month supply claims if a pharmacy provider changes a prescription written as a one-month supply with refills as long as the total quantity dispensed per prescription does not exceed the total quantity authorized by the prescriber.

Member Benefits

A three-month supply of a drug may benefit a member in the following ways:

- Aiding compliance in taking prescribed generic, maintenance medications.
- Reducing the cost of member copayments.
- Requiring fewer trips to the pharmacy.
- Allowing the member to obtain a larger quantity of generic, maintenance drugs for chronic conditions (e.g., hypertension).

Pharmaceutical Care

Pharmacy providers may be reimbursed for PC once per prescription, per member for a prescription that is changed to a three-month supply. If a pharmacy provider contacts a physician to change a prescription to a days' supply that is 84 days or greater, the pharmacy provider may submit a claim for PC. This PC code may be reimbursed only once per day and only four times per year, per member.

Pharmacy providers may only obtain a PC dispensing fee if a discussion between the pharmacy provider and the prescriber occurs to determine whether or not a three-month supply is clinically appropriate for the member and the prescription is changed so the drug may be dispensed in a three-month supply. If a prescription is not changed, a PC dispensing fee cannot be obtained.

A PC dispensing fee for a three-month supply is reimbursable for members enrolled in the Standard Plan, the Core Plan, Medicaid, and SeniorCare. For SeniorCare members, pharmacy providers are reimbursed directly for PC at the Medicaid rate when the member is in, or has reached, the copayment level of participation.

When submitting claims for PC for a SeniorCare member, providers are required to receive the member's prior consent for PC services when the member is in the spenddown or deductible level of participation. If the member refuses the PC service, the amount submitted on the claim must be reduced to not include the PC dispensing fee.

Providers should indicate their usual and customary charges on claims. The usual and customary charge should include the PC dispensing fee and allow the pharmacy provider to be reimbursed correctly for the drug. If the original prescription issued by the prescriber indicates a three-month supply, pharmacy providers may not submit a claim to receive the PC dispensing fee.

Documentation Requirements

To receive a PC dispensing fee when a three-month supply of a drug is dispensed, providers are required to document the following in the member?s file or on the prescription:

- The date the prescriber was contacted.
- The change to the prescription.
- The name of the person who contacted the prescriber.
- The name of the person in the prescriber?s office who authorized the change to the prescription.

Documentation must be provided if requested by ForwardHealth. Failure to provide the previous documentation may result in recoupment of the PC dispensing fee.

Service Limitations

If an override of a service limitation, such as a three-month supply policy override, is requested and the request does not meet service limitation override criteria, the policy override will be denied and the service will be a noncovered service.

In addition, if one of the following circumstances is met, a three-month supply of a drug is a noncovered service:

- If the member does not accept a three-month supply or the member perceives a safety concern with a drug and does not accept a three-month supply. (*Note:* If a member's primary insurance does not allow a three-month supply to be dispensed, a drug dispensed in less than a three-month supply is a covered service.)
- If the prescriber is not certified by Wisconsin Medicaid and is unwilling to approve a three-month supply or does not provide a valid reason for a three-month supply to be dispensed.
- If the prescriber is certified by Wisconsin Medicaid, but the prescriber does not approve a three-month supply or does not provide a valid reason for a three-month supply to be dispensed. (*Note:* Pharmacy providers should contact the DAPO Center for additional instructions in this instance.)

Pharmacy providers enrolled in the Standard Plan, Medicaid, and SeniorCare may collect payment from members in the previously listed circumstances. For members enrolled in the Benchmark Plan, the Core Plan, and the Basic Plan, the pharmacy provider may submit claims to BadgerRx Gold.

With the exception of previously described policies, pharmacies cannot collect payment from members for a three-month supply of a drug if the pharmacy provider does not follow the policies described above.

Members do not have appeal rights for noncovered drugs or service.

Drugs for Members in Long Term Care Facilities

Members in long term care facilities are exempt from the three-month supply policy. When serving members in long term care facilities, pharmacy providers are *not* required to contact the DAPO Center to obtain an override to dispense less than a three-month supply of drugs. If a member is in a long term care facility, providers should indicate the appropriate patient location on the claim. Patient location codes can be found in the NCPDP companion document.

Drugs without Signed Manufacturer Rebate Agreements

By federal law, pharmaceutical manufacturers who participate in state Medicaid programs must sign a rebate agreement with the CMS. BadgerCare Plus, Medicaid, and SeniorCare will cover legend and specific categories of OTC products of manufacturers who have signed a rebate agreement.

Members enrolled in BadgerCare Plus Standard Plan, Medicaid, or SeniorCare (Levels 1 and 2a)

BadgerCare Plus, Medicaid, and SeniorCare levels 1 and 2a may cover certain FDA approved legend drugs through the PA process even though the drug manufacturers did not sign rebate agreements.

To submit a PA request for a drug without a signed rebate agreement the prescriber should complete and submit the PA/DGA to the pharmacy where the drug will be dispensed. Pharmacies should complete the PA/RF and submit both forms and any supporting documentation to ForwardHealth. PAs can be submitted by paper, fax, or on the ForwardHealth Portal.

Included with the PA, the prescriber must submit documentation of medical necessity and cost effectiveness that the non-rebated drug is the only available and medically appropriate product for treating the member. The documentation must include:

- A copy of the medical record or documentation of the medical history detailing the member's medical condition and previous treatment results.
- Documentation by the prescriber that shows why other drug products have been ruled out as ineffective or unsafe for the member's medical condition.
- Documentation by the prescriber that shows why the non-rebated drug is the most appropriate and cost effective drug to treat the member's medical condition.

If a PA request for a drug without a signed manufacturer rebate is approved, claims for drugs without a signed rebate agreement must be submitted on paper. Providers should complete and submit the Noncompound Drug Claim indicating the actual NDC of the drug with the Pharmacy Special Handling Request form.

If a PA request for a drug without a signed manufacturer rebate is denied, the service is considered noncovered.

BadgerCare Plus Benchmark Plan and BadgerCare Plus Core Plan

PA is not available for drugs that are not included on the BadgerCare Plus Benchmark Plan NDC List and the BadgerCare Plus Core Plan Covered NDC List and Quick Reference. PA requests submitted for noncovered drugs will be returned to the provider unprocessed and the service will be noncovered. Members do not have appeal rights regarding returned PA requests for noncovered drugs.

Emergencies

Certain program requirements and reimbursement procedures are modified in emergency situations. Emergency services are defined in DHS 101.03(52), Wis. Admin. Code, as "those services that are necessary to prevent the death or serious impairment of the health of the individual." Emergency services are not reimbursed unless they are covered services.

Additional definitions and procedures for emergencies exist in other situations, such as dental and mental health.

Program requirements and reimbursement procedures may be modified in the following ways:

- PA or other program requirements may be waived in emergency situations.
- Noncertified providers may be reimbursed for emergency services.
- Non-U.S. citizens may be eligible for covered services in emergency situations.

Emergency Medication Dispensing

ForwardHealth strongly encourages pharmacy providers to dispense a 14-day emergency supply of a medication when a member receives a prescription for a covered drug with a PA restriction and the physician cannot be reached to obtain a new prescription or the appropriate documentation to override the PA restriction. Medications dispensed in emergency situations do not require PA.

The emergency medication dispensing policy overrides drug restriction policies and all PA policies, including the PDL, brand medically necessary, and diagnosis-restricted drug policies. However, other policies, such as member enrollment and noncovered services policies still apply.

When subsequent refills are dispensed, all current drug restriction policies and PA policies still apply.

Providers may dispense up to two consecutive 14-day emergency supplies of a drug while a PA request is under review. For members enrolled in the BadgerCare Plus Standard Plan, the BadgerCare Plus Core Plan, Medicaid, and SeniorCare, pharmacy providers are required to call Provider Services to obtain a policy override to exceed dispensing two consecutive emergency supplies of a drug.

This emergency medication dispensing policy applies to members enrolled in the Standard Plan, the Core Plan, Medicaid, and SeniorCare.

Claim Submission

When drugs are dispensed in an emergency situation, providers are required to submit a Noncompound Drug Claim form with a Pharmacy Special Handling Request form, indicating the nature of the emergency. Providers should mail completed Noncompound Drug Claim and Pharmacy Special Handling Request forms as indicated on the Pharmacy Special Handling Request. Providers may also fax these forms to ForwardHealth at (608) 221-0885.

Completing Claim Forms Correctly

Providers are required to correctly complete the Pharmacy Special Handling Request form and the Noncompound Drug Claim form to receive the appropriate reimbursement for an emergency medication supply. Wisconsin Medicaid is committed to reimbursing providers for emergency medications as long as claims are properly completed and submitted with a Pharmacy Special Handling Request form.

Claims are denied when a provider does not complete the "UD" field. Providers are reminded to complete Element 15 ("UD") on the Noncompound Drug Claim form with the appropriate unit dose value.

BadgerCare Plus Core Plan Members

The following are the only drugs for which emergency medication dispensing is allowed for all Core Plan members:

- Byetta® and Symlin®.
- Cytokine and CAM antagonists drugs.
- Provigil®.
- Suboxone® and Subutex.

In addition to the drugs listed above, emergency medication dispensing is allowed for a brand medically necessary mental health drug for which a transitioned Core Plan member has been grandfathered.

ForwardHealth encourages pharmacy providers to dispense a 14-day emergency supply of a Core Plan-covered medication when they determine it is medically necessary or an emergency.

Note: For Core Plan members, the only diagnosis-restricted drug for which ForwardHealth accepts PA requests is Spiriva®.

BadgerCare Plus Benchmark Plan Members

There are no drugs covered by the BadgerCare Plus Benchmark Plan that require PA; therefore, there is no emergency medication dispensing coverage for members enrolled in the Benchmark Plan.

Home Infusion Services

Home IV injections and TPN solution, including lipids, are covered and reimbursed as compounds. Supplies and equipment, such as infusion pumps associated with the IV, may be separately reimbursable. The DMEand DMS maximum allowable fee indices contain limitations and PA requirements for supplies and equipment.

Hospice

As defined in DHS 101.03(75m), Wis. Admin. Code, a hospice is a licensed public agency, a private organization, or a subdivision of either that primarily provides palliative care to persons experiencing the last stages of terminal illness. Hospice also provides supportive care for the family and other individuals caring for the terminally ill persons.

Members receiving hospice services usually receive care from one hospice and one physician. Members' prescriptions may be filled at any Medicaid-certified pharmacy.

Hospices are required to pay for medications directly related to the terminal illness, such as narcotics for pain management. Pharmacies should submit claims for these medications directly to the hospice. Pharmacies should submit claims to ForwardHealth for medications not directly related to the terminal illness (e.g., blood pressure medications).

Injectible Antipsychotic Drugs and Hemophilia Products for Core Plan Members

Provider-administered injectible antipsychotic drugs and hemophilia products are covered by the BadgerCare Plus Core Plan for all members. Claims for injectible antipsychotic drugs and hemophilia products may be submitted on the 837P transaction or on the 1500 Health Insurance Claim Form with a HCPCS procedure code and an NDC. An NDC is required on claims to comply with the requirements of the DRA.

Pharmacy providers cannot submit claims for injectible antipsychotic drugs for Core Plan members with only an NDC indicated. Pharmacy providers may submit claims for injectible antipsychotic drugs and hemophilia products with a HCPCS procedure code.

Providers, with the exception of pharmacy providers, should indicate on claims an appropriate administration procedure code to receive reimbursement for administration of injectible antipsychotic drugs and hemophilia products.

Pharmacy providers should indicate an allowable procedure code, an NDC, *and* modifier "U1" on claims for injectible antipsychotic drugs and hemophilia products to receive reimbursement for the dispensing fee.

Legend Drugs

Most legend drugs and many OTC drugs are covered.

As defined under DHS 101.03(94), Wis. Admin. Code, a legend drug is any drug that requires a prescription under federal code 21 USC 353(b). Legend drugs are covered when:

- The drug is approved by the FDA and is not on the Wisconsin Medicaid Negative Formulary List.
- The manufacturer has signed a federal rebate agreement for the drug.
- The manufacturer has reported the drug information to First DataBank.

Some covered drugs may require PA; others require an appropriate diagnosis code or have other restrictions for reimbursement. The Maximum Allowed Cost List contains information about diagnosis-restricted drugs and lists of covered drugs.

Mail Delivery Services

Current Wisconsin law permits Wisconsin Medicaid-certified pharmacies to deliver prescriptions to members via the mail. Wisconsin Medicaid-certified retail pharmacies may dispense and mail any prescription or OTC medication to a BadgerCare Plus fee-for-service or SeniorCare member at no additional cost to the member or to Wisconsin Medicaid.

When filling prescriptions for members, providers are encouraged to use the mail delivery option if requested by the member, particularly for prescriptions filled for a three-month supply.

Medical Necessity

Wisconsin Medicaid reimburses only for services that are medically necessary as defined under DHS 101.03(96m), Wis. Admin. Code. Wisconsin Medicaid may deny or recoup payment if a service fails to meet Medicaid medical necessity requirements.

Member Payment for Covered Services

Under state and federal laws, a Medicaid-certified provider may not collect payment from a member, or authorized person acting on behalf of the member, for covered services even if the services are covered but do not meet program requirements. Denial of a claim by ForwardHealth does not necessarily render a member liable. However, a covered service for which PA was denied is treated as a noncovered service. (If a member chooses to receive an originally requested service instead of the service approved on a modified PA request, it is also treated as a noncovered service.) If a member requests a covered service for which PA was denied (or modified), the provider may collect payment from the member if certain conditions are met.

If a provider collects payment from a member, or an authorized person acting on behalf of the member, for a covered service, the provider may be subject to program sanctions including termination of Medicaid certification.

Not Otherwise Classified Drugs

Providers who indicate procedure codes such as J3490 (Unclassified drugs), J3590 (Unclassified biologics), or J9999 (Not otherwise classified, antineoplastic drugs) on claims for NOC drugs must also indicate the following on the claim:

- The NDC of the drug dispensed.
- The name of the drug.
- The quantity billed.
- The unit of issue (i.e., ea, gm, or ml).

If this information is not included on the claim or if there is a more specific HCPCS procedure code for the drug, the claim will be denied. Compound drugs that do not include a drug approved by the FDA will be denied.

Providers are required to comply with the requirements of the federal DRA of 2005 and submit NDCs with HCPCS and CPT procedure codes for provider-administered drugs. Section 1927(a)(7)(B) of the Social Security Act requires NDCs to be indicated on all claims submitted to ForwardHealth, including Medicare crossover claims.

Opioid Monthly Prescription Fill Limit

Opioid drugs are limited to five prescription fills per calendar month for members enrolled in the BadgerCare Plus Standard Plan, the BadgerCare Plus Benchmark Plan, the BadgerCare Plus Core Plan, the BadgerCare Plus Basic Plan, Wisconsin Medicaid, and SeniorCare.

These limits do not affect members who are in a nursing home or hospice care.

The following drugs will be exempt from the opioid monthly prescription fill limit:

- Suboxone film and tablet.
- Buprenorphine tablet.
- Methadone solution.
- Opioid antitussive liquid.

Prescriber Responsibilities

If a member enrolled in the Standard Plan, Medicaid, and SeniorCare require more than five opioid prescription fills in a month, the prescriber may request a policy override through the DAPO Center. An override is required for each opioid fill that exceeds the five prescription fill limit per calendar month.

Members enrolled in the Benchmark Plan, the Core Plan, and the Basic Plan are not eligible to receive an opioid monthly prescription fill limit.

When calling the DAPO Center to request a policy override for opioids, the following information must be provided:

- Prescriber's name and NPI.
- Member's name and ID.
- Pharmacy's name and telephone number where the member attempted to have the prescription filled.
- Date the prescription was attempted to be filled.
- Drug name, strength, and quantity.
- Instructions for use.

The DAPO Center will provide information to the prescriber regarding the member's recent medication history.

If the prescriber determines an override is medically necessary, the DAPO Center will record the override, and the prescriber should contact the member and the pharmacy. When contacting the member, the prescriber should use this opportunity to discuss the appropriate use of opioids.

If the prescriber decides that it is not medically necessary to override the opioid monthly prescription fill limit, the prescriber should contact the member and discuss follow-up care. If the override is not given, the prescriber should contact the pharmacy to have the prescription canceled.

Pharmacy Responsibilities

When pharmacies are contacted by a prescriber and notified that an override is available, the pharmacy should submit the claim for the opioid. Pharmacies are responsible for submitting claims for opioids within three days of the override being obtained by the prescriber. If the pharmacy provider does not submit the claim within the three day time period, the claim will be denied.

Note: If the pharmacy provider contacts the DAPO Center to obtain an override, the DAPO Center will inform the pharmacy provider that the prescriber is responsible for obtaining the override.

If a prescriber does not override the opioid monthly prescription fill limit for members enrolled in the Standard Plan, Medicaid, or SeniorCare, the service is considered noncovered.

If a pharmacy has difficulty with claim submission related to the opioid monthly prescription limit, contact the DAPO Center.

Exceptions

Opioid prescription fill limit exceptions are covered for members enrolled in the Standard Plan, Medicaid, and SeniorCare.

Members enrolled in the Benchmark Plan, the Core Plan, and the Basic Plan are not eligible to receive an opioid prescription fill limit exception.

Schedule III-V drugs

If the prescriber is unavailable, the DAPO Center will grant a 96-hour supply exception to exceed the opioid monthly prescription fill limit for a Schedule III-V drug if the following conditions are met:

- Member is enrolled in the Standard Plan, Medicaid, or SeniorCare.
- The pharmacy attempted to contact the prescriber (or the prescriber's agent) but the prescriber is unavailable (e.g., clinic is closed).
- The pharmacy must document on the prescription order that the prescriber is not available.
- The pharmacist confirmed that dispensing a 96-hour supply is medically necessary.
- A 96-hour supply exception was not previously granted within the current calendar month.

If the prescriber is unavailable and the DAPO Center is closed, then pharmacy providers may dispense a 96 hour supply if the following conditions are met:

- Member is enrolled in the Standard Plan, Medicaid, or SeniorCare.
- The pharmacy attempted to contact the prescriber (or the prescriber's agent), but the prescriber is unavailable (e.g., clinic is closed).
- The pharmacy must document on the prescription order that the prescriber is not available.
- The pharmacist confirmed that dispensing a 96-hour supply is medically necessary.
- A 96-hour supply exception was not previously granted within the current calendar month.

Only one 96-hour supply exception for opioid drugs is allowed per calendar month. Once the DAPO Center is open, the pharmacy

must call to obtain the 96-hour supply exception.

The 96-hour supply exception may be retroactive up to five days (i.e., back dated).

If a 96-hour supply exception has already been provided in the same calendar month, the prescription is a noncovered service.

Schedule II Drugs

If the prescriber is unavailable, the DAPO Center may grant an exception for a Schedule II drug if the following conditions are met:

- Member is enrolled in the Standard Plan, Medicaid, or SeniorCare.
- The pharmacy attempted to contacted the prescriber (or the physician's agent), but the prescriber is unavailable (e.g., clinic is closed).
- The pharmacy must document on the prescription order that the prescriber is not available.
- The pharmacist confirmed that it is medically necessary to dispense the drug.
- An exception for Schedule II drugs was not previously granted within the current calendar month.
- The pharmacist may dispense the full quantity indicated on the prescription order.

If the prescriber is unavailable and the DAPO Center is closed, the pharmacy may dispense an exception for a Schedule II drug if the following conditions are met:

- Member is enrolled in the Standard Plan, Medicaid, or SeniorCare.
- The pharmacy attempted to contact the prescriber (or the physician's agent), but the prescriber is unavailable (e.g., clinic is closed).
- The pharmacy documented on the prescription order that the prescriber is not available.
- The pharmacist confirmed that it is medically necessary to dispense the drug.
- The pharmacist may dispense the full quantity indicated on the prescription order.

Pharmacy providers are required to submit a Noncompound Drug Claim form, with a Pharmacy Special Handling Request form, indicating the following:

- The drug dispensed was a Schedule II drug and the opioid monthly prescription fill limit was exceeded.
- The pharmacy attempted to contact the prescriber (or the physician's agent), but the prescriber is unavailable (e.g., clinic is closed).
- The pharmacist is required to provide justification why it was medically necessary to dispense the Schedule II opioid before discussing with the prescriber an exception to the opioid monthly prescription fill limit.

Only one exception for Schedule II opioid is allowed per calendar month.

If a Schedule II opioid exception has already been provided in the same calendar month, the prescription is a noncovered service.

Over-the-Counter Drugs

BadgerCare Plus and Wisconsin Medicaid

As required by the OBRA '90, the BadgerCare Plus Standard Plan, the BadgerCare Plus Benchmark Plan, the BadgerCare Plus Core Plan, the BadgerCare Plus Basic Plan, and Wisconsin Medicaid cover the generic products of specific categories of OTC drugs from manufacturers who have signed rebate agreements with CMS.

A written prescription from a prescriber is required in order for OTC drugs to be covered.

The estimated acquisition cost for OTC drugs is determined by applying a discount to the AWP as listed by First DataBank Inc.,

except for MAC list drugs.

As per DHS 107.10(3)(h)., Wis. Stats., certain classes of OTC drugs are covered.

BadgerCare Plus Benchmark Plan, Core Plan, Basic Plan, and SeniorCare

The BadgerCare Plus Benchmark Plan, the BadgerCare Plus Core Plan for Childless Adults, and the BadgerCare Plus Basic Plan cover a limited number of OTC drugs. The BadgerCare Plus Benchmark National Drug Code List and the BadgerCare Plus Core Plan National Drug Code List include covered OTC drugs.

As a reminder, with the exception of OTC insulin, SeniorCare does not cover OTC drugs.

HealthCheck "Other Services"

Additional OTCs may be covered for children 20 years of age or younger through HealthCheck "Other Services." If the OTC is covered through HealthCheck "Other Services," pharmacists must ensure there is verification the child received a comprehensive HealthCheck exam within the last 365 days. The member must have verification of the HealthCheck exam. This may be a completed HealthCheck card, verification of the date of the HealthCheck exam written on the prescription, or any document with the date of the HealthCheck exam and the provider's signature.

Covered Over-the-Counter Drugs

If the NDC for the medication dispensed is *not* covered and the medication is for a child who has had a HealthCheck exam, providers should refer to the following information.

Certain OTC drugs are covered without PA for children who have had a HealthCheck exam. Covered OTCs include the following:

- Antidiarrheals.
- Antifungals.
- Antiflatuents.
- Antiparasitics.
- Electrolyte Replacement.
- Ferrous sulfate and ferrous gluconate.
- Lactase products.
- Laxatives.
- Multivitamins.
- Topical protectants.

Other OTC drugs may be covered with PA. In that case, the pharmacy provider should complete PA forms and the following steps:

- Include a copy of the HealthCheck verification.
- Include a completed section II of the PA/DGA or a copy of the prescription.
- Select the "HealthCheck Other Services" checkbox in Element 1 of the PA/RF.
- Fax the form to (608) 221-8616 or mail it to the following address:

  ForwardHealth
  Prior Authorization
  Ste 88
  6406 Bridge Rd
  Madison WI 53784-0088

- If PA is approved, do all of the following:
  - Dispense the medication.

  - Submit the claim through the POS system or by using the 1500 Health Insurance Claim Form using the procedure code assigned on the PA/RF.

Providers may request to add an NDC to the list of covered OTC drugs by completing the Drug Addition Review Request form.

Prescriber Requirements

BadgerCare Plus, Medicaid, and SeniorCare cover medically necessary legend drugs and certain OTC drugs. Only certain licensed health professionals may prescribe legend drugs and OTC drugs according to DHS 107.10(1), Wis. Admin. Code. The professional must be authorized by Wisconsin Statutes or Wisconsin Administrative Code to prescribe legend and/or OTC drugs.

Prescribers may only prescribe items that are within their scope of practice. The following categories of licensed health professionals may prescribe covered legend drugs and OTC drugs:

- Dentist.
- Doctor of Medicine.
- Doctor of Osteopathy.
- Advanced Practice Nurse Prescriber.
- Optometrist.
- Physician assistant.
- Podiatrist.

Program Requirements

For a covered service to meet program requirements, the service must be provided by a qualified Medicaid-certified provider to an enrolled member. In addition, the service must meet all applicable program requirements, including, but not limited to, medical necessity, PA, claims submission, prescription, and documentation requirements.

Provider-Administered Drugs

A provider-administered drug is either an oral, injectible, intravenous, or inhaled drug administered by a physician or a designee of the physician (e.g., nurse, nurse practitioner, physician assistant) or incidental to a physician service. This includes, but is not limited to, all "J" codes and drug-related "Q" codes.

Providers may refer to the maximum allowable fee schedules for the most current HCPCS and CPT procedure codes for provider-administered drugs and reimbursement rates.

For Dates of Service On and After January 1, 2009

For DOS on and after January 1, 2009, for members enrolled in BadgerCare Plus HMOs, Medicaid SSI HMOs, and most special managed care programs, BadgerCare Plus and Medicaid fee-for-service, not the member's MCO, reimburse providers for the following if the service is covered by BadgerCare Plus and Medicaid:

- All "J" codes.
- Drug-related "Q" codes.
- A limited number of related administration codes.

For members enrolled in BadgerCare Plus HMOs, Medicaid SSI HMOs, and most special managed care programs, claims for these services should be submitted to BadgerCare Plus and Medicaid fee-for-service.

All fee-for-service policies and procedures related to provider-administered drugs, including copayment, cost sharing, diagnosis

restriction, PA, and pricing policies, apply to claims submitted to fee-for-service for members enrolled in an MCO.

Provider-administered drugs and related services for members enrolled in the PACE and the Family Care Partnership are provided and reimbursed by the special managed care program.

Obtaining Provider-Administered Drugs

To ensure the content and integrity of the drugs administered to members, prescribers are required to obtain all drugs that will be administered in their offices. If a member is given a drug to be administered by the provider for which storage, handling, and care instructions apply and the instructions are followed incorrectly, the dose may be ineffective. Prescribers may obtain a provider-administered drug from the member's pharmacy provider if the drug is transported directly from the pharmacy to the prescriber's office. Prescribers may also obtain a drug to be administered in the prescriber's office from a drug wholesaler. Pharmacy providers should not dispense a drug to a member if the drug will be administered in the prescriber's office.

Quantity Limits

ForwardHealth has established quantity limits on certain drug classes. If medically appropriate for members enrolled in the BadgerCare Plus Standard Plan, the BadgerCare Plus Benchmark Plan, the BadgerCare Plus Core Plan, the BadgerCare Plus Basic Plan, Medicaid, and SeniorCare, providers may request a policy override.

Refills

According to DHS 107.10(3), Wis. Admin. Code, BadgerCare Plus and Wisconsin SeniorCare limit refills in the following ways:

- Schedule II drug prescriptions cannot be refilled.
- Schedule III, IV, and V prescriptions are limited to the original dispensing plus five refills, if authorized by the prescriber, or six months from the date on the prescription, whichever comes first.
- All non-schedule drug prescriptions are limited to the original dispensing plus 11 refills, if authorized by the prescriber, or 12 months from the date on the original prescription, whichever comes first.

Resetting Service Limitations

Service limitations used by a member enrolled in the BadgerCare Plus Benchmark Plan and the BadgerCare Plus Core Plan within their continuous 12-month enrollment year will reset in the following situations:

- A fee-for-service member is enrolled in an HMO.
- A member switches from one HMO to another HMO (only allowable within the first 90 days of Core Plan enrollment).
- A member is disenrolled from an HMO and moves to fee-for-service.

Note: When a member goes from fee-for-service into an HMO and subsequently moves back to fee-for-service, service limitations will not be reset for the services that were received under the initial fee-for-service enrollment period.

PA requests for services beyond the covered service limitations will be denied.

Resetting service limitations does not change a member's Benchmark Plan enrollment year or a member's Core Plan enrollment year.

Services That Do Not Meet Program Requirements

As stated in DHS 107.02(2), Wis. Admin. Code, BadgerCare Plus may deny or recoup payment for covered services that fail to meet program requirements.

Examples of covered services that do not meet program requirements include the following:

- Services for which records or other documentation were not prepared or maintained.
- Services for which the provider fails to meet any or all of the requirements of DHS 106.03, Wis.Admin. Code, including, but not limited to, the requirements regarding timely submission of claims.
- Services that fail to comply with requirements or state and federal statutes, rules, and regulations.
- Services that the DHS, the PRO review process, or BadgerCare Plus determines to be inappropriate, in excess of accepted standards of reasonableness or less costly alternative services, or of excessive frequency or duration.
- Services provided by a provider who fails or refuses to meet and maintain any of the certification requirements under DHS 105, Wis. Admin. Code.
- Services provided by a provider who fails or refuses to provide access to records.
- Services provided inconsistent with an intermediate sanction or sanctions imposed by the DHS.

Tamiflu® Suspension is Covered for Children Enrolled in the Benchmark Plan

Tamiflu® Suspension is covered for children enrolled in the BadgerCare Plus Benchmark Plan. There is currently a shortage of the Tamiflu® suspension. To be reimbursed for compounding Tamiflu® suspension for children, pharmacies are required to use the following billing procedures:

- Submit a 1500 Health Insurance Claim Form to be reimbursed.
- Bill HCPCS code J3490 (unclassified drugs) on the 1500 Health Insurance Claim Form.
- Indicate the NDCs and NDC descriptions in the appropriate place for the products being dispensed in the compound drug along with procedure code J3490.
- Indicate the quantities and units of issue of all components of the compound drug on the claim as described in the 1500 Health Insurance Claim Form completion instructions.
- Submit the claim with the provider's usual and customary charge, which will also include a compound drug dispensing fee.
- Fax the 1500 Health Insurance Claim Form to Provider Services at (608) 221-0885, Attn: Pharmacy Unit, Tamiflu®.

Pharmacies should not charge the Benchmark Plan member for Tamiflu® suspension. A copayment of up to $5.00 applies to all Benchmark Plan prescriptions.

Once the DHS determines that Tamiflu® Suspension is sufficiently available in the marketplace, these billing procedures will be terminated and pharmacies should return to billing for the Tamiflu® Suspension using the NDC.

For all other benefit plans, providers should continue to submit claims using the NDCs for Tamiflu® Gelcaps and Tamiflu® Suspension where available. Pharmacies should continue to compound Tamiflu® Suspension when necessary.

Tobacco Cessation Drugs

The BadgerCare Plus Standard Plan and Medicaid cover generic legend drugs for tobacco cessation.

The Benchmark Plan and Core Plan cover generic legend drugs for tobacco cessation.

Nicotine gum or patches available over the counter are covered by the Standard Plan, the Benchmark Plan, the Core Plan, and Medicaid.

A written prescription from a prescriber is required for generic legend and OTC tobacco cessation products. Prescribers are required

to indicate the appropriate diagnosis on the prescription. PA is required for uses outside the approved diagnosis.

Diabetic Supplies

Diagnosis Restrictions

The following diabetic supplies are diagnosis-restricted:

- Blood glucose calibrator solutions and chips.
- Blood glucose meters.
- Blood glucose test strips.
- Insulin syringes.
- Lancets.
- Lancet devices.

An allowable diagnosis code for diabetic supplies must be indicated on claims and PA requests.

Preferred Products

Certain diabetic supplies have preferred products and non-preferred products. Non-preferred products require PA for members enrolled in Medicaid and the BadgerCare Plus Standard Plan. The following preferred and non-preferred diabetic supplies also have quantity limits and diagnosis restrictions:

- Blood glucose meters.
- Blood glucose test strips.

Non-preferred products are not covered for members enrolled in the BadgerCare Plus Benchmark Plan, the BadgerCare Plus Core Plan, and the BadgerCare Plus Basic Plan.

Not all blood glucose meters and blood glucose test strips provided by a preferred manufacturer are preferred products. For a complete list of preferred and non-preferred diabetic supplies, providers may refer to the Diabetic Supply List — Quick Reference.

If a member is currently using non-preferred diabetic supplies, providers should switch members to a preferred product if medically appropriate. If it is medically necessary for the member to remain on a non-preferred diabetic supply, providers must submit a PA request.

The following diabetic supplies are reimbursable by NDC:

- Blood glucose calibrator solutions and chips.
- Blood glucose meters.
- Blood glucose test strips.
- Insulin syringes.
- Lancets.
- Lancet devices.
- Pen needles.

Quantity Limits

Certain diabetic supplies have quantity limits.

Providers may dispense up to the allowed quantity to members, but may not exceed the quantity limit without requesting a quantity limit override. To request an override of quantity limits for diabetic supplies, providers may contact the DAPO Center.

For type I diabetics, the following are examples of when providers may request a quantity limit policy override for diabetic supplies:

- If the member is an uncontrolled type 1 diabetic with episodes of hypoglycemia and is being treated by an endocrinologist or has been referred to the primary care provider by an endocrinologist.
- If the member is using an insulin pump.
- If the member is using a continuous glucose monitoring system.

For type II diabetics, providers may request a quantity limit policy override for diabetic supplies, for example, when the member is using sliding scale insulin and the override is medically warranted. Requests for quantity limit policy overrides for type II diabetics will not be granted unless there is sufficient medical evidence to warrant the override.

Providers may request a quantity limit policy override for members, regardless of their benefit plan. If a quantity limit exception is not approved, the service is considered noncovered, and there are no appeal rights due to service limitation policy.

HealthCheck "Other Services"

Definition of HealthCheck "Other Services"

HealthCheck is a federally mandated program known nationally as EPSDT. HealthCheck services consist of a comprehensive health screening of members under 21 years of age. On occasion, a HealthCheck screening may identify the need for health care services that are not otherwise covered by or that exceed coverage limitations. These services are called HealthCheck "Other Services." Federal law requires that these services be reimbursed through HealthCheck "Other Services" if they are medically necessary and prior authorized. The purpose of HealthCheck "Other Services" is to assure that medically necessary medical services are available to BadgerCare Plus Standard Plan, BadgerCare Plus Benchmark Plan, and Medicaid members under 21 years of age.

Prior Authorization

To receive PA for HealthCheck "Other Services," providers are required to submit a PA request via the ForwardHealth Portal or to submit the following via fax or mail:

- A completed PA/RF (or PA/DRF, or PA/HIAS1).
  - The provider should mark the checkbox titled "HealthCheck Other Services" at the top of the form.
  - The provider may omit the procedure code if he or she is uncertain what it is. The ForwardHealth consultant will assign one for approved services.
- The appropriate service-specific PA attachment.
- Verification that a comprehensive HealthCheck screening has been provided within 365 days prior to ForwardHealth's receipt of the PA request. The date and provider of the screening must be indicated.
- Necessary supporting documentation.

Providers may call Provider Services for more information about HealthCheck "Other Services" and to determine the appropriate PA attachment.

Pharmacy providers should submit a completed PA/DGA to ForwardHealth to request PA for HealthCheck "Other Services."

Requirements

For a service to be reimbursed through HealthCheck "Other Services," the following requirements must be met:

- The condition being treated is identified in a HealthCheck screening that occurred within 365 days of the PA request for the service.
- The service is provided to a member who is under 21 years of age.
- The service may be covered under federal Medicaid law.
- The service is medically necessary and reasonable.
- The service is prior authorized before it is provided.
- Services currently covered are not considered acceptable to treat the identified condition.

BadgerCare Plus has the authority to do all of the following:

- Review the medical necessity of all requests.
- Establish criteria for the provision of such services.
- Determine the amount, duration, and scope of services as long as limitations are reasonable and maintain the preventive intent of the HealthCheck program.

Covered Over-the-Counter Drugs

All requests for HealthCheck "Other Services" require PA, except for the drugs listed below.

The following OTC drugs are covered under HealthCheck "Other Services." These drugs are covered when the member is under 21 years of age and a comprehensive HealthCheck screening has occurred within the last 365 days. These OTCs do not require PA.

HealthCheck "Other Services" Covered OTC Drugs
Antidiarrheals
Iron supplements
Lactase products
Laxatives
Multivitamins
Topical protectants

Noncovered Services

"Not for Retail Sale" Products

ForwardHealth does not reimburse for diabetic supplies considered "not for retail sale" by the manufacturer. "Not for retail sale" products are considered noncovered.

Basic Plan Noncovered Services

The following are among the services that are not covered under the BadgerCare Plus Basic Plan:

- Case management.
- Certain visits over the 10-visit limit.
- Community Recovery Services.
- Enteral nutrition.
- HealthCheck.
- Health education services.
- Hearing services, including hearing instruments, cochlear implants, and bone-anchored hearing aids, hearing aid batteries, and repairs.
- Home care services (home health, personal care, PDN).
- Inpatient mental health and substance abuse treatment services.
- Non-emergency transportation (i.e., common carrier, SMV).
- Nursing home.
- Obstetrical care and delivery.
- Outpatient mental health and substance abuse services.
- PNCC.
- Provider-administered drugs.
- Routine vision examinations billed with CPT codes 92002-92014 (without a qualifying diagnosis), determination of refractive state billed with CPT code 92015; vision materials such as glasses, contact lenses, and ocular prosthetics; repairs to vision materials; and services related to the fitting of contact lenses and spectacles.
- SBS.
- Transplants and transplant-related services.

Billing Members for Noncovered Services

Basic Plan members may request noncovered services from providers. In those cases, providers may collect payment for the noncovered service from the member if the member accepts responsibility for payment and makes payment arrangements with the provider. Providers are strongly encouraged to obtain a written statement in advance documenting that the member has accepted responsibility for payment of the service.

Providers may bill members up to their usual and customary charge for noncovered services. Basic Plan members do not have appeal rights for noncovered services.

Definition of Noncovered Services

A noncovered service is a service, item, or supply for which reimbursement is not available. DHS 101.03(103) and 107, Wis. Admin. Code, contain more information about noncovered services. In addition, DHS 107.03, Wis. Admin. Code, contains a general list of noncovered services.

Drugs for Basic Plan Members

The following are noncovered services by the BadgerCare Plus Basic Plan:

- Compound drugs.
- Oral antiretrovirals.
- Oral contraceptives.
- Drugs for use outside the allowable diagnosis.
- Drugs not listed on the closed formulary.

The policy allowing a 14-day emergency medication dispensing is not applicable for members enrolled in the Basic Plan.

Members do not have appeal rights for noncovered services.

Drugs for Benchmark and Core Plan Members

Compound drugs are *not* covered under the BadgerCare Plus Benchmark Plan or the BadgerCare Plus Core Plan.

PA is not available for drugs that are not included on the BadgerCare Plus Benchmark and Core Plan Covered National Drug Code List. PA requests submitted for noncovered drugs will be returned to the provider. Members do not have appeal rights regarding returned PA requests for noncovered drugs.

Options for Obtaining Necessary Drugs for Benchmark Plan and Core Plan Members

Members who become enrolled in the Benchmark Plan or the Core Plan may need drugs that are not covered by those plans. In some cases, the cost of noncovered drugs may be too high for members to afford. If possible, prescribers should consider switching the member to a generic drug that is covered under the Benchmark Plan or the Core Plan.

Pharmacies may receive a PC dispensing fee for working with prescribers to find generic equivalents for Benchmark Plan and Core Plan members.

There are several other options available for members whose drug coverage changed because they became enrolled in the Benchmark Plan or the Core Plan. Providers can help members in the following ways:

- Urge members to verify enrollment and eligibility for assistance programs using the following methods:
  - Verify enrollment with the local county or tribal agency.
  - Use ACCESS, an online tool that helps members determine possible enrollment for other state assistance programs.
- Offer members information about prescriptions and drug costs.
  - Check if a prescribed drug is included in the BadgerRx Gold formulary and explain the greater financial responsibility to the member.
  - Dispense a smaller quantity of a drug if a member needs it immediately but cannot afford a full prescription.
- Refer members to Member Services with questions and concerns about drug coverage.

Member Payment for Noncovered Services

A provider may collect payment from a member for noncovered services if certain conditions are met.

Providers may not collect payment from a member, or authorized person acting on behalf of the member, for certain noncovered services or activities provided in connection with covered services, including the following:

- Charges for missed appointments.
- Charges for telephone calls.
- Charges for time involved in completing necessary forms, claims, or reports.
- Translation services.

Missed Appointments

The federal CMS does not allow state Medicaid programs to permit providers to collect payment from a member, or authorized person acting on behalf of the member, for a missed appointment.

Avoiding Missed Appointments

ForwardHealth offers the following suggestions to help avoid missed appointments:

- Remind members of upcoming appointments (by telephone or postcard) prior to scheduled appointments.
- Encourage the member to call his or her local county or tribal agency if transportation is needed.
- If the appointment is made through the HealthCheck screening or targeted case management programs, encourage the staff from those programs to ensure that the scheduled appointments are kept.

Translation Services

Translation services are considered part of the provider's overhead cost and are not separately reimbursable. Providers may not collect payment from a member, or authorized person acting on behalf of the member, for translation services.

Providers should call the Affirmative Action and Civil Rights Compliance Officer at (608) 266-9372 for information about when translation services are required by federal law. Providers may also write to the following address:

AA/CRC Office
1 W Wilson St Rm 561
PO Box 7850
Madison WI 53707-7850

Non-preferred Diabetic Supplies

Non-preferred diabetic supplies are not covered for members enrolled in the BadgerCare Plus Benchmark Plan or BadgerCare Plus Core Plan. PA requests submitted for non-preferred diabetic supplies for members enrolled in the Benchmark Plan or Core Plan will be returned to the providers unprocessed. Members do not have appeal rights for noncovered diabetic supplies.

Noncovered Services for Core Plan Members

The following drugs are not covered by the BadgerCare Plus Core Plan:

- Compound drugs.
- Oral contraceptives.
- Oral antiretroviral drugs.

Core Plan members do not have appeal rights for noncovered services.

Nursing Facility Members

Excluded Pharmaceutical Care Codes

Certain PC codes on the PC Worksheet for Payable Codes and the PC Reason Codes and Billing Information are excluded for members in nursing facilities.

Nursing Facility Daily Rate Covered Items

The following is a partial list of items that are covered in the nursing facility daily rate under Section 5.100 of the Nursing Home Methods of Implementation. BadgerCare Plus and SeniorCare retain authority under s. 49.45(10), Wis. Stats., to amend, modify, or delete items on the list.

Over-the-Counter Drugs

- Acetaminophen.
- Antidiarrheals.
- Aspirin.
- Decubitus treatments.
- Digestive aids.
- Hemorrhoidal products.
- Ibuprofen.
- Laxatives.
- Minerals.
- Noncovered antihistamines.
- Noncovered cough and cold products.
- Noncovered ophthalmic products.
- Noncovered vaginal products.
- Quinine.
- Saliva substitutes.
- Vitamins.

Dietary Supplies

- Artificial sweeteners.
- Diet supplements (e.g., Metrecal, Ensure, Vivonex, and related/similar products).
- Salt substitutes (e.g., Neocurtasal, etc.)
- Sugar substitutes.

Incontinence Supplies

- Catheters (Foley and Condom), catheter sets, component parts (e.g., tubing, urine collection apparatus, bags, bed bags, etc.)
- Diapers — disposable and reusable (including purchased diaper services).
- Underpads — disposable and reusable.

Personal Comfort Items and Medical Supplies

- Alcohols (e.g., rubbing, antiseptic, swabs).

- Analgesic rubs (e.g., Ben-Gay, Infrarub, Vicks, Vapo-rub, etc.)
- Antiseptics (e.g., Betadine, iodine, mercurochrome, merthiolate, and similar products).
- Baby, comfort, and foot powders.
- Body lotions, skin lubricants, moisturizers, and protectants, including:
  - Olive oil.
  - Nivea oil/cream/lotion.
  - Lubath.
  - Alpha-Keri.
  - Keri Lot sween cream.
  - Aluminum paste.
  - Zinc Oxide ointment/paste.
- Cotton-tipped applicators and cotton balls.
- Denture products (e.g., adhesives, cleaning products).
- Deodorants and antiperspirants.
- Disposable tissues (e.g., Kleenex).
- Dressings (e.g., adhesive pads, abdominal pads, gauze pads and rolls, eye pads, sanitary pads, stockinette, Op-site, and related products).
- Enema administration apparatus.
- Gloves (latex or vinyl).
- Hydrogen peroxide.
- Lemon or glycerin swabs.
- Lubricating jellies (e.g., Vaseline, K-Y jelly).
- Oral hygiene products (e.g., dental floss, toothpaste, toothbrush, Waterpik).
- Phosphate enemas.
- Plastic or adhesive bandages (e.g., Band-aids).
- Shampoos (except specialized shampoos that are legend products, e.g., Selsun).
- Soaps (antiseptic and non-antiseptic).
- Straws (paper, plastic, etc.)
- Syringes and needles (disposable or reusable).
- Tapes (all types).
- Tincture of benzoin.
- Tongue depressors. Tracheotomy care sets and suction catheters.
- Tube feeding sets and component parts.

Durable Medical Equipment

Most DME items are covered in the nursing facility daily rate. Max fee schedules identify items that can be separately billed for nursing facility members.

Personal Needs Account

The following is a list of items that may be paid from a member's personal needs account, if the member has been informed that the item is not covered by BadgerCare Plus or SeniorCare. BadgerCare Plus and SeniorCare retain authority under s. 49.45(10), Wis. Stats., to amend, modify, or delete items from the list:

- Less-than-effective drugs such as Peritrate, Naldecon, Midrin, Tigan Capsule/Suppository, Vioform-HC.
- Wisconsin Negative Formulary drugs (e.g., Gaviscon, Rogaine [Minoxidil topical]). Also, legend vitamin products that are not covered, such as Eldec, Vicon Forte, Poly-Vi-Flor, Tri-Vi-Flor, Cefol, and Larobec.
- Covered products for which PA *has been denied* for the member.
- Other items considered to be not medically necessary (e.g., Menthol-based lozenges [such as Hall's Mentho-Lyptus, Vicks Throat Lozenges, Throat Disks], Luden's Cough Drops, lemon drops, hard candy, beer, brandy, wine, and cigarettes).

Purchasing Items for Nursing Facility Members

There are three ways pharmacy items can be purchased for BadgerCare Plus members or SeniorCare participants who reside in a nursing facility. Pharmacies and nursing facilities are responsible for using one of the following the methods to submit claims for nursing facility members:

- BadgerCare Plus pharmacy claim — Claims for prescribed BadgerCare Plus-covered and SeniorCare-covered drugs and certain OTC products (except OTCs included in the nursing facility daily rate) must be submitted using an appropriate claims submission method.

  Note: SeniorCare covers OTC insulin.

- Nursing facility daily rate — Under Section 5.100 of the Nursing Home Methods of Implementation, personal care and other hygiene products, dietary supplies, and incontinence supplies are included in the nursing facility daily rate. Pharmacy providers should not submit claims for these items separately to ForwardHealth, to the nursing facility member, or to the member's family.
- Member's personal needs account — If a member has been informed that a particular pharmacy item is not covered, but the member chooses to purchase the item anyway, the member is liable for payment.

  This type of pharmacy item includes:

  - Noncovered legend drugs, including less-than-effective drugs, negative formulary drugs, and drugs for which the pharmacy has been denied PA for a specific member.
  - Sundry items such as cough drops, cigarettes, candy, and alcoholic beverages.

Services Provided to Nursing Facility Members

Identical unit dose drugs ordered for nursing facility members for two or more separate intervals during a billing period or for multiple, simultaneous dosing schedules must be totaled and billed as a single unit dose at the end of the billing period.

A billing period does not need to be from the first day of a calendar month to the last day of that month. For example, a billing period could be from June 15 through July 14, and the provider submits a claim on July 15. The date on the claim form, however, must be the last DOS (e.g., July 14).

Unused Medications

Phar 7.04, Wis. Admin. Code, specifies that a health care facility may return certain drugs or personal hygiene items to the dispensing pharmacy if the medication is in its original container and the pharmacist determines that the contents are unadulterated and uncontaminated. Under federal law, controlled substances can not be returned to the pharmacy.

Pharmacy providers that accept returned Medicaid-covered or SeniorCare-covered medications from nursing facilities must assure facility and pharmacy compliance with these regulations by taking the following steps:

- Verifying that the nursing facility maintains complete records of all discontinued medications, whether or not they are returned to the pharmacy.
- Verifying that the pharmacy's records of returned medications are properly maintained.
- Establishing criteria for pharmacy staff to determine what drugs are acceptable for reuse by the pharmacy.
- Identfying and destroying medications unacceptable for reuse.

Refund For Returned, Reusable Medications

A refund must be made on any item returned that is over $5 per prescription. Pharmacies may not accept returned medications from

nursing facilities unless they credit all reusable medications. BadgerCare Plus and SeniorCare allow a pharmacy to retain 20 percent of the net amount identified as the total cost of reusable units of each drug returned to cover the pharmacy's administrative costs. Dispensing fees are not considered part of the total cost and, therefore, the dispensing fees do not need to be returned.

For claims that were submitted real-time, providers may refund BadgerCare Plus or SeniorCare by reversing the original claim within 365 days of the submission. A new claim with the adjusted quantity should then be submitted. After 365 days, a paper adjustment is required to change the quantity on an allowed claim. Pharmacy providers should complete an Adjustment/Reconsideration Request to change the quantity on the allowed claim.

Pharmacy providers who choose not to reverse or adjust the original claim must refund BadgerCare Plus or SeniorCare by check. If this option is chosen, the pharmacy must remit a check to BadgerCare Plus or SeniorCare for funds representing these reusable drugs no more than once per month or no less than once every three months. Providers remitting a check for returned, reusable medications are required to maintain a record of the transaction.

Make checks payable to "Department of Health Services" and write "Returned Drugs" on the check. Include a provider number and the dates (MM/DD/YYYY) referenced by the check. Send checks to:

ForwardHealth
Cash Unit
6406 Bridge Rd
Madison WI 53784-0004

Reversing Claims

Providers may reverse (or void) claims on the ForwardHealth Portal to return overpayments. This way of returning overpayments may be a more efficient and timely way for providers as a reversed claim is a complete recoupment of that claim payment. Once a claim has been reversed, the claim can no longer be adjusted; however, the services provided and indicated on the reversed claim may be resubmitted on a new claim.

If a provider returns an overpayment by mail, reversed claims will have ICNs beginning with "67." Overpayments that are adjusted on the Portal will have ICNs that begin with "59."

Destruction of Medications by Nursing Facilities

Unless otherwise ordered by a physician, the nursing facility is required to destroy a member's medication not returned to the pharmacy for credit within 72 hours of the following circumstances:

- A physician's order discontinuing the medication's use.
- The member's discharge from the nursing facility.
- The member's death.
- The medication's expiration date.

A nursing facility may not retain a member's medication for more than 30 days unless the prescriber orders in writing, every 30 days, that the facility must retain the medication. DHS 132.65(6)(c), Wis. Admin. Code, defines the procedural and record keeping requirements that nursing facilities must follow for members' unused medications.

Pharmaceutical Care

A Comprehensive Overview

Under the 1995 Wisconsin Act 27, the state biennial budget, Wisconsin Medicaid was required to develop an incentive-based pharmacy payment system that reimburses providers for PC services.

PC is a nationwide movement promoting a patient-centered, outcomes-oriented practice of pharmacy. Its purpose is to maximize the effectiveness of medications for the patient through intervention by the pharmacist.

BadgerCare Plus and SeniorCare's PC program provides pharmacists with an enhanced dispensing fee for PC services provided to BadgerCare Plus and SeniorCare members. This enhanced fee reimburses pharmacists for additional actions they take beyond the standard dispensing and counseling for a prescription drug.

Claim Submissions

PC service claims can be submitted through the real-time pharmacy POS system or on a paper Noncompound Drug Claim form indicating PC codes in the three fields shared with DUR and the LOE field.

Reimbursement

There are limitations on PC billing and reimbursement. Responding to DUR alerts is not automatically considered a PC service. Not all PC services for which a provider receives a DUR alert are reimbursable under the PC benefit.

For SeniorCare members, pharmacies are reimbursed directly for PC at the Medicaid rate when the member is in, or has reached, the copayment level of participation. When the member has a spenddown or deductible, the pharmacy must obtain member consent for PC services prior to providing them.

Documentation Requirements

The following documentation is required for PC claims and must be maintained in the member's file:

- Date of intervention.
- Professional time (in minutes) spent on intervention. Exclude documentation time.
- Time (in minutes) spent on documentation.
- The drug name.
- A summary of and a basis for the recommendation(s).
- The outcome, including a summary of any communication with the prescriber or member.
- If the intervention was for safety, efficacy, compliance, or cost savings-only purposes.
- The ICD-9-CM diagnosis code for diagnosis, disease, or intended use of the medication involved in the submitted intervention.
- The pharmacist's identity.
- PC Documentation Form.

Providers may use any format to document PC, but that format must include all of the elements in the model form provided in BadgerCare Plus and SeniorCare PC dispensing fee documentation.

Pharmacy providers are required to document the following in the member's file or on the prescription when a PC dispensing fee is submitted to ForwardHealth:

- The date the prescriber was contacted.
- The change to the prescription.
- The name of the pharmacy provider who made the contact.
- The name of the person in the prescriber's office who authorized the change to the prescription.

Documentation Requirements for Therapeutic Interchange

Providers are required to document the following in the member's file or on the prescription when a PC dispensing fee for therapeutic interchange is submitted to ForwardHealth:

- The date the prescriber was contacted.
- The change to the prescription.
- The name of the person who contacted the prescriber.
- The name of the person in the prescriber's office who authorized the change to the prescription.

Documentation for therapeutic interchange must be provided if requested by ForwardHealth. Failure to provide the previous documentation may result in recoupment of the PC dispensing fee.

Pharmaceutical Care Dispensing Fee

Reimbursement for the PC dispensing fee requires the pharmacist to meet all basic requirements of federal and state law for dispensing a drug, plus completing specified activities that result in a positive outcome for members and BadgerCare Plus or SeniorCare. Positive outcomes include increasing patient compliance or preventing potential adverse drug reactions.

Reimbursement is based on the following:

- The reason for intervention.
- The professional service provided by the pharmacist.
- The result of that action.
- The time spent performing the activity (i.e., the level of effort).

The BadgerCare Plus PC Worksheet for Payable Codes, the BadgerCare Plus PC Reason Codes with Billing Information, and the MAC List for PC codes provide information about allowed combinations of reason, professional service, and result codes.

Billing limitations for PC codes include the following:

- BadgerCare Plus and SeniorCare will only reimburse for one PC dispensing fee per member, per provider, per day. (In most cases, payments using PC dispensing fees are limited to one, two, or four fees per year, per member, per pharmacy.)
- Some PC codes have a maximum billing frequency allowed. (The BadgerCare Plus PC Reason Codes with Billing Information contains a complete list of these limits.)
- Allowable PC codes have maximum allowable reimbursement levels.
- PC claims cannot be submitted for compound drugs.
- Certain codes cannot be submitted for nursing facility members.

Claim Submission

Information is available for DOS on and after November 1, 2010.

Providers are required to submit PC claims for their usual and customary charge for PC dispensing fee services. Providers should retain documentation of their usual and customary charges. Claims for PC services may be submitted using the real-time pharmacy POS system or on a Noncompound Drug Claim form using PC codes shared with DUR and LOE. Claims for PC cannot be submitted for compound drugs. The pharmacy provider should determine the total claims submission amount by adding together the

usual and customary charge for the drug and the usual and customary charge for PC.

PC claim submission requires a valid ICD-9-CM diagnosis code. If the diagnosis code field is left blank, the PC for the claim will be denied. The traditional dispensing fee is substituted when the PC code is denied.

Include the usual and customary charge for the PC in the "Billed Amount" field along with the usual and customary charge for the drug.

To submit claims for PC:

- Enter the appropriate reason for service code in the DUR conflict field.
- Enter the appropriate professional service code in the DUR intervention field.
- Enter the appropriate result of service code in the DUR outcome field.
- Enter the appropriate LOE in the LOE field.

If a drug is not dispensed, but a PC service is provided for a BadgerCare Plus-covered or SeniorCare-covered and payable drug, then the PC may be reimbursed. Submit the claim for the PC in the following way:

- Use the NDC of the drug that was not dispensed.
- Indicate the quantity as zero.
- PC fee as the charge.
- Indicate the appropriate PC information.
- Indicate "0" (traditional packaging) or "2" (unit dose packaging) in the unit dose field. These are the only acceptable values when a drug has not been dispensed.
- Indicate the number in the days' supply field that reflects the amount that would have been dispensed.

A BadgerCare Plus-payable or SeniorCare-payable drug is reimbursed for even if the PC code is submitted incorrectly.

Pharmaceutical Care Profile

A PC profile must be created and maintained for a BadgerCare Plus or SeniorCare member prior to submitting a PC claim. It must include the intended use or diagnosis information for each drug the member is actively using. The source of information and level of confidence must also be documented. To facilitate a more thorough understanding of the member's medical condition(s), inclusion of the ICD-9-CM codes for each diagnosis or intended use is recommended.

The member PC profile establishes a basis for all PC activities provided. As part of the PC profile, the pharmacist must certify that sufficient clinical information has been collected and documented about the member so clinically relevant PC interventions are possible. This includes his or her disease state(s), diagnosis(es), or intended use(s) for each OTC and legend drug(s) the member is actively using.

A PC profile must contain all information required under Pharmacy Examining Board and Medicaid rules. In addition, a face-to-face member interview and medication work-up must be completed by a pharmacist. Providers must know and document the basis for the member's complete medication therapy regimen. Each provider must adopt and use a clinically oriented standard interview and work-up form and process.

Clinical information may be obtained from the member, agent of the member, prescriber, or any combination of the three. For members in a health care facility, information may be obtained from member records and prescriber orders via facility staff. The pharmacist should document the source (physician, member, inferred, etc.) and reliability (high, somewhat, questionable, etc.) of the information for future users. The pharmacist is required to determine the intended use or target disease state for each drug listed on the profile.

The pharmacist must determine that sufficient clinical information has been gathered and documented. Lack of sufficient clinical information about the member and his or her medical condition precludes reimbursing PC dispensing fees.

Documentation

The following documentation must be retrievable and must be provided if requested by BadgerCare Plus and SeniorCare. Failure to provide this documentation may result in recoupment of the PC dispensing fee:

- A member profile which meets the Pharmacy Examining Board, prospective DUR, and BadgerCare Plus and SeniorCare requirements.
- Results from the member interview and medication work-up.
- Member-specific diagnoses, disease state, or intended use for each drug.
- Date PC profile was created (may be different from date on first PC claim).
- Identification of the pharmacist doing the medication history and profile preparation.
- Source and reliability of clinical information collected for the profile.
- Recommendations, plans, PC needs of the member, etc., if any.
- Information about each PC intervention attempted and completed.

Additional Discussion

Each PC profile must contain sufficient clinical information about the member to make relevant clinical decisions and recommendations. All PC profile information must be immediately available to the pharmacist and must be reviewed and updated each time a prescription is filled for the member.

Professional Service Time

Professional PC service time includes the following:

- Time spent resolving a specific drug therapy problem.
- Time spent communicating with the prescriber about a specific member condition and its definition or resolution.
- Time spent communicating with the member, or agent of the member, about a specific therapeutic problem including its definition or resolution.
- Time spent resolving problems identified during drug regimen reviews for nursing home residents when performed at a level greater than drug regimen review requirements and not compensated for under drug regimen review payments from the facility.

The following situations are not included in the service time:

- Time spent researching a drug therapy problem, including reviewing medical literature or peer-reviewed literature.
- Time spent consulting with another professional (e.g., another pharmacist, medical professional, or poison center) regarding a therapy problem.
- Time spent in continuing education classes.
- Time spent reviewing PC profiles for drug therapy problems.
- Time spent performing drug regimen reviews and documenting irregularities for nursing home residents.

Reason Codes

Providers are required to indicate a reason code on claims for PC.

Managed Care

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Managed Care:Claims

Appeals to BadgerCare Plus and Wisconsin Medicaid

The provider has 60 calendar days to file an appeal with BadgerCare Plus or Wisconsin Medicaid after the HMO or SSI HMO either does not respond in writing within 45 calendar days or if the provider is dissatisfied with the HMO's or SSI HMO's response.

BadgerCare Plus or Wisconsin Medicaid will not review appeals that were not first made to the HMO or SSI HMO. If a provider sends an appeal directly to BadgerCare Plus or Wisconsin Medicaid without first filing it with the HMO or SSI HMO, the appeal will be returned to the provider.

Appeals will only be reviewed for enrollees who were eligible for and who were enrolled in a BadgerCare Plus HMO or Medicaid SSI HMO on the date of service in question.

Appeals must be made in writing and must include:

- A letter, clearly marked "APPEAL," explaining why the claim should be paid or a completed Managed Care Program Provider Appeal form.
- A copy of the claim, clearly marked "APPEAL."
- A copy of the provider's letter to the HMO or SSI HMO.
- A copy of the HMO's or SSI HMO's response to the provider.
- Any documentation that supports the case.

The appeal will be reviewed and any additional information needed will be requested from the provider or the HMO or SSI HMO. Once all pertinent information is received, BadgerCare Plus or Wisconsin Medicaid has 45 calendar days to make a final decision.

The provider and the HMO or SSI HMO will be notified in writing of the final decision. If the decision is in favor of the provider, the HMO or SSI HMO is required to pay the provider within 45 calendar days of the final decision. The decision is final, and all parties must abide by the decision.

Appeals to HMOs and SSI HMOs

Providers are required to first file an appeal directly with the BadgerCare Plus HMO or Medicaid SSI HMO within 60 calendar days of receipt of the initial denial. Providers are required to include a letter explaining why the HMO or SSI HMO should pay the claim. The appeal should be sent to the address indicated on the HMO's or SSI HMO's denial notice.

The HMO or SSI HMO then has 45 calendar days to respond in writing to the appeal. The HMO or SSI HMO decides whether to pay the claim and sends the provider a letter stating the decision.

If the HMO or SSI HMO does not respond in writing within 45 calendar days, or if the provider is dissatisfied with the HMO's or SSI HMO's response, the provider may send a written appeal to ForwardHealth within 60 calendar days.

Claims Submission

BadgerCare Plus HMOs and Medicaid SSI HMOs have requirements for timely filing of claims, and providers are required to follow HMO and SSI HMO claims submission guidelines. Contact the enrollee's HMO or SSI HMO for organization-specific submission deadlines.

Extraordinary Claims

Extraordinary claims are BadgerCare Plus or Medicaid claims for a BadgerCare Plus HMO or Medicaid SSI HMO enrollee that have been denied by an HMO or SSI HMO but may be paid as fee-for-service claims.

The following are some examples of extraordinary claims situations:

- The enrollee was not enrolled in an HMO or SSI HMO at the time he or she was admitted to an inpatient hospital, but then enrolled in an HMO or SSI HMO during the hospital stay. In this case, all claims related to the stay (including physician claims) should be submitted to fee-for-service. For the physician claims associated with the inpatient hospital stay, the provider is required to include the date of admittance and date of discharge in Element 18 of the paper 1500 Health Insurance Claim Form.
- The claims are for orthodontia/prosthodontia services that began before HMO or SSI HMO coverage. Include a record with the claim of when the bands were placed.

Submitting Extraordinary Claims

When submitting an extraordinary claim, include the following:

- A legible copy of the completed claim form, in accordance with billing guidelines.
- A letter detailing the problem, any claim denials, and any steps taken to correct the situation.

Submit extraordinary claims to:

ForwardHealth
Managed Care Extraordinary Claims
PO Box 6470
Madison WI 53716-0470

Medicaid as Payer of Last Resort

Wisconsin Medicaid is the payer of last resort for most covered services, even when a member is enrolled in a BadgerCare Plus HMO or Medicaid SSI HMO. Before submitting claims to HMOs and SSI HMOs, providers are required to submit claims to other health insurance sources. Contact the enrollee's HMO or SSI HMO for more information about billing other health insurance sources.

Provider Appeals

When a BadgerCare Plus HMO or Medicaid SSI HMO denies a provider's claim, the HMO or SSI HMO is required to send the provider a notice informing him or her of the right to file an appeal.

An HMO or SSI HMO network or non-network provider may file an appeal to the HMO or SSI MCO when:

- A claim submitted to the HMO or SSI HMO is denied payment.
- The full amount of a submitted claim is not paid.

Providers are required to file an appeal with the HMO or SSI HMO *before* filing an appeal with ForwardHealth.

Covered and Noncovered Services

Covered Services

HMOs

HMOs are required to provide at least the same benefits as those provided under fee-for-service arrangements. Although BadgerCare Plus requires contracted HMOs and Medicaid SSI HMOs to provide all medically necessary covered services, the following services may be provided by BadgerCare Plus HMOs at their discretion:

- Dental.
- Chiropractic.

If the HMO does not include these services in their benefit package, the enrollee receives the services on a fee-for-service basis.

Noncovered Services

The following are not covered by BadgerCare Plus HMOs or Medicaid SSI HMOs but are provided to enrollees on a fee-for-service basis provided the member's fee-for-service plan covers the service:

- CRS.
- CSP benefits.
- Crisis intervention services.
- Environmental lead inspections.
- CCC services.
- Pharmacy services and some drug-related supplies.
- PNCC services.
- Provider-administered drugs, including all "J" codes, drug-related "Q" codes, and a limited number of related administration codes.
- SBS.
- Targeted case management services.
- Transportation by common carrier (unless the HMO has made arrangements to provide this service as a benefit). Milwaukee HMOs and SSI HMOs are mandated to provide transportation for their enrollees.
- Directly observed therapy and monitoring for TB-only.

Enrollment

Disenrollment and Exemptions

In some situations, a member may be exempt from enrolling in a BadgerCare Plus HMO or Medicaid SSI HMO. Exempted members receive health care under fee-for-service. Exemptions allow members to complete a course of treatment with a provider who is not contracted with the member's HMO or SSI HMO. For example, in certain circumstances, women in high-risk pregnancies or women who are in the third trimester of pregnancy when they are enrolled in an HMO or SSI HMO *may* qualify for an exemption.

The contracts between the DHS and the HMO or SSI HMO provide more detail on the exemption and disenrollment requirements.

Enrollee Grievances

Enrollees have the right to file grievances about services or benefits provided by a BadgerCare Plus HMO or Medicaid SSI HMO. Enrollees also have the right to file a grievance when the HMO or SSI HMO refuses to provide a service. All HMOs and SSI HMOs are required to have written policies and procedures in place to handle enrollee grievances. Enrollees should be encouraged to work with their HMO's or SSI HMO's customer service department to resolve problems first.

If enrollees are unable to resolve problems by talking to their HMO or SSI HMO, or if they would prefer to speak with someone outside their HMO or SSI HMO, they should contact the Enrollment Specialist or the Ombudsman Program.

The contracts between the DHS and the HMO or SSI HMO describes the responsibilities of the HMO or SSI HMO and the DHS regarding enrollee grievances.

Enrollment Eligibility

BadgerCare Plus HMOs

Members enrolled in the BadgerCare Plus Standard Plan and the BadgerCare Plus Benchmark Plan are eligible for enrollment in a BadgerCare Plus HMO. BadgerCare Plus Core Plan members are enrolled in BadgerCare Plus HMOs.

An individual who receives Family Planning Only Services, the TB-Only benefit, SeniorCare, or Wisconsin Well Woman Medicaid cannot be enrolled in a BadgerCare Plus HMO.

Information about a member's HMO enrollment status and commercial health insurance coverage may be verified by using Wisconsin's EVS or the ForwardHealth Portal.

SSI HMOs

Members of the following subprograms are eligible for enrollment in a Medicaid SSI HMO:

- Individuals ages 19 and older, who meet the SSI and SSI-related disability criteria.
- Dual eligibles for Medicare and Medicaid.

Individuals who are living in an institution, nursing home, or participating in a Home and Community-Based Waiver program are not eligible to enroll in an SSI MCO.

Enrollment Periods

HMOs

Members are sent enrollment packets that explain the BadgerCare Plus HMOs and the enrollment process and provide contact information. Once enrolled, enrollees may change their HMO assignment within the first 90 days of enrollment in an HMO (whether they chose the HMO or were auto-assigned). If an enrollee no longer meets the criteria, he or she will be disenrolled from the HMO.

SSI HMOs

Members are sent enrollment packets that explain the Medicaid SSI HMO's enrollment process and provide contract information. Once enrolled, enrollees may disenroll after a 60-day trial period and up to 120 days after enrollment and return to Medicaid fee-for-service if they choose.

Enrollment Specialist

The Enrollment Specialist provides objective enrollment, education, outreach, and advocacy services to BadgerCare Plus HMO and Medicaid SSI HMO enrollees. The Enrollment Specialist is a knowledgeable single point of contact for enrollees, solely dedicated to managed care issues. The Enrollment Specialist is not affiliated with any health care agency.

The Enrollment Specialist provides the following services to HMO and SSI HMO enrollees:

- Education regarding the correct use of HMO and SSI HMO benefits.
- Telephone and face-to-face support.
- Assistance with enrollment, disenrollment, and exemption procedures.

Member Enrollment

HMOs

BadgerCare Plus HMO enrollment is either mandatory or voluntary based on ZIP code-defined enrollment areas as follows:

- Mandatory enrollment — Enrollment is mandatory for eligible members who reside in ZIP code areas served by two or more BadgerCare Plus HMOs. Some members may meet criteria for exemption from BadgerCare Plus HMO enrollment.
- Voluntary enrollment — Enrollment is voluntary for members who reside in ZIP code areas served by only one BadgerCare Plus HMO.

Members living in areas where enrollment is mandatory are encouraged to choose their BadgerCare Plus HMO. Automatic assignment to a BadgerCare Plus HMO occurs if the member does not choose a BadgerCare Plus HMO. In general, all members of a member's immediate family eligible for enrollment must choose the same HMO.

Members in voluntary enrollment areas can choose whether or not to enroll in a BadgerCare Plus HMO. There is no automatic assignment for members who live within ZIP codes where enrollment is voluntary.

SSI HMOs

Medicaid SSI HMO enrollment is either mandatory or voluntary as follows:

- Mandatory enrollment — Most SSI and SSI-related members are required to enroll in an SSI HMO. A member may choose the SSI HMO in which he or she wishes to enroll.

- Voluntary enrollment — Some SSI and SSI-related members may choose to enroll in an SSI HMO on a voluntary basis.

Ombudsman Program

The Ombudsmen, or Ombuds, are resources for enrollees who have questions or concerns about their BadgerCare Plus HMO or Medicaid SSI HMO. Ombuds provide advocacy and assistance to help enrollees understand their rights and responsibilities in the grievance and appeal process.

BadgerCare Plus HMO/Medicaid SSI HMO Ombudsmen
PO Box 6470
Madison WI 53716-0470

Release of Billing or Medical Information

BadgerCare Plus supports BadgerCare Plus HMO and Medicaid SSI HMO enrollee rights regarding the confidentiality of health care records. BadgerCare Plus has specific standards regarding the release of an HMO or SSI HMO enrollee's billing information or medical claim records.

Managed Care Information

BadgerCare Plus HMO Program

An HMO is a system of health care providers that provides a comprehensive range of medical services to a group of enrollees. HMOs receive a fixed, prepaid amount per enrollee from BadgerCare Plus (called a capitation payment) to provide medically necessary services.

BadgerCare Plus HMOs are responsible for providing or arranging all contracted covered medically necessary services to enrollees. BadgerCare Plus members enrolled in state-contracted HMOs are entitled to at least the same benefits as fee-for-service members; however, HMOs may establish their own requirements regarding PA, claims submission, adjudication procedures, etc., which may differ from BadgerCare Plus fee-for-service policies and procedures. BadgerCare Plus HMO network providers should contact their HMO for more information about its policies and procedures.

Managed Care

Managed Care refers to the BadgerCare Plus HMO program, the Medicaid SSI HMO program, and the several special managed care programs available.

The primary goals of the managed care programs are:

- To improve the quality of member care by providing continuity of care and improved access.
- To reduce the cost of health care through better care management.

Managed Care Contracts

The contract between the DHS and the BadgerCare Plus HMO or Medicaid SSI HMO takes precedence over other ForwardHealth provider publications. Information contained in ForwardHealth publications is used by the DHS to resolve disputes regarding covered benefits that cannot be handled internally by HMOs and SSI HMOs. If there is a conflict, the HMO or SSI HMO contract prevails. If the contract does not specifically address a situation, Wisconsin Administrative Code ultimately prevails. HMO and SSI HMO contracts can be found on the Managed Care Organization area of the ForwardHealth Portal.

SSI HMO Program

Medicaid SSI HMOs provide the same benefits as Medicaid fee-for-service (e.g. medical, dental, mental health/substance abuse, vision, and prescription drug coverage) at no cost to their enrollees through a care management model. Medicaid members and SSI-related Medicaid members in certain counties may be eligible to enroll in an SSI HMO.

SSI-related Medicaid members receive coverage from Wisconsin Medicaid because of a disability determined by the Disability Determination Bureau.

Member Enrollment

Members who meet the following criteria are eligible to enroll in an SSI HMO:

- Medicaid-eligible individuals living in a service area that has implemented an SSI managed care program.
- Individuals ages 19 and older.

- Individuals who are enrolled in Wisconsin Medicaid and SSI or receive SSI-related Medicaid.

Individuals who are living in an institution or nursing home or are participating in a home and community-based waiver program or FamilyCare are not eligible to enroll in an SSI HMO.

Ozaukee and Washington Counties

Most SSI and SSI-related Medicaid members who reside in Ozaukee and Washington counties are required to choose the HMO in which they wish to enroll. Dual eligibles (members receiving Medicare and Wisconsin Medicaid) are not required to enroll. After a 60-day trial period and up to 120 days after enrollment, enrollees may disenroll and return to Medicaid fee-for-service if they choose.

Southwestern Wisconsin Counties

SSI members and SSI-related Medicaid members who reside in Buffalo, Jackson, La Crosse, Monroe, Trempealeau, and Vernon counties may choose to receive coverage from the HMO or remain in Wisconsin Medicaid fee-for-service.

Continuity of Care

Special provisions are included in the contract for SSI HMOs for continuity of care for SSI members and SSI-related Medicaid members. These provisions include the following:

- Coverage of services provided by the member's current provider for the first 60 days of enrollment in the SSI program or until the first of the month following completion of an assessment and care plan, whichever comes later. The contracted provider should get a referral from the member's HMO after this.
- Honoring a PA that is currently approved by Wisconsin Medicaid. The PA must be honored for 60 days or until the month following the HMO's completion of the assessment and care plan, whichever comes later.
- Coverage of drugs that an SSI member is currently taking until a prescriber orders different drugs.

Special Managed Care Programs

Wisconsin Medicaid has several special managed care programs that provide services to individuals who are elderly and/or who have disabilities. These members may be eligible to enroll in voluntary regional managed care programs such as Family Care, the PACE, and the Family Care Partnership Program. Additional information about these special managed care programs may be obtained from the Managed Care Organization area of the ForwardHealth Portal.

Prior Authorization

Prior Authorization Procedures

BadgerCare Plus HMOs and Medicaid SSI HMOs may develop PA guidelines that differ from fee-for-service guidelines. However, the application of such guidelines may not result in less coverage than fee-for-service. Contact the enrollee's HMO or SSI HMO for more information regarding PA procedures.

Provider Information

Copayments

Providers cannot charge Medicaid SSI HMO enrollees copayments for covered services except in cases where the Medicaid SSI HMO does not cover services such as dental, chiropractic, and pharmacy. When services are provided through fee-for-service or to members enrolled in a BadgerCare Plus HMO, copayments will apply.

Emergencies

Non-network providers may provide services to BadgerCare Plus HMO and Medicaid SSI HMO enrollees in an emergency without authorization or in urgent situations when authorized by the HMO or SSI HMO. The contract between the DHS and the HMO or SSI HMO defines an emergency situation and includes general payment requirements.

Unless the HMO or SSI HMO has a written agreement with the non-network provider, the HMO or SSI HMO is only liable to the extent fee-for-service would be liable for an emergency situation, as defined in 42 CFR s. 438.114. Billing procedures for emergencies may vary depending on the HMO or SSI HMO. For specific billing instructions, non-network providers should always contact the enrollee's HMO or SSI HMO.

Non-network Providers

Providers who do not have a contract with the enrollee's BadgerCare Plus HMO or Medicaid SSI HMO are referred to as non-network providers. (HMO and SSI HMO network providers agree to payment amounts and billing procedures in a contract with the HMO or SSI HMO.) Non-network providers are required to direct enrollees to HMO or SSI HMO network providers except in the following situations:

- When a non-network provider is treating an HMO or SSI HMO enrollee for an emergency medical condition as defined in the contract between the DHS and the HMO or SSI HMO.
- When the HMO or SSI HMO has authorized (in writing) an out-of-plan referral to a non-network provider.
- When the service is not provided under the HMO's or SSI HMO's contract with the DHS (such as dental, chiropractic, and pharmacy services).

Non-network providers may not serve BadgerCare Plus HMO or Medicaid SSI HMO enrollees as private-pay patients.

Out-of-Area Care

BadgerCare Plus HMOs and Medicaid SSI HMOs may cover medically necessary care provided to enrollees when they travel outside the HMO's or SSI HMO's service area. The HMO or SSI HMO is required to authorize the services before the services are provided, except in cases of emergency. If the HMO or SSI HMO does not authorize the services, the enrollee may be held responsible for the cost of those services.

Provider Participation

Providers interested in participating in a BadgerCare Plus HMO or Medicaid SSI HMO or changing HMO or SSI HMO network affiliations should contact the HMO or SSI HMO for more information. Conditions and terms of participation in an HMO or SSI HMO are pursuant to specific contract agreements between HMOs or SSI HMOs and providers. An HMO or SSI HMO has the right to choose whether or not to contract with any provider.

Referrals

Non-network providers may at times provide services to BadgerCare Plus HMO and Medicaid SSI HMO enrollees on a referral basis. Non-network providers are always required to contact the enrollee's HMO or SSI HMO. Before services are provided, the non-network provider and the HMO or SSI HMO should discuss and agree upon billing procedures and fees for all referrals. Non-network providers and HMOs or SSI HMOs should document the details of any referral in writing before services are provided.

Billing procedures for out-of-plan referrals may vary depending on the HMO or SSI HMO. For specific billing instructions, non-network providers should always contact the enrollee's HMO or SSI HMO.

Services Not Provided by HMOs or SSI HMOs

If an enrollee's BadgerCare Plus HMO's or Medicaid SSI HMO's benefit package does not include a covered service, such as chiropractic or dental services, any Medicaid-certified provider may provide the service to the enrollee and submit claims to fee-for-service.

Member Information

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Archive Date:03/01/2011

Member Information:Birth to 3 Program

Administration and Regulations

In Wisconsin, B-3 services are administered at the local level by county departments of community programs, human service departments, public health agencies, or any other public agency designated or contracted by the county board of supervisors. The DHS monitors, provides technical assistance, and offers other services to county B-3 agencies.

The enabling federal legislation for the B-3 Program is 34 CFR Part 303. The enabling state legislation is s. 51.44, Wis. Stats., and the regulations are found in ch. DHS 90, Wis. Admin. Code.

Providers may contact the appropriate county B-3 agency for more information.

Enrollment Criteria

A child from birth up to (but not including) age 3 is eligible for B-3 services if the child meets one of the following criteria:

- The child has a diagnosed physical or mental condition that has a high probability of resulting in a developmental delay.
- The child has at least a 25 percent delay in one or more of the following areas of development:
  - Cognitive development.
  - Physical development, including vision and hearing.
  - Communication skills.
  - Social or emotional development.
  - Adaptive development, which includes self-help skills.
- The child has atypical development affecting his or her overall development, as determined by a qualified team using professionally acceptable procedures and informed clinical opinion.

BadgerCare Plus provides B-3 information because many children enrolled in the B-3 Program are also BadgerCare Plus members.

Individualized Family Service Plan

A B-3 member receives an IFSP developed by an interdisciplinary team that includes the child's family. The IFSP provides a description of the outcomes, strategies, supports, services appropriate to meet the needs of the child and family, and the natural environment settings where services will be provided. All B-3 services must be identified in the child's IFSP.

Requirements for Providers

Title 34 CFR Part 303 for B-3 services requires all health, social service, education, and tribal programs receiving federal funds, including Medicaid providers, to do the following:

- Identify children who may be eligible for B-3 services. These children must be referred to the appropriate county B-3 program within *two working days* of identification. This includes children with developmental delays, atypical development, disabilities, and children who are substantiated as abused or neglected. For example, if a provider's health exam or developmental screen indicates that a child may have a qualifying disability or developmental delay, the child must be referred to the county B-3 program for evaluation. (Providers are encouraged to explain the need for the B-3 referral to the child's parents or guardians.)
- Cooperate and participate with B-3 service coordination as indicated in the child's IFSP. B-3 services must be provided by providers who are employed by, or under agreement with, a B-3 agency to provide B-3 services.
- Deliver B-3 services in the child's natural environment, unless otherwise specified in the IFSP. The child's natural environment

includes the child's home and other community settings where children without disabilities participate. (Hospitals contracting with a county to provide therapy services in the child's natural environment must receive separate certification as a therapy group to be reimbursed for these therapy services.)

- Assist parents or guardians of children receiving B-3 services to maximize their child's development and participate fully in implementation of their child's IFSP. For example, an occupational therapist is required to work closely with the child's parents and caretakers to show them how to perform daily tasks in ways that maximize the child's potential for development.

Services

The B-3 Program covers the following types of services when they are included in the child's IFSP:

- Evaluation and assessment.
- Special instruction.
- OT.
- PT.
- SLP.
- Audiology.
- Psychology.
- Social work.
- Assistive technology.
- Transportation.
- Service coordination.
- Certain medical services for diagnosis and evaluation purposes.
- Certain health services to enable the child to benefit from early intervention services.
- Family training, counseling, and home visits.

Enrollment Categories

BadgerCare Expansion for Certain Pregnant Women

As a result of 2005 Wisconsin Act 25, the 2005-07 biennial budget, BadgerCare has expanded coverage to the following individuals:

- Pregnant non-U.S. citizens who are not qualified aliens but meet other eligibility criteria for BadgerCare.
- Pregnant individuals detained by legal process who meet other eligibility criteria for BadgerCare.

The BadgerCare Expansion for Certain Pregnant Women is designed to provide better birth outcomes.

Women are eligible for all covered services from the first of the month in which their pregnancy is verified or the first of the month in which the application for BadgerCare Plus is filed, whichever is later. Members are enrolled through the last day of the month in which they deliver or the pregnancy ends. Postpartum care is reimbursable *only* if provided as part of global obstetric care. Even though enrollment is based on pregnancy, these women are eligible for *all* covered services. (They are not limited to pregnancy-related services.)

These women are not presumptively eligible. Providers should refer them to the appropriate county/tribal social or human services agency where they can apply for this coverage.

Fee-for-Service

Pregnant non-U.S. citizens who are not qualified aliens and pregnant individuals detained by legal process receive care only on a fee-for-service basis. Providers are required to follow all program requirements (e.g., claims submission procedures, PA requirements) when providing services to these women.

Emergency Services for Non-U.S. Citizens

When BadgerCare Plus enrollment ends for pregnant non-U.S. citizens who are not qualified aliens, they receive coverage for emergency services. These women receive emergency coverage for 60 days after the pregnancy ends; this coverage continues through the end of the month in which the 60th day falls (e.g., a woman who delivers on June 20, 2006, would be enrolled through the end of August 2006).

BadgerCare Plus Basic Plan

The BadgerCare Plus Basic Plan is a self-funded plan that focuses on providing BadgerCare Plus Core Plan waitlist members with access to vital, cost-effective primary and preventive care. This option will allow members to have some minimal form of coverage until space becomes available in the Core Plan and will help prevent bankruptcy due to excessive medical debt.

Member participation or non-participation in the Basic Plan does not affect an individual's status on the Core Plan waitlist.

Services for the Basic Plan are covered under fee-for-service. Basic Plan members will not be enrolled in state-contracted HMOs.

Applicant Enrollment Requirements

Applicants are required to apply for the Core Plan and be put on the waitlist before they can enroll in the Basic Plan. The applicant must meet the following program requirements to enroll in the Core Plan and thus qualify for the Core Plan waitlist and the Basic Plan:

- Is a Wisconsin resident.
- Is a United States citizen or legal immigrant.
- Is between the ages of 19 and 64.
- Does not have any children under age 19 under his or her care.
- Is not pregnant.
- Is not eligible for or enrolled in Medicaid, the BadgerCare Plus Standard Plan, or the BadgerCare Plus Benchmark Plan. Applicants may be enrolled in Family Planning Only Services or TB-Only).
- Is not eligible for or enrolled in Medicare.
- Has a monthly gross income that does not exceed 200 percent of the FPL.
- Is not covered by health insurance currently or in the previous 12 months unless there is justifiable cause.
- Has not had access to employer-sponsored insurance in the previous 12 months and does not have access to employer-subsidized insurance during the month of application or any of the three months following application.

Application Process for New Members

Individuals who wish to enroll in the Basic Plan must first apply for the Core Plan online or via a toll-free telephone number. A pre-screening tool will help determine which individuals may be eligible to enroll in the Core Plan. Applications for Core Plan members are processed by the ESC, not by county agencies.

Once the Core Plan application process is complete and the individual has been placed on the waitlist for the Core Plan, the individual will have the option to enroll in the Basic Plan. An informational letter will be mailed to individuals on the waitlist with Basic Plan information and a coupon the individual can use to request enrollment in the Basic Plan and submit their initial premium payment. Members of the Basic Plan will be required to pay a monthly premium of approximately $130.00 to maintain coverage. Members who fail to pay the monthly premium will have their Basic Plan coverage terminated and will be subject to a restrictive re-enrollment period, which will not allow the member to re-enroll for 12 months. Termination of Basic Plan coverage does not affect a member's status on the Core Plan waitlist or his or her eligibility for the Core Plan if room becomes available.

Conditions That End Member Enrollment in the Basic Plan

A member's enrollment in the Basic Plan will end if the member:

- Becomes eligible for Medicare, Medicaid, the Standard Plan, the Benchmark Plan, or the Core Plan.
- Becomes incarcerated or becomes institutionalized in an IMD.
- Becomes pregnant. (*Note:* A Basic Plan member who becomes pregnant should be referred to Member Services for more information about enrollment in the Standard Plan or the Benchmark Plan.)
- No longer resides in the state of Wisconsin.
- Obtains health insurance coverage.
- Turns 65 years of age.
- Fails to pay the monthly premium.

Note: Enrollment in the Basic Plan does not end if the member's income increases.

Providers are reminded that the Basic Plan does not cover obstetrical services or delivery services.

Providers are required to notify ForwardHealth if they have reason to believe that a person is misusing or abusing BadgerCare Plus or Medicaid benefits or the ForwardHealth identification card.

Basic Plan Member Fact Sheets

Fact sheets providing additional member information about the Basic Plan are available.

Enrollment Certification Period for Basic Plan Members

A member's enrollment will begin on the first of the month and will continue through the end of the 12th month. For example, if the individual's enrollment in the Basic Plan begins on July 1, 2010, the enrollment certification period will continue through June 30, 2011, unless conditions occur that end enrollment.

Premium payments are due on the fifth of each month, prior to the month of coverage. Members who fail to pay the monthly premium will have their benefits terminated and will also be subject to a 12-month restrictive re-enrollment period.

Basic Plan Members Enrolled in Wisconsin Chronic Disease Program

For Basic Plan members who are also enrolled in WCDP, providers should submit claims for all covered services to the Basic Plan first and then to WCDP. For pharmacy services, if both programs deny the pharmacy claim, providers should submit the claim to BadgerRx Gold.

Basic Plan Members and HIRSP Coverage

Basic Plan members may also be enrolled in the HIRSP as long as the member meets the eligibility requirements for both the Basic Plan and HIRSP. For Basic Plan members who are also enrolled in HIRSP, providers should submit claims for all Basic Plan covered services to HIRSP first and then to the Basic Plan.

Basic Plan members may not be enrolled in the Basic Plan and the Federal Temporary High Risk Insurance Pool. Information that is being distributed to Core Plan members on the waitlist regarding HIRSP and the Federal Temporary High Risk Insurance Pool is available.

BadgerCare Plus Basic Plan Members Diagnosed with Cancer

Information is available for DOS before January 1, 2011.

BadgerCare Plus Basic Plan members with certain diagnoses may be enrolled in the BadgerCare Plus Core Plan if they meet the Core Plan enrollment rules. If a member has any of the following, they can bypass the Core Plan waitlist and be enrolled in the Core Plan if they meet all of the Core Plan enrollment rules:

- Cancer (except non-melanoma skin cancers).
- Hypertension and high cholesterol combined.
- Atherosclerosis.
- Heart failure.
- Heart disease.

The diagnosis may be a new diagnosis since the member was enrolled in the Basic Plan or it may be a pre-existing condition.

Application Process for Basic Plan Members with Certain Diagnoses

To enroll a Basic Plan member diagnosed with cancer, hypertension and high cholesterol combined, atherosclerosis, heart failure or heart disease in the Core Plan, the provider who has diagnosed the member is required to complete the Core Plan Waitlist — Medical Bypass Determination form. The provider is required to indicate a description of the diagnoses on the form.

Note: Basic Plan members with a diagnosis of one of the non-melanoma skin cancers are not eligible to apply for the Core Plan through the Core Plan waitlist bypass process.

The form must be submitted to the ESC by fax at (888) 415-2115 or by mail to the following address:

Enrollment Services Center
PO Box 7190
Madison WI 53707-7190

Providers are encouraged to submit completed forms by fax to ForwardHealth to avoid delays in mailing of forms.

A copy of the completed Core Plan Waitlist — Medical Bypass Determination should be kept in the member's medical record.

Enrollment Process

After the completed Core Plan Waitlist — Medical Bypass Determination form is received by ForwardHealth, the ESC will verify the information on the form and contact the member to complete the application process via telephone. If the member cannot be reached via telephone, a letter will be mailed to encourage him or her to complete the application process. If the member is eligible for the Core Plan, enrollment will begin on the next first or fifteenth day of the month after the application is approved. The enrollment process is designed to ensure there is no gap in coverage during a member's transition from the Basic Plan to the Core Plan.

If the member does not meet eligibility criteria for the Core Plan, a notice of denial will be mailed to the member and enrollment in the Basic Plan will be terminated since the eligibility criteria for the Core Plan and the Basic Plan are the same.

The usual application processing fee for the Core Plan does not apply to members who have one of the diagnoses and who will transition from the Basic Plan to the Core Plan. The member's most recent premium paid for the Basic Plan is applied as the enrollment fee for the Core Plan.

Members Enrolled in the Wisconsin Well Woman Program and the Basic Plan

Women may be enrolled in the WWWP and the Basic Plan at the same time. Women who are diagnosed with breast cancer or cervical cancer while enrolled in WWWP are eligible to be enrolled in WWWMA through the WWWP. WWWMA covers the same services as Wisconsin Medicaid; therefore, enrollment in WWWMA enables members to receive comprehensive treatment, including services not related to their diagnosis.

Once a woman is enrolled in WWWMA, she is no longer eligible for the Basic Plan. If the woman becomes ineligible for WWWMA in the future, she may be eligible to receive benefits from the Basic Plan.

BadgerCare Plus Core Plan

The BadgerCare Plus Core Plan covers basic health care services including primary care, preventive care, certain generic and OTC drugs, and a limited number of brand name drugs.

Applicant Enrollment Requirements

An applicant must meet the following enrollment requirements in order to qualify for the Core Plan:

- Is a Wisconsin resident.
- Is a United States citizen or legal immigrant.
- Is between the ages of 19 and 64.
- Does not have any children under age 19 under his or her care.
- Is not pregnant.
- Is not eligible for or enrolled in Medicaid, the BadgerCare Plus Standard Plan, or the BadgerCare Plus Benchmark Plan. This would not include benefits provided under Family Planning Only Services or those benefits provided to individuals who qualify for TB-Only.
- Is not eligible for or enrolled in Medicare.

- Has a monthly gross income that does not exceed 200 percent of the FPL.
- Is not covered by health insurance currently or in the previous 12 months.
- Has not had access to employer-sponsored insurance in the previous 12 months and does not have access to employer-subsidized insurance during the month of application or any of the three months following application.

Application Process for New Members

The Core Plan application process will be streamlined and user-friendly. Individuals who wish to enroll may apply for the Core Plan using the Access tool online or via the ESC. A pre-screening tool will help determine which individuals may be eligible to enroll in the Core Plan. Applications for Core Plan members will be processed centrally by the ESC, not by county agencies.

To complete the application process, applicants must meet the following requirements:

- Complete a Health Survey.
- Pay a non-refundable, annual processing fee of $60.00 per individual or per couple for married couples. The fee will be waived for homeless individuals. There are no monthly premiums.

Medicaid-certified providers cannot pay the $60.00 application processing fee on behalf of Core Plan applicants. An offer by a Medicaid-certified provider to pay a fee on behalf of a prospective Medicaid member may violate federal laws against kickbacks. These laws are federal criminal statutes that are interpreted and enforced by federal agencies such as the United States DOJ and the Department of HHS's OIG.

Conditions That End Member Enrollment in the Core Plan

A member's enrollment will end if the member:

- Becomes eligible for Medicare, Medicaid, the Standard Plan, or the Benchmark Plan.
- Becomes incarcerated or institutionalized in an IMD.
- Becomes pregnant.
- No longer resides in the state of Wisconsin.
- Obtains health insurance coverage.
- Turns 65 years of age.

Providers are reminded that the Core Plan does not cover obstetrical services, including the delivery of a child or children. A Core Plan member who becomes pregnant should be referred to the ESC for more information about enrollment in the Standard Plan or the Benchmark Plan.

Enrollment Certification Period for Core Plan Members

Once determined eligible for enrollment in the Core Plan, a member's enrollment will begin either on the first or 15th of the month, whichever is first, and will continue through the end of the 12th month. For example, if the individual submits all of his or her application materials, including the application fee, by September 17, 2009, and the DHS reviews the application and approves it on October 6, 2009, the individual is eligible for enrollment beginning on October 15, 2009, the next possible date of enrollment. The enrollment certification period will continue through October 31, 2010.

The enrollment certification period for individuals who qualify for the Core Plan is 12 months, regardless of income changes.

Core Plan Members Enrolled in Wisconsin Chronic Disease Program

For Core Plan members who are also enrolled in WCDP, providers should submit claims for all covered services to the Core Plan first and then to WCDP. For pharmacy services, if both programs deny the pharmacy claim, providers should submit claims to BadgerRx Gold.

Core Plan Members with HIRSP Coverage

Core Plan members may also be enrolled in HIRSP as long as the member meets the eligibility requirements for both the Core Plan and HIRSP. For Core Plan members who are also enrolled in HIRSP, providers should submit claims for all Core Plan covered services to the Core Plan. For services not covered by the Core Plan, providers should submit claims to HIRSP. For members enrolled in the Core Plan, HIRSP is always the payer of last resort.

Note: HIRSP will only cover noncovered Core Plan services if the services are covered under the HIRSP benefit.

BadgerCare Plus Standard Plan and Benchmark Plan

BadgerCare Plus is a state-sponsored health care program that expands coverage of Wisconsin residents and ensures that all children in Wisconsin have access to affordable health care.

The key initiatives of BadgerCare Plus are:

- To ensure that all Wisconsin children have access to affordable health care.
- To ensure that 98 percent of Wisconsin residents have access to affordable health care.
- To streamline program administration and enrollment rules.
- To expand coverage and provide enhanced benefits for pregnant women.
- To promote prevention and healthy behaviors.

BadgerCare Plus expands enrollment in state-sponsored health care to the following:

- All uninsured children.
- More pregnant women.
- More parents and caretaker relatives.
- Parents with children in foster care who are working to reunify their families.
- Young adults exiting out-of-home care, such as foster care, because they have turned 18 years of age.
- Certain farmers and other self-employed parents and caretaker relatives.

Where available, BadgerCare Plus members will be enrolled in BadgerCare Plus HMOs. In those areas of Wisconsin where HMOs are not available, services will be reimbursed on a fee-for-service basis.

Benefit Plans Under BadgerCare Plus

BadgerCare Plus is comprised of four benefit plans, the BadgerCare Plus Standard Plan, the BadgerCare Plus Benchmark Plan, the BadgerCare Plus Core Plan, and the BadgerCare Plus Basic Plan.

BadgerCare Plus Standard Plan

The Standard Plan covers children, parents and caretaker relatives, young adults aging out of foster care, and pregnant women with incomes at or below 200 percent of the FPL. The services covered under the Standard Plan are the same as the Wisconsin Medicaid program.

BadgerCare Plus Benchmark Plan

The Benchmark Plan was adapted from Wisconsin's largest commercial, low-cost health care plan. The Benchmark Plan is for children and pregnant women with incomes above 200 percent of the FPL and certain self-employed parents, such as farmers with incomes above 200 percent of the FPL. The services covered under the Benchmark Plan are more limited than those covered under

the Wisconsin Medicaid program.

BadgerCare Plus Core Plan

The Core Plan provides adults who were previously not eligible to enroll in state and federal health care programs with access to basic health care services including primary care, preventive care, certain generic and OTC drugs, and a limited number of brand name drugs.

BadgerCare Plus Basic Plan

The Basic Plan provides Core Plan waitlist members with access to vital, cost-effective primary and preventive care. This option allows members to have some form of minimal coverage until space becomes available in the Core Plan.

Express Enrollment for Children and Pregnant Women

EE for Pregnant Women Benefit is a limited benefit category that allows a pregnant woman to receive immediate pregnancy-related outpatient services while her application for full-benefit BadgerCare Plus is processed. Enrollment is not restricted based on the member's other health insurance coverage. Therefore, a pregnant woman who has other health insurance may be enrolled in the benefit.

To determine enrollment for EE for Pregnant Women, providers should use the income limits for 200 percent and 300 percent of the FPL.

The EE for Children Benefit allows certain members under 18 years of age to receive BadgerCare Plus benefits under the BadgerCare Plus Standard Plan while an application for BadgerCare Plus is processed.

Fee-for-Service

Women and children who are temporarily enrolled in BadgerCare Plus through the EE process are not eligible for enrollment in an HMO until they are determined eligible for full benefit BadgerCare Plus by the county/tribal office.

Family Planning Only Services

Family Planning Only Services is a limited benefit program that provides routine contraceptive-related services to low-income individuals who are at least 15 years of age who are otherwise not eligible for Wisconsin Medicaid or BadgerCare Plus. There is no upper age limit for Family Planning Only Services enrollment as long as the member is of childbearing age. Members receiving Family Planning Only Services must be receiving routine contraceptive-related services.

The goal of Family Planning Only Services is to provide members with information and services to assist them in preventing pregnancy, making BadgerCare Plus enrollment due to pregnancy less likely. Providers should explain the purpose of Family Planning Only Services to members and encourage them to contact their certifying agency to determine their enrollment options if they are not interested in, or do not need, contraceptive services.

Members enrolled in Family Planning Only Services receive routine services to prevent or delay pregnancy and are not eligible for other services (e.g., PT services, dental services). Even if a medical condition is discovered during a family planning visit, treatment for the condition is not covered under Family Planning Only Services unless the treatment is identified in the list of allowable procedure codes for Family Planning Only Services.

Members are also not eligible for certain other services that are covered under the Wisconsin Medicaid and BadgerCare Plus family planning benefit (e.g., mammograms and hysterectomies). If a medical condition, other than an STD, is discovered during contraceptive-related services, treatment for the medical condition is not covered under Family Planning Only Services.

Colposcopies and treatment for STDs are only covered through Family Planning Only Services if they are determined medically necessary during routine contraceptive-related services. A colposcopy is a covered service when an abnormal result is received from a pap test, prior to the colposcopy, while the member is enrolled in Family Planning Only Services and receiving contraceptive-related services.

Family Planning Only Services members diagnosed with cervical cancer, precancerous conditions of the cervix, or breast cancer may be eligible for Wisconsin Well Woman Medicaid. Providers should assist eligible members with the enrollment process for Well Woman Medicaid.

Providers should inform members about other service options and provide referrals for care not covered by Family Planning Only Services.

Temporary Enrollment for Family Planning Only Services

Members whose providers are submitting an initial Family Planning Only Services application on their behalf and who meet the enrollment criteria may receive routine contraceptive-related services immediately through TE for Family Planning Only Services for up to two months. Services covered under the TE for Family Planning Only Services are the same as those covered under Family Planning Only Services and must be related to routine contraceptive management.

To determine enrollment for Family Planning Only Services, providers should use the income limit for 300 percent of the FPL.

TE for Family Planning Only Services providers may issue white paper TE for Family Planning Only Services identification cards for members to use until they receive a ForwardHealth identification card. Providers should remind members that the benefit is temporary, despite their receiving a ForwardHealth card.

ForwardHealth and ForwardHealth interChange

ForwardHealth brings together many DHS health care programs with the goal to create efficiencies for providers and to improve health outcomes for members. ForwardHealth interChange is the DHS claims processing system that supports multiple state health care programs and Web services, including:

- BadgerCare Plus.
- BadgerCare Plus and Medicaid managed care programs.
- SeniorCare.
- WCDP.
- WIR.
- Wisconsin Medicaid.
- Wisconsin Well Woman Medicaid.
- WWWP.

ForwardHealth interChange is supported by the state's fiscal agent, HP.

Limited Benefit Categories Overview

Certain members may be enrolled in a limited benefit category. These limited benefit categories include the following:

- BadgerCare Plus Expansion for Certain Pregnant Women.
- EE for Children.
- EE for Pregnant Women.
- Family Planning Only Services, including TE for Family Planning Only Services.
- QDWI.

- QI-1.
- QMB Only.
- SLMB.
- TB-Only Benefit.

Members may be enrolled in full-benefit Medicaid or BadgerCare Plus and also be enrolled in certain limited benefit programs, including QDWI, QI-1, QMB Only, and SLMB. In those cases, a member has full Medicaid or BadgerCare Plus coverage in addition to limited coverage for Medicare expenses.

Members enrolled in BadgerCare Plus Expansion for Certain Pregnant Women, Family Planning Only Services, EE for Children, EE for Pregnant Women, or the TB-Only Benefit cannot be enrolled in full-benefit Medicaid or BadgerCare Plus. These members receive benefits through the limited benefit category.

Providers should note that a member may be enrolled in more than one limited benefit category. For example, a member may be enrolled in Family Planning Only Services and the TB-Only Benefit.

Providers are strongly encouraged to verify dates of enrollment and other coverage information using the EVS to determine whether a member is in a limited benefit category, receives full-benefit Medicaid or BadgerCare Plus, or both.

Providers are responsible for knowing which services are covered under a limited benefit category. If a member of a limited benefit category requests a service that is not covered under the limited benefit category, the provider may collect payment from the member if certain conditions are met.

Medicaid

Medicaid is a joint federal/state program established in 1965 under Title XIX of the Social Security Act to pay for medical services for selected groups of people who meet the program's financial requirements.

The purpose of Medicaid is to provide reimbursement for and assure the availability of appropriate medical care to persons who meet the criteria for Medicaid. Wisconsin Medicaid is also known as the Medical Assistance Program, WMAP, MA, Title XIX, or T19.

A Medicaid member is any individual entitled to benefits under Title XIX of the Social Security Act and under the Medical Assistance State Plan as defined in ch. 49, Wis. Stats.

Wisconsin Medicaid enrollment is determined on the basis of financial need and other factors. A citizen of the United States or a "qualified immigrant" who meets low-income financial requirements may be enrolled in Wisconsin Medicaid if he or she is in one of the following categories:

- Age 65 and older.
- Blind.
- Disabled.

Some needy and low-income people become eligible for Wisconsin Medicaid by qualifying for programs such as:

- Katie Beckett.
- Medicaid Purchase Plan.
- Subsidized adoption and foster care programs.
- SSI.
- WWWP.

Providers may advise these individuals or their representatives to contact their certifying agency for more information. The following agencies certify people for Wisconsin Medicaid enrollment:

- Local county or tribal agencies.
- Medicaid outstation sites.
- SSA offices.

In limited circumstances, some state agencies also certify individuals for Wisconsin Medicaid.

Medicaid fee-for-service members receive services through the traditional health care payment system under which providers receive a payment for each unit of service provided. Some Medicaid members receive services through state-contracted MCOs.

Qualified Disabled Working Individual Members

QDWI members are a limited benefit category of Medicaid members. They receive payment of Medicare monthly premiums for Part A.

QDWI members are certified by their local county or tribal agency. To qualify, QDWI members are required to meet the following qualifications:

- Have income under 200 percent of the FPL.
- Be entitled to, but not necessarily enrolled in, Medicare Part A.
- Have income or assets too high to qualify for QMB Only and SLMB.

Qualified Medicare Beneficiary-Only Members

QMB-Only members are a limited benefit category of Medicaid members. They receive payment of the following:

- Medicare monthly premiums for Part A, Part B, or both.
- Coinsurance, copayment, and deductible for Medicare-allowed services.

QMB-Only members are certified by their local county or tribal agency. QMB-Only members are required to meet the following qualifications:

- Have an income under 100 percent of the FPL.
- Be entitled to, but not necessarily enrolled in, Medicare Part A.

Qualifying Individual 1 Members

QI-1 members are a limited benefit category of Medicaid members. They receive payment of Medicare monthly premiums for Part B.

QI-1 members are certified by their local county or tribal agency. To qualify, QI-1 members are required to meet the following qualifications:

- Have income between 120 and 135 percent of the FPL.
- Be entitled to, but not necessarily enrolled in, Medicare Part A.

SeniorCare

Wisconsin SeniorCare is a prescription drug assistance program for Wisconsin residents who are 65 years of age or older who meet enrollment criteria.

Wisconsin SeniorCare is administered by the DHS. Within the DHS, the DHCAA is directly responsible for managing SeniorCare.

Individuals enrolled in Wisconsin SeniorCare are called members. When a member receives a prescription, the pharmacist will know that a member is eligible for Wisconsin SeniorCare by a SeniorCare card that the member should show each time a prescription is filled. The member may have an out-of-pocket expense depending on his or her level of participation.

Specified Low-Income Medicare Beneficiaries

SLMB members are a limited benefit category of Medicaid members. They receive payment of Medicare monthly premiums for Part B.

SLMB members are certified by their local county or tribal agency. To qualify, SLMB members are required to meet the following qualifications:

- Have an income under 120 percent of the FPL.
- Be entitled to, but not necessarily enrolled in, Medicare Part A.

Tuberculosis-Related Services-Only Benefit

The TB-Only Benefit is a limited benefit category that allows individuals with TB infection or disease to receive covered TB-related outpatient services.

Wisconsin Well Woman Medicaid

Wisconsin Well Woman Medicaid provides full Medicaid benefits to underinsured or uninsured women ages 35 to 64 who have been screened and diagnosed by WWWP or Family Planning Only Services, meet all other enrollment requirements, and are in need of treatment for any of the following:

- Breast cancer.
- Cervical cancer.
- Precancerous conditions of the cervix.

Services provided to women who are enrolled in Well Woman Medicaid are reimbursed through Medicaid fee-for-service.

Members Enrolled into Wisconsin Well Woman Medicaid from Benchmark Plan or Core Plan

Women diagnosed with breast cancer or cervical cancer while enrolled in the BadgerCare Plus Benchmark Plan or BadgerCare Plus Core Plan for Adults with No Dependent Children are eligible to be enrolled in Wisconsin Well Woman Medicaid. Wisconsin Well Woman Medicaid covers the same services as Wisconsin Medicaid and enables members to receive comprehensive treatment, including services not related to their diagnosis.

Women who are diagnosed with breast cancer, cervical cancer, or a precancerous condition of the cervix must have the diagnosis of their condition confirmed by one of the following Medicaid-certified providers:

- Nurse practitioners, for cervical conditions only.
- Osteopaths.
- Physicians.

Women with Medicare or other insurance that covers treatment for her cancer are not allowed to be enrolled into WWWMA.

Covered and Noncovered Services

Wisconsin Well Woman Medicaid covers the same services as Wisconsin Medicaid regardless of whether the service is related to her cancer treatment.

Reimbursement

Providers will be reimbursed for services provided to members enrolled in WWWMA at the Wisconsin Medicaid rate of reimbursement for covered services. Providers are required to reimburse members for any copayments members paid on or after the date of diagnosis while still enrolled in the Benchmark Plan or the Core Plan.

Copayments

There are no copayments for any Medicaid covered service for WWWMA members who have been enrolled into WWWMA from the Benchmark or the Core Plan.

Enrollment Responsibilities

General Information

Members have certain responsibilities per DHS 104.02, Wis. Admin. Code, and the ForwardHealth Enrollment and Benefits booklet.

Loss of Enrollment — Financial Liability

Some covered services consist of a series of sequential treatment steps, meaning more than one office visit is required to complete treatment.

In most cases, if a member loses enrollment midway through treatment, BadgerCare Plus will *not* reimburse services (including prior authorized services) after enrollment has lapsed.

Members are financially responsible for any services received after their enrollment has been terminated. If the member wishes to continue treatment, it is a decision between the provider and the member whether the service should be given and how the services will be paid. The provider may collect payment from the member if the member accepts responsibility for payment of a service and certain conditions are met.

To avoid misunderstandings, it is recommended that providers remind members that they are financially responsible for any continued care after enrollment ends.

To avoid potential reimbursement problems that can arise when a member loses enrollment midway through treatment, the provider is encouraged to verify the member's enrollment using the EVS or the ForwardHealth Portal prior to providing each service, even if an approved PA request is obtained for the service.

Member Cooperation

Members are responsible for giving providers full and accurate information necessary for the correct submission of claims. If a member has other health insurance, it is the member's obligation to give full and accurate information to providers regarding the insurance.

Members Should Present Card

It is important that providers determine a member's enrollment and other insurance coverage *prior to* each DOS that services are provided. Pursuant to DHS 104.02(2), Wis. Admin. Code, a member should inform providers that he or she is enrolled in BadgerCare Plus or Wisconsin Medicaid and should present a current ForwardHealth identification card before receiving services.

Note: Due to the nature of their specialty, certain providers — such as anesthesiologists, radiologists, DME suppliers, independent laboratories, and ambulances — are not always able to see a member's ForwardHealth identification card because they might not have direct contact with the member prior to providing the service. In these circumstances, it is still the provider's responsibility to obtain member enrollment information.

Prior Identification of Enrollment

Except in emergencies that preclude prior identification, members are required to inform providers that they are receiving benefits and must present their ForwardHealth identification card before receiving care. If a member forgets his or her ForwardHealth card,

providers may verify enrollment without it.

Reporting Changes to Caseworkers

Members are required to report certain changes to their caseworker at their certifying agency. These changes include, but are not limited to, the following:

- A new address or a move out of state.
- A change in income.
- A change in family size, including pregnancy.
- A change in other health insurance coverage.
- Employment status.
- A change in assets for members who are over 65 years of age, blind, or disabled.

Enrollment Rights

Appealing Enrollment Determinations

Applicants and members have the right to appeal certain decisions relating to BadgerCare Plus or Medicaid enrollment. An applicant, a member, or authorized person acting on behalf of the applicant or member, or former member may file the appeal with the DHA.

Pursuant to HA 3.03, Wis. Admin. Code, an applicant, member, or former member may appeal any adverse action or decision by an agency or department that affects their benefits. Examples of decisions that may be appealed include, but are not limited to, the following:

- Individual was denied the right to apply.
- Application for BadgerCare Plus or Wisconsin Medicaid was denied.
- Application for BadgerCare Plus or Wisconsin Medicaid was not acted upon promptly.
- Enrollment was unfairly discontinued, terminated, suspended, or reduced.

In the case when enrollment is cancelled or terminated, the date the member, or authorized person acting on behalf of the member, files an appeal with the DHA determines what continuing coverage, if any, the member will receive until the hearing decision is made. The following scenarios describe the coverage allowed for a member who files an appeal:

- If a member files an appeal before his or her enrollment ends, coverage will continue pending the hearing decision.
- If a member files an appeal within 45 days after his or her enrollment ends, a hearing is allowed but coverage is not reinstated.

If the member files an appeal more than 45 days after his or her enrollment ends, a hearing is not allowed. Members may file an appeal by submitting a Request for Fair Hearing form.

Claims for Appeal Reversals

If a claim is denied due to termination of enrollment, a hearing decision that reverses that determination will allow the claim to be resubmitted and paid. The provider is required to obtain a copy of the appeal decision from the member, attach the copy to the previously denied claim, and submit both to ForwardHealth at the following address:

ForwardHealth
Specialized Research
Ste 50
6406 Bridge Rd
Madison WI 53784-0050

If a provider has not yet submitted a claim, the provider is required to submit a copy of the hearing decision along with a paper claim to Specialized Research.

As a reminder, claims submission deadlines still apply even to those claims with hearing decisions.

Freedom of Choice

Members may receive covered services from *any* willing Medicaid-certified provider, unless they are enrolled in a state-contracted MCO or assigned to the Pharmacy Services Lock-In Program.

General Information

Members are entitled to certain rights per DHS 103, Wis. Admin. Code.

Notification of Discontinued Benefits

When the DHS intends to discontinue, suspend, or reduce a member's benefits, or reduce or eliminate coverage of services for a general class of members, the DHS sends a written notice to members. This notice is required to be provided at least 10 days before the effective date of the action.

Prompt Decisions on Enrollment

Individuals applying for BadgerCare Plus or Wisconsin Medicaid have the right to prompt decisions on their applications. Enrollment decisions are made within 60 days of the date the application was signed for those with disabilities and within 30 days for all other applicants.

Requesting Retroactive Enrollment

An applicant has the right to request retroactive enrollment when applying for BadgerCare Plus or Wisconsin Medicaid. Enrollment may be backdated to the first of the month three months prior to the date of application for eligible members. Retroactive enrollment does not apply to QMB-Only members.

Identification Cards

ForwardHealth Basic Plan Identification Cards

Members enrolled in the BadgerCare Plus Basic Plan will receive a ForwardHealth Basic Plan card. All identification cards include the member's name and 10-digit member identification number. The identification cards may be used to verify a member's enrollment, but possession of an identification card does not guarantee enrollment. It is possible that a member will present a card when he or she is not enrolled; therefore, it is essential that providers verify enrollment before providing services.

Providers should always check enrollment for a member who presents a ForwardHealth card to verify if the member is enrolled in the Basic Plan or in one of the other ForwardHealth programs. (Providers may use the same methods of enrollment verification under the Basic Plan as they do for other ForwardHealth programs such as Medicaid. These methods include the ForwardHealth Portal, WiCall, magnetic stripe readers, and the 270/271 transactions.) Members who present a ForwardHealth card or a ForwardHealth Basic Plan card may have been enrolled in a different plan since the card was issued. Providers should be careful to verify the plan in which the member is enrolled and know which services are covered under that plan.

Basic Plan members should call Member Services with questions about premiums and covered services. The ForwardHealth Basic Plan cards include the Member Services telephone number on the back.

ForwardHealth Core Plan Identification Cards

Members enrolled in the BadgerCare Plus Core Plan will receive a ForwardHealth Core Plan card. All identification cards include the member's name and 10-digit member identification number. The identification cards may be used to verify a member's enrollment, but possession of an identification card does not guarantee enrollment. It is possible that a member will present a card when he or she is not enrolled; therefore, it is essential that providers verify enrollment before providing services.

Core Plan members should call the ESC with questions about enrollment criteria, HMO enrollment, and covered services. The ForwardHealth Core Plan cards include the Enrollment Services Center telephone number, (800) 291-2002, on the back.

Providers should always check enrollment for a member who presents a ForwardHealth card to verify if the member is enrolled in the Core Plan or in one of the other ForwardHealth programs. Members who present a ForwardHealth card or a ForwardHealth Core Plan card may have been enrolled in a different plan since the card was issued. Providers should be careful to verify the plan in which the member is enrolled and know which services are covered under that plan.

ForwardHealth Identification Cards

Each enrolled member receives an identification card. Possession of a program identification card does not guarantee enrollment. It is possible that a member will present a card during a lapse in enrollment; therefore, it is essential that providers verify enrollment before providing services. Members are told to keep their cards even though they may have lapses in enrollment.

ForwardHealth Identification Card Features

The ForwardHealth identification card includes the member's name, 10-digit member ID, magnetic stripe, signature panel, and the Member Services telephone number. The card also has a unique, 16-digit card number on the front for internal program use.

The ForwardHealth card does not need to be signed to be valid; however, adult members are encouraged to sign their cards. Providers may use the signature as another means of identification.

The toll-free number on the back of each of the cards is for member use only. The address on the back of each card is used to return a lost card to ForwardHealth if it is found.

If a provider finds discrepancies with the identification number or name between what is indicated on the ForwardHealth card and the provider's file, the provider should verify enrollment with Wisconsin's EVS.

Identification Number Changes

Some providers may question whether services should be provided if a member's 10-digit identification number on his or her ForwardHealth card does not match the EVS response. If the EVS indicates the member is enrolled, services should be provided.

A member's identification number may change, and the EVS will reflect that change. However, ForwardHealth does not automatically send a replacement ForwardHealth card with the new identification number to the member. ForwardHealth cross-references the old and new identification numbers so a provider may submit claims with either number. The member may request a replacement ForwardHealth card that indicates the new number.

Member Name Changes

If a member's name on the ForwardHealth card is different than the response given from Wisconsin's EVS, providers should use the name from the EVS response. When a name change is reported and on file, a new card will automatically be sent to the member.

Deactivated Cards

When any member identification card has been replaced for any reason, the previous identification card is deactivated. If a member presents a deactivated card, providers should encourage the member to discard the deactivated card and use only the new card.

Although a member identification card may be deactivated, the member ID is valid and the member still may be enrolled in a ForwardHealth program.

If a provider swipes a ForwardHealth card using a magnetic stripe card reader and finds that it has been deactivated, the provider may request a second form of identification if he or she does not know the member. After the member's identity has been verified, providers may verify a member's enrollment by using one of the EVS methods such as AVR.

Defective Cards

If a provider uses a card reader for a ForwardHealth card and the magnetic stripe is defective, the provider should encourage the member to call Member Services at the number listed on the back of the member's card to request a new card.

If a member presents a ForwardHealth card with a defective magnetic stripe, providers may verify the member's enrollment by using an alternate enrollment verification method. Providers may also verify a member's enrollment by entering the member ID or 16-digit card number on a touch pad, if available, or by calling WiCall or Provider Services.

Lost Cards

If a member needs a replacement ForwardHealth card, he or she may call Member Services to request a new one.

If a member lost his or her ForwardHealth card or never received one, the member may call Member Services to request a new one.

Managed Care Organization Enrollment Changes

Members do not receive a new ForwardHealth card if they are enrolled in a state-contracted MCO or change from one MCO to

another. Providers should verify enrollment with the EVS every time they see a member to ensure they have the most current managed care enrollment information.

Temporary Enrollment for Family Planning Only Services Identification Cards

Qualified providers may issue white paper TE for Family Planning Only Services identification cards for women to use temporarily until they receive a ForwardHealth identification card. The identification card is included with the TE for Family Planning Only Services Application.

The TE for Family Planning Only Services identification cards have the following message printed on them: "Temporary Identification Card for Temporary Enrollment for Family Planning Only Services." Providers should accept the white TE for Family Planning Only Services identification cards as proof of enrollment for the dates provided on the cards and are encouraged to keep a photocopy of the card.

Temporary Express Enrollment Cards

There are two types of temporary EE identification cards. One is issued for pregnant women and the other for children that are enrolled in BadgerCare Plus through EE. The EE cards are valid for 14 days. Samples of temporary EE cards for children and pregnant women are available.

Providers may assist pregnant women with filling out an application for temporary ambulatory prenatal care benefits (formerly known as PE) through the online EE process. EE identification cards are included on the bottom portion of the enrollment notice that is printed out and provided to the member after the online enrollment process is completed.

The paper application may also be used to apply for temporary ambulatory prenatal benefits for pregnant women. The beige paper identification card is attached to the last page of the application and provided to the woman after she completes the enrollment process. A sample of an EE temporary card from the back of the EE application is available.

The online EE process is also available for adults to apply for full BadgerCare Plus benefits for children. EE identification cards are included on the bottom portion of the enrollment notice that is printed out and provided to the member after the online enrollment process is completed. This temporary identification card is different, since providers may see more than one child listed if multiple children in one household are enrolled through EE. However, each child will receive his or her own ForwardHealth card after the application is submitted.

Each member who is enrolled through EE will receive a ForwardHealth card usually within three business days after the EE application is submitted and approved. To ensure children and pregnant women receive needed services in a timely manner, providers should accept the printed paper EE cards for children and either the printed paper EE card or the beige identification cards for pregnant women as proof of enrollment for the dates provided on the cards. Providers may use Wisconsin's EVS to verify enrollment for DOS after those printed on the card. Providers are encouraged to keep a photocopy of the card.

Temporary ForwardHealth Identification Cards

All Medicaid certifying agencies have the authority to issue green paper temporary identification cards to applicants who meet enrollment requirements. Temporary cards are usually issued only when an applicant is in need of medical services prior to receiving the ForwardHealth card. Providers should accept temporary cards as proof of enrollment. Eligible applicants may receive covered services for the dates shown on the card.

Providers are encouraged to keep a photocopy of the temporary card and should delay submitting claims for one week from the enrollment start date until the enrollment information is transmitted to ForwardHealth.

ForwardHealth accepts properly completed and submitted claims for covered services provided to applicants possessing a temporary card as long as the DOS is within the dates shown on the card.

If a claim is denied with an enrollment-related explanation, even though the provider verified the member's enrollment before providing the service, a good faith claim may be submitted.

Types of Identification Cards

ForwardHealth members receive an identification card upon initial eligibility determination. Identification cards may be in any of the following formats:

- White plastic ForwardHealth cards.
- White plastic ForwardHealth Core Plan cards.
- White plastic ForwardHealth Basic Plan cards.
- Green paper temporary cards.
- Paper printout temporary card for EE for children.
- Paper printout temporary card for EE for pregnant women.
- Beige paper temporary card for EE for pregnant women.
- White paper TE for Family Planning Only Services cards.

Misuse and Abuse of Benefits

Examples of Member Abuse or Misuse

Examples of member abuse or misuse are included in DHS 104.02(5), Wis. Admin. Code.

Notifying ForwardHealth

Providers are required to notify ForwardHealth if they have reason to believe that a person is misusing or abusing BadgerCare Plus or Medicaid benefits or the ForwardHealth identification card. Section 49.49, Wis. Stats., defines actions that represent member misuse or abuse of benefits and the resulting sanctions that may be imposed. Providers are under no obligation to inform the member that they are doing so. A provider may not confiscate a ForwardHealth card from a member in question.

If a provider suspects that a member is abusing his or her benefits or misusing his or her ForwardHealth card, providers are required to notify ForwardHealth by calling Provider Services or by writing to the following office:

Division of Health Care Access and Accountability
Bureau of Program Integrity
PO Box 309
Madison WI 53701-0309

ForwardHealth monitors member records and can impose sanctions on those who misuse or abuse their benefits. For more information on member misuse and abuse and the resulting sanctions, refer to s. 49.49, Wis. Stats.

Pharmacy Services Lock-In Program

Information for DOS on and after April 1, 2011, is available.

Overview of the Pharmacy Services Lock-In Program

The purpose of the Pharmacy Services Lock-In Program is to coordinate the provision of health care services for members who abuse or misuse Medicaid, BadgerCare Plus, or SeniorCare benefits by seeking duplicate or medically unnecessary services, particularly prescriptions for controlled substances.

Coordination of member health care services is intended to do the following:

- Curb the abuse or misuse of controlled substance medications.
- Improve the quality of care for a member.
- Reduce unnecessary physician utilization.

The Pharmacy Services Lock-In Program focuses on the abuse or misuse of controlled substance medications. Abuse or misuse is defined under Recipient Duties in DHS 104.02(5), Wis. Admin. Code. The abuse and misuse definition includes, but is not limited to, the following:

- Duplicating or altering prescriptions.
- Feigning illness, using false pretense, providing incorrect enrollment status, or providing false information to obtain service.
- Seeking duplicate care from more than one provider for the same or similar condition.
- Seeking medical care that is excessive or not medically necessary.

Members enrolled in the Pharmacy Services Lock-In Program are assigned to one primary care provider and one pharmacy to reduce unnecessary physician and pharmacy utilization and to discourage the non-medical or excessive use of prescription drugs.

The Pharmacy Services Lock-In program applies to members in fee-for-service as well as members enrolled in Medicaid SSI HMOs and BadgerCare Plus HMOs. Members remain enrolled in the Pharmacy Services Lock-In Program for two years and are continuously monitored for their prescription drug usage. At the end of the two-year enrollment period an assessment is made to determine if the member should continue enrollment in the Pharmacy Services Lock-In Program.

HID administers the Pharmacy Services Lock-In Program. Providers may contact the Pharmacy Services Lock-In Program by calling (800) 225-6998, extension 3045.

Reporting Suspected Member Misuse of Benefits

ForwardHealth operates a therapeutic DUR program designed to routinely monitor prescription drug use by members. The purpose of the DUR program is to identify potential clinical problems related to drug therapy and instances of potentially inappropriate drug use. When a member is identified through the DUR Program of suspected misuse of benefits, the member and the member's primary care provider(s) and pharmacy(s) may be notified.

Providers may also report members suspected of inappropriate prescription drug use by completing the Pharmacy Services Lock-In Program Request for Review of Member Prescription Drug Use form and submitting the form to the Pharmacy Services Lock-In Program. When a provider refers a member for review, the Lock-In Program assesses the member's history of prescription drug claims to identify patterns that suggest possible misuse of prescription drugs.

The Pharmacy Services Lock-In Program monitors claims for pharmacy services and prescription drugs specifically. The Pharmacy Services Lock-In Program does not address other types of member fraud or misuse of benefits, such as misuse of the ForwardHealth identification card or excessive use of emergency room services.

Designated Lock-In Pharmacy and Primary Care Provider

Members enrolled in the Pharmacy Services Lock-In Program are required to designate one Lock-In pharmacy and one Lock-In primary care provider. If the member fails to designate Lock-In providers, ForwardHealth or the member's HMO choose for the member. During the member's enrollment in the Lock-In Program, the member may only receive services from the Lock-In primary care provider and the Lock-In pharmacy unless a referral is in place for another provider.

Fee-for-service members are assigned to one pharmacy and one primary care provider.

Members enrolled in an HMO are assigned to one pharmacy. The HMO is assigned as the member's designated Lock-In primary care provider. The HMO may in turn assign the member to one of the HMO's primary care providers.

Role of the Lock-In Pharmacy and Primary Care Provider

The Lock-In pharmacy fills prescriptions that are medically necessary for the member and works with the Lock-In primary care provider or HMO to ensure the member's drug regimen is consistent with the overall care plan. The Lock-In pharmacy may fill prescriptions from prescribers other than the Lock-In primary care provider, but the Lock-In pharmacy must assure that prescriptions are medically necessary, are consistent with the care plan, and are not overlapping with other similar medications. If the member presents a prescription from an emergency room visit, the pharmacist at the Lock-In pharmacy must use his or her professional judgment as to whether or not to fill the prescription.

The Lock-In primary care provider determines what services are medically necessary for the member, provides those services at his or her discretion, and refers the member to other providers if needed. The Lock-In primary care provider also may contact the Lock-In pharmacy to give the pharmacist(s) guidelines as to which medications should be filled for the member and from whom.

Changing the Designated Lock-In Provider

If circumstances arise that require a change to the member's designated Lock-In pharmacy or primary care provider, contact the Pharmacy Services Lock-In Program at (800) 225-6998, extension 3045. Providers should allow at least one business day for the change to be applied to the member's file.

Referrals for Members Enrolled in the Pharmacy Services Lock-In Program

For all non-emergency, medically necessary, non-pharmacy services, the member's designated Lock-In primary care provider may perform the service or refer the member to another provider, as necessary. The member's Lock-In pharmacy may refer the member to other pharmacies to fill prescriptions if needed.

Referrals to other providers must be on file with the Pharmacy Services Lock-In Program before the member may receive services from any provider other than the designated Lock-In primary care provider or pharmacy. Services provided by providers other than the member's designated Lock-In primary care provider or pharmacy are not reimbursable unless a referral is on file with ForwardHealth.

If the member requires a referral, the Lock-In provider is required to complete the Pharmacy Services Lock-In Program Designation of Alternate Prescriber for Restricted Medication Services form. Referrals for fee-for-service members must be on file with the Pharmacy Services Lock-In Program. Referrals for HMO members must be on file with the Pharmacy Services Lock-In Program and the member's HMO.

Note: Emergency medical care is the only exception to the referral requirement.

Looking Up Referral Providers on the ForwardHealth Portal

ForwardHealth Portal member enrollment verification indicates a member's referral providers under the Pharmacy Services Lock-In Program. When a provider looks up member enrollment information, the Portal lists the member's Lock-In pharmacy, Lock-In primary care provider (when applicable), and referral providers.

Providers May Refuse to Provide Services

Providers may refuse to provide services to a BadgerCare Plus or Medicaid member in situations when there is reason to believe that the person presenting the ForwardHealth identification card is misusing or abusing it.

Members who abuse or misuse BadgerCare Plus or Wisconsin Medicaid benefits or their ForwardHealth card may have their benefits terminated or be subject to limitations under the Pharmacy Services Lock-In Program or to criminal prosecution.

Requesting Additional Proof of Identity

Providers may request additional proof of identity from a member if they suspect fraudulent use of a ForwardHealth identification card. If another form of identification is not available, providers can compare a person's signature with the signature on the back of the ForwardHealth identification card if it is signed. (Adult members are encouraged to sign the back of their cards; however, it is not mandatory for members to do so.)

Verifying member identity, as well as enrollment, can help providers detect instances of fraudulent ForwardHealth card use.

Special Enrollment Circumstances

Medicaid Members from Other States

Wisconsin Medicaid does not pay for services provided to members enrolled in other state Medicaid programs. Providers are advised to contact other state Medicaid programs to determine whether the service sought is a covered service under that state's Medicaid program.

Members Traveling Out of State

When a member travels out of state but is within the United States (including its territories), Canada, or Mexico, BadgerCare Plus covers medical services in any of the following circumstances:

- An emergency illness or accident.
- When the member's health would be endangered if treatment were postponed.
- When the member's health would be endangered if travel to Wisconsin were undertaken.
- When PA has been granted to the out-of-state provider for provision of a nonemergency service.
- When there are coinsurance, copayment, or deductible amounts remaining after Medicare payment or approval for dual eligibles.

Note: Some providers located in a state that borders Wisconsin may be Wisconsin Medicaid certified as a border-status provider if the provider notifies ForwardHealth in writing that it is common practice for members in a particular area of Wisconsin to seek his or her medical services. Border-status providers follow the same policies as Wisconsin providers.

Non-U.S. Citizens — Emergency Services

Certain non-U.S. citizens who are not qualified aliens are eligible for BadgerCare Plus services only in cases of acute emergency medical conditions. Providers should use the appropriate ICD-9-CM diagnosis code to document the nature of the emergency.

An emergency medical condition is a medical condition manifesting itself by acute symptoms of such severity that one could reasonably expect the absence of immediate medical attention to result in the following:

- Placing the person's health in serious jeopardy.
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.

Due to federal regulations, BadgerCare Plus does not cover services for non-U.S. citizens who are not qualified aliens related to routine prenatal or postpartum care, major organ transplants (e.g., heart, liver), or ongoing treatment for chronic conditions where there is no evidence of an acute emergent state. For the purposes of this policy, all labor and delivery is considered an emergency service.

Note: Babies born to certain non-qualifying immigrants are eligible for Medicaid enrollment under the CEN option. However, babies born to women with incomes over 300 percent of the FPL are not eligible for CEN status. The baby may still qualify for BadgerCare Plus. These mothers should report the birth to the local agencies within ten calendar days.

A provider who gives emergency care to a non-U.S. citizen should refer him or her to the local county or tribal agency or ForwardHealth outstation site for a determination of BadgerCare Plus enrollment. Providers may complete the Certification of Emergency for Non-U.S. Citizens form, for clients to take to the local county or tribal agency in their county of residence where the

BadgerCare Plus enrollment decision is made.

Providers should be aware that a client's enrollment does not guarantee that the services provided will be reimbursed by BadgerCare Plus.

Out-of-State Youth Program

The OSY program is responsible for health care services provided to Wisconsin children placed outside the state in foster and subsidized adoption situations. These children are eligible for coverage. The objective is to assure that these children receive quality medical care.

Out-of-state providers not located in border-status-eligible communities may qualify as border-status providers if they deliver services as part of the OSY program. However, providers who have border status as part of the OSY program are reimbursed only for services provided to the specific foster care or subsidized adopted child. In order to receive reimbursement for services provided to other members, the provider is required to follow rules for out-of-state noncertified providers.

For subsidized adoptions, benefits are usually determined through the adoption assistance agreement and are provided by the state where the child lives. However, some states will not provide coverage to children with state-only funded adoption assistance. In these cases, Wisconsin will continue to provide coverage.

OSY providers are subject to the same regulations and policies as other certified border-status providers. For more information about the OSY program, call Provider Services or write to ForwardHealth at the following address:

ForwardHealth
Out-of-State Youth
Ste 50
6406 Bridge Rd
Madison WI 53784-0050

Persons Detained by Legal Process

Most individuals detained by legal process are *not* eligible for BadgerCare Plus or Wisconsin Medicaid benefits. Only those individuals who qualify for the BadgerCare Plus Expansion for Certain Pregnant Women may receive benefits.

"Detained by legal process" means a person who is incarcerated (including some Huber Law prisoners) because of law violation or alleged law violation, which includes misdemeanors, felonies, delinquent acts, and day-release prisoners. The justice system oversees health care-related needs for individuals detained by legal process who do not qualify for the BadgerCare Plus Expansion for Certain Pregnant Women.

Retroactive Enrollment

Retroactive enrollment occurs when an individual has applied for BadgerCare Plus or Medicaid and enrollment is granted with an effective date prior to the date the enrollment determination was made. A member's enrollment may be backdated to allow retroactive coverage for medical bills incurred prior to the date of application.

The retroactive enrollment period may be backdated up to three months prior to the month of application if all enrollment requirements were met during the period. Enrollment may be backdated more than three months if there were delays in determining enrollment or if court orders, fair hearings, or appeals were involved.

Reimbursing Members in Cases of Retroactive Enrollment

When a member receives retroactive enrollment, he or she has the right to request the return of payments made to a Medicaid-certified provider for a covered service during the period of retroactive enrollment, according to DHS 104.01(11), Wis. Admin. Code. A Medicaid-certified provider is required to submit claims to Medicaid for covered services provided to a member during periods of retroactive enrollment. Medicaid cannot directly refund the member.

If a service(s) that requires PA was performed during the member's period of retroactive enrollment, the provider is required to submit a PA request and receive approval from Medicaid *before* submitting a claim.

If a provider receives reimbursement from Medicaid for services provided to a retroactively enrolled member and the member has paid for the service, the provider is required to reimburse the member or authorized person acting on behalf of the member (e.g., local General Relief agency) the full amount that the member paid for the service.

If a claim cannot be filed within 365 days of the DOS due to a delay in the determination of a member's retroactive enrollment, the provider is required to submit the claim to Timely Filing within 180 days of the date the retroactive enrollment is entered into Wisconsin's EVS (if the services provided during the period of retroactive enrollment were covered).

Spenddown to Meet Financial Enrollment Requirements

Occasionally, an individual with significant medical bills meets all enrollment requirements except those pertaining to income. These individuals are required to "spenddown" their income to meet financial enrollment requirements.

The certifying agency calculates the individual's spenddown (or deductible) amount, tracks all medical costs the individual incurs, and determines when the medical costs have satisfied the spenddown amount. (A payment for a medical service does not have to be made by the individual to be counted toward satisfying the spenddown amount.)

When the individual meets the spenddown amount, the certifying agency notifies ForwardHealth and the provider of the last service that the individual is eligible beginning on the date that the spenddown amount was satisfied.

If the individual's last medical bill is greater than the amount needed to satisfy the spenddown amount, the certifying agency notifies the affected provider by indicating the following:

- The individual is eligible for benefits as of the DOS on the last bill.
- A claim for the service(s) on the last bill should be submitted to ForwardHealth. (The claim should indicate the full cost of the service.)
- The portion of the last bill that the individual must pay to the provider.

The certifying agency also informs ForwardHealth of the individual's enrollment and identifies the following:

- The DOS of the final charges counted toward satisfying the spenddown amount.
- The provider number of the provider of the last service.
- The spenddown amount remaining to be satisfied.

When the provider submits the claim, the spenddown amount will automatically be deducted from the provider's reimbursement for the claim. The spenddown amount is indicated in the Member's Share element on the Medicaid Remaining Deductible Update form sent to providers by the member's certifying agency. The provider's reimbursement is then reduced by the amount of the member's obligation.

Prior Authorization

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Archive Date:03/01/2011

Prior Authorization:Brand Medically Necessary Drugs

Approval Criteria for Brand Name Drugs

The prescriber is required to document why it is medically necessary for the member to receive the brand name drug on the PA/BMNA. Criteria for approval of a PA request for a brand name drug include the following:

- Treatment failure(s) with the generic equivalent drug(s).
- Clinically significant adverse drug reaction(s) to the generic equivalent drug(s).
- Allergic reaction(s) to the generic equivalent drug(s).
- A medical condition that causes a contraindication to the use of the generic equivalent drug(s).

Documentation on the PA/BMNA must indicate how the brand medically necessary drug will prevent recurrence of an adverse reaction, allergic reaction, or therapeutic failure of the generic drug.

Brand Medically Necessary Drugs on the Preferred Drug List

The PDL policy regarding non-preferred drugs applies to brand medically necessary drug PA requests. For example, a prescriber writes a prescription for a brand name drug. The generic drug is currently a non-preferred drug on the PDL. Before a PA request may be approved for the brand name drug, both of the following must occur:

- Trial and failure of multiple PDL preferred drugs.
- Multiple trial and failures of preferred generic equivalent drugs.

Approval Criteria for Narrow Therapeutic Index Drugs

The clinical criteria for approval of a PA request for NTI drugs includes an *anticipated* therapeutic failure of the brand name drug.

Documentation Requirements

A PA request for a brand name NTI drug may be approved if the prescriber documents an *anticipated* therapeutic failure with a switch to a generic drug for the member. Documentation on the PA/BMNA must include the prescriber's belief that switching the member to a generic drug is likely to cause an adverse reaction.

Brand Medically Necessary Amendments

Pharmacy providers should amend a PA request if a different strength of a brand medically necessary drug is prescribed in place of a brand medically necessary drug that has an approved PA. (Providers cannot amend a denied or returned PA request.) To amend the original PA request, use the following instructions:

- Photocopy the original, approved brand medically necessary PA/RF.
- Indicate the new NDC, drug description, and other information on the photocopy of the PA/RF.
- Indicate "Brand Medically Necessary Amendment" on the top of the photocopy of the PA/RF.
- Attach a photocopy of the new prescription to the PA/RF.
- Mail or fax the completed PA amendment and the photocopy of the prescription to ForwardHealth.

Prescribers are required to complete a new PA/BMNA for each new brand medically necessary drug. Drug strength and dose changes for a brand medically necessary drug that has an approved PA request does not require a new PA/BMNA.

Documentation Requirements

BadgerCare Plus must receive adequate documentation on the PA/BMNA or attached to the PA request for the pharmacist consultant to make a determination about the request. The following are documentation requirements for PA requests for brand name drugs.

The prescriber is required to document specific details on the PA/BMNA about the previous treatment(s) with generic equivalent drugs, including the dose of medication and the approximate dates the generic equivalent drugs were taken. For each previous treatment with a generic equivalent drug, documentation on the PA/BMNA should include, but not be limited to, the following:

- Detailed documentation about the adverse drug reaction(s), allergic drug reaction(s), or treatment failure(s), including why the use of the brand name drug will prevent recurrence and achieve the desired treatment outcome.
- The duration and approximate dates of the previous treatment(s).
- The dose of medication that was taken.
- The indication for use, either a diagnosis code or diagnosis description.
- A description of the medical condition that causes a contraindication to the use of the generic equivalent drug(s).

If a member experienced a treatment failure while taking generic equivalent drugs, the prescriber should include specific details on the PA/BMNA about the treatment failure(s), as well as how the brand name drug could resolve the issue.

While the specific details indicated above may not apply to all brand medically necessary PA requests, the provider is required to indicate complete and comprehensive documentation on the PA/BMNA.

Prescribers are reminded to also document adverse drug reaction or treatment failure information completely and accurately in the member's medical record.

Medical Necessity

All brand medically necessary PA requests are reviewed by a pharmacist consultant to ensure that medical necessity requirements for brand name drugs are met. The pharmacist reviews the member's profile of pharmacy claims reimbursed by BadgerCare Plus along with the supporting PA documentation submitted by the prescriber.

In most circumstances, it will be necessary for a member to try more than one generic equivalent drug before a brand medically necessary PA request may be approved by BadgerCare Plus.

To demonstrate the medical necessity of a brand name drug, the PA request must include documentation about how the generic equivalent drug(s) failed to achieve the desired treatment outcome and why the brand name drug is expected to achieve the desired outcome. Prescribers should document on the PA request the specific details about the previous treatment results with generic equivalent drugs, including the generic equivalent drugs that the member tried.

Pharmacy Provider Requirements

To receive brand name reimbursement, pharmacies need to do the following:

- Obtain a prescription with "Brand Medically Necessary" written in the prescriber's own handwriting.
- Complete a PA/RF to be submitted with the PA/BMNA, completed by the prescriber.
- Obtain Brand Medically Necessary Prior Authorization.
- Submit claims with a "1" or "8" in the Dispense as Written Product Selection Code Field, as appropriate.

When a prescriber telephones a prescription to a pharmacy and indicates a medical need for the innovator drug, the pharmacy is

required to inform the prescriber that a handwritten certification is necessary to meet ForwardHealth's requirements. Pharmacy providers are required to have this documentation available before submitting claims to ForwardHealth. The prescriber may fax the information to the pharmacy.

Prescriber Requirements

To assist pharmacy providers in obtaining PA for brand medically necessary drugs, prescribers are required to do the following:

- Provide a prescription with "Brand Medically Necessary" written in the prescriber's own handwriting and written directly on the prescription or on the face of each new prescription or on a separate order attached to the original prescription. Typed certification, signature stamps, or certification handwritten by someone other than the prescriber does not satisfy this requirement.
- Complete the PA/BMNA. Documentation on the PA/BMNA must indicate how the brand name drug will prevent recurrence of the adverse or allergic reaction or therapeutic failure.
- Submit the prescription and PA/BMNA to the pharmacy where the prescription will be filled. Prescribers should *not* send prescription drug PA forms to ForwardHealth. The pharmacy is required to complete a PA/RF and submit the PA/BMNA, the PA/RF, and a copy of the prescription to ForwardHealth.

Prior Authorization/Brand Medically Necessary Attachment

A PA/BMNA must be completed by the prescriber for brand medically necessary drugs. The prescriber's name, address, and telephone number must be indicated on the PA/BMNA.

Clinical criteria for prescribing brand medically necessary drugs must be documented by the prescriber on the PA/BMNA. The prescriber is required to submit completed PA/BMNAs to the pharmacy provider. For new and refill prescriptions, the prescriber may mail, fax, or e-mail a completed copy of the PA/BMNA to the pharmacy, or he or she may send a completed copy with the member to the pharmacy provider. A PA/BMNA must accompany all brand medically necessary PA requests.

The phrase "brand medically necessary" must appear in the prescriber's handwriting on the face of each new prescription for a brand medically necessary drug. It must also appear on each new nursing facility order. A typed certification, a signature stamp, or a certification handwritten by someone other than the prescriber does not satisfy the requirement. Blanket authorization for an individual member, drug, or prescriber is not acceptable documentation.

Prescribers are responsible for providing pharmacy providers with the required brand medically necessary documentation to assist providers in obtaining PA. Pharmacy providers are responsible for submitting this documentation with the PA request to ForwardHealth.

Pharmacy providers are required to attach the completed PA/BMNA to a PA/RF and submit the forms and specific prescription information (i.e., a copy of the prescription) to ForwardHealth. The pharmacy provider may contact the prescriber to obtain a completed copy of the form. Prescribers may also change the prescription to FDA-approved generic equivalent if medically appropriate for the recipient.

Prescribers are not required to submit a new PA/BMNA when a new strength of the same medication is prescribed. Prescribers are required to submit a new, completed PA/BMNA only when prescribing a new brand medically necessary drug. Pharmacy providers may contact prescribers regarding members who receive prescriptions with "Brand Medically Necessary" written on them. The pharmacy provider may request that the prescriber complete the PA/BMNA and submit it to the pharmacy provider so the member may continue to receive the brand name drug.

Pharmacy providers and prescribers are encouraged to retain copies of approved PA/RFs or approved PA/RFs and PA/BMNA forms with modifications in a member's medical record.

Titration

A prescriber who titrates a brand medically necessary drug for a member may require more than one strength of the drug on a PA/BMNA form. The prescriber should include a prescription for each strength of the titrated brand medically necessary drug with the PA/BMNA form. Pharmacy providers should include the NDCs of all requested strengths of the drug on the PA/RF.

Decisions

An Overview

ForwardHealth will make a decision regarding 24-hour PA requests, such as PA requests for brand medically necessary drugs, within 24 hours with the receipt of all the necessary information and telephone or fax the decision to the provider who submitted the PA request.

Approved Requests

PA requests are approved for varying periods of time based on the clinical justification submitted. The provider receives a copy of a PA decision notice when a PA request for a service is approved. Providers may then begin providing the approved service on the grant date given.

An approved request means that the requested *service*, not necessarily the code, was approved. For example, a similar procedure code may be substituted for the originally requested procedure code. Providers are encouraged to review approved PA requests to confirm the services authorized and confirm the assigned grant and expiration dates.

Listing Procedure Codes Approved as a Group on the Decision Notice Letter

In certain circumstances, ForwardHealth will approve a PA request for a group of procedure codes with a total quantity approved for the entire group. When this occurs, the quantity approved for the entire group of codes will be indicated with the first procedure code. All of the other approved procedure codes within the group will indicate a quantity of zero.

Providers may submit claims for any combination of the procedure codes in the group up to the approved quantity.

Once a PA request is approved, a member may go to any certified pharmacy provider to obtain the prior authorized drug. The member's PA does not need to be enddated when the member changes pharmacies.

Communicating Prior Authorization Decisions

ForwardHealth will make a decision regarding a provider's PA request within 20 working days from the receipt of all the necessary information. After processing the PA request, ForwardHealth will send the provider either a decision notice letter or a returned provider review letter. Providers will receive a decision notice letter for PA requests that were approved, approved with modifications, or denied. Providers will receive a returned provider review letter for PA requests that require corrections or additional information. The decision notice letter or returned provider review letter will clearly indicate what is approved or what correction or additional information ForwardHealth needs to continue adjudicating the PA request.

Providers submitting PA requests via the ForwardHealth Portal will receive a decision notice letter or returned provider review letter via the Portal.

If the provider submitted a PA request via mail or fax and the provider has a Portal account, the decision notice letter or returned provider review letter will be sent to the provider via the Portal as well as by mail.

If the provider submitted a paper PA request via mail or fax and does not have a Portal account, the decision notice letter or returned provider review letter will be sent to the address indicated in the provider's file as his or her PA address (or to the physical address if there is no PA address on file), *not* to the address the provider wrote on the PA request.

The decision notice letter or returned provider review letter will not be faxed back to providers who submitted their paper PA request via fax. Providers who submitted their paper PA request via fax will receive the decision notice letter or returned provider letter via mail.

Correcting Returned Prior Authorization Requests and Request Amendments on the Portal

If a provider received a returned provider review letter or an amendment provider review letter, he or she will be able to correct the errors identified on the returned provider review letter directly on the ForwardHealth Portal. Once the provider has corrected the error(s), the provider can resubmit the PA request or amendment request via the Portal to ForwardHealth for processing.

Decision Notice Letters and Returned Provider Review Letters on the Portal

Providers can view PA decision notices and provider review letters via the secure area of the ForwardHealth Portal. Prior authorization decision notices and provider review letters can be viewed when the PA is selected on the Portal.

Note: The PA decision notice or the provider review letter will not be available until the day after the PA request is processed by ForwardHealth.

Denied Requests

When a PA request is denied, both the provider and the member are notified. The provider receives a PA decision notice, including the reason for PA denial. The member receives a Notice of Appeal Rights letter that includes a brief statement of the reason PA was denied and information about his or her right to a fair hearing. Only the *member, or authorized person acting on behalf of the member*, can appeal the denial.

Providers may call Provider Services for clarification of why a PA request was denied.

Providers are required to discuss a denied PA request with the member and are encouraged to help the member understand the reason the PA request was denied.

Providers have three options when a PA request is denied:

- Not provide the service.
- Submit a *new* PA request. Providers are required to submit a copy of the original denied PA request and additional supporting clinical documentation and medical justification along with a new PA/RF, PA/DRF, or PA/HIAS1.
- Provide the service as a noncovered service.

If the member does not appeal the decision to deny the PA request or appeals the decision but the decision is upheld and the member chooses to receive the service anyway, the member may choose to receive the service(s) as a noncovered service.

Modified Requests

Modification is a change in the services originally requested on a PA request. Modifications could include, but are not limited to, either of the following:

- The authorization of a procedure code different than the one originally requested.

- A change in the frequency or intensity of the service requested.

When a PA request is modified, both the provider and the member are notified. The provider will be sent a decision notice letter. The decision notice letter will clearly indicate what is approved or what correction or additional information is needed to continue adjudicating the PA request. The member receives a Notice of Appeal Rights letter that includes a brief statement of the reason PA was modified and information on his or her right to a fair hearing. Only the *member, or authorized person acting on behalf of the member*, can appeal the modification.

Providers are required to discuss with the member the reasons a PA request was modified.

Providers have the following options when a PA request is approved with modification:

- Provide the service as authorized.
- Submit a request to amend the modified PA request. Additional supporting clinical documentation and medical justification must be included.
- Not provide the service.
- Provide the service as originally requested as a noncovered service.

If the member does not appeal the decision to modify the PA request or appeals the decision but the decision is upheld and the member chooses to receive the originally requested service anyway, the member may choose to receive the service(s) as a noncovered service.

Providers may call Provider Services for clarification of why a PA request was modified.

Response Time

For most drugs, BadgerCare Plus and SeniorCare respond by fax or telephone to the provider's paper PA request within 24 hours of the receipt of the request. The response consists of an acknowledgment that the PA request was received by ForwardHealth.

Weekend and Holiday Processing

Paper PA requests received Monday through Friday (except holidays) are handled as follows:

- If the request is received before 1 p.m. central time, BadgerCare Plus and SeniorCare make an attempt to notify the provider by telephone or fax within 24 hours.
- If the request is received after 1 p.m. central time, BadgerCare Plus and SeniorCare make an attempt to notify the provider by telephone or fax on the next regular business day.

Exceptions to the 24-Hour Response

BadgerCare Plus and SeniorCare respond within 24 hours except when:

- The PA request contains insufficient, incorrect, or illegible information so that BadgerCare Plus and SeniorCare cannot identify the requesting provider or determine that the requested service requires a 24-hour response.
- The PA request does not have the provider's telephone or fax number.

BadgerCare Plus and SeniorCare make three attempts to contact the provider by telephone or fax within 24 hours of receiving the PA request.

Returned Provider Review Letter Response Time

Thirty Days to Respond to the Returned Provider Review Letter

ForwardHealth must receive the provider's response within 30 calendar days of the date on the returned provider review letter, whether the letter was sent to the provider by mail or through the ForwardHealth Portal. If the provider's response is received within 30 calendar days, ForwardHealth still considers the original receipt date on the PA request when authorizing a grant date for the PA.

If ForwardHealth does not receive the provider's response within 30 calendar days of the date the returned provider review letter was sent, the PA status becomes inactive and the provider is required to submit a new PA request. This results in a later grant date if the PA request is approved. Providers will not be notified when their PA request status changes to inactive, but this information will be available on the Portal and through WiCall.

If ForwardHealth receives additional information from the provider after the 30-day deadline has passed, a letter will be sent to the provider stating that the PA request is inactive and the provider is required to submit a new PA request.

Returned Requests

A PA request may be returned to the provider when forms are incomplete, inaccurate, or additional clinical information or corrections are needed. When this occurs, the provider will be sent a provider review letter.

Returned Provider Review Letter

The returned provider review letter will indicate the PA number assigned to the request and will specify corrections or additional information needed on the PA request. Providers are required to make the corrections or supply the requested information in the space provided on the letter or attach additional information to the letter before mailing the letter to ForwardHealth. Providers can also correct PAs that have been placed in returned provider review status in the ForwardHealth Portal.

The provider's paper documents submitted with the PA request will not be returned to the provider when corrections or additional information are needed; however, X-rays, photographs, and dental molds will be returned once the PA is finalized for dentists, physicians, and DME providers. Therefore, providers are required to make a copy of their PA requests (including attachments and any supplemental information) before mailing the requests to ForwardHealth. The provider is required to have a copy on file for reference purposes if more information is required about the PA request.

Note: When changing or correcting the PA request, providers are reminded to revise or update the documentation retained in their records.

Diabetic Supplies

Prior Authorizations Approved with HCPCS Procedure Codes

Approved PAs with HCPCS procedure codes will be honored until their expiration date or until December 31, 2010, whichever is earlier. The HCPCS procedure code on the approved PA must continue to be indicated on professional claims for services for which a PA request has been approved. Effective for DOS on and after January 1, 2011, an NDC must be indicated on all claims and PA requests for diabetic supplies, with the exception of crossover claims.

Requesting Prior Authorization for Diagnosis Restricted Diabetic Supplies

Some diabetic supplies may be used to treat or monitor conditions related to diabetes. PA may be approved for blood glucose meters, blood glucose strips, control solutions, lancets, and lancet devices if the member has one of the following diagnoses:

- 249.00 (Secondary diabetes mellitus without complications [not stated]).
- 249.01 (Secondary diabetes without complications [uncontrolled]).
- 250.8 (Diabetic Hypoglycemia).
- 251.1 (Hyperinsulinemic hypoglycemia).
- 277.7 (Dysmetabolic syndrome X).
- 790.21 (Impaired fasting glucose).
- 790.22 (Abnormal glucose tolerance test).

A diagnosis from the ones listed above must be included on the PA request and on claims.

To request PA for members having one of the diagnoses above, providers are required to submit the following:

- A PA/RF.
- A PA/DGA.
- Supporting documentation.

If the PA request is denied, the supply is considered noncovered. PA requests are only considered for members enrolled in the BadgerCare Plus Standard Plan and Medicaid.

Requesting Prior Authorization for Non-Preferred Diabetic Supplies

Providers may submit PAs for non-preferred products. To receive PA for non-preferred products, members are required to try and fail on at least one product by each of the preferred manufactures.

Providers must submit a prior authorization request using the Prior Authorization Drug Attachment for Diabetic Supplies. PA requests may be submitted using the ForwardHealth Portal or by fax or mail.

For PA requests submitted by fax or mail, the following information must be submitted:

- A PA/RF.
- Prior Authorization Drug Attachment for Diabetic Supplies.
- Any supporting documentation.

Once the PA request is approved, the member may go to any certified provider to obtain the prior authorized supplies. As a result, the member's PA does not need to be enddated when the member changes providers.

Emergent and Urgent Situations

Emergency Services

In emergency situations, the PA requirement may be waived for services that normally require PA. Emergency services are defined in DHS 101.03(52), Wis. Admin. Code, as "those services which are necessary to prevent the death or serious impairment of the health of the individual."

Reimbursement is not guaranteed for services that normally require PA that are provided in emergency situations. As with all covered services, emergency services must meet all program requirements, including medical necessity, to be reimbursed by Wisconsin Medicaid. For example, reimbursement is contingent on, but not limited to, eligibility of the member, the circumstances of the emergency, and the medical necessity of the services provided.

Wisconsin Medicaid will not reimburse providers for noncovered services provided in any situation, including emergency situations.

Urgent Services

Telephone consultations with DHCAA staff regarding a prospective PA request can be given only in urgent situations when medically necessary. An urgent, medically necessary situation is one where a delay in authorization would result in undue hardship for the member or unnecessary costs for Medicaid as determined by the DHCAA. All telephone consultations for urgent services should be directed to the DHCAA's Bureau of Program Integrity at (608) 266-2521. Providers should have the following information ready when calling:

- Member's name.
- Member identification number.
- Service(s) needed.
- Reason for the urgency.
- Diagnosis of the member.
- Procedure code of the service(s) requested.

Providers are required to submit a PA request to ForwardHealth within 14 calendar days after the date of the telephone consultation. PA may be denied if the request is received more than two weeks after the consultation. If the PA request is denied in this case, the provider cannot request payment from the member.

Follow-Up to Decisions

Amendment Decisions

ForwardHealth will make a decision regarding a provider's amendment request within 20 working days from the receipt of all the information necessary. If the provider submitted the amendment request via the ForwardHealth Portal, the decision notice letter or returned amendment provider review letter will be sent to the provider via the Portal.

If the provider submitted an amendment request via mail or fax and the provider has a Portal account, the decision notice letter or returned amendment provider review letter will be sent to the provider via the Portal as well as by mail.

If the provider submitted a paper amendment request via mail or fax and does not have a Portal account, the decision notice letter or returned amendment provider review letter will be sent to the address indicated in the provider's file as his or her PA address (or to the physical address if there is no PA address on file), *not* to the address the provider wrote on the amendment request.

Neither the decision notice letter nor the returned amendment provider review letter will be faxed back to providers who submitted their paper amendment request via fax. Providers who submitted their paper amendment request via fax will receive the decision notice letter or returned amendment provider review letter via mail.

Amendments

Providers are required to use the Prior Authorization Amendment Request to amend an approved or modified PA request.

ForwardHealth does not accept a paper amendment request submitted on anything other than the Prior Authorization Amendment Request. The Prior Authorization Amendment Request may be submitted through the ForwardHealth Portal as well as by mail or fax. If ForwardHealth receives a PA amendment on a previous version of the Prior Authorization Amendment Request form, a letter will be sent to the provider stating that the provider is required to submit a new PA amendment request using the proper forms.

Examples of when providers may request an amendment to an approved or modified PA request include the following:

- To temporarily modify a member's frequency of a service when there is a short-term change in his or her medical condition.
- To change the rendering provider information when the billing provider remains the same.
- To change the ForwardHealth Member Identification Number.
- To add or change a procedure code.

Note: ForwardHealth recommends that, under most circumstances, providers should enddate the current PA request and submit a new one if there is a significant, long-term change in services required.

Appeals

If a PA request is denied or modified by ForwardHealth, only a member, or authorized person acting on behalf of the member, may file an appeal with the DHA. Decisions that may be appealed include the following:

- Denial or modification of a PA request.
- Denial of a retroactive authorization for a service.

The member is required to file an appeal within 45 days of the date of the Notice of Appeal Rights letter.

To file an appeal, members may complete and submit a Request for Fair Hearing form.

Though providers cannot file an appeal, they are encouraged to remain in contact with the member during the appeal process. Providers may offer the member information necessary to file an appeal and help present his or her case during a fair hearing.

Fair Hearing Upholds ForwardHealth's Decision

If the hearing decision upholds the decision to deny or modify a PA request, the DHA notifies the member and ForwardHealth in writing. The member may choose to receive the service (or in the case of a modified PA request, the originally requested service) as a noncovered service, not receive the service at all, or appeal the decision.

Fair Hearing Overturns ForwardHealth's Decision

If the hearing decision overturns the decision to deny or modify the PA request, the DHA notifies ForwardHealth and the member. The letter includes instructions for the provider and for ForwardHealth.

If the DHA letter instructs the provider(s) to submit a claim for the service, each provider should submit the following to ForwardHealth after the service(s) has been performed:

- A paper claim with "HEARING DECISION ATTACHED" written in red ink at the top of the claim.
- A copy of the hearing decision.
- A copy of the denied PA request.

Providers are required to submit claims with hearing decisions to the following address:

ForwardHealth
Specialized Research
Ste 50
6406 Bridge Rd
Madison WI 53784-0050

Claims with hearing decisions sent to any other address may not be processed appropriately.

If the DHA letter instructs the provider to submit a new PA request, the provider is required to submit the *new* PA request along with a copy of the hearing decision to the PA Unit at the following address:

ForwardHealth
Prior Authorization
Ste 88
6406 Bridge Rd
Madison WI 53784-0088

ForwardHealth will then approve the PA request with the revised process date. The provider may then submit a claim following the usual claims submission procedures after providing the service(s).

Financial Responsibility

If the member asks to receive the service *before* the hearing decision is made, the provider is required to notify the member before rendering the service that the member will be responsible for payment if the decision to deny or modify the PA request is upheld.

If the member accepts responsibility for payment of the service before the hearing decision is made, and if the appeal decision *upholds* the decision to deny or modify the PA request, the provider may collect payment from the member if certain conditions are met.

If the member accepts responsibility for payment of the service before the hearing decision is made, and if the appeal decision *overturns* the decision to deny or modify a PA request, the provider may submit a claim to ForwardHealth. If the provider collects payment from the member for the service before the appeal decision is overturned, the provider is required to refund the member for the *entire* amount of payment received from the member after the provider receives Medicaid's reimbursement.

Wisconsin Medicaid does not directly reimburse members.

Enddating

Providers are required to use the Prior Authorization Amendment Request to enddate most PA requests. ForwardHealth does not accept requests to enddate a PA request for any service, except drugs, on anything other than the Prior Authorization Amendment Request. PA for drugs may be enddated by using STAT-PA in addition to submitting a Prior Authorization Amendment Request.

Providers may submit a Prior Authorization Amendment Request on the ForwardHealth Portal, or by fax or mail.

If a request to enddate a PA is not submitted on the Prior Authorization Amendment Request, a letter will be sent to the provider stating that the provider is required to submit the request using the proper forms.

Examples of when a PA request should be enddated include the following:

- A member chooses to discontinue receiving prior authorized services.
- A provider chooses to discontinue delivering prior authorized services.

Examples of when a PA request should be enddated and a new PA request should be submitted include the following:

- There is an interruption in a member's continual care services.
- There is a change in the member's condition that warrants a long-term change in services required.
- The service(s) is no longer medically necessary.

Returned Amendment Provider Review Letter

If the amendment request needs correction or additional information, a returned amendment provider review letter will be sent. The letter will show how the PA appears currently in the system and providers are required to respond by correcting errors identified on the letter. Providers are required to make the corrections or supply the requested information in the space provided on the letter or attach additional information to the letter before mailing the letter to ForwardHealth. Providers can also correct an amendment request that has been placed in returned provider review status in the ForwardHealth Portal.

ForwardHealth must receive the provider's response within 30 calendar days of the date the returned amendment provider review letter was sent. After 30 days the amendment request status becomes inactive and the provider is required to submit a new amendment request. The ForwardHealth interChange system will continue to use the original approved PA request for processing claims.

The provider's paper documents submitted with the amendment request will not be returned to the provider when corrections or additional information are needed; however, X-rays, photographs, and dental models will be returned once the amendment request is finalized for dentists, physicians, and DME providers. Therefore, providers are required to make a copy of their amendment requests (including attachments and any supplemental information) before mailing the requests to ForwardHealth. The provider is required to have a copy on file for reference purposes if ForwardHealth requires more information about the amendment request.

Note: When changing or correcting the amendment request, providers are reminded to revise or update the documentation retained in their records.

Searching for Previously Submitted Prior Authorization Requests on the Portal

Providers will be able to search for all previously submitted PA requests, regardless of how the PA was initially submitted. If the provider knows the PA number, he or she can enter the number to retrieve the PA information. If the provider does not know the PA number, he or she can search for a PA by entering information in one or more of the following fields:

- Member identification number.
- Requested start date.
- Prior authorization status.
- Amendment status.

If the provider does not search by any of the information above, providers will retrieve all their PA requests submitted to ForwardHealth.

Forms and Attachments

An Overview

Depending on the service being requested, most PA requests must be comprised of the following:

- The PA/RF, PA/DRF, or PA/HIAS1.
- A service-specific PA attachment(s).
- Additional supporting clinical documentation.

Attachments

In addition to the PA/RF, PA/HIAS1, or PA/DRF, a service-specific PA attachment must be submitted with each PA request. The PA attachment allows a provider to document the clinical information used to determine whether or not the standards of medical necessity are met for the requested service(s). Providers should include adequate information for ForwardHealth to make a reasonable judgment about the case.

ForwardHealth will scan each form with a barcode as it is received, which will allow greater efficiencies for processing PA requests.

Obtaining Forms and Attachments

Providers may obtain paper versions of all PA forms and attachments. In addition, providers may download and complete most PA attachments from the ForwardHealth Portal.

Paper Forms

Paper versions of all PA forms and PA attachments are available by writing to ForwardHealth. Include a return address, the name of the form, the form number (if applicable), and mail the request to the following address:

ForwardHealth
Form Reorder
6406 Bridge Rd
Madison WI 53784-0003

Providers may also call Provider Services to order paper copies of forms.

Downloadable Forms

Most PA attachments can be downloaded and printed in their original format from the Portal. Many forms are available in fillable PDF and fillable Microsoft® Word formats.

Web Prior Authorization Via the Portal

Certain providers may complete the PA/RF and PA attachments through the Portal. Providers may then print the PA/RF (and in some cases the PA attachment), and send the PA/RF, service-specific PA attachments, and any supporting documentation on paper by mail or fax to ForwardHealth.

Pharmacy Prior Authorization Forms

PA/PDL forms, PA drug attachment forms, and the PA/DGA are available on the Forms page of the ForwardHealth Portal.

Prior Authorization Forms for Core Plan Members

Prescribers are required to complete the following PA forms to request PA for Core Plan members:

- Prior Authorization Drug Attachment for Provigil.
- PA/PDL for Suboxone and Buprenorphine.

Prescribers should complete the appropriate PA form and submit it to the pharmacy provider where the prescription will be filled.

For PA requests for cytokine and CAM antagonist drugs, providers should complete and submit the appropriate PA/PDL form to ForwardHealth.

Submitting Prior Authorization Requests

Providers are required to complete and submit the following information to ForwardHealth with each PA request:

- A PA/RF completed by the pharmacy provider.
- The appropriate PA form completed by the prescriber.
- Additional supporting clinical documentation from the prescriber.

Certain PA requests may require additional supporting clinical documentation to justify the medical necessity for a service(s). Supporting documentation may include, but is not limited to, a physician's prescription, clinical reports, and other materials related to the member's condition.

Prior Authorization Request Form

The PA/RF is used by ForwardHealth and is mandatory for most providers when requesting PA. The PA/RF serves as the cover page of a PA request.

Providers are required to complete the basic provider, member, and service information on the PA/RF. Each PA request is assigned a unique ten-digit number. ForwardHealth remittance information will report to the provider the PA number used to process claim for prior authorized services.

Prior Authorization Request Form Completion Instructions for Pharmacy Services and Diabetic Supplies

A sample PA/RF for pharmacy services and diabetic supplies is available.

ForwardHealth requires certain information to enable the programs to authorize and pay for medical services provided to eligible members.

Members of ForwardHealth are required to give providers full, correct, and truthful information for the submission of correct and complete claims for reimbursement. This information should include, but is not limited to, information concerning enrollment status, accurate name, address, and member identification number (DHS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about program applicants and members is confidential and is used for purposes directly related to ForwardHealth administration such as determining eligibility of the applicant, processing PA requests, or processing provider claims for reimbursement. The use of the PA/RF is mandatory to receive PA for certain items. Failure to supply the information requested by the form may result in denial of PA or payment for the service.

Providers should make duplicate copies of all paper documents mailed to ForwardHealth. Providers may submit PA requests, along with all applicable service-specific attachments, by fax to ForwardHealth at (608) 221-8616 or by mail to the following address:

ForwardHealth
Prior Authorization
Ste 88
6406 Bridge Rd
Madison WI 53784-0088

The provision of services that are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s).

SECTION I — PROVIDER INFORMATION

Element 1 — HealthCheck "Other Services" and Wisconsin Chronic Disease Program (WCDP)
Enter an "X" in the box next to HealthCheck "Other Services" if the services requested on the PA/RF are for HealthCheck "Other Services." Enter an "X" in the box next to WCDP if the services requested on the PA/RF are for a WCDP member.

Element 2 — Process Type
Enter the process type 131 — Drugs. The process type is a three-digit code used to identify a category of service requested.

Element 3 — Telephone Number — Billing Provider
Enter the telephone number, including the area code, of the office, clinic, facility, or place of business of the billing provider.

Element 4 — Name and Address — Billing Provider
Enter the name and complete address (street, city, state, and ZIP+4 code) of the billing provider. Providers are required to include both the ZIP code and the four-digit extension for timely and accurate billing. The name listed in this element must correspond with the billing provider number listed in Element 5a.

Element 5a — Billing Provider Number
Enter the NPI of the billing provider. The NPI in this element must correspond with the provider name listed in Element 4.

Element 5b — Billing Provider Taxonomy Code
Enter the national 10-digit alphanumeric taxonomy code that corresponds to the NPI of the billing provider in Element 5a.

SECTION II — MEMBER INFORMATION

Element 6 — Member Identification Number
Enter the member ID. Do not enter any other numbers or letters. Use the ForwardHealth identification card or Wisconsin's EVS to obtain the correct number.

Element 7 — Date of Birth — Member
Enter the member's date of birth in MM/DD/CCYY format.

Element 8 — Address — Member
Enter the complete address of the member's place of residence, including the street, city, state, and ZIP code. If the member is a resident of a nursing home or other facility, include the name of the nursing home or facility.

Element 9 — Name — Member

Enter the member's last name, followed by his or her first name and middle initial. Use the EVS to obtain the correct spelling of the member's name. If the name or spelling of the name on the ForwardHealth card and the EVS do not match, use the spelling from the EVS.

Element 10 — Gender — Member
Enter an "X" in the appropriate box to specify male or female.

SECTION III — DIAGNOSIS / TREATMENT INFORMATION

Element 11 — Diagnosis — Primary Code and Description
Enter the appropriate ICD-9-CM diagnosis code and description most relevant to the service/procedure requested.

Element 12 — Start Date — SOI (not required)

Element 13 — First Date of Treatment — SOI (not required)

Element 14 — Diagnosis — Secondary Code and Description
Enter the appropriate secondary ICD-9-CM diagnosis code and description relevant to the service/procedure requested, if applicable.

Element 15 — Requested PA Start Date
Enter the requested start DOS in MM/DD/CCYY format, if a specific start date is requested.

Element 16 — Rendering Provider Number
Enter the prescribing provider's NPI.

Element 17 — Rendering Provider Taxonomy Code
Enter the national 10-digit alphanumeric taxonomy code that corresponds to the provider who will be performing the service, only if this code is different from the taxonomy code listed for the billing provider in Element 5b.

Element 18 — Procedure Code
Enter the appropriate NDC for each service/procedure/item requested.

Element 19 — Modifiers
Enter the modifier(s) corresponding to the service code listed if a modifier is required.

Element 20 — POS
Enter the appropriate NCPDP patient location code designating where the requested item would be provided/performed/dispensed.

Element 21 — Description of Service
Enter a written description corresponding to the appropriate NDC for each item requested.

Element 22 — QR
Enter the appropriate quantity (e.g., days' supply) requested for the procedure code listed.

Element 23 — Charge
Enter the provider's usual and customary charge for each service/procedure/item requested. If the quantity is greater than "1.0," multiply the quantity by the charge for each service/procedure/item requested. Enter that total amount in this element.

Note: The charges indicated on the request form should reflect the provider's usual and customary charge for the procedure requested. Providers are reimbursed for authorized services according to provider *Terms of Reimbursement* issued by the DHS.

Element 24 — Total Charges
Enter the anticipated total charges for this request.

Element 25 — Signature — Requesting Provider
The original signature of the provider requesting/performing/dispensing this service/procedure/item must appear in this element.

Element 26 — Date Signed
Enter the month, day, and year the PA/RF was signed (in MM/DD/CCYY format).

Prior Authorization Request Form Completion Instructions for Prescribers for Drugs

ForwardHealth requires certain information to enable the programs to authorize and pay for medical services provided to eligible members.

Members of ForwardHealth are required to give providers full, correct, and truthful information for the submission of correct and complete claims for reimbursement. This information should include, but is not limited to, information concerning enrollment status, accurate name, address, and member identification number (DHS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about program applicants and members is confidential and is used for purposes directly related to ForwardHealth administration such as determining eligibility of the applicant, processing PA requests, or processing provider claims for reimbursement. The use of this form is mandatory to receive PA of certain procedures/services/items. Failure to supply the information requested by the form may result in denial of PA or payment for the service.

Providers should make duplicate copies of all paper documents mailed to ForwardHealth. Providers may submit PA requests, along with all applicable service-specific attachments by fax to ForwardHealth at (608) 221-8616 or by mail to the following address:

ForwardHealth
Prior Authorization
Ste 88
6406 Bridge Rd
Madison WI 53784-0088

The provision of services that are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s).

SECTION I — PROVIDER INFORMATION

Element 1 — HealthCheck "Other Services" and Wisconsin Chronic Disease Program (WCDP)

Leave the box next to HealthCheck "Other Services" blank. Enter an "X" in the box next to WCDP if the services requested on the PA/RF are for a WCDP member.

Element 2 — Process Type

Enter process type 131 — Drugs. The process type is a three-digit code used to identify a category of service requested. PA requests will be returned without adjudication if no process type is indicated.

Element 3 — Telephone Number — Billing Provider

Enter the telephone number, including the area code, of the office, clinic, facility, or place of business of the billing provider.

Note: Prescribers who are certified by Wisconsin Medicaid should indicate their name and address as the billing provider on PA

requests. Prescribers who are not certified by Wisconsin Medicaid should indicate the name and address of the Wisconsin Medicaid-certified billing provider (e.g., clinic) with which they are affiliated on PA requests.

Element 4 — Name and Address — Billing Provider

Enter the name and complete address (street, city, state, and ZIP+4 code) of the billing provider. Providers are required to include both the ZIP code and four-digit extension for timely and accurate billing. The name listed in this element must correspond with the billing provider number listed in Element 5a.

Note: Prescribers who are certified by Wisconsin Medicaid should indicate their name and address as the billing provider on PA requests. Prescribers who are not certified by Wisconsin Medicaid should indicate the name and address of the Wisconsin Medicaid-certified billing provider (e.g., clinic) with which they are affiliated on PA requests.

Element 5a — Billing Provider Number

Enter the NPI of the billing provider. The NPI in this element must correspond with the provider name listed in Element 4.

Note: Prescribers who are certified by Wisconsin Medicaid should indicate their name and address as the billing provider on PA requests. Prescribers who are not certified by Wisconsin Medicaid should indicate the name and address of the Wisconsin Medicaid-certified billing provider (e.g., clinic) with which they are affiliated on PA requests.

Element 5b — Billing Provider Taxonomy Code

Enter the national 10-digit alphanumeric taxonomy code that corresponds to the NPI of the billing provider in Element 5a.

Note: Prescribers who are certified by Wisconsin Medicaid should indicate their name and address as the billing provider on PA requests. Prescribers who are not certified by Wisconsin Medicaid should indicate the name and address of the Wisconsin Medicaid-certified billing provider (e.g., clinic) with which they are affiliated on PA requests.

SECTION II — MEMBER INFORMATION

Element 6 — Member Identification Number

Enter the member ID. Do not enter any other numbers or letters. Use the ForwardHealth identification card or Wisconsin's EVS to obtain the correct number.

Element 7 — Date of Birth — Member

Enter the member's date of birth in MM/DD/CCYY format.

Element 8 — Address — Member

Enter the complete address of the member's place of residence, including the street, city, state, and ZIP code. If the member is a resident of a nursing home or other facility, include the name of the nursing home or facility.

Element 9 — Name — Member

Enter the member's last name, followed by his or her first name and middle initial. Use the EVS to obtain the correct spelling of the member's name. If the name or spelling of the name on the ForwardHealth card and the EVS do not match, use the spelling from the EVS.

Element 10 — Gender — Member

Enter an "X" in the appropriate box to specify male or female.

SECTION III — DIAGNOSIS / TREATMENT INFORMATION

Element 11 — Diagnosis — Primary Code and Description

Enter the appropriate ICD-9-CM diagnosis code and description most relevant to the service/procedure requested.

Element 12 — Start Date — SOI (not required)

Element 13 — First Date of Treatment — SOI (not required)

Element 14 — Diagnosis — Secondary Code and Description

Enter the appropriate secondary ICD-9-CM diagnosis code and description relevant to the service/procedure requested, if applicable.

Element 15 — Requested PA Start Date

Enter the requested start DOS in MM/DD/CCYY format.

Element 16 — Rendering Provider Number

Enter the prescriber's NPI, only if the NPI is different from the NPI of the billing provider listed in Element 5a.

Element 17 — Rendering Provider Taxonomy Code

Enter the national 10-digit alphanumeric taxonomy code that corresponds to the prescriber only if this code is different from the taxonomy code listed for the billing provider in Element 5b.

Element 18 — Procedure Code (not required)

Element 19 — Modifiers (not required)

Element 20 — POS

Enter the NCPDP patient location code of "0" (Not Specified).

Element 21 — Description of Service

Enter the drug name and dose for each item requested (e.g., drug name, milligrams, capsules).

Element 22 — QR

Enter the appropriate quantity (e.g., days' supply) requested for each item requested.

Element 23 — Charge (not required)

Element 24 — Total Charges (not required)

Element 25 — Signature — Requesting Provider

The original signature of the provider requesting this item must appear in this element.

Element 26 — Date Signed

Enter the month, day, and year the PA/RF was signed (in MM/DD/CCYY format).

Supporting Clinical Documentation

Certain PA requests may require additional supporting clinical documentation to justify the medical necessity for a service(s). Supporting documentation may include, but is not limited to, X-rays, photographs, a physician's prescription, clinical reports, and other materials related to the member's condition.

All supporting documentation submitted with a PA request must be clearly labeled and identified with the member's name and member identification number. Securely packaged X-rays and photographs will be returned to providers with the finalized PA request. X-rays and photographs must be mailed with the PA request. Mailing dental models with PA requests is recommended.

General Information

An Overview

The PA review process continues to include both a clerical review and a clinical review. The PA request will have one of the statuses detailed in the following table.

Prior Authorization Status	Description
Approved	The PA request was approved.
Approved with Modifications	The PA request was approved with modifications to what was requested.
Denied	The PA request was denied.
Returned — Provider Review	The PA request was returned to the provider for correction or for additional information.
Pending — Fiscal Agent Review	The PA request is being reviewed by the Fiscal Agent.
Pending — Dental Follow-up	The PA request is being reviewed by a Fiscal Agent dental specialist.
Pending — State Review	The PA request is being reviewed by the State.
Suspend — Provider Sending Information	The PA request was submitted via the ForwardHealth Portal and the provider indicated they will be sending additional supporting information on paper.
Inactive	The PA request is inactive due to no response within 30 days to the returned provider review letter and cannot be used for PA or claims processing.

Clinical Criteria for Singulair for Core Plan Members

Singulair® 10 mg is a diagnosis-restricted drug for members enrolled in the BadgerCare Plus Core Plan. PA is required for Singulair® 10 mg outside the approved diagnosis. Singulair® 10 mg is the only strength of the drug that is covered for Core Plan members.

Allergic rhinitis is the only diagnosis outside the diagnosis of asthma for which providers may submit PA requests for members enrolled in the Core Plan. PA requests will not be approved for any other diagnosis. Singulair® 10 mg is a noncovered drug if the member does not meet the diagnosis restriction for asthma or meet the PA requirements for allergic rhinitis.

PA requests for Singulair® 10 mg for Core Plan members must be submitted on the Prior Authorization Drug Attachment for Singulair® for use when the drug requires PA for allergic rhinitis.

Criteria for approval of a PA request for Singulair® are the following:

- The member has tried loratadine and experienced an adverse drug reaction or tried loratadine for at least one week and experienced a treatment failure.
- The member has tried certirizine and experienced an adverse drug reaction or tried certirizine for at least one week and experienced a treatment failure.
- The member has tried fluticasone and experienced an adverse drug reaction or tried fluticasone for at least two weeks and experienced a treatment failure.
- The member has tried flunisolide and experienced an adverse drug reaction or tried flunisolide for at least two weeks and experienced a treatment failure.
- The member has taken loratadine or certirizine in combination with fluticasone or flunisolide for at least two weeks and has experienced a treatment failure.

Communication with Members

ForwardHealth recommends that providers inform members that PA is required for certain specified services *before* delivery of the services. Providers should also explain that, if required to obtain PA, they will be submitting member records and information to ForwardHealth on the member's behalf. Providers are required to keep members informed of the PA request status throughout the *entire* PA process.

Member Questions

A member may call Member Services to find out whether or not a PA request has been submitted and, if so, when it was received by ForwardHealth. The member will be advised to contact the provider if more information is needed about the status of an individual PA request.

Definition

PA is the electronic or written authorization issued by ForwardHealth to a provider prior to the provision of a service. In most cases, providers are required to obtain PA *before* providing services that require PA. When granted, a PA request is approved for a specific period of time and specifies the type and quantity of service allowed.

Drug Prior Authorizations

Drug PAs are not provider specific. Once the PA request is approved, the member may go to any certified pharmacy provider to obtain the prior authorized drug. As a result, the member's PA does not need to be enddated when the member changes pharmacies.

Designating an Address for Prior Authorization Correspondence

Correspondence related to PA will be sent to the practice location address on file with ForwardHealth unless the provider designates a separate address for receipt of PA correspondence. This policy applies to all PA correspondence, including decision notice letters, returned provider review letters, returned amendment provider letters, and returned supplemental documentation such as X-rays and photographs.

Providers who want to designate a separate address for PA correspondence have the following options:

- Update demographic information online via the ForwardHealth Portal. (This option is only available to providers who have established a provider account on the Portal.)
- Submit a Provider Change of Address or Status form.

Drugs

Wisconsin Medicaid has the authority to require PA for certain drug products under DHS 107.10(2), Wis. Admin. Code, and the federal Omnibus Budget Reconciliation Acts of 1990 and 1993 (OBRA '90 and '93).

Most drugs do not require PA. For drugs that require PA, pharmacy providers may submit PA requests through the STAT-PA system, on the ForwardHealth Portal, using an NCPDP transaction, or on paper.

Drugs That Require Paper Prior Authorization

Paper PA request submission is required to determine medical necessity for the following drugs. Diagnosis and information regarding the medical requirements for these drug categories must be provided on the PA request for members enrolled in the BadgerCare Plus Standard Plan, Medicaid, and SeniorCare.

Drug Products That Require Paper PA Submission
Alitretinoin gel (when used to treat Kaposi's sarcoma lesions)
Brand medically necessary drugs
Diagnosis-restricted drugs that require PA outside approved diagnoses
Drugs without signed manufacturer rebate agreements*
Fertility enhancement drugs (when used to treat conditions other than infertility)
Impotence treatment drugs (when used for a condition other than impotence)
Unlisted or investigational drugs*
*SeniorCare does not cover prescription drugs, even with a PA request, that do not have a signed rebate agreement between the DHS and the manufacturer; however, these drug products may be covered for BadgerCare Plus members if a paper PA request is submitted to BadgerCare Plus.

Submitting Paper Prior Authorization Requests

Paper PA requests that are mailed to BadgerCare Plus or SeniorCare will receive an adjudication response via telephone one business day after they are received. Providers who submit PA requests by mail should be aware that this option requires additional time for the PA request to reach BadgerCare Plus and SeniorCare and for BadgerCare Plus or SeniorCare to complete the adjudication process.

To avoid delayed adjudication, do not fax and mail duplicate copies of the same PA request forms.

Pharmacy providers may contact Provider Services to determine the status of any PA request that has been submitted.

Approved, Returned, and Denied Paper Requests

A paper PA request submitted to BadgerCare Plus or SeniorCare may be approved, returned, or denied.

When a PA request is approved:

- The "approved" box on the PA/RF is checked.
- The grant and expiration dates are indicated.
- A signature and a date signed are indicated.
- A specific days' supply is indicated.

When a PA request is returned:

- The "return" box on the PA/RF is checked.
- An explanation for the return is indicated.

A PA request is returned because additional information is needed or because information on the request must be corrected. A returned PA request is not the same as a denied request. Providers should correct or add the missing information to the original PA request and resubmit it to BadgerCare Plus or SeniorCare.

When a PA request is denied:

- The "denied" box on the PA/RF is checked and an explanation is given.
- A signature and date signed are indicated.

Drugs That Require Prior Authorization

PA is required to determine medical necessity for drugs. For drugs that require PA, diagnosis and information regarding the medical requirements for these drug categories must be provided by the prescriber to the pharmacy provider.

Prior Authorization Numbers

Upon receipt of the PA/RF, ForwardHealth will assign a PA number to each PA request.

The PA number consists of 10 digits, containing valuable information about the PA (e.g., the date the PA request was received by ForwardHealth, the medium used to submit the PA request).

Each PA request is assigned a unique PA number. This number identifies valuable information about the PA. The following table provides detailed information about interpreting the PA number.

Type of Number and Description	Applicable Numbers and Description
Media — One digit indicates media type.	Digits are identified as follows: 1= paper; 2 = fax; 3 = STAT-PA; 4 = STAT-PA; 5 = Portal; 6 = Portal; 7 = NCPDP transaction
Year — Two digits indicate the year ForwardHealth received the PA request.	For example, the year 2008 would appear as 08.
Julian date — Three digits indicate the day of the year, by Julian date, that ForwardHealth received the PA request.	For example, February 3 would appear as 034.
Sequence number — Four digits indicate the sequence number.	The sequence number is used internally by ForwardHealth.

Prior Authorization and Day Supply

Drug PAs are approved based on day supply. If a claim exceeds the day supply remaining on a PA, the claim will be denied. For example, a PA was granted for a 180 day supply and 160 days supply of the drug has already been dispensed. If a claim for 30 day supply is submitted it will be denied. However, a claim for 20 day supply will be reimbursed if all other billing requirements are met.

Prior Authorization for Core Plan Members

With one exception for transitioned BadgerCare Plus Core Plan members, the following are the only drugs for which PA is required for all Core Plan members:

- Cytokine and CAM antagonist drugs.
- Provigil®.
- Suboxone® and buprenorphine.

A PA request submitted for a drug that does not require PA will be returned to the provider.

If a drug requires PA and a valid PA is not obtained, the claim will be denied with an EOB code.

Core Plan members do not have appeal rights if a PA request for a drug is denied or approved with modifications by ForwardHealth.

Claims for drugs for which PA requests have been denied may be submitted to BadgerRx Gold.

Reasons for Prior Authorization

Only about four percent of all services covered by Wisconsin Medicaid require PA. PA requirements vary for different types of services. Refer to ForwardHealth publications and DHS 107, Wis. Admin. Code, for information regarding services that require PA. According to DHS 107.02(3)(b), Wis. Admin. Code, PA is designed to do the following:

- Safeguard against unnecessary or inappropriate care and services.
- Safeguard against excess payments.
- Assess the quality and timeliness of services.
- Promote the most effective and appropriate use of available services and facilities.
- Determine if less expensive alternative care, services, or supplies are permissible.
- Curtail misutilization practices of providers and members.

PA requests are processed based on criteria established by the DHS.

Providers should not request PA for services that do not require PA simply to determine coverage or establish a reimbursement rate for a manually priced procedure code. Also, new technologies or procedures do not necessarily require PA. PA requests for services that do not require PA are typically returned to the provider. Providers having difficulties determining whether or not a service requires PA may call Provider Services.

Referrals to Out-of-State Providers

PA may be granted to non-certified out-of-state providers when nonemergency services are necessary to help a member attain or regain his or her health and ability to function independently. The PA request may be approved only when the services are not reasonably accessible to the member in Wisconsin.

Out-of-state providers are required to meet Wisconsin Medicaid's guidelines for PA approval. This includes sending PA requests, required attachments, and supporting documentation to ForwardHealth before the services are provided.

Note: Emergency services provided out-of-state do not require PA; however, claims for such services must include appropriate documentation (e.g., anesthesia report, medical record) to be considered for reimbursement. Providers are required to submit claims with supporting documentation on paper.

When a Wisconsin Medicaid provider refers a member to an out-of-state, non-certified provider, the referring provider should refer the out-of-state provider to the ForwardHealth Portal or Provider Services to obtain appropriate certification materials, PA forms, and claim instructions.

All out-of-state nursing homes, regardless of location, are required to obtain PA for all services. All other out-of-state non-border-status providers are required to obtain PA for all nonemergency services except for home dialysis supplies and equipment.

Reimbursement Not Guaranteed

Wisconsin Medicaid may decline to reimburse a provider for a service that has been prior authorized if one or more of the following program requirements is not met:

- The service authorized on the approved PA request is the service provided.
- The service is provided within the grant and expiration dates on the approved PA request.
- The member is eligible for the service on the date the service is provided.
- The provider is certified by Wisconsin Medicaid on the date the service is provided.

- The service is billed according to service-specific claim instructions.
- The provider meets other program requirements.

Providers may not collect payment from a member for a service requiring PA under any of the following circumstances:

- The provider failed to seek PA before the service was provided.
- The service was provided before the PA grant date or after the PA expiration date.
- The provider obtained PA but failed to meet other program requirements.
- The service was provided before a decision was made, the member did not accept responsibility for the payment of the service before the service was provided, and the PA was denied.

There are certain situations when a provider may collect payment for services in which PA was denied.

Other Health Insurance Sources

Providers are encouraged, but not required, to request PA from ForwardHealth for covered services that require PA when members have other health insurance coverage. This is to allow payment by Wisconsin Medicaid for the services provided in the event that the other health insurance source denies or recoups payment for the service. If a service is provided before PA is obtained, ForwardHealth will not consider backdating a PA request solely to enable the provider to be reimbursed.

Sources of Information

Providers should verify that they have the most current sources of information regarding PA. It is critical that providers and staff have access to these documents:

- Wisconsin Administrative Code: Chapters DHS 101 through DHS 109 are the rules regarding Medicaid administration.
- Wisconsin Statutes: Sections 49.43 through 49.99 provide the legal framework for Wisconsin Medicaid.
- ForwardHealth Portal: The Portal gives the latest policy information for all providers, including information about Medicaid managed care enrollees.

Status Inquiries

Providers may inquire about the status of a PA request through one of the following methods:

- Accessing WiCall, ForwardHealth's AVR system.
- Calling Provider Services.

Providers should have the 10-digit PA number available when making inquiries.

Grant and Expiration Dates

Backdating

Backdating an initial PA request or SOI to a date prior to ForwardHealth's initial receipt of the request may be allowed in limited circumstances.

A request for backdating may be approved if all of the following conditions are met:

- The provider specifically requests backdating in writing on the PA or SOI request.
- The request includes clinical justification for beginning the service before PA or SOI was granted.
- The request is received by ForwardHealth within 14 calendar days of the start of the provision of services.

Expiration Date

The expiration (end) date of an approved or modified PA request is the date through which services are prior authorized. PA requests are granted for varying periods of time. Expiration dates may vary and do not automatically expire at the end of the month or calendar year. In addition, providers may request a specific expiration date. Providers should carefully review all approved and modified PA requests and make note of the expiration dates.

Grant Date

The grant (start) date of an approved or modified PA request is the first date in which services are prior authorized and will be reimbursed under this PA number. On a PA request, providers may request a specific date that they intend services to begin. If no grant date is requested or the grant date is illegible, the grant date will typically be the date the PA request was reviewed by ForwardHealth.

Renewal Requests

To prevent a lapse in coverage or reimbursement for ongoing services, all renewal PA requests (i.e., subsequent PA requests for ongoing services) must be received by ForwardHealth *prior to the expiration date* of the previous PA request. Each provider is solely responsible for the timely submission of PA request renewals. Renewal requests will not be backdated for continuation of ongoing services.

Member Eligibility Changes

Loss of Enrollment During Treatment

Some covered services consist of sequential treatment steps, meaning more than one office visit or service is required to complete treatment.

In most cases, if a member loses enrollment midway through treatment, or at any time between the grant and enddates, Wisconsin Medicaid will *not* reimburse services (including prior authorized services) provided during an enrollment lapse. Providers should not assume Wisconsin Medicaid covers completion of services after the member's enrollment has been terminated.

To avoid potential reimbursement problems when a member loses enrollment during treatment, providers should follow these procedures:

- Ask to see the member's ForwardHealth identification card to verify the member's enrollment or consult Wisconsin's EVS before the services are provided at each visit.
- When the PA request is approved, verify that the member is still enrolled and eligible to receive the service before providing it. An approved PA request does not guarantee payment and is subject to the enrollment of the member.

Members are financially responsible for any services received after their enrollment has ended. If the member wishes to continue treatment, it is a decision between the provider and the member whether the service should be given and how payment will be made for the service.

To avoid misunderstandings, providers should remind members that they are financially responsible for any continued care after their enrollment ends.

Retroactive Disenrollment from State-Contracted MCOs

Occasionally, a service requiring fee-for-service PA is performed during a member's enrollment period in a state-contracted MCO. After the service is provided, and it is determined that the member should be retroactively disenrolled from the MCO, the member's enrollment is changed to fee-for-service for the DOS. The member is continuously eligible for BadgerCare Plus or Wisconsin Medicaid but has moved from MCO enrollment to fee-for-service status.

In this situation, the state-contracted MCO would deny the claim because the member was not enrolled on the DOS. Fee-for-service would also deny the claim because PA was not obtained.

Providers may take the following steps to obtain reimbursement in this situation:

- For a service requiring PA for fee-for-service members, the provider is required to submit a retroactive PA request. For a PA request submitted on paper, indicate "RETROACTIVE FEE-FOR-SERVICE" along with a written description of the service requested/provided under "Description of Service." Also indicate the actual date(s) the service(s) was provided. For a PA request submitted via the ForwardHealth Portal, indicate "RETROACTIVE FEE-FOR-SERVICE" along with a description of the service requested/provided under the "Service Code Description" field or include additional supporting documentation. Also indicate the actual date(s) the service(s) was provided.
- If the PA request is approved, the provider is required to follow fee-for-service policies and procedures for claims submission.
- If the PA request is denied, Wisconsin Medicaid will not reimburse the provider for the services. A PA request would be denied for reasons such as lack of medical necessity. A PA request would not be denied due to the retroactive fee-for-service status of the member.

Retroactive Enrollment

If a service(s) that requires PA was performed during a member's retroactive enrollment period, the provider is required to submit a PA request and receive approval from ForwardHealth *before* submitting a claim. For a PA request submitted on paper, indicate the words "RETROACTIVE ENROLLMENT" at the top of the PA request along with a written description explaining that the service was provided at a time when the member was retroactively enrolled under "Description of Service." Also include the actual date(s) the service(s) was provided. For a PA request submitted via the ForwardHealth Portal, indicate the words "RETROACTIVE ENROLLMENT" along with a description explaining that the service was provided at a time when the member was retroactively eligible under the "Service Code Description" field or include additional supporting documentation. Also include the actual date(s) the service(s) was provided.

If the member was retroactively enrolled, and the PA request is approved, the service(s) may be reimbursable, and the earliest effective date of the PA request will be the date the member receives retroactive enrollment. If the PA request is denied, the provider will not be reimbursed for the service(s). Members have the right to appeal the decision to deny a PA request.

If a member requests a service that requires PA before his or her retroactive enrollment is determined, the provider should explain to the member that he or she may be liable for the full cost of the service if retroactive enrollment is not granted and the PA request is not approved. This should be documented in the member's record.

Preferred Drug List

A Comprehensive Overview

PDL recommendations are made to the Wisconsin Medicaid Pharmacy PA Advisory Committee based on the therapeutic significance of individual drugs and the cost-effectiveness and supplemental rebates with drug manufacturers. Drugs to be included on the PDL are recommended to the PA Advisory Committee based on research from peer-reviewed medical literature, drug studies and trials, and clinical information prepared by clinical pharmacists.

The PDL is not a drug formulary and is not a comprehensive list of the drugs that are covered by the BadgerCare Plus Standard Plan, Medicaid, and SeniorCare.

Most drugs and drug classes included on the PDL are covered by the BadgerCare Plus Standard Plan, Medicaid, and SeniorCare, but certain drugs may have restrictions (e.g., diagnosis, quantity limits, age limits). Prescribers are encouraged to write prescriptions for preferred drugs if medically appropriate. Most preferred drugs do not require PA, except in a limited number of classes (e.g., growth hormone drugs, cytokine and CAM antagonists).

Non-preferred drugs may be covered with an approved PA. Preferred and non-preferred drugs may have other restrictions, including diagnosis, quantity limit, and age limit restrictions. Noncovered drugs (e.g., drugs used for hair loss or cosmetic purposes) are not reimbursed, even with PA.

Prescribers are required to provide clinical information so that pharmacy providers can request and obtain PA. Prescribers are required to complete the PA/PDL Exemption Request for non-preferred drugs that do not have specific clinical criteria requirements.

Clinical Criteria

Clinical criteria for approval of a non-preferred drug must be documented by the prescriber on the appropriate PA/PDL form. PA requests submitted on paper for non-preferred drugs must be submitted on the PA/PDL Exemption Request unless otherwise indicated.

If the member's condition does not meet the clinical criteria, a paper PA request and peer-reviewed medical literature must be submitted to BadgerCare Plus or SeniorCare with PA requests for non-preferred drugs.

Submitting Prior Authorization Requests

PA requests for non-preferred drugs may be submitted via the following:

- The STAT-PA system.
- On paper.
- The ForwardHealth Portal.

STAT-PA

Pharmacy providers should submit PA requests for non-preferred drugs using the STAT-PA system if possible. If a pharmacy provider submits a PA request using the STAT-PA system, the provider will receive an immediate response. A STAT-PA request may be backdated by up to 14 calendar days.

If a PA request is submitted for a preferred drug using the STAT-PA system, pharmacy providers will receive a response that states, "This is a preferred drug. Prior authorization is not required." Providers should submit the claim through the real-time POS system or

on a Noncompound Drug Claim form.

Paper

Providers may submit paper PA requests for non-preferred drugs.

If a PA request must be submitted on paper, prescribers are required to complete, sign, and date the appropriate PA/PDL form and submit it, along with any supporting documentation, to the pharmacy where the prescription will be filled. The pharmacy provider is required to complete, sign, and submit a PA/RF and information from the PA/PDL form to ForwardHealth.

Decisions for paper PA requests are made within 20 working days from the receipt of all information necessary to process the request; however, most decisions are made within 10 working days.

ForwardHealth should not receive PA/PDL forms unless the pharmacy provider submits a PA request on paper.

Paper PA requests will be returned to providers who submit a PA/PDL form for a preferred drug because it is not needed.

Brand Medically Necessary Drugs on the Preferred Drug List

The PDL policy regarding non-preferred drugs applies to brand medically necessary drug PA requests. For example, a prescriber writes a prescription for a brand name drug. The generic drug is currently a non-preferred drug on the PDL. Before a PA request may be approved for the brand name drug, both of the following must occur:

- Trial and failure of multiple PDL preferred drugs.
- Multiple trial and failures of preferred generic equivalent drugs.

ePocrates

ForwardHealth providers may access the Wisconsin Medicaid, BadgerCare Plus, and SeniorCare PDL using their PDAs or personal computers through ePocrates. ePocrates' products provide clinical reference information specifically for health care providers to use at the point of care. Prescribers and pharmacy providers who use PDAs may also subscribe and download the PDL by accessing the ePocrates Web site.

Antibiotics, Inhaled

Tobi is a preferred drug and Cayston is a non-preferred drug that requires PA in the antibiotics, inhaled drug class. Providers should submit PA requests for Cayston on paper using the PA/DGA and the PA/RF. Clinical documentation supporting the use of Cayston must be submitted with each PA request.

Clinical criteria for approval of a PA request for Cayston are the following:

- The member has a diagnosis of cystic fibrosis.
- The prescriber has confirmed the member currently has a positive sputum culture for Pseudomonas aeruginosa or the member had a positive sputum culture for Pseudomonas aeruginosa within the past 12 months. Providers should indicate the date of the positive sputum culture.
- The prescriber has confirmed the member currently does not have Burkholderia cepacia colonized in the lungs.
- The member is 7 years of age or older.
- The member has previously used Tobi and experienced a clinically significant adverse drug reaction or an unsatisfactory therapeutic response. Providers should indicate the specific details about the clinically significant adverse drug reaction or the unsatisfactory therapeutic response and the approximate dates Tobi was taken on the PA request.
- The prescriber has confirmed the member's FEV1 percent predicted is greater than or equal to 25 percent and less than or equal to 75 percent. Providers should indicate the member's current FEV1 percent predicted on the PA request.

- The member is not receiving treatment with other inhaled/nebulized antibiotics or inhaled/nebulized anti-infective agents, including alternating treatment schedules. Providers should provide a history of all inhaled/nebulized antibiotics or inhaled/nebulized anti-infective agents and a history of all systemic antibiotics/anti-infective agents within the most recent 90-day period.

The following indicate how PA requests for Cayston will be approved:

- PA requests may be approved for a maximum of a 28-day supply per dispensing.
- PA requests may be approved with an alternating month treatment schedule of one month of Cayston treatment with one month of no inhaled/nebulized antibiotics or inhaled/nebulized anti-infective agents.
- PA requests may be approved for a maximum approval period of 183 days.

Cayston is not covered by the BadgerCare Plus Benchmark Plan, the BadgerCare Plus Core Plan, or the BadgerCare Plus Basic Plan.

Antidepressants, Other

Cymbalta

A step therapy policy applies for Cymbalta. Cymbalta is a non-preferred drug that requires PA.

PA requests for Cymbalta must be submitted on the most appropriate PA/PDL for Step Therapy for Cymbalta form. If Cymbalta is being prescribed for more than one indication, providers should complete and submit the PA form most appropriate to the primary indication. PA requests for Cymbalta may be submitted on the following forms:

- The PA/PDL for Step Therapy for Cymbalta for DPN.
- The PA/PDL for Step Therapy for Cymbalta for Fibromyalgia.
- The PA/PDL for Step Therapy for Cymbalta for GAD.
- The PA/PDL for Step Therapy for Cymbalta for MDD.

Cymbalta is not covered by the BadgerCare Plus Benchmark Plan, the BadgerCare Plus Core Plan, or the BadgerCare Plus Basic Plan; however, for Core Plan members who were grandfathered on Cymbalta, effective for DOS on and after July 1, 2009, Cymbalta continues to be covered.

Clinical Criteria for Cymbalta for Diabetic Peripheral Neuropathy

Clinical criteria for approval of a PA request for Cymbalta for DPN are the following:

- The member has a diagnosis of DPN.
- The member has Type I or Type II diabetes.
- The member has previously taken Lyrica for DPN and experienced an unsatisfactory therapeutic response, or
- The member has experienced a clinically significant adverse drug reaction to Lyrica, or
- There is a clinically significant drug interaction between another medication the member is taking and Lyrica, or
- The member has a medical condition or contraindication that prevents him or her from taking Lyrica.

Members must try and fail Lyrica before PA may be requested for Cymbalta.

Clinical Criteria for Cymbalta for Fibromyalgia

Clinical criteria for approval of a PA request for Cymbalta for fibromyalgia are the following:

- The member has previously taken Lyrica for fibromyalgia and experienced an unsatisfactory therapeutic response, or

- The member has experienced a clinically significant adverse drug reaction to Lyrica, or
- There is a clinically significant drug interaction between another medication the member is taking and Lyrica, or
- The member has a medical condition or contraindication that prevents him or her from taking Lyrica, and
- The member has taken Savella for fibromyalgia and experienced an unsatisfactory therapeutic response.
- The member experienced a clinically significant adverse drug reaction to Savella, or
- There is a clinically significant drug interaction between another medication the member is taking and Savella, or
- The member has a medical condition or contraindication that prevents him or her from taking Savella.

Members must try and fail Lyrica and Savella before PA may be requested for Cymbalta.

Clinical Criteria for Cymbalta for Generalized Anxiety Disorder

Clinical criteria for approval of a PA request for Cymbalta for GAD are the following:

- The member has a diagnosis of GAD.
- The member has experienced a clinically significant adverse drug reaction to paroxetine, or
- There is a clinically significant drug interaction between another medication the member is taking and paroxetine, or
- The member has a medical condition or contraindication that prevents him or her from taking paroxetine, and
- The member has taken any formulation of venlafaxine for GAD and experienced an unsatisfactory therapeutic response, or
- The member has experienced a clinically significant adverse drug reaction to venlafaxine.

Members must try and fail paroxetine and venlafaxine before PA may be requested for Cymbalta.

Clinical Criteria for Cymbalta for Major Depressive Disorder

Clinical criteria for approval of a PA request for Cymbalta for MDD are the following:

- The member has a diagnosis of MDD.
- The member has previously taken a preferred SSRI drug for MDD and one of the following:
  - Experienced an unsatisfactory therapeutic response.
  - Experienced a clinically significant adverse drug reaction.
- The member has taken other preferred antidepressant drug(s) for MDD and one of the following:
  - Experienced an unsatisfactory therapeutic response.
  - Experienced a clinically significant adverse drug reaction.

Members must try and fail a preferred SSRI drug and an other preferred antidepressant drug before PA may be requested for Cymbalta; however, if the member is currently taking Cymbalta for MDD for 30 days or more with a measureable therapeutic response and the member has not taken drug-company provided samples of Cymbalta in the past 30 days, PA requests for Cymbalta may be approved.

Antiemetics, Cannabinoids

PA is required for all antiemetic, cannabinoid drugs. To request PA, prescribers are required to complete and submit the PA/PDL for Antiemetics, Cannabinoids to the pharmacy where the prescription will be filled.

PA requests for antiemetic, cannabinoid drugs will be approved for a maximum of 183 days per request.

Antiemetics, cannabinoid drugs are not covered by the BadgerCare Plus Benchmark Plan or the BadgerCare Plus Core Plan.

Marinol®

Marinol® is a preferred, brand name drug that is excluded from brand medically necessary PA requirements. Pharmacy providers may indicate NCPDP DAW code "6" on claims for drugs excluded from brand medically necessary PA requirements. Members pay the generic drug copayment, not the brand name copayment, for drugs for which ForwardHealth has indicated that a preferred, brand name drug is less costly than its non-preferred generic counterpart and DAW code "6" is indicated on claims.

Members who are prescribed Marinol® for the treatment of appetite/weight loss caused by HIV or AIDS are not required to have previously tried ondansetron or Emend®.

Members are required to experience a treatment failure, an adverse drug reaction, or a contraindication with ondansetron and Emend® and trial and failure of Marinol® before a PA request may be submitted for Cesamet.

Dronabinol

Dronabinol, the generic of Marinol®, is a non-preferred antiemetic, cannabinoid drug that requires PA. PA requests for dronabinol cannot be submitted using the STAT-PA system.

For PA requests for dronabinol, members must meet the same clinical criteria as they would for Marinol®. Prescribers are required to indicate on the PA/PDL for Antiemetics, Cannabinoids form documentation that clinically justifies the need for the generic equivalent drug instead of Marinol®.

Bladder Relaxants

Oxybutynin ER is a non-preferred drug; however, PA is not required for oxybutynin ER for members who are 18 years of age or younger. For members 19 years of age or older, PA is required for oxybutynin ER.

Bronchodilators, Beta Agonists

Albuterol 1.25 mg/3mL (0.042 percent) for inhalation is a non-preferred drug; however, PA is not required for albuterol 1.25 mg/3mL (0.042 percent) for members who are 12 years of age or younger. Albuterol 1.25 mg/3mL (0.042 percent) is covered for members 12 years of age or younger who are enrolled in the BadgerCare Plus Benchmark Plan.

Clinical Criteria for Antiemetics, Cannabinoids

Clinical criteria for the approval of a PA request for antiemetic, cannabinoid drugs are the following:

- The member is currently receiving chemotherapy treatment for cancer (if requesting PA for Marinol® and Cesamet).
- The member has experienced a treatment failure, an adverse drug reaction, or a contraindication with ondansetron and Emend® for chemotherapy-related nausea and vomiting (if requesting PA for Marinol® and Cesamet).
- The member has experienced a treatment failure with Marinol® for chemotherapy-related nausea and vomiting (if requesting PA for Cesamet).
- The member is diagnosed with appetite/weight loss caused by HIV or AIDS (if requesting PA for Marinol®).

Clinical Criteria for Cytokine and Cell Adhesion Molecule Antagonist Drugs for Ankylosing Spondylitis

Enbrel® and Humira® are approved to treat ankylosing spondylitis.

Simponi™ is a non-preferred drug used to treat ankylosing spondylitis. For PA requests for Simponi™, the member must meet all clinical criteria below and experience a treatment failure on a preferred cytokine and CAM antagonist drug.

Clinical criteria for approval of a PA request for cytokine and CAM antagonist drugs to treat ankylosing spondylitis are all of the following:

- The member has a diagnosis of ankylosing spondylitis.
- The prescription is written by a rheumatologist or through a rheumatology consultation and the following is true:
  - The member has moderate to severe axial symptoms of ankylosing spondylitis or the member has received **one** or more of the following drugs and taken each drug for at least **three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction:
    - Corticosteroids.
    - Leflunomide.
    - Methotrexate.
    - An NSAID or COX-2 inhibitor drug.
    - Sulfasalazine.

PA requests for drugs for ankylosing spondylitis must be submitted on the PA/PDL for Cytokine and CAM Antagonist Drugs for Ankylosing Spondylitis.

Criteria for approval of a PA request for cytokine and CAM antagonist drugs for BadgerCare Plus Core Plan members are the same as the clinical criteria requirements for the BadgerCare Plus Standard Plan. Only preferred cytokine and CAM antagonist drugs are covered for Core Plan members.

Clinical PA is required for all cytokine and CAM antagonist drugs, including preferred cytokine and CAM antagonist drugs.

The drugs in the cytokine and CAM antagonist drug class are not covered for BadgerCare Plus Benchmark Plan or BadgerCare Plus Basic Plan members.

Clinical Criteria for Cytokine and Cell Adhesion Molecule Antagonist Drugs for Crohn's Disease

Cimzia® and Humira® are approved to treat Crohn's disease.

Clinical criteria for approval of a PA request for cytokine and CAM antagonist drugs to treat Crohn's disease are all of the following:

- The member has a diagnosis of Crohn's disease.
- The member has moderate to severe symptoms of Crohn's disease.
- The prescription is written by a gastroenterologist or through a gastroenterology consultation.
- The member has received **two** or more of the following drugs and taken each drug for at least **three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction:
  - 5-aminosalicylic (5-ASA).
  - 6-mercaptopurine (6MP).
  - Azathioprine.
  - Corticosteroids.
  - Methotrexate.
  - Sulfasalazine.

PA requests for drugs for Crohn's Disease must be submitted on the PA/PDL for Cytokine and CAM Antagonist Drugs for Crohn's Disease.

Criteria for approval of a PA request for cytokine and CAM antagonist drugs for BadgerCare Plus Core Plan members are the same

as the clinical criteria requirements for the BadgerCare Plus Standard Plan. Only preferred cytokine and CAM antagonist drugs are covered for Core Plan members.

Clinical PA is required for all cytokine and CAM antagonist drugs, including preferred cytokine and CAM antagonist drugs.

The drugs in the cytokine and CAM antagonist drug class are not covered for BadgerCare Plus Benchmark Plan or BadgerCare Plus Basic Plan members.

Clinical Criteria for Cytokine and Cell Adhesion Molecule Antagonist Drugs for Plaque Psoriasis

Enbrel® and Humira® are approved to treat plaque psoriasis.

Clinical criteria for approval of a PA request for cytokine and CAM antagonist drugs to treat plaque psoriasis are all of the following:

- The member has a diagnosis of plaque psoriasis and at least one of the following:
  - The member has moderate to severe symptoms of plaque psoriasis involving greater than or equal to 10 percent or more of his or her body surface area.
  - The member has a diagnosis of debilitating palmoplantar psoriasis.
- The prescription was written by a dermatologist through a dermatology consultation.
- The member has received **one** or more of the following treatments and received each treatment for at least **three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse reaction:
  - Cyclosporine.
  - Methotrexate.
  - Phototherapy.
  - Soriatane.

PA requests for drugs for plaque psoriasis must be submitted on the PA/PDL for Cytokine and CAM Antagonist Drugs for Plaque Psoriasis.

Criteria for approval of a PA request for cytokine and CAM antagonist drugs for BadgerCare Plus Core Plan members are the same as the clinical criteria requirements for the BadgerCare Plus Standard Plan. Only preferred cytokine and CAM antagonist drugs are covered for Core Plan members.

Clinical PA is required for all cytokine and CAM antagonist drugs, including preferred cytokine and CAM antagonist drugs.

The drugs in the cytokine and CAM antagonist drug class are not covered for BadgerCare Plus Benchmark Plan or BadgerCare Plus Basic Plan members.

Clinical Criteria for Cytokine and Cell Adhesion Molecule Antagonist Drugs for Psoriatic Arthritis

Enbrel® and Humira® are approved to treat psoriatic arthritis.

Simponi™ is a non-preferred drug used to treat psoriatic arthritis. For PA requests for Simponi™, the member must meet all clinical criteria below and experience a treatment failure on a preferred cytokine and CAM antagonist drug.

Clinical criteria for approval of a PA request for cytokine and CAM antagonist drugs to treat psoriatic arthritis are all of the following:

- The member has a diagnosis of psoriatic arthritis.

- The member has moderate to severe symptoms of psoriatic arthritis.
- The prescription is written by a dermatologist or rheumatologist or through a dermatology or rheumatology consultation.
- The member has moderate to severe axial symptoms of psoriatic arthritis or the member has received **two** or more of the following drugs and taken each drug for at least **three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction:
  - Azathioprine.
  - Corticosteroids.
  - Cyclosporine.
  - Hydroxychloroquine.
  - Leflunomide.
  - Methotrexate.
  - An NSAID or COX-2 inhibitor drug.

PA requests for drugs for psoriatic arthritis must be submitted on the PA/PDL for Cytokine and CAM Antagonist Drugs for Psoriatic Arthritis.

Criteria for approval of a PA request for cytokine and CAM antagonist drugs for BadgerCare Plus Core Plan members are the same as the clinical criteria requirements for the BadgerCare Plus Standard Plan. Only preferred cytokine and CAM antagonist drugs are covered for Core Plan members.

Clinical PA is required for all cytokine and CAM antagonist drugs, including preferred cytokine and CAM antagonist drugs.

The drugs in the cytokine and CAM antagonist drug class are not covered for BadgerCare Plus Benchmark Plan or BadgerCare Plus Basic Plan members.

Clinical Criteria for Cytokine and Cell Adhesion Molecule Antagonist Drugs for Rheumatoid Arthritis

Cimzia®, Enbrel®, and Humira® are preferred drugs used to treat RA. Enbrel® and Humira® are preferred drugs used to treat polyarticular juvenile RA.

Kineret® and Simponi™ are non-preferred drugs used to treat RA. For PA requests for Kineret® and Simponi™, the member must meet all clinical criteria below and experience a treatment failure on a preferred cytokine and CAM antagonist drug. For PA requests for Simponi™, members must continue to take methotrexate in combination with Simponi™.

PA requests for drugs for RA must be submitted on the PA/PDL for Cytokine and CAM Antagonist Drugs for RA and Polyarticular Juvenile RA.

Criteria for approval of a PA request for cytokine and CAM antagonist drugs for BadgerCare Plus Core Plan members are the same as the clinical criteria requirements for the BadgerCare Plus Standard Plan. Only preferred cytokine and Cam antagonist drugs are covered for Core Plan members.

Clinical PA is required for all cytokine and CAM antagonist drugs, including preferred cytokine and CAM antagonist drugs.

The drugs in the cytokine and CAM antagonist drug class are not covered for BadgerCare Plus Benchmark Plan or BadgerCare Plus Basic Plan members.

Clinical Criteria for Rheumatoid Arthritis

Clinical criteria for approval of a PA request for cytokine and CAM antagonist drugs to treat RA are all of the following:

- The member has a diagnosis of RA.
- The member has moderate to severe symptoms of RA.
- The prescription is written by a rheumatologist or through a rheumatology consultation.
- The member has received **two** or more of the following drugs and taken each drug for at least **three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction:
  - Azathioprine.
  - Corticosteroids.
  - Cyclosporine.
  - Hydroxychloroquine.
  - Leflunomide.
  - Methotrexate.
  - An NSAID or COX-2 inhibitor drug.
  - Penicillamine.
  - Sulfasalazine.

Clinical Criteria for Polyarticular Juvenile Rheumatoid Arthritis

Clinical criteria for approval of a PA request for cytokine and CAM antagonist drugs to treat polyarticular juvenile RA are all of the following:

- The member has a diagnosis of polyarticular juvenile RA.
- The prescription is written by a rheumatologist or through a rheumatology consultation.
- The member has received **two** or more of the following drugs and taken each drug for at least **three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction:
  - Azathioprine.
  - Corticosteroids.
  - Cyclosporine.
  - Hydroxychloroquine.
  - Leflunomide.
  - Methotrexate.
  - An NSAID or COX-2 inhibitor drug.
  - Penicillamine.
  - Sulfasalazine.

Clinical Criteria for Elidel and Protopic

Clinical critieria for approval of a PA request for Elidel® and Protopic® are the following:

- The prescription is written by a dermatologist or allergist or through a dermatology or allergy consultation.
- The member is not immunocompromised.
- The member has not taken an antiretroviral or antineoplastic drug in the past two years.
- The member has experienced a treatment failure or a clinically significant adverse drug reaction to a topical corticosteroid in the past 183 days or the member has received treatment with Elidel® or Protopic® in the past 183 days and achieved a measurable therapeutic response.

Members must be at least 16 years of age or older to receive Protopic® 0.1%. Members must be at least 2 years of age or older to receive Protopic® 0.03% or Elidel®.

Prescribers are required to attest on the PA/PDL for Elidel® and Protopic® to having discussed the potential risks and warnings of prescribing Elidel® or Protopic® for members under 2 years of age with the member's parent or guardian.

Note: If the prescriber determines that Elidel® or Protopic® 0.03% is medically necessary for a member under 2 years of age, PA requests for the drug may be approved if the prescriber attests on the PA/PDL for Elidel® and Protopic® to discussing the potential risks and warnings of using the products on children under 2 years of age. PA requests submitted when a prescriber determines that Elidel® or Protopic® 0.03% is medically necessary for a member under 2 years of age must be submitted on paper by mail or fax. PA requests cannot be submitted using the STAT-PA system or on the Portal.

PA requests for Elidel® or Protopic® may be approved for a maximum of 183 days per request.

Elidel® and Protopic® are not covered by the BadgerCare Plus Benchmark Plan or the BadgerCare Plus Core Plan.

Clinical Criteria for Growth Hormone Drugs

Prescribers are required to provide clinical documentation on the PA/PDL for Growth Hormone Drugs form so pharmacy providers can submit PA requests to ForwardHealth for growth hormone drugs. PA requests for preferred and non-preferred growth hormone drugs may be submitted to ForwardHealth via the STAT-PA system.

When a STAT-PA request is returned because a member has not had a stimulated growth hormone test, additional information is required for PA review. If the member has a medical condition, such as hypopituitary disease, and a stimulated growth hormone test is not medically indicated, medical records supporting the growth hormone deficiency are required. The medical records should be included with a *paper* PA request, which includes a completed PA/RF, PA/PDL for Growth Hormone Drugs form, and all supporting documentation.

Clinical Criteria for Hypoglycemics for Adjunct Therapy

The hypoglycemics, adjunct therapy drug class is split into two categories, the hypoglycemics, GLP-1 agents drug class and the hypoglycemics, Symlin drug class.

Hypoglycemics, GLP-1 Agents

In the hypoglycemics, GLP-1 agents drug class, Byetta and Victoza are non-preferred drugs that require clinical PA.

PA requests for GLP-1 agents must be submitted on the Prior Authorization Drug Attachment for GLP-1 Agents. PA requests for GLP-1 agents may be submitted on the ForwardHealth Portal, by fax, or by mail.

The following are clinical criteria for approval of a PA request for Byetta:

- The member has Type II diabetes mellitus. (*Note:* Diagnosis code 250.00 or 250.02 should be indicated on PA requests for Byetta.)
- The member is 18 years of age or older.
- The member is not currently receiving basal- or meal-time insulin injections.
- The member does not currently have or have a history of pancreatitis.
- The member does not currently have or have a history of gastroparesis.
- The member is participating in lifestyle interventions (e.g., diet, exercise) to improve glucose control.
- The member is taking the maximum effective dose of metformin (1,700 mg/day to 2,500 mg/day) and the maximum effective dose of a sulfonylurea, and the member's HbA1c is still above 6.5 percent.
- One of the following applies to the member:
  - The member is taking the maximum effective dose of metformin (1,700 mg/day to 2,500 mg/day) and cannot tolerate sulfonylurea because of a drug interaction, adverse drug reaction, or because the sulfonylurea is contraindicated as a result of another medical condition, and the member's HbA1c is still above 6.5 percent.
  - The member is taking the maximum effective dose of a sulfonylurea and cannot tolerate metformin because of a drug interaction, adverse drug reaction, or because the metformin is contraindicated as a result of another medical condition,

  - and the member's HbA1c is still above 6.5 percent.
  - The member cannot tolerate metformin or a sulfonylurea because of a drug interaction, adverse drug reaction, or because the drug is contraindicated as a result of another medical condition, and the member's HbA1c is still above 6.5 percent.

For PA requests for Victoza, members must meet the above clinical criteria for Byetta and try and fail on the maximum dose of Byetta.

PA requests for GLP-1 agents may be initially approved for six months. Renewal PA requests will be approved only if the member's HbA1c decreases by at least 0.5 percent from the member's initial HbA1c or if the member's initial HbA1c was above 7 percent and the HbA1c drops below 7 percent. Renewal PA requests will be approved for one year. For ongoing PA renewal requests, the member must continue to maintain the improved HbA1c value.

Hypoglycemics, Symlin

Symlin will be a non-preferred drug that requires clinical PA. PA requests for Symlin must be submitted on the PA/PDL for Symlin. PA requests for Symlin may be submitted using the STAT-PA system, on the Portal, or by fax or mail.

Clinical criteria for approval of a PA request for Symlin are the following:

- The member has Type I or Type II diabetes mellitus. (*Note:* Diagnosis code 250.00 to 250.03 should be indicated on PA requests for Symlin.)
- The member is not using the drug for weight loss.
- The member is currently receiving insulin injections.
- The member is currently receiving meal-time insulin injections.
- The member is 18 years of age or older.
- The member does not currently have or have a history of gastroparesis.
- The member does not currently have or have a history of hypoglycemia unawareness.
- The member has not obtained emergency treatment for severe hypoglycemia more than twice in the past six months.
- The member's HbA1c is less than 9 percent.

Clinical Criteria for Nonsteroidal Anti-Inflammatory Drugs

ForwardHealth members are required to try and fail two preferred, generic NSAIDs or have had an adverse drug reaction before a non-preferred NSAID, including cyclo-oxygenase inhibitors and Celebrex®, can be prescribed.

The two preferred, generic NSAIDs taken cannot be ibuprofen or naproxen.

Clinical criteria for approval of a PA request for Celebrex® are the following:

- The member has a history of FAP.
- The member has medical record documentation of thrombocytopenia or platelet dysfunction.
- The member has medical record documentation of peptic ulcer disease, history of GI bleeding, or a history of NSAID-induced GI bleeding.
- The member is currently taking oral anticoagulation therapy.
- The member has been prescribed daily low-dose aspirin for cardioprotection and requires NSAID therapy.
- The member is 65 years of age or older.

For non-preferred NSAIDs, prescibers may complete the PA/PDL for NSAIDs, Including COX-2 Inhibitors form.

Clinical Criteria for Opioid Dependency Agents

Suboxone® film is a preferred drug that requires clinical PA in the opioid dependency agents drug class.

Effective for DOS on and after February 1, 2011, PAs for Suboxone® tablets for BadgerCare Plus Standard Plan, BadgerCare Plus Core Plan, Medicaid, and SeniorCare members are no longer valid. Prescribers should switch members' prescriptions to Suboxone® film or provide clinical documentation about why the member cannot use Suboxone® film and why it is medically necessary the member receive Suboxone® tablets instead of the film.

PA requests for Suboxone® and buprenorphine will be approved for a maximum of 183 days per request and may be renewed for up to a maximum of two years. PA requests for Suboxone® and buprenorphine will not be approved for use outside treatment for opioid dependence. A diagnosis of opioid-type dependence should be indicated on claims and PA requests for Suboxone® and buprenorphine.

PA requests for Suboxone and buprenorphine must be submitted on the PA/PDL for Suboxone and Buprenorphine.

New and renewal PA requests for Suboxone® tablets will only be accepted on paper if the member's medical necessity has been documented.

Suboxone® tablets and buprenorphine are noncovered drugs for BadgerCare Plus Benchmark Plan and BadgerCare Plus Basic Plan members.

Prior Authorization Requests for Suboxone® Film

PA requests for Suboxone® film for Standard Plan, Medicaid, and SeniorCare members may be submitted using the STAT-PA system or on paper by fax or mail. For Core Plan members, PA requests for Suboxone® film may only be submitted on paper by fax or mail.

Prior Authorization Requests for Suboxone® Tablets

PA requests for Suboxone® tablets for Standard Plan, Medicaid, and SeniorCare members must be submitted on paper by fax or mail.

Suboxone® tablets are noncovered drugs for Core Plan members.

Clinical Criteria for Suboxone® and Buprenorphine

Clinical criteria for approval of a PA request for Suboxone® and buprenorphine are all of the following:

- The member is 16 years of age or older.
- The drug is being prescribed by a physician who has obtained a Drug Addiction Treatment Act (DATA 2000) waiver allowing him or her to prescribe Suboxone® or buprenorphine for opioid dependence.
- The member is not taking other opioids, tramadol, or carisoprodol.
- The member does not have untreated or unstable psychiatric conditions that may interfere with compliance.

The prescribing physician must indicate that he or she has read the attestation statement on the form and that he or she agrees to follow guidelines set forth by the U.S. Department of Health and Human Services Federation of State Medical Boards — Model Policy Guidelines for Opioid Addiction Treatment.

Additional criteria for approval of a PA request for buprenorphine are as follows:

- The member is nursing or pregnant.
- The prescribing physician discussed with the member that methadone maintenance is the standard of care for opioid addiction treatment in pregnant and nursing women.
- The prescribing physician informed the member about the limited safety data for the support of buprenorphine use in pregnant and nursing women.

For PA requests for Suboxone® tablets, providers are required to indicate clinical information about why the member cannot use Suboxone® film and why it is medically necessary that the member received Suboxone® tablets instead of Suboxone® film.

Clinical Criteria for Proton Pump Inhibitor Drugs

Nexium 10 mg suspension, Nexium 20 mg suspension, and Prevacid SoluTab 15 mg are non-preferred drugs; however, PA is not required for Nexium 10 mg suspension, Nexium 20 mg suspension, and Prevacid SoluTab 15 mg for members 12 years of age or younger. PA requests for suspension products or orally disintegrating tablets for members 13 years of age or older must be submitted on the PA/PDL for PPI Drugs.

PA requests for non-preferred PPI drugs must be submitted on the PA/PDL for PPI Drugs form.

Criteria for approval of a PA request for non-preferred PPI drugs are the following:

- The member is unable to take Aciphex as a result of one of the following:
  - The member experienced a treatment failure on the maximum dose of Aciphex (20 mg/day).
  - The member experienced a clinically significant adverse drug reaction to Aciphex.
  - There is a clinically significant drug interaction between another medication the member is taking and Aciphex.
- The member is unable to take omeprazole as a result of one of the following:
  - The member experienced a treatment failure on the maximum dose of omeprazole (40 mg/day).
  - The member experienced a clinically significant adverse drug reaction to omeprazole.
  - There is a clinically significant drug interaction between another medication the member is taking and omeprazole.

Note: Members will be required to try and fail Aciphex and omeprazole before a PA request may be approved for a non-preferred PPI drug.

For PA requests for Protonix suspension or Prevacid SoluTab, a member must have a swallowing condition that prevents him or her from swallowing a tablet or capsule.

Criteria for approval of a PA request for Nexium suspension or Prilosec suspension are the following:

- The member is unable to take Protonix suspension as a result of one of the following:
  - The member experienced a treatment failure on the maximum dose of Protonix suspension (40 mg/day).
  - The member experienced a clinically significant adverse drug reaction to Protonix suspension.
  - There is a clinically significant drug interaction between another medication the member is taking and Protonix suspension.
- The member is unable to take Prevacid SoluTab as a result of one of the following:
  - The member experienced a treatment failure on the maximum dose of Prevacid SoluTab (30 mg/day).
  - The member experienced a clinically significant adverse drug reaction to Prevacid SoluTab.
  - There is a clinically significant drug interaction between another medication the member is taking and Prevacid SoluTab.

Note: Members will be required to try and fail Protonix suspension and Prevacid SoluTab before a PA request for Nexium suspension or Prilosec suspension may be approved.

Clinical Criteria for Stimulants and Related Agents

For non-preferred stimulants and related agents, prescribers should indicate a stimulant-approved diagnosis code on the PA/PDL for Stimulants and Related Agents form. Drugs in this class are diagnosis restricted. For PA requests for stimulants and related agents, providers should complete the section of the form appropriate to the drug being requested.

An allowable diagnosis code must be indicated on claims and PA requests for all stimulant and related agent drugs, except for Provigil® and Nuvigil®.

Clinical Criterion for Non-Preferred Stimulants

Clinical criterion for approval of a PA request for a non-preferred stimulant is the member has experienced unsatisfactory therapeutic responses or clinically significant adverse drug reactions with two preferred stimulants.

Clinical Criteria for Intuniv™ and Kapvay™

Intuniv™ and Kapvay™ are non-preferred drugs in the stimulants and related agents drug class.

Clinical criteria for approval of a PA request for Intuniv™ and Kapvay™ require one of the following:

- The member will take Intuniv™ or Kapvay™ in combination with a preferred stimulant.
- The member has experienced a treatment failure with a preferred stimulant.
- The member has a medical condition preventing the use of a preferred stimulant.
- There is a clinically significant drug interaction between another medication the member is taking and a preferred stimulant.
- The member has experienced a clinically significant adverse drug reaction to a preferred stimulant.

Intuniv™ and Kapvay™ are age-restricted drugs approved for members 6 through 20 years of age.

Clinical Criteria for Strattera®

Clinical criteria for approval of a PA request for Strattera® require one of the following:

- The member has experienced unsatisfactory therapeutic responses or clinically significant adverse drug reactions with **two** preferred stimulants.
- The member has a medical condition (e.g., Tourette's syndrome, obsessive compulsive disorder) that prevents the use of a preferred stimulant.
- The member has a medical history of substance abuse or misuse.
- The member has a serious risk of drug diversion.

Strattera® is a covered drug for BadgerCare Plus Standard Plan, Medicaid, SeniorCare, and transitioned BadgerCare Plus Core Plan members.

Straterra® is a noncovered drug for BadgerCare Plus Benchmark Plan and BadgerCare Plus Basic Plan members. For all Core Plan members except transitioned Core Plan members, Strattera® is a noncovered drug.

PA for Straterra® cannot be obtained for Core Plan members. Therefore, claims for Strattera® should be submitted to BadgerRx Gold.

Clinical Criteria for Provigil® and Nuvigil®

PA requests for Provigil® and Nuvigil® for members enrolled in the Standard Plan, Medicaid, and SeniorCare should be submitted using the Prior Authorization Drug Attachment for Provigil® and Nuvigil®.

Pharmacy providers may submit PA requests for Provigil® and Nuvigil® by fax or mail. Requests for Provigil® and Nuvigil® cannot be submitted through the STAT-PA system.

Members are required to try and fail Provigil® before PA may be requested for Nuvigil®. A member must have tried and failed Provigil® and be diagnosed with either narcolepsy, OSAHS, or shift work sleep disorder before PA may be requested for Nuvigil®.

Criteria for approval of a PA request for Provigil® and Nuvigil® are the following:

- The member is at least 16 years of age.
- The member is not currently taking any other stimulants.
- For members with a diagnosis of narcolepsy:
  - A PSG has been performed for the member. (*Note:* Test results for the PSG must be submitted with the PA request.)
  - A MSLT has been performed for the member. (*Note:* Test results for the MSLT must be submitted with the PA request.)
- For members with a diagnosis of OSAHS:
  - The member has tried a CPAP machine.
  - A PSG has been performed for the member. (*Note:* Test results for the PSG must be submitted with the PA request.)
  - The member's apnea-hypopnea index measures more than five events per hour.
- For members with a diagnosis of shift work sleep disorder:
  - The member is a night shift worker.
  - The member is not currently taking hypnotics, sleep aids, or drugs that cause sleepiness.
- For Provigil® for members with a diagnosis of ADD or ADHD:
  - The member has a history of substance abuse/misuse or a serious risk of drug diversion.
  - The member has tried and failed two preferred stimulants or the member had a clinically significant adverse reaction.

Providers who are requesting PA for Nuvigil® should not complete Element 16 on the Prior Authorization Drug Attachment for Provigil® and Nuvigil®.

Nuvigil® is a noncovered drug for members enrolled in the Core Plan. Claims for Nuvigil® for Core Plan members should be submitted to BadgerRx Gold.

Provigil® and Nuvigil® are not covered by the Benchmark Plan.

Clinical Criteria for Provigil® for Core Plan Members

For Core Plan members, criteria for approval of a PA request for Provigil® are the following:

- The member is at least 16 years of age.
- The member is not currently taking any other stimulants.
- For members with a diagnosis of narcolepsy:
  - A PSG has been performed for the member. (*Note:* Test results for the PSG must be submitted with the PA request.)
  - A MSLT has been performed for the member. (*Note:* Test results for the MSLT must be submitted with the PA request.)
- For members with a diagnosis of OSAHS:
  - The member has tried a CPAP machine.
  - A PSG has been performed for the member. (*Note:* Test results for the PSG must be submitted with the PA request.)
  - The member's apnea-hypopnea index measures over five events per hour.
- For members with a diagnosis of shift work sleep disorder:

  - The member is a night shift worker.
  - The member is not currently taking hypnotics, sleep aids, or drugs that cause sleepiness.
- For members with a diagnosis of ADD or ADHD:
  - The member has a history of substance abuse/misuse or a serious risk of drug diversion.
  - The member has tried and failed Strattera® or the member had a clinically significant adverse reaction to Strattera®.

Clinical Criteria for Xyrem®

Xyrem® requires clinical PA. Clinical criteria have been established for Xyrem®. Providers should submit PA requests for Xyrem® by fax or mail using the PA/DGA and a PA/RF.

Clinical criteria for approval of a PA request for Xyrem® are all of the following:

- The member has a diagnosis of narcolepsy or narcolepsy with cataplexy.
- The member has experienced one of the following:
  - An unsatisfactory therapeutic response.
  - A clinically significant adverse drug reaction.
  - A medical condition that prevents treatment.
  - A clinically significant drug interaction between another medication that prevents treatment with all of the following:
    - Antidepressants.
    - Stimulants.
    - Provigil® or Nuvigil®.

For initial PA requests for Xyrem®, in addition to documenting on the PA/DGA the clinical information listed above, prescribers are required to submit documentation from the member's medical record that supports the member's diagnosis of narcolepsy or narcolepsy with cataplexy. In addition, test results from the member's PSG and MSLT must be submitted.

An allowable diagnosis code must be indicated on claims and PA requests for Xyrem®. Allowable diagnosis codes for Xyrem® are 347.00 (Narcolepsy without cataplexy) and 347.01 (Narcolepsy with cataplexy). PA requests for Xyrem® will not be approved for use outside treatment for narcolepsy (e.g., for treatment for sleep disorders, hypersomnia, fatigue, or other medical conditions).

Initial PA requests for Xyrem® may be approved for a maximum of six months. Subsequent PA requests may be approved if the prescriber supplies documentation from the member's medical record of clinical improvement and patient compliance with medication use and safety precautions.

Xyrem® is a noncovered drug for Benchmark Plan, Core Plan, and Basic Plan members and SeniorCare members in levels 2b and 3.

Fentanyl Mucosal Agents

PA requests for the following non-preferred fentanyl mucosal agents must be submitted on the PA/PDL for Fentanyl Mucosal Agents:

- Fentanyl citrate oral transmucosal lozenges.
- Fentora.
- Onsolis.

Quantity limits apply to certain fentanyl mucosal agents.

Clinical Criteria for Fentanyl Citrate Oral Transmucosal Lozenges

Clinical criteria for approval of a PA request for fentanyl citrate oral transmucosal lozenges are the following:

- The member has cancer that is causing persistent pain.
- The member is tolerant to around-the-clock opioid therapy for his or her underlying, persistent cancer pain.
- The member is currently taking a long-acting opioid analgesic drug.
- The member has breakthrough cancer pain that is not relieved by other short-acting opioid analgesic drugs.

Clinical Criteria for Fentora and Onsolis

For PA requests for Fentora and Onsolis, members must meet the previously listed clinical criteria for approval of a PA request for fentanyl citrate oral transmucosal lozenges. In addition, one of the following clinical criteria must be met:

- The member has previously taken fentanyl citrate oral transmucosal lozenges for cancer pain and experienced an unsatisfactory therapeutic response.
- The member has a medical condition that prevents him or her from taking fentanyl citrate oral transmucosal lozenges.

PA requests for fentanyl mucosal agents may be approved for a maximum of 183 days.

Grandfathering Overview

If a BadgerCare Plus Standard Plan, Medicaid, or SeniorCare member is grandfathered on a brand name drug and a generic equivalent is available or will become available, grandfathering of the brand name drug for the member will be discontinued when the brand name drug is added to the Brand Medically Necessary Drugs That Require Prior Authorization data table. The data table is revised monthly.

This policy applies to brand name drugs where a generic equivalent is currently available and brand name drugs where a generic equivalent will be released in the future.

Providers should submit a PA request for brand name drugs for the member to continue taking the drug. To request PA for a brand name drug, prescribers are required to complete and submit to the pharmacy provider the PA/BMNA, the prescription with "Brand Medically Necessary" handwritten on it, and all of the appropriate supporting documentation. The pharmacy provider completes a PA/RF and submits to ForwardHealth the following:

- A completed PA/BMNA from the prescriber.
- Supporting documentation submitted by the prescriber. (The PA request must include sufficient supporting documentation for a pharmacist consultant to make a determination about the request.)
- A copy of the prescription with "Brand Medically Necessary" handwritten by the prescriber.
- A completed PA/RF.

In most circumstances, it will be necessary for a member to try more than one generic equivalent drug before a brand medically necessary PA request may be approved. If a generic equivalent drug is a non-preferred drug on the PDL, the member must try and fail preferred, generic drugs before a brand medically necessary PA request may be approved.

Documentation Requirements

Supporting documentation should include how the generic equivalent drug failed to achieve the desired treatment outcome and why the brand name drug is expected to achieved the desired outcome.

Prescribers should document on the PA request the specific details about the previous treatment results with generic equivalent drugs, including the generic equivalent drugs that the member tried.

Grandfathering Brand Name Drugs for BadgerCare Plus Core Plan Members

If a BadgerCare Plus Core Plan member is currently grandfathered on a brand name drug and a generic equivalent becomes available, grandfathering of the brand name drug for the member will be discontinued.

Providers may refer to the Core Plan Covered Pharmacy Services Exceptions for Transitioned Members for information about brand medically necessary PA for grandfathered transitioned Core Plan members.

Grandfathering for Antifungals, Oral

Vfend® is a non-preferred drug that requires PA. Members currently taking Vfend® will be grandfathered on the drug. PA is not required for a grandfathered drug. Other policies (e.g., diagnosis restrictions) for grandfathered drugs may apply.

Grandfathering for Antiparkinson's Agents

Requip XL™ tablets are a non-preferred drug; however, BadgerCare Plus Standard Plan, Medicaid, SeniorCare, and transitioned BadgerCare Plus Core Plan members who are currently taking Requip XL™ tablets will be grandfathered until a generic becomes available. After the generic becomes available, grandfathering of Requip XL™ tablets will end for all members.

PA is required for Requip XL™ for Standard Plan, Medicaid, and SeniorCare members who have not previously taken the drug.

Requip XL™ tablets continue to be a diagnosis-restricted drug. An allowable diagnosis code must be indicated on claims and PA requests for Requip XL™ tablets.

Requip XL™ tablets continue to be a noncovered drug for BadgerCare Plus Benchmark Plan and BadgerCare Plus Basic Plan members. For all Core Plan members except transitioned Core Plan members, Requip XL tablets are a noncovered drug.

Grandfathering for Antipsychotics

As a result of safety concerns, thioridazine is a non-preferred drug; however, BadgerCare Plus Standard Plan, BadgerCare Plus Core Plan, Medicaid, and SeniorCare members who are currently taking thioridazine will be grandfathered until a future drug class review by the Wisconsin Medicaid Pharmacy PAC occurs.

Since thioridazine is a non-preferred drug for Standard Plan, Core Plan, Medicaid, and SeniorCare members, it is a noncovered drug for BadgerCare Plus Benchmark Plan and BadgerCare Plus Basic Plan members.

Grandfathering for Cytokine and Cell Adhesion Molecule Antagonist Drugs

Kineret® is a non-preferred drug; however, BadgerCare Plus Standard Plan, BadgerCare Plus Core Plan, Medicaid, and SeniorCare members who are currently taking Kineret® will be grandfathered until a generic becomes available. After the generic becomes available, grandfathering of Kineret® will end for all members.

Kineret® is a noncovered drug for Core Plan members who are not grandfathered on the drug.

Grandfathering for Multiple Sclerosis Agents, Immunomodulators

Avonex is a non-preferred drug in the multiple sclerosis agents, immunomodulators drug class; however, members enrolled in the BadgerCare Plus Standard Plan, the BadgerCare Plus Core Plan, Medicaid, and SeniorCare who are currently taking Avonex will be grandfathered. Providers will be reimbursed for Avonex until the generic becomes available. After the generic becomes available, grandfathering of Avonex will end for all members.

Avonex is a noncovered drug for members enrolled in the Core Plan if members are not grandfathered on the drug.

Grandfathering for Pancreatic Enzymes

Creon is a non-preferred drug; however, BadgerCare Plus Standard Plan, BadgerCare Plus Core Plan, Medicaid, and SeniorCare members who are currently taking Creon will be grandfathered until a generic becomes available. After the generic becomes available, grandfathering of Creon will end for all members.

Grandfathering for Platelet Aggregation Inhibitors

Ticlopidine is a non-preferred drug. Ticlopidine will be grandfathered indefinitely for members who are currently taking the drug. Claims for BadgerCare Plus Core Plan members who are not grandfathered on ticlopidine should be submitted to BadgerRx Gold.

Grandfathering for Stimulants and Related Agents

Methylin chewable tablets and solution are non-preferred drugs; however, BadgerCare Plus Standard Plan, Medicaid, SeniorCare, and transitioned BadgerCare Plus Core Plan members who are currently taking Methylin chewable tablets or Methylin solution will be grandfathered until a generic becomes available. After the generic becomes available, grandfathering of Methylin chewable tablets and solution will end for all members.

PA is required for Methylin chewable tablets and for Methylin solution for Standard Plan, Medicaid, and SeniorCare members who have not previously taken the drug.

Methylin chewable tablets and solution continue to be diagnosis-restricted. Members must have one of the allowable diagnosis codes for PA requests to be approved.

Methylin chewable tablets and solution continue to be a noncovered drug for Benchmark Plan and Basic Plan members. For all Core Plan members except transitioned Core Plan members, Methylin chewable tablets and solution are noncovered drugs.

Hypoglycemics, Thiazolidinediones

Effective for DOS on and after September 27, 2010, as a result of FDA safety concerns, Avandia, Avandamet, and Avandaryl are non-preferred drugs that require clinical PA for BadgerCare Plus Standard Plan, Medicaid, and SeniorCare members. Avandia, Avandamet, and Avandaryl are noncovered drugs for BadgerCare Plus Benchmark Plan, BadgerCare Plus Core Plan, and BadgerCare Plus Basic Plan members.

Standard Plan, Core Plan, Medicaid, and SeniorCare members currently taking Avandia, Avandamet, or Avandaryl will be grandfathered on the drug they are currently taking. For members grandfathered on Avandia, Avandamet, or Avandaryl, prescribers should re-evaluate with the member if it is medically necessary for the member to remain on the drug or be switched to a preferred hypoglycemic, thiazolidinedione drug.

PA is required for Standard Plan, Medicaid, and SeniorCare members who have not previously taken Avandia, Avandamet, or Avandaryl.

Clinical Criteria for Prior Authorization Approval

- The member has a diagnosis of type II diabetes, and
- The member has experienced a treatment failure with multiple preferred drugs used for the treatment of type II diabetes. A treatment failure includes the following:
  - The member did not achieve adequate glycemic control.
  - A medical condition that prevents the use of preferred drugs used for the treatment of type II diabetes.
  - A clinically significant drug interaction between another medication the member is taking and preferred drugs used for the treatment of type II diabetes.
  - A clinically significant adverse drug reaction while taking a preferred drug, and
- The member is unable to take Actos or one of its combination products due to one of the following:
  - A medical condition that prevents the use of Actos or one of its combination products.
  - A clinically significant drug interaction between another medication the member is taking and Actos or one of its combination products.
  - A treatment failure with Actos or one or more of its combination products.
  - A clinically significant adverse drug reaction to Actos or one or more of its combination products.

For PA requests for Avandia, Avandamet, and Avandaryl to be approved, the member must have a diagnosis of type II diabetes, a demonstrated treatment failure of multiple preferred diabetic drugs, and a demonstrated treatment failure of Actos.

Allowable Diagnosis Codes

Avandia, Avandamet, and Avandaryl require a diagnosis of type II diabetes. One of the following allowable diagnosis codes must be indicated on PA requests for Avandia, Avandamet, and Avandaryl:

- 250.00 (Diabetes mellitus without mention of complication; type II or unspecified type, not stated as uncontrolled).
- 250.02 (Diabetes mellitus without mention of complication; type II or unspecified type, uncontrolled).

If an allowable diagnosis code is not indicated or if an inappropriate diagnosis is indicated, the PA request will be denied and the drug will be a noncovered service. Members do not have appeal rights for noncovered services.

Prior Authorization Requests

For PA requests for Avandia, Avandamet, and Avandaryl, the prescriber must submit the following to the pharmacy where the prescription will be filled:

- A PA/DGA completed by the prescriber, not the pharmacy provider.
- Additional supporting documentation attached to the PA/DGA attesting how the member meets the previously listed clinical criteria.

Prescribers are required to indicate the following in Element 16 on the PA/DGA:

- That they have reviewed information with members describing the safety concerns associated with Avandia, Avandamet, and Avandaryl.
- That the member acknowledged he or she understands the risks.

Prescribers are required to sign and date the PA/DGA. When a prescriber signs and dates the PA/DGA, he or she is indicating that the member meets all clinical criteria. The signature also provides an attestation that the prescriber and member agree that Avandia, Avandamet, or Avandaryl is the appropriate drug therapy.

Pharmacy providers are required to complete the PA/RF and submit the completed PA/DGA, the completed PA/RF, and supporting documentation to ForwardHealth by fax or mail.

Providers may call the DAPO Center with questions about PA requests for Avandia, Avandamet, or Avandaryl.

Intranasal Rhinitis Agents

Nasonex is a preferred drug for members ages two to four. Nasonex is a non-preferred drug for members younger than two years of age and for members five years of age and older; therefore, PA is required for those members.

Lipotropics, Other

A step therapy policy applies for Zetia. Zetia is a non-preferred drug that requires PA. Members must try and fail a preferred HMG-CoA reductase inhibitor (i.e., statin) drug and Vytorin before PA may be requested for Zetia. PA requests for Zetia for members enrolled in the BadgerCare Plus Standard Plan, Medicaid, and SeniorCare must be submitted on the PA/PDL for Step Therapy for Zetia.

Clinical Criteria for Zetia

Clinical criteria for approval of a PA request for Zetia are the following:

- The member is being treated for an elevated total cholesterol level, or
- The member is being treated for an elevated low-density lipoprotein cholesterol level, and
- The member has taken a preferred statin drug for at least three consecutive months and experienced an unsatisfactory therapeutic response, and
- The member has taken Vytorin for at least three consecutive months and experienced an unsatisfactory therapeutic response, or
- The member has a medical condition or contraindication that prevents him or her from taking a statin drug, or
- There is a clinically significant drug interaction between another medication the member is taking and a statin drug, or
- The member has experienced a clinically significant adverse drug reaction to a statin drug.

Zetia is not covered by the BadgerCare Plus Benchmark Plan, the BadgerCare Plus Core Plan, or the BadgerCare Plus Basic Plan.

Migraine Agents, Triptans

A step therapy policy applies for triptans. Sumatriptan and Maxalt are preferred drugs. Members must try and fail any dosage form of sumatriptan before taking Maxalt. Members must try and fail any dosage form of sumatriptan and any dosage form of Maxalt before PA may be requested for a non-preferred triptan.

Claims

A claim for any dosage form of sumatriptan or any dosage form of Maxalt must be in the member's claims history in the last 365 days before a claim for any dosage form of Maxalt may be approved. If a claim for any dosage form of sumatriptan or any dosage form of Maxalt is not present in the member's claims history in the last 365 days, PA is required for Maxalt.

Prior Authorization Requests

Prior authorization requests for triptans must be submitted on the PA/PDL for Step Therapy for Migraine Agents, Triptans.

Clinical Criteria for Maxalt

The clinical criteria for Maxalt and Maxalt MLT is that the member has previously taken any dosage form of sumatriptan and experienced an unsatisfactory therapeutic response.

Clinical Criteria for Non-preferred Migraine Agents, Triptans

Clinical criteria for approval of a PA request for non-preferred migraine agents, triptans are that the member has previously taken any dosage form of sumatriptan and experienced an unsatisfactory therapeutic response and the member has previously taken Maxalt or Maxalt MLT within the last 365 days and experienced an unsatisfactory therapeutic response.

Multiple Sclerosis Agents, Immunomodulators

Gilenya™

Gilenya™ is new drug used to treat multiple sclerosis. Gilenya™ is a non-preferred drug in the multiple sclerosis agents, immunomodulators drug class. Providers are required to submit PA requests for Gilyena™ on paper by fax or mail using the PA/DGA and the PA/RF. Clinical documentation supporting the use of Gilenya™ must be submitted with each PA request.

Clinical criteria for approval of a PA request for Gilenya™ are one of the following:

- The member has experienced a treatment failure with a preferred drug. If the member has experienced a treatment failure on the preferred product(s), indicate the drug on which the member experienced the treatment failure and the approximate dates the drug was taken.
- The member has a medical condition preventing the use of a preferred drug. If the member has a medical condition that prevents the use of a preferred drug, indicate the member's medical condition.
- The member has experienced a clinically significant drug interaction with a preferred drug. If the member has experienced a clinically significant drug interaction, indicate the medications and the drug interaction(s).
- The member has experienced a clinically significant drug reaction with a preferred drug. If the member has experienced a clinically significant drug reaction, indicate the medication and the drug reaction.

For PA requests for Gilenya™, providers are required to indicate clinical information about why the member cannot use a preferred drug and why it is medically necessary that the member receives Gilenya™ instead of a preferred drug.

Gilenya™ is a diagnosis-restricted drug. The allowable diagnosis code for Gilenya™ is 340 (Multiple sclerosis).

Gilenya™ is not covered by the BadgerCare Plus Benchmark Plan, the BadgerCare Plus Core Plan, or the BadgerCare Plus Basic Plan.

Multiple Sclerosis Agents, Other

Ampyra

Ampyra is a non-preferred drug that requires clinical PA in the multiple sclerosis agents, other drug class. Providers should submit PA requests for Ampyra on paper using the PA/DGA and the PA/RF. Clinical documentation supporting the use of Ampyra must be submitted with the PA request.

A diagnosis code must be indicated on claims and PA requests for Ampyra.

Clinical Criteria for Ampyra

Clinical information that must be documented on PA requests for Ampyra are the following:

- The type of MS with which the member has been diagnosed.
- When the member was diagnosed with MS.

- The date of the member's last relapse and how complete the member's recovery was.
- The member's ambulation ability, including the distance, length of time, and the assistive devices he or she uses.
- When the member's ambulation ability was last measured.
- The measurement used to document ambulation ability, including the measurement that will be used to continue to document ambulation improvement or decline.

Providers are required to measure the member's ambulation before PA is requested for Ampyra, prior to the renewal of a PA request for Ampyra at 6 months of treatment, and at least yearly when the member is taking Ampyra.

Initial PA requests for Ampyra may be approved for 183 days. If ambulation improves, renewal PA requests for Ampyra may be approved for one year.

Ampyra is not covered by the BadgerCare Plus Benchmark Plan, the BadgerCare Plus Core Plan, or the BadgerCare Plus Basic Plan.

Pharmacy Provider Responsibilities for Prior Authorization for Preferred Drug List Drugs

Pharmacy providers should review the Wisconsin Medicaid, BadgerCare Plus Standard, and SeniorCare Preferred Drug List — Quick Reference for the most current list of preferred and non-preferred drugs. Most preferred drugs do not require PA, but may have other restrictions (e.g., age, diagnosis).

If a member presents a prescription for a non-preferred drug, the pharmacy provider is encouraged to contact the prescriber to discuss preferred drug options. The prescriber may choose to change the prescription to a preferred drug, if medically appropriate for the member, or the prescriber may complete the appropriate PA form.

Pharmacies are required to submit the PA request using the STAT-PA system or on paper by fax or mail.

Pharmacy providers are required to retain a completed copy of the PA form.

For BadgerCare Plus Benchmark Plan, BadgerCare Plus Core Plan, and BadgerCare Plus Basic Plan members, pharmacy providers should be aware of drugs covered by the benefit plan.

For Benchmark Plan, Core Plan, and Basic Plan members, if a drug is a noncovered drug or PA cannot be obtained for the drug, claims for the drug may be submitted to BadgerRx Gold.

Prescriber Responsibilities for Prior Authorization for Preferred Drug List Drugs

Prescribers should determine the ForwardHealth benefit plan in which a member is enrolled before writing a prescription. If a member is enrolled in the BadgerCare Plus Standard Plan, Medicaid, or SeniorCare, prescribers are encouraged to write prescriptions for preferred drugs. Prescribers are encouraged to prescribe more than one preferred drug before a non-preferred drug is prescribed.

If a non-preferred drug or a preferred drug that requires clinical PA is medically necessary for a member, the prescriber is required to complete a PA request for the drug. Prescribers are required to complete the appropriate PA form and submit it to the pharmacy provider where the prescription will be filled. Prescribers are required to include accurate and complete answers and clinical information about the member's medical history on the PA form. When completing the PA form, prescribers are required to provide a handwritten signature and date on the form. PA request forms may be faxed or mailed to the pharmacy provider, or the member may carry the form with the prescription to the pharmacy provider. The pharmacy provider will use the completed form to submit a PA request to ForwardHealth. Prescribers should not submit PA forms to ForwardHealth.

Prescribers are required to retain a completed copy of the PA form.

For BadgerCare Plus Benchmark Plan, BadgerCare Plus Core Plan, and BadgerCare Plus Basic Plan members, prescribers should be aware of drugs covered by the benefit plan and write prescriptions for drugs that are covered by the plan.

If a noncovered drug is medically necessary for a Benchmark Plan, Core Plan, or Basic Plan member, the prescriber should inform the member the drug is not covered by the benefit plan. The prescriber should instruct the member to work with his or her pharmacy provider to determine whether or not the drug is covered by BadgerRx Gold.

Pulmonary Arterial Hypertension Drugs

All drugs in the pulmonary arterial hypertension drug class are diagnosis restricted. The allowable diagnosis code of 416.0 (Primary pulmonary hypertension) and 416.8 (Chronic pulmonary heart disease, other) are required on claims and PA requests for all pulmonary arterial hypertension drugs.

Members currently taking Tracleer® are grandfathered and may remain on the drug indefinitely without PA until a generic is available.

Review Process

Clerical Review

The first step of the PA request review process is the clerical review. The provider, member, diagnosis, and treatment information indicated on the PA/RF, PA/HIAS1, and PA/DRF forms is reviewed during the clerical review of the PA request review process. The following are examples of information verified during the clerical review:

- Billing and/or rendering provider number is correct and corresponds with the provider's name.
- Provider's name is spelled correctly.
- Provider is Medicaid certified.
- Procedure codes with appropriate modifiers, if required, are covered services.
- Member's name is spelled correctly.
- Member's identification number is correct and corresponds with the member's name.
- Member enrollment is verified.
- All required elements are complete.
- Forms, attachments, and additional supporting clinical documentation are signed and dated.
- A current physician's prescription for the service is attached, if required.

Clerical errors and omissions are responsible for the majority of PA requests that are returned to providers for correction or additional information. Since having to return a PA request for corrections or additional information can delay approval and delivery of services to a member, providers should ensure that all clerical information is correctly and completely entered on the PA/RF, PA/DRF, or PA/HIAS1.

If clerical errors are identified, the PA request is returned to the provider for corrections before undergoing a clinical review. One way to reduce the number of clerical errors is to complete and submit PA/RFs through Web PA.

Clinical Review

Upon verifying the completeness and accuracy of clerical items, the PA request is reviewed to evaluate whether or not each service being requested meets Wisconsin Medicaid's definition of "medically necessary" as well as other criteria.

The PA attachment allows a provider to document the clinical information used to determine whether the standards of medical necessity are met for the requested service. Wisconsin Medicaid considers certain factors when determining whether to approve or deny a PA request pursuant to DHS 107.02(3)(e), Wis. Admin. Code.

It is crucial that a provider include adequate information on the PA attachment so that the ForwardHealth consultant performing the clinical review can determine that the service(s) being requested meets all the elements of Wisconsin Medicaid's definition of "medically necessary", including elements that are not strictly medical in nature. Documentation must provide the justification for the service requested specific to the member's current condition and needs. Pursuant to DHS 101.03(96m), Wis. Admin. Code, "medically necessary" is a service under ch. HFS 107 that meets certain criteria.

Determination of Medical Necessity

The definition of "medically necessary" is a legal definition identifying the standards that must be met for approval of the service. The definition imposes parameters and restrictions that are both medical and nonmedical.

The determination of medical necessity is based on the documentation submitted by the provider. For this reason, it is essential that documentation is submitted completely and accurately and that it provides the justification for the service requested, specific to the

member's current condition and needs. To be approved, a PA request must meet all of the standards of medical necessity including those that are not strictly medical in nature.

To determine if a requested service is medically necessary, ForwardHealth consultants obtain direction and/or guidance from multiple resources including:

- Federal and state statutes.
- Wisconsin Administrative Code.
- PA guidelines set forth by the DHS.
- Standards of practice.
- Professional knowledge.
- Scientific literature.

Services Requiring Prior Authorization

Alpha-1 Proteinase Inhibitor Drugs

Although pharmacy providers are responsible for obtaining PA for drugs that are on the brand medically necessary list or the PDL, prescribers may be asked to provide clinical information to support the medical necessity for alpha-1 proteinase inhibitor drugs (Prolastin and Aralast).

Prior Authorization Requests and Amendments for Synagis

Synagis® requires PA. Prescribers, *not* pharmacy providers, are required to submit PA requests for Synagis®. Members who have previously been administered Synagis® will not be grandfathered and are required to have a valid PA on file for Synagis® for each treatment season. If the first dose of Synagis® is administered in a hospital, the dose does not require PA.

PA requests for Synagis® may be submitted beginning September 15 of each year.

Prescribers or their designees must request PA for Synagis® using only one of the following options:

- DAPO Center.
- Portal.
- Fax.
- Mail.

If prescribers call the DAPO Center to obtain PA, they may complete, sign, and date the PA request form and keep it in a member's medical records.

PA requests for Synagis® submitted through the Portal or by mail or fax will not be processed as 24-hour drug PA requests because providers may call the DAPO Center to obtain an immediate decision about a PA request.

Prior Authorization Requests Submitted by Fax or Mail

If a prescriber or his or her designee chooses to submit a paper PA request for Synagis® by fax or mail, the following must be completed and submitted to ForwardHealth:

- PA/RF for physician services.
- Prior Authorization Drug Attachment for Synagis.
- Supporting documentation, as appropriate.

The Prior Authorization Fax Cover Sheet is available for providers submitting the forms and documentation by fax.

Prior Authorization Amendments

If a member's weight changes, resulting in a change in Synagis® dosage during a treatment season, prescribers are required to amend an approved PA for the appropriate dose. PA requests may be amended through the following:

- By calling the DAPO Center.
- On the Portal.
- By submitting a Prior Authorization Amendment Request to ForwardHealth by mail or fax.

Prescribers are required to indicate the following on PA amendment requests for Synagis®:

- The member's most recent weight.
- The date the member's weight was measured.
- The new Synagis® dose calculation.

Clinical Criteria

To be approved, PA requests must document that the member meets the following clinical criteria:

- For chronic lung disease, the member is a child younger than 24 months of age at the start of the RSV season with chronic lung disease who requires medical therapy (i.e., supplemental oxygen, bronchodilators, diuretics, or corticosteroid therapy) within six months of the start of the RSV season. In this case, a maximum of five doses of Synagis® will be approved.
- For congenital heart disease, the member is a child younger than 24 months of age at the start of the RSV season with hemodynamically significant cyanotic or acyanotic congenital heart disease and is receiving medication to control congestive heart failure, has moderate to severe pulmonary hypertension, or has cyanotic heart disease. In this case, a maximum of five doses of Synagis® will be approved.
- For immunocompromised children, the member is a child younger than 24 months of age at the start of the RSV season with a severe immunodeficiency (i.e., SCID or advanced AIDS). In this case, a maximum of five doses of Synagis® will be approved.

To be approved, PA requests for pre-term infants must document that the member meets the following clinical criteria:

- The member is an infant born before 29 weeks gestation (i.e., zero days through 28 weeks, six days) who is less than 12 months of age at the start of the RSV season. In this case, a maximum of five doses of Synagis® will be approved.
- The member is an infant born at or greater than 29 weeks gestation but less than 32 weeks gestation (i.e., 29 weeks, zero days through 31 weeks, six days) who is less than six months of age at the start of the RSV season. In this case, a maximum of five doses of Synagis® will be approved.
- The member is an infant born at or greater than 32 weeks gestation but less than 35 weeks gestation (i.e., 32 weeks, zero days through 34 weeks, six days) who is less than three months of age at the start of the RSV season or is born during the RSV season and has the following risk factors:
  - The member is less than 3 months of age at the start of the RSV season or is born during the RSV season with at least one of the following risk factors:
    - Infant attends child care.
    - Infant has siblings younger than five years of age.
  - The member should receive prophylaxis only until he or she reaches 3 months of age. The member should only receive a maximum of three monthly doses; many members will receive only one or two doses until they reach 3 months of age.
- The member is an infant born before 35 weeks gestation (i.e., 34 weeks, six days) who is less than 12 months of age at the start of the RSV season with either congenital abnormalities of the airway or a neuromuscular condition that compromises handling of respiratory secretions. In this case, a maximum of five doses of Synagis® will be approved.

PA requests will be approved only for the Synagis® treatment season of November through March. ForwardHealth will not approve more than five doses of Synagis® per season.

Prior Authorization for Anti-Obesity Drugs

PA requests for the following anti-obesity drugs may be submitted on the Prior Authorization Drug Attachment for Anti-Obesity Drugs:

- Diethylpropion.
- Phentermine.
- Phendimetrazine.
- Xenical.

Note: Anti-obesity drugs are not covered by the BadgerCare Plus Benchmark Plan or the BadgerCare Plus Core Plan.

Anti-obesity drugs are covered for dual eligibles enrolled in a Medicare Part D PDP.

A 34-day supply is the maximum amount of any anti-obesity drug that may be dispensed each month.

Clinical Criteria

Clinical criteria for approval of a PA request for anti-obesity drugs require one of the following:

- The member has a BMI greater than or equal to 30.
- The member has a BMI greater than or equal to 27 but less than 30 and two or more of the following risk factors:
    - Coronary heart disease.
    - Dyslipidemia.
    - Hypertension.
    - Sleep apnea.
    - Type II diabetes mellitus.

In addition, all of the following must be true:

- The member is 16 years of age or older. (*Note:* Members need only to be 12 years of age or older to take Xenical®.)
- The member is not pregnant or nursing.
- The member does not have a history of an eating disorder (e.g., anorexia, bulimia).
- The member does not have a medical contraindication to the selected medication.
- The member has participated in a weight loss treatment plan (e.g., nutritional counseling, an exercise regimen, a calorie-restricted diet) in the past six months and will continue to follow the treatment plan while taking an anti-obesity drug.

PA requests for anti-obesity drugs will not be renewed if a member's BMI is below 24.

Note: ForwardHealth does not cover the brand name (i.e., innovator) anti-obesity drug if an FDA-approved generic equivalent is available. In addition, ForwardHealth does not cover OTC anti-obesity drugs. ForwardHealth will return PA requests for OTC and brand name anti-obesity drugs with generic equivalents as noncovered services.

Benzphetamine, Diethylpropion, Phendimetrazine, and Phentermine

If clinical criteria for anti-obesity drugs are met, initial PA requests for benzphetamine, diethylpropion, phendimetrazine, and phentermine will be approved for three months. If the member meets a weight loss goal of at least 10 pounds during the initial three month approval, PA may be requested for an additional three months of treatment. The maximum length of continuous drug therapy for benzphetamine, diethylpropion, phendimetrazine, and phentermine is six months.

If the member does not meet a weight loss goal of at least 10 pounds during the initial three month approval, the member must wait six months before PA is requested for any anti-obesity drug.

ForwardHealth allows only two weight loss attempts with this group of drugs (benzphetamine, diethylpropion, phendimetrazine, and phentermine) during a member's lifetime. Additional PA requests will not be approved. ForwardHealth will return additional PA requests to the provider as noncovered services.

Xenical®

If clinical criteria are met, initial PA requests for Xenical® (orlistat) will be approved for six months. If the member does not meet a weight loss goal of at least 10 pounds during the initial six-month approval, the member must wait six months before PA is requested for any anti-obesity drug. If the member meets a weight loss goal of at least 10 pounds during the first six months of treatment, PA may be requested for an additional six months of treatment. If the member continues to lose weight, subsequent PA renewal periods for Xenical® are a maximum of six months.

PA requests for Xenical® may be approved for a maximum treatment period of 24 continuous months of drug therapy. Additional PA requests will not be approved. ForwardHealth will return additional PA requests to the provider as noncovered services.

ForwardHealth allows only two weight loss attempts with Xenical® during a member's lifetime.

If a member has reached his or her goal weight and continues treatment with Xenical® to maintain weight loss, a PA request may be approved for a maximum of six months if the member does not gain weight during the PA renewal period and the maximum treatment period of 24 months of drug therapy is not exceeded.

Submitting Prior Authorization Requests

PA requests for anti-obesity drugs must be submitted by prescribers or their designees, not pharmacy providers.

Prescribers or their billing providers are required to be certified by Wisconsin Medicaid to submit PA requests to ForwardHealth. Prescribers who are certified by Wisconsin Medicaid should indicate their name and NPI as the billing provider on PA requests. Prescribers who are not certified by Wisconsin Medicaid should indicate the name and NPI of the Wisconsin Medicaid-certified billing provider (e.g., clinic) with which they are affiliated on PA requests.

PA requests for anti-obesity drugs may be submitted through the following:

- DAPO Center.
- Fax.
- Mail.

Note: Pharmacy providers cannot request PA for anti-obesity drugs using the STAT-PA system. If a PA request for anti-obesity drugs is submitted using the STAT-PA system, providers will receive a message that states, "Procedure not valid for STAT-PA."

Current, approved PAs will be honored until their expiration date. For members to continue taking an anti-obesity drug beyond an approved PA's expiration date, a new PA must be submitted.

PA request submission procedures apply to members enrolled in the BadgerCare Plus Standard Plan, Medicaid, and SeniorCare.

Prior Authorization Requests Submitted by Fax or Mail

Prescribers may also submit PA requests for anti-obesity drugs by fax to (608) 221-8616 or by mail to the following address:

ForwardHealth
Prior Authorization
Ste 88
6406 Bridge Rd
Madison WI 53784-0088

If a prescriber or his or her designee chooses to submit a paper PA request for anti-obesity drugs by fax or mail, the following must be completed and submitted to ForwardHealth:

- PA/RF for prescribers for drugs.
- Prior Authorization Drug Attachment for Anti-Obesity Drugs.
- Supporting documentation, as appropriate.

The Prior Authorization Fax Cover Sheet is available for providers submitting the forms and documentation by fax.

Prior authorization requests for anti-obesity drugs submitted by mail or fax will not be processed as 24-hour drug PA requests because providers may call the DAPO Center to obtain an immediate decision about a PA request.

Prior Authorization for Lovaza

Lovaza® is a preferred drug that requires clinical PA. To request PA for Lovaza®, prescribers are required to complete and submit to ForwardHealth the Prior Authorization Drug Attachment for Lovaza.

Lovaza® is not covered for members enrolled in the BadgerCare Plus Benchmark Plan and the BadgerCare Plus Core Plan.

Clinical Criteria

Clinical criteria for approval of a PA request for Lovaza® are the following:

- The member is 18 years of age or older.
- The member does not have an allergy or sensitivity to fish.
- Medical conditions (e.g., diabetes mellitus, hypothyroidism) that may contribute to hypertriglyceremia have been identified and are being managed appropriately.
- Medications (e.g., beta blockers, thiazides, estrogens) that may contribute to hypertriglyceremia have been identified and modified if appropriate.
- The member is aware of and compliant with lifestyle modifications (e.g., diet, exercise, weight loss, alcohol consumption) that may improve triglyceride levels.
- The member currently has a triglyceride level of 500 mg/dL or greater, or for members with triglyceride levels below 500 mg/dL, the member must have both of the following:
  - A triglyceride level of 500 mg/dL or greater within the last five years. (*Note:* The test date of the triglyceride level must be indicated on the PA request.)
  - A current triglyceride level between 200 and 499 mg/dL while taking a fibrate or niacin. If a member's triglyceride level is below 200 mg/dL, a PA request will be denied.

Submitting Prior Authorization Requests

PA requests for Lovaza® must be submitted by prescribers or their designees, not pharmacy providers.

Prescribers or their billing providers are required to be certified by Wisconsin Medicaid to submit PA requests to ForwardHealth. Prescribers who are certified by Wisconsin Medicaid should indicate their name and NPI as the billing provider on PA requests. Prescribers who are not certified by Wisconsin Medicaid should indicate the name and NPI of the Wisconsin Medicaid-certified billing provider (e.g., clinic) with which they are affiliated on PA requests.

PA requests for Lovaza® may be submitted through the following:

- DAPO Center.
- Fax.
- Mail.

Note: Pharmacy providers cannot request PA for Lovaza® using the STAT-PA system. If a PA request for Lovaza® is submitted using the STAT-PA system, providers will receive a message that states, "Procedure not valid for STAT-PA."

Current, approved PAs will be honored until their expiration date. For members to continue taking Lovaza® beyond an approved PA's expiration date, a new PA must be submitted.

PA request submission procedures apply to members enrolled in the BadgerCare Plus Standard Plan, Medicaid, and SeniorCare.

Prior Authorization Requests Submitted by Fax or Mail

Prescribers may also submit PA requests for Lovaza® by fax to (608) 221-8616 or by mail to the following address:

> ForwardHealth
> Prior Authorization
> Ste 88
> 6406 Bridge Rd
> Madison WI 53784-0088

If a prescriber or his or her designee chooses to submit a paper PA request for Lovaza® by fax or mail, the following must be completed and submitted to ForwardHealth:

- PA/RF for prescribers for drugs.
- Prior Authorization Drug Attachment for Lovaza.
- Supporting documentation, as appropriate.

The Prior Authorization Fax Cover Sheet is available for providers submitting the forms and documentation by fax.

Prior authorization requests for Lovaza® submitted by mail or fax will not be processed as 24-hour drug PA requests because providers may call the DAPO Center to obtain an immediate decision about a PA request.

Approved Prior Authorization Requests

If an initial PA request for Lovaza® is approved, the request will be approved for four months. For subsequent PA requests, the member's triglyceride levels must decrease by 20 percent from the baseline triglyceride level for a renewal PA request to be approved. Renewal requests may be approved for up to one year.

Lipid panels, including triglyceride levels, are required for each yearly PA renewal request thereafter.

Situations Requiring New Requests

Changes to Member Enrollment Status

Changes to a member's enrollment status may affect PA determinations. In the following cases, providers are required to obtain valid, approved PA for those services that require PA:

- A member enrolled in the BadgerCare Plus Standard Plan has a change in income level and becomes eligible for the BadgerCare Plus Benchmark Plan. The member's enrollment status changes to Benchmark Plan.
- A member enrolled in the Benchmark Plan has a change in income level or medical condition and becomes eligible for the Standard Plan or Medicaid. The member's enrollment status changes to Standard Plan or Medicaid accordingly.

Some changes in a member's enrollment status do not affect PA determinations. In the following cases, providers are not required to obtain separate PA because PA will continue to be valid:

- A member enrolled in the Standard Plan becomes eligible for Medicaid coverage. PA granted under the Standard Plan will be valid for Medicaid.
- A member switches from the Standard Plan to the Benchmark Plan and there is already a valid PA on file for the member under the Benchmark Plan.
- A member switches from the Benchmark Plan to the Standard Plan or Medicaid and there is already a valid PA on file for the member under the Standard Plan or Medicaid.

Providers are encouraged to verify enrollment before every office visit or service rendered. Verifying enrollment will help providers identify changes in member enrollment status and take appropriate actions to obtain PA for services when necessary.

The first time a member switches plans, the provider is required to submit a new PA request, including all required PA forms and attachments. If a member switches back into either of the plans and there is a valid, approved PA on file under that plan, the provider does not need to submit a new PA request.

Providers who have a provider account on the ForwardHealth Portal may use the Portal to check if a valid PA is on file for the service.

Calculating Limits for Services Requiring Prior Authorization

Any limits that pertain to services requiring PA will accumulate separately under each plan.

Prior Authorization for BadgerCare Plus Plans

Providers are required to obtain PA separately for the Standard Plan, the Benchmark Plan, the BadgerCare Plus Core Plan, and the BadgerCare Plus Basic Plan for the same or similar services. If a member's enrollment status changes, PA granted under one plan will not be valid for the other plans. Providers are required to submit new PA requests in these cases to obtain a valid PA for the member. Separate PAs are required due to differences in coverage between the Standard Plan, the Benchmark Plan, the Core Plan, and the Basic Plan.

Services Not Performed Before Expiration Date

Generally, a new PA request with a new requested start date must be submitted to ForwardHealth if the amount or quantity of prior authorized services is not used by the expiration date of the PA request and the service is still medically necessary.

Submission Options

Dispensing STAT-PA Drugs When STAT-PA Is Unavailable

If the STAT-PA system is unavailable, a provider may still dispense a STAT-PA-approved drug. If a provider dispenses a new prescription for a STAT-PA-approved drug, the following steps must be taken:

1. Obtain the member's ForwardHealth identification card, green paper temporary card, beige paper or white paper EE card, or SeniorCare identification card, and verify enrollment. Enrollment verification may be done by submitting a real-time claim for the drug or by using one of the other enrollment verification methods such as Wisconsin's EVS.
2. Determine that the diagnosis is appropriate.
3. Determine that the member is not taking any other drug in the same category. (The prospective DUR system may identify therapeutic duplications at other pharmacies.)
4. Dispense up to a 14 days' supply of the drug.
5. Request PA from the STAT-PA system when it is available. A PA request submitted using the STAT-PA system may be backdated up to 14 days using the STAT-PA system.

If a STAT-PA request is returned, submit a paper PA request within 14 days of dispensing along with documentation supporting what was done in steps 2 through 5 of this process.

Drug Authorization and Policy Override Center

The DAPO Center is a specialized drug helpdesk for prescribers, their designees, and pharmacy providers to submit PA requests for specific drugs and diabetic supplies and to request policy overrides for specific policies over the telephone. After business hours, prescribers may leave a voicemail message for DAPO Center staff to return the next business day.

The DAPO Center is staffed by pharmacists and certified pharmacy technicians.

With the establishment of the DAPO Center, ForwardHealth's goal is to streamline for prescribers and pharmacy providers the process for requesting policy overrides and PA for specific drugs and diabetic supplies. In addition, DAPO Center staff survey current pharmacy claims to identify potential drug therapy concerns.

Prior Authorization Requests and Policy Override Decisions

Providers who call the DAPO Center to request a PA or policy override are given an immediate decision about the PA or policy override, allowing members to receive drugs or diabetic supplies in a timely manner. The DAPO Center reviews PA requests and policy overrides for members enrolled in BadgerCare Plus, Medicaid, and SeniorCare.

Prior Authorization Requests

Prescribers or their billing providers are required to be certified by Wisconsin Medicaid to submit PA requests to ForwardHealth. Prescribers who are certified by Wisconsin Medicaid should indicate their name and NPI as the billing provider on PA requests. Providers who are not certified by Wisconsin Medicaid should indicate the name and NPI of the Wisconsin Medicaid-certified billing provider (e.g., clinic) with which they are affiliated on PA requests.

When calling the DAPO Center, a pharmacy technician will ask prescribers a series of questions based on a Prior Authorization Drug Attachment form. Prescribers are encouraged to have all of the information requested on the appropriate Prior Authorization Drug

Attachment completed or the member's medical record available when they call the DAPO Center. DAPO Center staff will ask for the name of the caller and the caller's credentials. (i.e., Is the caller an RN, physician's assistant, certified medical assistant?)

Generally by the end of the call, if clinical PA criteria are met, DAPO Center staff will approve the PA request based on the information provided by the caller. If the PA request is approved, a decision notice letter will be mailed to the billing provider. After a PA has been approved, the prescriber should send the prescription to the pharmacy and the member can pick up the drug or diabetic supply. The member does not need to wait for the prescriber to receive the decision notice to pick the drug or diabetic supply at the pharmacy.

Note: If the provider receives a decision notice letter for a drug for which he or she did not request PA, the provider should notify the DAPO Center within 14 days of receiving the letter to inactivate the PA.

If a prescriber or his or her designee calls the DAPO Center to request PA and the clinical criteria for the PA are not met, the caller will be informed that the PA request is not approved because it does not meet the clinical criteria. If the prescriber chooses to submit additional medical documentation for consideration, he or she may submit the PA request to ForwardHealth for review by a pharmacist. The prescriber is required to submit a PA/RF and the applicable PA drug attachment form with the additional medical documentation. Documentation may be submitted to ForwardHealth through the Portal or by fax or mail.

Providers with questions about pharmacy policies and procedures may continue to call Provider Services.

Policy Override Decisions

When calling the DAPO Center to request a policy override, the following information must be provided:

- Member information.
- Provider information.
- Prescription information.
- The reason for the override request.

Fax

Faxing of all PA requests to ForwardHealth may eliminate one to three days of mail time. The following are recommendations to avoid delays when faxing PA requests:

- Follow the PA fax procedures.
- Providers should *not* fax the same PA request more than once.
- Providers should *not* fax *and* mail the same PA request. This causes delays in processing.

PA requests containing X-rays, dental molds, or photos as documentation must be mailed; they may not be faxed.

To help safeguard the confidentiality of member health care records, providers should include a fax transmittal form containing a confidentiality statement as a cover sheet to all faxed PA requests. The Prior Authorization Fax Cover Sheet includes a confidentiality statement and may be photocopied.

Providers are encouraged to retain copies of all PA requests and supporting documentation before submitting them to ForwardHealth.

Prior Authorization Fax Procedures

Providers may fax PA requests to ForwardHealth at (608) 221-8616. PA requests sent to any fax number other than (608) 221-8616 may result in processing delays.

When faxing PA requests to ForwardHealth, providers should follow the guidelines/procedures listed below.

Fax Transmittal Cover Sheet

The completed fax transmittal cover sheet must include the following:

- Date of the fax transmission.
- Number of pages, including the cover sheet. The ForwardHealth fax clerk will contact the provider by fax or telephone if all the pages do not transmit.
- Provider contact person and telephone number. The ForwardHealth fax clerk may contact the provider with any questions about the fax transmission.
- Provider number.
- Fax telephone number to which ForwardHealth may send its adjudication decision.
- To: "ForwardHealth Prior Authorization."
- ForwardHealth's fax number ([608] 221-8616). PA requests sent to any other fax number may result in processing delays.
- ForwardHealth's telephone numbers. For specific PA questions, providers should call Provider Services. For faxing questions, providers should call (608) 221-4746, extension 80118.

Incomplete Fax Transmissions

If the pages listed on the initial cover sheet do not all transmit (i.e., pages stuck together, the fax machine has jammed, or some other error has stopped the fax transmission), or if the PA request is missing information, providers will receive the following by fax from the ForwardHealth fax clerk:

- A cover sheet explaining why the PA request is being returned.
- Part or all of the original incomplete fax that ForwardHealth received.

If a PA request is returned to the provider due to faxing problems, providers should do the following:

- Attach a completed cover sheet with the number of pages of the fax.
- Resend the entire original fax transmission and the additional information requested by the fax clerk to (608) 221-8616.

General Guidelines

When faxing information to ForwardHealth, providers should not reduce the size of the PA/RF or the PA/HIAS1 to fit on the bottom half of the cover page. This makes the PA request difficult to read and leaves no space for consultants to write a response if needed or to sign the request.

If a photocopy of the original PA request and attachments is faxed, the provider should make sure these copies are clear and legible. If the information is not clear, it will be returned to the provider.

If the provider does not indicate his or her fax number, ForwardHealth will mail the decision back to the provider.

ForwardHealth will attempt to fax a response to the PA request to a provider three times. If unsuccessful, the PA request will be mailed to the provider.

If providers are not sure if an entire fax was sent, they should call ForwardHealth's fax clerk at (608) 221-4746, extension 80118, to inquire about the status of the fax.

Prior Authorization Request Deadlines

Faxing a PA request eliminates one to three days of mail time. However, the adjudication time of the PA request has not changed. All actions regarding PA requests are made within the predetermined time frames.

Faxed PA requests received after 1:00 p.m. will be considered as received the following business day. Faxed PA requests received on a Saturday, Sunday, or holiday will be processed on the next business day.

Avoid Duplicating Prior Authorization Requests

After faxing a PA request, providers should not send the original paperwork, such as the carbon PA/RF, by mail. Mailing the original paperwork after faxing the PA request will create duplicate PA requests in the system and may result in a delay of several days to process the faxed PA request.

Refaxing a PA request before the previous PA request has been returned will also create duplicate PA requests and may result in delays.

Response Back from ForwardHealth

Once ForwardHealth reviews a PA request, ForwardHealth will fax one of three responses back to the provider:

- "Your approved, modified, or denied PA request(s) is attached."
- "Your PA request(s) requires additional information (see attached). Resubmit the entire PA request, including the attachments, with the requested additional information."
- "Your PA request(s) has missing pages and/or is illegible (see attached). Resubmit the entire PA request, including the attachments."

Resubmitting Prior Authorization Requests

When resubmitting a faxed PA request, providers are required to resubmit the faxed copy of the PA request, including attachments. This will allow the provider to obtain the earliest possible grant date for the PA request (apart from backdating for retroactive enrollment). If any attachments or additional information that was requested is received without the rest of the PA request, the information will be returned to the provider.

ForwardHealth Portal Prior Authorization

Providers can use the following PA features on the ForwardHealth Portal to do the following:

- Submit PA requests and amendments for all services that require PA.
- Receive decision notice letters and returned provider review letters.
- Correct returned PA requests and PA amendment requests.
- Search and view previously submitted PA requests.
- Print a PA cover sheet.

Submitting Prior Authorization Requests and Amendment Requests

Providers can submit PA requests for all services that require PA to ForwardHealth via the secure Provider area of the Portal. To save time, providers can copy and paste information from plans of care and other medical documentation into the appropriate fields on the PA request. Except for those providers exempt from NPI requirements, NPI and related data are required on PAs submitted via the Portal.

When completing PA attachments on the Portal, providers can take advantage of an Additional Information field at the end of the PA attachment that holds up to five pages of text that may be needed.

Providers may also submit amendment requests via the Portal for PAs with a status of "Approved" or "Approved with Modifications."

PA Attachments on the Portal

Almost all PA request attachments can be completed and submitted on the Portal. When providers are completing PA requests, the Portal presents the necessary attachments needed for that PA request. For example, if a physician is completing a PA request for physician-administered drugs, the Portal will prompt a PA/JCA, and display the form for the provider to complete.

All PA request attachment forms are available on the Portal to download and print to submit by fax or mail.

Providers may also choose to submit their PA request on the Portal and mail or fax the PA attachment(s) and/or additional supporting documentation to ForwardHealth. If the PA attachment(s) are mailed or faxed, a system-generated Portal PA Cover Sheet, must be printed and sent with the attachment to ForwardHealth for processing. Providers must list the attachments on the Portal PA Cover Sheet. When ForwardHealth receives the PA attachments by mail or fax, they will be matched up with the PA/RF that was completed on the Portal.

*Please note: If the cover sheet could not be generated while submitting the PA request due to technical difficulties, providers can print the cover sheet from the main Portal PA page.

Before submitting any PA documents, providers should save or print a copy for their records. Once the PA request is submitted, it cannot be retrieved for further editing.

As a reminder, ForwardHealth does not mail back any PA request documents submitted by the providers.

Additional Supporting Information

Providers may choose to submit additional supporting information via mail or fax. If additional supporting information is needed, providers are prompted to print a system-generated Portal PA Cover Sheet to be sent with the information to ForwardHealth for processing. Providers must list the additional supporting information on the Portal PA Cover Sheet.

For certain PA process types, providers can choose to upload electronic supporting information through the Portal. Files can be uploaded if the user selects a process type of 117 (Physician services), 124 (Dental services), or 125 (Orthodontic services). Photographs, X-rays and dental models may be uploaded through the Portal if the images are in a JPEG format or created with OrthoCad software (available free on the Web). Dental model OrthoCad files must be uploaded with an extension of ".3dm." JPEG files must be uploaded with an extension of ".jpg" or ".jpeg."

Mail

Any type of PA request may be submitted on paper. Providers may mail completed PA requests, amendments to PA requests, and requests to enddate a PA request to ForwardHealth at the following address:

ForwardHealth
Prior Authorization
Ste 88
6406 Bridge Rd
Madison WI 53784-0088

Providers are encouraged to retain copies of all PA requests and supporting documentation before submitting them to ForwardHealth.

NCPDP Transactions

ForwardHealth accepts the following NCPDP Telecommunication Standard Format Version 5.1 PA transactions: P2 reversal, P3 inquiry, and the P4 request. These transactions enable providers to reverse or inactivate a PA, inquire about PA status, or submit a PA request.

Providers should work closely with their software vendors or information technology staff and software user guides to ensure that electronic PAs are submitted accurately according to the ForwardHealth Companion Document to HIPAA Implementation Guide: NCPDP V5.1.

The following are descriptions and/or requirements for each type of NCPDP PA transaction:

P2 Reversal

To reverse (i.e., change the PA to an inactive status) a PA using the P2 transaction, the following must be true:

- The provider must be the provider who obtained PA and must have the provider number used to obtain the PA.
  - The PA must be in one of the following statuses:
    - Approved — The PA request was approved as requested.
    - Returned — The PA request was returned to the provider for correction or for additional information.
    - Pending — The PA request is being reviewed by the Fiscal Agent.
    - Pending — The PA request is being reviewed by the State.
    - Suspend — The PA request was submitted via the ForwardHealth Portal and the provider indicated they will be sending additional supporting information on paper.
- None of the services on an approved PA have been used.

P3 Inquiry

Providers may submit inquiries about PAs they have submitted and receive authorization information on PAs approved or approved with modifications from ForwardHealth using the P3 inquiry.

P4 Request

Providers may submit a PA request using the P4 request transaction, however this will not result in real-time approval. The P4 request transaction does not allow providers to submit the appropriate PA attachment needed to adjudicate the PA request. When a P4 request is received, the request will be processed and placed in a "returned provider review" status. ForwardHealth will send the provider a returned provider review letter and the provider will have 30 calendar days from the date on the returned provider review letter to submit the remaining information or the PA request will be inactivated.

STAT-PA

Providers can submit STAT-PA requests for a limited number of services (e.g., certain drugs, selected orthopedic shoes, lead inspections for HealthCheck). The STAT-PA system is an automated system accessed by providers by touch-tone telephone that allows them to receive an immediate decision for certain PA requests.

NPI and related data are required when using the STAT-PA system.

Providers are encouraged to retain copies of all PA requests and supporting documentation before submitting them to ForwardHealth.

Note: A PA request cannot be submitted through STAT-PA for members enrolled in the BadgerCare Plus Benchmark Plan, the BadgerCare Plus Core Plan, or the BadgerCare Plus Basic Plan. PA requests for members enrolled in the Benchmark Plan, the Core Plan, and the Basic Plan may be submitted online via the ForwardHealth Portal or on paper.

Most drugs do not require PA. For drugs that require PA, pharmacy providers may submit PA requests through the STAT-PA system, on the ForwardHealth Portal, using an NCPDP transaction, or on paper.

The STAT-PA Quick Reference Guide includes information about STAT-PA inquiries.

The STAT-PA system allows certified pharmacy providers to request and receive PA electronically, rather than on paper, for certain drugs. Providers are allowed to submit up to 24 PA requests per connection for touch-tone telephone and Helpdesk queries. The STAT-PA system can be accessed in the following ways and at the following times:

- Touch-tone telephone, available 24 hours a day, seven days a week. To contact STAT-PA by telephone, providers may call (800) 947-1197.
- Provider Services. Select "STAT-PA" from the call center menu.

STAT-PA Request Follow-Up

A STAT-PA request will either be approved or returned. Providers will receive a STAT-PA receipt confirmation notice during the transaction and by mail for any STAT-PA request submitted, whether it was approved or returned.

When a STAT-PA request is approved:

- A PA number is assigned at the end of the transaction.
- The grant and expiration dates are indicated.
- The allowable days' supply is indicated.
- The claim may be submitted immediately.

When a STAT-PA request is returned:

- A PA number is assigned at the end of the transaction.
- The STAT-PA system indicates the reason for the return.
- The STAT-PA system indicates that more clinical documentation is required and the provider may submit a paper PA request using the same PA number for reconsideration.

Reconsideration of a STAT-PA Request

Submit the following on paper for reconsideration of a STAT-PA request:

- A PA/RF. List the PA number assigned to the returned STAT-PA on the front of the PA/RF in the description field.
- An appropriate PA form.
- A fax number, if available.

Amending Drug Prior Authorizations via STAT-PA

Providers may amend drug PAs that were initially approved through the STAT-PA system. Providers will be able to enddate, backdate, and change the quantity on an existing PA.

The following are requirements for each type of amendment.

Enddate a Prior Authorization via STAT-PA

To enddate a PA through STAT-PA, all of the following must be true:

- The PA must be for a drug.
- The provider must be the provider who obtained PA and must have the provider number used to obtain the PA.
- The PA must have been approved through STAT-PA initially.
- Prior authorization for the drug can be submitted through STAT-PA currently.
- The enddate must be after the grant date and before the expiration date.

- The PA must *not* have been previously amended.
- The enddate must be equal to or after the services (days' supply) that are already used on the PA.

Backdate a Prior Authorization via STAT-PA

Providers can backdate up to 14 days prior to the date on which the PA was initially submitted. To backdate a PA through STAT-PA, all of the following must be true:

- The PA must be for a drug.
- The provider must be the provider who obtained PA and must have the provider number used to obtain the PA.
- The PA must have been approved through STAT-PA initially.
- PA for the drug can be submitted through STAT-PA currently.
- The backdate must be before the grant date.
- The PA must *not* have been previously amended.
- The backdated PA must not duplicate another PA.

Change the Days Supply of a Prior Authorization via STAT-PA

To change the days supply of a PA through STAT-PA, all of the following must be true:

- The PA must be for a drug.
- The provider must be the provider who obtained PA and must have the provider number used to obtain the PA.
- The PA must have been approved through STAT-PA initially.
- PA for the drug can be submitted through STAT-PA currently.
- The PA must *not* have been previously amended.
- The change in days' supply must not duplicate another PA.
- The change in days' supply does not exceed the maximum allowed days' supply for the PA.

If all of the criteria to amend a drug PA through STAT-PA cannot be met, providers may submit a PA amendment request on paper or via the Portal.

Reimbursement

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Archive Date:03/01/2011

Reimbursement:Amounts

Acceptance of Payment

The amounts allowed as payment for covered services must be accepted as payment in full. Therefore, total payment for the service (i.e., any amount paid by other health insurance sources, any BadgerCare Plus or Medicaid copayment or spenddown amounts paid by the member, and any amount paid by BadgerCare Plus) may not exceed the BadgerCare Plus-allowed amount. As a result, providers may not collect payment from a member, or authorized person acting on behalf of the member, for the difference between their usual and customary charge and the BadgerCare Plus-allowed amount for a service (i.e., balance billing).

Other health insurance payments may exceed the BadgerCare Plus-allowed amount if no additional payment is received from the member or BadgerCare Plus.

Billing Service and Clearinghouse Contracts

According to DHS 106.03(5)(c)2, Wis. Admin. Code, contracts with outside billing services or clearinghouses may not be based on commission in which compensation for the service is dependent on reimbursement from BadgerCare Plus. This means compensation must be unrelated, directly or indirectly, to the amount of reimbursement or the number of claims and is not dependent upon the actual collection of payment.

Dispensing Fees

BadgerCare Plus and SeniorCare reimburse the same dispensing fees for services provided. These fees include the following:

- Traditional dispensing fee. (Services covered under the traditional dispensing fee include record keeping, patient profile preparation, prospective DUR, and counseling.)
- A traditional dispensing fee with a repackaging allowance.
- Compound drug dispensing fee.
- PC dispensing fee.

Traditional Dispensing Fee

A traditional dispensing fee is usually paid once per member, per service, per month, per provider, depending on the physician's prescription.

The dispensing fee for covered brand name drugs is $3.44 per prescription. For covered generic drugs, the dispensing fee is $3.94.

Repackaged Drugs and Repackaging Allowances

The repackaging allowance is limited to drugs that are not considered unit dose. However, the traditional dispensing fee may be allowed for unit dose drugs.

Pharmacy providers can continue to submit the value "2" in the Submission Clarification Code field to obtain a repackaging allowance for drugs that are repackaged by the pharmacy. If this field is present on a pharmacy claim when the drug is defined as unit dose, the repackaging allowance will not be reimbursed. Providers will receive an EOB code and a reject code for repackaged drugs and repackaging allowances.

The repackaging allowance only applies to drugs dispensed in whole units, such as capsules and tablets. The repackaging allowance is

not allowed for liquids and creams.

Repackaged manufacturers products are not covered by BadgerCare Plus, Medicaid, and SeniorCare. Providers will receive an EOB code and a reject code for such a service.

Compound Drug Dispensing Fee

BadgerCare Plus and SeniorCare reimburse providers for the pharmacist's compounding time. Compounding time is indicated in the level of effort field.

Pharmaceutical Care Dispensing Fee

Providers may receive an enhanced PC dispensing fee if they perform certain additional, documented services. These services are required to go beyond the basic activities required by federal and state standards for recordkeeping, profiles, prospective DUR, and counseling when dispensing, and must result in a positive outcome for both the member and for BadgerCare Plus or SeniorCare. Examples of these services include increasing patient compliance or preventing potential adverse drug reactions.

The MAC List for PC Codes and the PC Reason Codes with Billing Information provide information about the PC dispensing fee.

Electronic Funds Transfer

EFT allows ForwardHealth to directly deposit payments into a provider's designated bank account for a more efficient delivery of payments than the current process of mailing paper checks. Electronic Funds Transfer is secure, eliminates paper, and reduces the uncertainty of possible delays in mail delivery.

Only in-state and border-status providers who submit claims and MCOs are eligible to receive EFT payments.

Provider Exceptions

EFT payments are not available to the following providers:

- In-state emergency providers.
- Out-of-state providers.
- Out-of-country providers.
- SMV providers during their provisional certification period.

Enrolling in Electronic Funds Transfer

A ForwardHealth Portal account is required to enroll into EFT as all enrollments must be completed via a secure Provider Portal account or a secure MCO Portal account. Paper enrollments are not accepted. A separate EFT enrollment is required for each financial payer a provider bills.

Providers who do not have a Portal account may Request Portal Access online. Providers may also call the Portal Helpdesk for assistance in requesting a Portal account.

The following guidelines apply to EFT enrollment:

- Only a Portal Administrator or a clerk that has been assigned the new "EFT" role on the Portal may complete the EFT enrollment information.
- Organizations cannot revert back to receiving paper checks once enrolled in EFT.
- Organizations may change their EFT information at any time.

- Organizations will continue to receive their Remittance Advice as they do currently.

Refer to the ForwardHealth Portal Electronic Funds Transfer User Guide and the Electronic Funds Transfer Fact Page for instructions and more information about EFT enrollment.

Providers will continue to receive payment via paper check until the enrollment process moves into "Active" status and the provider's ForwardHealth EFT enrollment is considered complete.

Recoupment and Reversals

Enrollment in EFT does not change the current process of recouping funds. Overpayments and recoupment of funds will continue to be conducted through the reduction of payments.

Note: Enrolling in EFT does not authorize ForwardHealth to make unauthorized debits to the provider's EFT account; however, in some instances an EFT reversal of payment may be necessary. For example, if the system generates a payment twice or the amount entered manually consists of an incorrect value (e.g., a decimal point is omitted creating a $50,000 keyed value for a $500 claim), a reversal will take place to correct the error and resend the correct transaction value. ForwardHealth will notify the designated EFT contact person of an EFT reversal if a payment is made in error due to a system processing or manual data entry error.

Problem Resolution

If payment is not deposited into the designated EFT account according to the ForwardHealth payment cycle, providers should first check with their financial institution to confirm the payment was received. If the payment was not received, providers should then call Provider Services to resolve the issue and payment by paper check will be reinstated until the matter has been resolved.

Fee Schedules

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

- Interactive fee schedule.
- Downloadable fee schedule in TXT files.

Certain fee schedules are interactive. Interactive fee schedules provide coverage information as well as maximum allowable fees for all reimbursable procedure codes. The downloadable TXT files are free of charge and provide basic maximum allowable fee information for BadgerCare Plus by provider service area.

A provider may request a paper copy of a fee schedule by calling Provider Services.

Providers may call Provider Services in the following cases:

- Internet access is not available.
- There is uncertainty as to which fee schedule should be used.
- The appropriate fee schedule cannot be found on the Portal.
- To determine coverage or maximum allowable fee of procedure codes not appearing on a fee schedule.

Drug Search Tool

The Drug Search Tool is designed to help users to identify and calculate ingredient reimbursement rates of drugs covered by BadgerCare Plus, Medicaid, and SeniorCare. Covered drugs and reimbursement rate information is updated regularly.

Ingredient Cost Reimbursement

The DHS determines maximum reimbursement rates for all covered pharmaceutical drugs and OTC items. Maximum reimbursement rates may be adjusted to reflect market rates, reimbursement limits, or limits on the availability of federal funding as specified in federal law (42 CFR 447.331).

Some covered legend drugs are reimbursed at either the drug's AWP minus 14 percent plus a dispensing fee, or the provider's usual and customary charge, whichever is less. Other legend drugs are reimbursed at either the drug's price on the MAC List data table plus a dispensing fee or the provider's usual and customary charge, whichever is less.

The AWP reimbursement for brand name legend drugs is AWP minus 14 percent.

Maximum Allowed Cost Policy

Under Wisconsin's State Medicaid Plan approved by the U.S. Department of Health and Human Services, Wisconsin Medicaid and WCDP may assign MACs to establish an upper limit for payment of brand or generic versions of the same drug (federal legend or OTC drugs), regardless of manufacturer. MAC rates are set by using best estimates of prices currently in the marketplace in comparison to AWP as stated in the approved Wisconsin State Plan.

Providers will receive an informational EOB on pharmacy non-compound and compound claims that are reimbursed at the MAC rate.

Provider Payment

State law limits what pharmacies may charge SeniorCare members for covered drugs. SeniorCare payment rates are based on the BadgerCare Plus payment rate, plus the applicable dispensing fee. Regardless of the member's level of participation, pharmacies should always submit their usual and customary charge.

SeniorCare's payment rate for brand name drugs is the AWP of an NDC minus 14 percent plus the applicable dispensing fee.

Maximum Allowable Fees

Maximum allowable fees are established for most covered services. Maximum allowable fees are based on various factors, including a review of usual and customary charges submitted, 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 reimbursed at the lesser of their billed amount and the maximum allowable fee for the procedure.

Maximum Allowed Cost Drug Pricing Review

To request a review of MAC pricing, pharmacy providers are required to submit the Maximum Allowed Cost Drug Pricing Review Request along with supporting documentation.

Pharmacy providers are required to submit the following supporting documentation along with the Maximum Allowed Cost Drug Pricing Review Request form signed by a pharmacist certifying that the price listed is the actual new cost after rebates or discounts from a wholesaler. Supporting documentation must include:

- Date of purchase.
- Invoiced provider.
- Wholesaler name.
- Product NDC. If the NDC is not indicated on the invoice, the provider is required to handwrite the NDC on the invoice.

- Invoice price.

The Maximum Allowed Cost Drug Pricing Review Request form and the supporting documentation must be submitted to the DAPO Center via fax at (608) 250-0246 or by mail to the following address:

ForwardHealth
Drug Authorization and Policy Override Center
6406 Bridge Rd
Madison WI 53784-0088

Any action taken by ForwardHealth will be reflected in the MAC data table.

Pharmacy Services and Some Drug-Related Supplies

Pharmacy services and some drug-related supplies for managed care members are reimbursed by fee-for-service.

The following provider-administered drugs and related administration codes are reimbursed by fee-for-service, not a member's MCO, for members enrolled in BadgerCare Plus HMOs, Medicaid SSI HMOs, and most special managed care programs if the service is covered by BadgerCare Plus and Medicaid:

- All "J" codes.
- Drug-related "Q" codes.
- A limited number of related administration codes.

For members enrolled in BadgerCare Plus HMOs, Medicaid SSI HMOs, and most special managed care programs, claims for these services should be submitted to BadgerCare Plus and Medicaid fee-for-service.

MCOs are responsible for reimbursing providers for all other provider-administered drugs, such as drug claims submitted with a CPT code, such as CPT code 90378 (Respiratory syncytial virus immune globulin [RSV-IgIM], for intramuscular use, 50 mg, each).

Prescription drugs and related services and provider-administered drugs for members enrolled in the PACE and the Family Care Partnership are provided and reimbursed by the special managed care program.

Claims

Claims for drug-related supplies should be submitted with the appropriate HCPCS procedure code indicated.

Reimbursement for Brand Name and Generic Drugs

BadgerCare Plus and SeniorCare reimburse providers for innovator drugs (i.e., the patented brand name product of the generic drug on the Maximum Allowed Cost List) at an amount greater than the Medicaid maximum allowable cost only if the prescriber indicates "Brand Medically Necessary" on the prescription, and the pharmacy provider obtains PA for the innovator drug. If PA is not obtained for a brand medically necessary drug, and the drug is dispensed without a "Brand Medically Necessary" indication on the prescription, BadgerCare Plus will reimburse pharmacy providers at the generic rate; however, SeniorCare will deny a claim for a brand medically necessary drug unless the prescriber obtains PA and indicates "Brand Medically Necessary" on the prescription.

Specialty Drug Reimbursement

An EAC is established for specialty pharmacy drugs by therapeutic class. The EAC will be based on the AWP minus a specified percent. Providers may refer to the Specialty Pharmacy Drug Reimbursement Rate data table for a list of specialty pharmacy drugs, EAC, and effective dates.

Collecting Payment From Members

Conditions That Must Be Met

A member may request a noncovered service, a covered service for which PA was denied (or modified), or a service that is not covered under the member's limited benefit category. The charge for the service may be collected from the member if the following conditions are met *prior* to the delivery of that service:

- The member accepts responsibility for payment.
- The provider and member make payment arrangements for the service.

Providers are strongly encouraged to obtain a *written* statement in advance documenting that the member has accepted responsibility for the payment of the service.

Furthermore, the service must be separate or distinct from a related, covered service. For example, a vision provider may provide a member with eyeglasses but then, upon the member's request, provide and charge the member for anti-glare coating, which is a noncovered service. Charging the member is permissible in this situation because the anti-glare coating is a separate service and can be added to the lenses at a later time.

Situations When Member Payment Is Allowed

Providers may not collect payment from a member, or authorized person acting on behalf of the member, *except* for the following:

- Required member copayments for certain services.
- Commercial insurance payments made to the member.
- Spenddown.
- Charges for a private room in a nursing home or hospital.
- Noncovered services if certain conditions are met.
- Covered services for which PA was denied (or an originally requested service for which a PA request was modified) if certain conditions are met. These services are treated as noncovered services.
- Services provided to a member in a limited benefit category when the services are not covered under the limited benefit and if certain conditions are met.

If a provider inappropriately collects payment from a member, or authorized person acting on behalf of the member, that provider may be subject to program sanctions including termination of Medicaid certification.

Copayment

Amounts

Information is available for DOS before January 1, 2011.

BadgerCare Plus Standard Plan and Medicaid

The copayment amount for generic drugs is $1.00, while the BadgerCare Plus Standard Plan and Medicaid copayment amount for brand name drugs is $3.00, up to a maximum copayment of $12.00 per member, per provider, per calendar month. The copayment amount for OTC drugs (excluding iron supplements for pregnant or lactating women) is $0.50 for each new or refilled prescription.

For OTC drugs, DMS, and DME, there is no limitation on the total amount of copayment a member may be required to pay in a calendar month. However, member copayment amounts for OTC drugs, DMS, or DME may change to a different copayment level if the maximum allowable fee for the drug or supply changes. Providers should collect copayment for OTC drugs, DMS, and DME based on the maximum allowable fee of the supply for each DOS. The quantity of the supply dispensed on that DOS is not a factor when determining copayment amounts.

BadgerCare Plus Benchmark Plan

Copayment for drugs covered under the BadgerCare Plus Benchmark Plan is up to $5.00 per prescription with no monthly or annual limits. If the reimbursement amount for a prescription is less than $5.00, the member should be charged the lesser amount as copayment.

Under the Benchmark Plan, a provider has the right to deny services if the member fails to make his or her copayment.

BadgerCare Plus Core Plan

Copayment for drugs covered by BadgerCare Plus Core Plan is up to $4.00 per generic prescription and up to $8.00 per brand name prescription, with a monthly maximum of $24.00 per member, per provider.

Under the Core Plan, a provider has the right to deny services if the member fails to make his or her copayment.

BadgerCare Plus Basic Plan

Copayment for drugs covered by BadgerCare Plus Basic Plan is $5.00 per generic prescription and $10.00 per brand name prescription. Vaccines, including the flu shot (influenza vaccine), have a $10 copayment. There is no monthly copayment upper limit for pharmacy services for members enrolled in the Basic Plan.

Under the Basic Plan, a provider has the right to deny services if the member fails to make his or her copayment.

Copayment for Diabetic Supplies

Copayment for diabetic supplies is $0.50 per prescription for all benefit plans with no monthly or annual limits. For example, if a member has one prescription for two boxes of lancets, the copayment would be $0.50 and one prescription for one box of syringes, the copayment would be $0.50. The member's total copayment is $1.00.

Exemptions

Wisconsin Medicaid Exemptions

According to DHS 104.01(12), Wis. Admin. Code, providers are prohibited from collecting copayment from the following Wisconsin Medicaid members:

- Members under 18 years of age with incomes at or below 100 percent of the FPL. (For HealthCheck services, members under 19 years old are exempt.)
- Members under 18 years of age who are members of a federally recognized tribe regardless of income.
- Members enrolled in Medicaid because they are in foster care regardless of age.
- Members enrolled in Medicaid through subsidized adoption regardless of age.
- Members enrolled in Medicaid through the Katie Beckett program regardless of age.
- Nursing home residents.
- Members enrolled in Medicaid SSI HMOs or Medicaid special managed care programs receiving managed care-covered services.
- Pregnant women.

The following services do not require copayment:

- Case management services.
- Crisis intervention services.
- CSP services.
- Emergency services.
- Family planning services, including sterilizations.
- Home care services.
- Hospice care services.
- Immunizations.
- Independent laboratory services.
- Injections.
- PDN and PDN services for ventilator-dependent members.
- SBS.
- Substance abuse day treatment services.
- Surgical assistance.

BadgerCare Plus Standard Plan Exemptions

Providers are prohibited from collecting copayment from the following BadgerCare Plus Standard Plan members:

- Members in nursing homes.
- Members under 18 years old who are members of a federally recognized tribe regardless of income.
- Members under 18 years old with incomes at or below 100 percent of the FPL.
- Pregnant women.

The following services do not require copayment:

- Case management services.
- Crisis intervention services.
- CSP services.
- Emergency services.
- Family planning services, including sterilizations.
- Home care services.

- Hospice care services.
- Immunizations.
- Independent laboratory services.
- Injections.
- PDN and PDN services for ventilator-dependent members.
- SBS.
- Substance abuse day treatment services.
- Surgical assistance.

Wisconsin Well Woman Medicaid Exemptions

Providers are prohibited from collecting copayment from members who have been enrolled into WWWMA from the BadgerCare Plus Benchmark Plan or the BadgerCare Plus Core Plan for any Medicaid covered service.

BadgerCare Plus Benchmark Plan Exemptions

Certain Benchmark Plan members are exempt from copayment requirements, including the following:

- Members under 18 years old who are members of a federally recognized tribe.
- Pregnant women.

Providers should always use Wisconsin's EVS to verify member enrollment and to check if the member is subject to a copayment.

The following services do not require copayment under the Benchmark Plan:

- Family planning services.
- Preventive services, including HealthCheck screenings.

Limitations

Providers should verify that they are collecting the correct copayment for services as some services have monthly or annual copayment limits. Providers may not collect member copayments in amounts that exceed copayment limits.

Resetting Copayment Limitations

Copayment amounts paid by a member enrolled in the BadgerCare Plus Benchmark Plan and the BadgerCare Plus Core Plan within their continuous 12-month enrollment year will reset in the following situations:

- A fee-for-service member is enrolled in an HMO.
- A member switches from one HMO to another HMO (only allowable within the first 90 days of Core Plan enrollment).
- A member is disenrolled from an HMO and moves to fee-for-service.

Note: When a member goes from fee-for-service into an HMO and subsequently moves back to fee-for-service, copayments will not be reset for the services that were received under the initial fee-for-service enrollment period.

Resetting copayment limitations does not change a member's Benchmark Plan enrollment year or a member's Core Plan enrollment year.

Refund/Collection

If a provider collects a copayment before providing a service and BadgerCare Plus does not reimburse the provider for any part of

the service, the provider is required to return or credit the entire copayment amount to the member.

If BadgerCare Plus deducts less copayment than the member paid, the provider is required to return or credit the remainder to the member. If BadgerCare Plus deducts more copayment than the member paid, the provider may collect the remaining amount from the member.

Requirements

Federal law permits states to charge members a copayment for certain covered services. Providers are required to request copayments from members. Providers may not deny services to a Wisconsin Medicaid or BadgerCare Plus Standard Plan member who fails to make a copayment; however, providers may deny services to a BadgerCare Plus Benchmark Plan member, BadgerCare Plus Core Plan member, or BadgerCare Plus Basic Plan member who fails to make a copayment.

Chapter 49.45(18), Wis. Stats., requires providers to make a reasonable attempt to collect copayment from the member unless the provider determines that the cost of collecting the copayment exceeds the amount to be collected.

Payer of Last Resort

Instances When Medicaid Is Not Payer of Last Resort

Wisconsin Medicaid or BadgerCare Plus are *not* the payer of last resort for members who receive coverage from certain governmental programs, such as:

- B-3.
- Crime Victim Compensation Fund.
- GA.
- HCBS waiver programs.
- IDEA.
- Indian Health Service.
- Maternal and Child Health Services.
- WCDP.
  - Adult Cystic Fibrosis.
  - Chronic Renal Disease.
  - Hemophilia Home Care.

Providers should ask members if they have coverage from these other governmental programs.

If the member becomes retroactively enrolled in Wisconsin Medicaid or BadgerCare Plus, providers who have already been reimbursed by one of these government programs may be required to submit the claims to ForwardHealth and refund the payment from the government program.

Other Health Insurance Sources

BadgerCare Plus reimburses only that portion of the allowed cost remaining after a member's other health insurance sources have been exhausted. Other health insurance sources include the following:

- Commercial fee-for-service plans.
- Commercial managed care plans.
- Medicare supplements (e.g., Medigap).
- Medicare.
- Medicare Advantage.
- TriCare.
- CHAMPVA.
- Other governmental benefits.

Payer of Last Resort

Except for a few instances, Wisconsin Medicaid or BadgerCare Plus are the payer of last resort for any covered services. Therefore, the provider is required to make a reasonable effort to exhaust all existing other health insurance sources before submitting claims to ForwardHealth or to a state-contracted MCO.

Primary and Secondary Payers

The terms "primary payer" and "secondary payer" indicate the relative order in which insurance sources are responsible for paying

claims.

In general, commercial health insurance is primary to Medicare, and Medicare is primary to Wisconsin Medicaid and BadgerCare Plus. Therefore, Wisconsin Medicaid and BadgerCare Plus are secondary to Medicare, and Medicare is secondary to commercial health insurance.

Reimbursement Not Available

Drugs

Reimbursement is not available from Wisconsin Medicaid, BadgerCare, and SeniorCare for the following drugs.

Reimbursment Not Available
Alginate
Eflornithine (Vaniqa) Topical
Finasteride (Propecia)
Gaviscon
Less-than-effective drugs
Minoxidil Topical
Drugs without signed manufacturer rebate agreements*
Progesterone for PMS
Legend Multivitamins (nonprenatal) - excludes HealthCheck
*Wisconsin SeniorCare does not cover prescription drugs, even with a PA request, that do not have a signed rebate agreement between the DHS and the manufacturer; however, these drugs may be covered for Wisconsin Medicaid members if a paper PA request is submitted to Wisconsin Medicaid.

Reimbursement Not Available: Fertility Enhancement Drugs (When Used to Treat Infertility)
Chorionic Gonadotropin
Clomiphene
Crinone
Gonadorelin
Menotropins
Urofollitropin

Reimbursement Not Available: Impotence Treatment Drugs
Alprostadil Intracavernosal (Caverject, Edex)
Phentolamine Intracavernosal (Regitine)
Tadalafil (Cialis)
Sildenafil (Viagra)
Urethral suppository (Muse)
Vardenafil (Levitra)
Yohimbine

Reimbursement Not Available

Wisconsin Medicaid may deny or recoup payment for covered services that fail to meet program requirements. Medicaid reimbursement is also not available for noncovered services.

The following are not reimbursable as pharmacy services under DHS 107.10(4), Wis. Admin. Code:

- Drugs produced by manufacturers who have not signed a rebate agreement.
- A drug for a specific member for which PA has been requested and denied.
- Refills of Schedule II drugs. (Partial fills are acceptable if they comply with Board of Pharmacy regulations.)
- Refills beyond those described under Refills.
- Claims from pharmacy providers for reimbursement for drugs, DMS, and DME included in the nursing facility daily rate for nursing facility residents.
- Items that are in the inventory of a nursing facility.
- Brand name OTC analgesics, antacids, cough syrups, and iron supplements.
- Personal care items.
- Cosmetics.
- Common medicine chest items (e.g., antiseptics and Band-Aids™.)
- Personal hygiene items.
- Patent medicines.
- Uneconomically small package sizes.
- Drugs where the manufacturer has refused to sign a rebate agreement with CMS.
- Less-than-effective/identical, related, or similar drugs including drugs that were determined to have little therapeutic value, are not medically necessary, or are not cost-effective.

Convenience and Combination Packaging

ForwardHealth does not reimburse for convenience or combination packaging. Drugs that are sold in small package sizes (e.g., single-use packages) are considered to be convenience packaging. Drugs that are sold in a package that includes a prescription drug along with a noncovered item; such as an OTC drug (fish oil), a personal care item (skin moisturizer), and a common medicine chest item (Band-Aids™) are combination packaging. In some cases, the drug may be separately reimbursable. For example, an acne agent packaged with an OTC face wash is not covered, but the acne agent may be covered by itself.

Reimbursement Not Available Through a Factor

BadgerCare Plus will not reimburse providers through a factor, either directly or by virtue of a power of attorney given to the factor by the provider. A factor is an organization (e.g., a collection agency) or person who advances money to a provider for the purchase or transferal of the provider's accounts receivable. The term "factor" does not include business representatives, such as billing services, clearinghouses, or accounting firms, which render statements and receive payments in the name of the provider.

Services Not Separately Reimbursable

If reimbursement for a service is included in the reimbursement for the primary procedure or service, it is not separately reimbursable. For example, routine venipuncture is not separately reimbursable, but it is included in the reimbursement for the laboratory procedure or the laboratory test preparation and handling fee. Also, DME delivery charges are included in the reimbursement for DME items.

Resources

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Archive Date:03/01/2011

Resources:Contact Information

Member Services

Providers should refer ForwardHealth members with questions to Member Services. The telephone number for Member Services is for member use only.

Provider Relations Representatives

The Provider Relations representatives, also known as field representatives, conduct training sessions on various ForwardHealth topics for both large and small groups of providers and billers. In addition to provider education, field representatives are available to assist providers with complex billing and claims processing questions. Field representatives are located throughout the state to offer detailed assistance to all ForwardHealth providers and all ForwardHealth programs.

Field Representative Specialization

The field representatives are assigned to specific regions of the state. In addition, the field representatives have specialized in a group of provider types. This specialization allows the field representatives to most efficiently and effectively address provider inquiries. To better direct inquiries, providers should contact the field representative in their region who specializes in their provider type.

Provider Education

The field representatives' primary focus is provider education. They provide information on ForwardHealth programs and topics in the following ways:

- Conducting provider training sessions throughout the state.
- Providing training and information for newly certified providers and/or new staff.
- Participating in professional association meetings.

Providers may also contact the field representatives if there is a specific topic, or topics, on which they would like to have an individualized training session. This could include topics such as use of the Portal (information about claims, enrollment verification, and PA requests on the Portal). Refer to the Providers Trainings page for the latest information on training opportunities.

Additional Inquiries

Providers are encouraged to initially obtain information through the ForwardHealth Portal, WiCall, and Provider Services. If these attempts are not successful, field representatives may be contacted for the following types of inquiries:

- Claims, including discrepancies regarding enrollment verification and claim processing.
- PES claims submission software.
- Claims processing problems that have not been resolved through other channels (e.g., telephone or written correspondence).
- Referrals by a Provider Services telephone correspondent.
- Complex issues that require extensive explanation.

Field representatives primarily work outside their offices to provide on-site service; therefore, providers should be prepared to leave a complete message when contacting field representatives, including all pertinent information related to the inquiry. Member inquiries should not be directed to field representatives. Providers should refer members to Member Services at (800) 362-3002.

If contacting a field representative by e-mail, providers should ensure that no individually identifiable health information, known as PHI, is included in the message. PHI can include things such as the member's name combined with his/her identification number or SSN.

Information to Have Ready

Providers or their representatives should have the following information ready when they call:

- Name or alternate contact.
- County and city where services are provided.
- Name of facility or provider whom they are representing.
- NPI or provider number.
- Telephone number, including area code.
- A concise statement outlining concern.
- Days and times when available.

For questions about a specific claim, providers should also include the following information:

- Member's name.
- Member identification number.
- Claim number.
- DOS.

Provider Services

Providers should call Provider Services to answer enrollment, policy, and billing questions. Members should call Member Services for information. Members should *not* be referred to Provider Services.

The Provider Services Call Center provides service-specific assistance to Medicaid, BadgerCare Plus, WCDP, and WWWP providers.

Ways Provider Services Can Help

The Provider Services Call Center is organized to include program-specific and service-specific assistance to providers. The Provider Services call center supplements the ForwardHealth Portal and WiCall by providing information on the following:

- Billing and claim submissions.
- Certification.
- COB (e.g., verifying a member's other health insurance coverage).
- Assistance with completing forms.
- Assistance with remittance information and claim denials.
- Policy clarification.
- PA status.
- Verifying covered services.

Information to Have Ready

When contacting or transferring from WiCall to the call center, callers will be prompted to enter their NPI or provider ID. Additionally, to facilitate service, providers are recommended to have all pertinent information related to their inquiry on hand when contacting the call center, including:

- Provider name and NPI or provider ID.

- Member name and member identification number.
- Claim number.
- PA number.
- DOS.
- Amount billed.
- RA.
- Procedure code of the service in question.
- Reference to any provider publications that address the inquiry.

Call Center Correspondent Team

The ForwardHealth call center correspondents are organized to respond to telephone calls from providers. Correspondents offer assistance and answer inquiries specific to the program (i.e., Medicaid, WCDP, or WWWP) or to the service area (i.e., pharmacy services, hospital services) in which they are designated.

Call Center Menu Options and Inquiries

Providers contacting Provider Services are prompted to select from the following menu options:

- WCDP and WWWP (for inquiries from all providers regarding WCDP or WWWP).
- Dental (for all inquiries regarding dental services).
- Medicaid or SeniorCare Pharmacy (for pharmacy providers) or STAT-PA for STAT-PA inquiries, including inquiries from pharmacies, DME providers for orthopedic shoes, and HealthCheck providers for environmental lead inspections.
- Medicaid and BadgerCare Plus institutional services (for inquiries from providers who provide hospital, nursing home, home health, personal care, ESRD, and hospice services or NIP).
- Medicaid and BadgerCare Plus professional services (for inquiries from all other providers not mentioned in the previous menu prompts).

Walk-in Appointments

Walk-in appointments offer face-to-face assistance for providers at the Provider Services office. Providers are encouraged to contact the Provider Services Call Center to schedule a walk-in appointment.

Written Inquiries

Providers may contact Provider Services through the Portal by selecting the "Contact Us" link. Provider Services will respond to the inquiry by the preferred method of response indicated within five business days. All information is transmitted via a secure connection to protect personal health information.

Providers may submit written inquiries to ForwardHealth by mail using the Written Correspondence Inquiry form. The Written Correspondence Inquiry form may be photocopied or downloaded via a link from the Portal. Written correspondence should be sent to the following address:

> ForwardHealth
> Provider Services Written Correspondence
> 6406 Bridge Rd
> Madison WI 53784-0005

Providers are encouraged to use the other resources before mailing a written request to ForwardHealth. Provider Services will respond to written inquiries in writing unless otherwise specified.

Provider Suggestions

The DHCAA is interested in improving its program for providers and members. Providers who would like to suggest a revision of any policy or procedure stated in provider publications or who wish to suggest new policies are encouraged to submit recommendations on the Provider Suggestion form.

Resources Reference Guide

The Provider Services and Resources Reference Guide lists services and resources available to providers and members with contact information and hours of availability.

Electronic Data Interchange

Companion Documents

Purpose of Companion Documents

ForwardHealth companion documents provide trading partners with useful technical information on ForwardHealth's standards for nationally recognized electronic transactions.

The information in companion documents applies to BadgerCare Plus, Medicaid, SeniorCare, WCDP, and WWWP. Companion documents are intended for information technology and systems staff who code billing systems or software.

The companion documents complement the federal HIPAA Implementation Guides and highlight information that trading partners need to successfully exchange electronic transactions with ForwardHealth, including general topics such as the following:

- Methods of exchanging electronic information (e.g., exchange interfaces, transaction administration, and data preparation).
- Instructions for constructing the technical component of submitting or receiving electronic transactions (e.g., claims, RA, and enrollment inquiries).

Companion documents do *not* include program requirements, but help those who create the electronic formats for electronic data exchange.

Companion documents cover the following specific subjects:

- Getting started (e.g., identification information, testing, and exchange preparation).
- Transaction administration (e.g., tracking claims submissions, contacting the EDI Helpdesk).
- Transaction formats.

Revisions to Companion Documents

Companion documents may be updated as a result of changes to federal requirements. When this occurs, ForwardHealth will do the following:

- Post the revised companion document on the ForwardHealth Portal.
- Post a message on the banner page of the RA.
- Send an e-mail to trading partners.

Trading partners are encouraged to periodically check for the revised companion documents on the Portal. If trading partners do not follow the revisions identified in the companion document, transactions may not process successfully (e.g., claims may deny or process incorrectly).

A revision log located at the front of the revised companion document lists the changes that have been made. The date on the companion document reflects the last date the companion document was revised. In addition, the version number located in the footer of the first page is changed with each revision.

Data Exchange Methods

The following data exchange methods are supported by the EDI Helpdesk:

- Remote access server dial-up, using a personal computer with a modem, browser, and encryption software.
- Secure Web, using an Internet Service Provider and a personal computer with a modem, browser, and encryption software.
- Real-time, by which trading partners exchange the NCPDP 5.1, 270/271, or 276/277 transactions via an approved clearinghouse.

The EDI Helpdesk supports the exchange of the transactions for BadgerCare Plus, Medicaid, SeniorCare, WCDP, and WWWP.

Electronic Data Interchange Helpdesk

The EDI Helpdesk assists anyone interested in becoming a trading partner with getting started and provides ongoing support pertaining to electronic transactions. Providers, billing services, and clearinghouses are encouraged to contact the EDI Helpdesk for test packets and/or technical questions.

Providers with policy questions should call Provider Services.

Electronic Transactions

Trading partners may submit claims and adjustment requests, inquire about member enrollment, claim status, and ForwardHealth payment advice by exchanging electronic transactions.

Through the EDI Department, trading partners may exchange the following electronic transactions:

- 270/271. The 270 is the electronic transaction for inquiring about a member's enrollment. The 271 is received in response to the inquiry.
- 276/277. The 276 is the electronic transaction for checking claim status. The 277 is received in response.
- 835. The electronic transaction for receiving remittance information.
- 837. The electronic transaction for submitting claims and adjustment requests.
- 997. The electronic transaction for reporting whether a transaction is accepted or rejected.
- TA1 Interchange Acknowledgment. The electronic transaction for reporting a transaction that is rejected for interchange level errors.
- NCPDP 5.1 Telecommunication Standard for Retail Pharmacy Claims. The real-time POS electronic transaction for submitting pharmacy claims.

Provider Electronic Solutions Software

ForwardHealth offers electronic billing software at no cost to providers. The PES software allows providers to submit NCPDP 1.1 batch format pharmacy transactions, reverse claims, and check claim status. To obtain PES software, providers may download it from the ForwardHealth Portal. For assistance installing and using PES software, providers may call the EDI Helpdesk.

Trading Partner Profile

A Trading Partner Profile must be completed and signed for each billing provider number that will be used to exchange electronic transactions.

In addition, billing providers who do not use a third party to exchange electronic transactions, billing services, and clearinghouses are required to complete a Trading Partner Profile.

To determine whether a Trading Partner Profile is required, providers should refer to the following:

- Billing providers who do not use a third party to exchange electronic transactions, including providers who use the PES

software, are required to complete the Trading Partner Profile.
- Billing providers who use a third party (billing services and clearinghouses) to exchange electronic transactions are required to submit a Trading Partner Profile.
- Billing services and clearinghouses, including those that use PES software, that are authorized by providers to exchange electronic transactions on a provider's behalf, are required to submit a Trading Partner Profile.

Providers who change billing services and clearinghouses or become a trading partner should keep their information updated by contacting the EDI Helpdesk.

Trading Partners

ForwardHealth exchanges nationally recognized electronic transactions with trading partners. A "trading partner" is defined as a covered entity that exchanges electronic health care transactions. The following covered entities are considered trading partners:

- Providers who exchange electronic transactions directly with ForwardHealth.
- Billing services and clearinghouses that exchange electronic transactions directly with ForwardHealth on behalf of a billing provider.

Enrollment Verification

270/271 Transactions

The 270/271 transactions allow for batch enrollment verification, including information for the current benefit month or for any date of eligibility the member has on file, through a secure Internet connection. The 270 is the electronic transaction for inquiring about a member's enrollment. The 271 is received in response to the inquiry.

For those providers who are federally required to have an NPI, an NPI is required on the 270/271 transactions. The NPI indicated on the 270 is verified to ensure it is associated with a valid certification on file with ForwardHealth. The 271 response will report the NPI that was indicated on the 270.

For those providers exempt from NPI, a provider ID is required on the 270/271 transactions. The provider ID indicated on the 270 is verified to ensure it is associated with a valid certification on file with ForwardHealth. The 271 response will report the provider ID that was indicated on the 270.

An Overview

Providers should always verify a member's enrollment before providing services, both to determine enrollment for the current date (since a member's enrollment status may change) and to discover any limitations to the member's coverage. Each enrollment verification method allows providers to verify the following prior to services being rendered:

- A member's enrollment in a ForwardHealth program(s).
- State-contracted MCO enrollment.
- Medicare enrollment.
- Limited benefits categories.
- Any other commercial health insurance coverage.
- Exemption from copayments for BadgerCare Plus members.

Commercial Enrollment Verification Vendors

ForwardHealth has agreements with several commercial enrollment verification vendors to offer enrollment verification technology to ForwardHealth providers. Commercial enrollment verification vendors have up-to-date access to the ForwardHealth enrollment files to ensure that providers have access to the most current enrollment information. Providers may access Wisconsin's EVS to verify member enrollment through one or more of the following methods available from commercial enrollment verification vendors:

- Magnetic stripe card readers.
- Personal computer software.
- Internet.

Vendors sell magnetic stripe card readers, personal computer software, Internet access, and other services. They also provide ongoing maintenance, operations, and upgrades of their systems. Providers are responsible for the costs of using these enrollment verification methods.

Note: Providers are *not* required to purchase services from a commercial enrollment verification vendor. For more information on other ways to verify member enrollment or for questions about ForwardHealth identification cards, contact Provider Services.

The real-time enrollment verification methods allow providers to print a paper copy of the member's enrollment information, including

a transaction number, for their records. Providers should retain this number or the printout as proof that an inquiry was made.

Magnetic Stripe Card Readers

The magnetic stripe card readers resemble credit card readers. Some ForwardHealth identification cards have a magnetic stripe and signature panel on the back, and a unique, 16-digit card number on the front. The 16-digit card number is valid only for use with a magnetic card reader.

Providers receive current member enrollment information after passing the ForwardHealth card through the reader or entering the member identification number or card number into a keypad and entering the DOS about which they are inquiring.

Personal Computer Software

Personal computer software can be integrated into a provider's current computer system by using a modem and can access the same information as the magnetic stripe card readers.

Internet Access

Some enrollment verification vendors provide real-time access to enrollment from the EVS through the Internet.

Copayment Information

If a member is enrolled in BadgerCare Plus and is exempted from paying copayments for services, providers will receive the following response to an enrollment query from all methods of enrollment verification:

- The name of the benefit plan.
- The member's enrollment dates.
- The message, "No Copay."

If a member is enrolled in BadgerCare Plus and is required to pay copayments, providers will be given the name of the benefit plan in which the member is enrolled and the member's enrollment dates for the benefit plan only.

Note: The BadgerCare Plus Core Plan may also charge different copayments for hospital services depending on the member's income level. Members identified as "BadgerCare Plus Core Plan 1" are subject to lower copayments for hospital services. Members identified as "BadgerCare Plus Core Plan 2" are subject to higher copayments for hospital services.

Enrollment Verification System

Member enrollment issues are the primary reason claims are denied. To reduce claim denials, providers should *always* verify a member's enrollment before providing services, both to determine enrollment for the current date (since a member's enrollment status may change) and to discover any limitations to the member's coverage. Providers may want to verify the member's enrollment a second time before submitting a claim to find out whether the member's enrollment information has changed since the appointment.

Providers can access Wisconsin's EVS to receive the most current enrollment information through the following methods:

- ForwardHealth Portal.
- WiCall, Wisconsin's AVR system.
- Commercial enrollment verification vendors.
- 270/271 transactions.
- Provider Services.

Providers cannot charge a member, or authorized person acting on behalf of the member, for verifying his or her enrollment.

The EVS does not indicate other government programs that are secondary to Wisconsin Medicaid.

Enrollment Verification on the Portal

The secure ForwardHealth Portal offers real-time member enrollment verification for all ForwardHealth programs. Providers will be able to use this tool to determine:

- The benefit plan(s) in which the member is enrolled.
- If the member is enrolled in a state-contracted managed care program (for Medicaid and BadgerCare Plus members).
- If the member has any other coverage, such as Medicare or commercial health insurance.
- If the member is exempted from copayments (BadgerCare Plus members only).

To access enrollment verification via the ForwardHealth Portal, providers will need to do the following:

- Go to the ForwardHealth Portal.
- Establish a provider account.
- Log into the secure Portal.
- Click on the menu item for enrollment verification.

Providers will receive a unique transaction number for each enrollment verification inquiry. Providers may access a history of their enrollment inquiries using the Portal, which will list the date the inquiry was made and the enrollment information that was given on the date that the inquiry was made. For a more permanent record of inquiries, providers are advised to use the "print screen" function to save a paper copy of enrollment verification inquiries for their records or document the transaction number at the beginning of the response, for tracking or research purposes. This feature allows providers to access enrollment verification history when researching claim denials due to enrollment issues.

The Provider Portal is available 24 hours a day, seven days a week.

Entering Dates of Service

Enrollment information is provided based on a "From" DOS and a "To" DOS that the provider enters when making the enrollment inquiry. For enrollment inquires, a "From" DOS is the earliest date for which the provider is requesting enrollment information and the "To" DOS is the latest date for which the provider is requesting enrollment information.

Providers should use the following guidelines for entering DOS when verifying enrollment for Wisconsin Medicaid, BadgerCare Plus, SeniorCare, or WCDP members:

- The "From" DOS is the earliest date the provider requires enrollment information.
- The "To" DOS must be within 365 days of the "From" DOS.
- If the date of the request is prior to the 20th of the current month, then providers may enter a "From" DOS and "To" DOS up to the end of the current calendar month.
- If the date of the request is on or after the 20th of the current month, then providers may enter a "From" DOS and "To" DOS up to the end of the following calendar month.

For example, if the date of the request was November 15, 2008, the provider could request dates up to and including November 30, 2008. If the date of the request was November 25, 2008, the provider could request dates up to and including December 31, 2008.

Member Forgets ForwardHealth Identification Card

Even if a member does not present a ForwardHealth identification card, a provider can use Wisconsin's EVS to verify enrollment, otherwise, the provider may choose not to provide the service(s) until a member brings in a ForwardHealth card.

A provider may use a combination of the member's name, date of birth, ForwardHealth identification number, or SSN with a "0" at the end to access enrollment information through the EVS.

A provider may call Provider Services with the member's full name and date of birth to obtain the member's enrollment information if the member's identification number or SSN is not known.

Member Identification Card Does Not Guarantee Enrollment

Most members receive a member identification card, but possession of a program identification card does not guarantee enrollment. Periodically, members may become ineligible for enrollment, only to re-enroll at a later date. Members are told to keep their cards even though they may have gaps in enrollment periods. It is possible that a member will present a card when he or she is not enrolled; therefore, it is essential that providers verify enrollment before providing services. To reduce claim denials, it is important that providers verify the following information prior to each DOS that services are provided:

- If a member is enrolled in any ForwardHealth program, including benefit plan limitations.
- If a member is enrolled in a managed care organization.
- If a member is in primary provider lock-in status.
- If a member has Medicare or other insurance coverage.

Responses Are Based on Financial Payer

When making an enrollment inquiry through Wisconsin's EVS, the returned response will provide information on the member's enrollment in benefit plans based on financial payers.

There are three financial payers under ForwardHealth:

- Medicaid (Medicaid is the financial payer for Wisconsin Medicaid, BadgerCare Plus, and SeniorCare).
- WCDP.
- WWWP.

Within each financial payer are benefit plans. Each member is enrolled under at least one of the three financial payers, and under each financial payer, is enrolled in at least one benefit plan. An individual member may be enrolled under more than one financial payer. (For instance, a member with chronic renal disease may have health care coverage under the BadgerCare Plus Standard Plan and the WCDP chronic renal disease program. The member is enrolled under two financial payers, Medicaid and WCDP.) Alternatively, a member may have multiple benefits under a single financial payer. (For example, a member may be covered by the TB-Only Benefit and Family Planning Only Services at the same time, both of which are administered by Medicaid.)

Forms

An Overview

ForwardHealth requires providers to use a variety of forms for PA, claims processing, and documenting special circumstances.

Fillable Forms

Most forms may be obtained from the Forms page of the ForwardHealth Portal.

Forms on the Portal are available as fillable PDF files, which can be viewed with Adobe Reader® computer software. Providers may also complete and print fillable PDF files using Adobe Reader®.

To complete a fillable PDF, follow these steps:

- Select a specific form.
- Save the form to the computer.
- Use the "Tab" key to move from field to field.

Note: The Portal provides instructions on how to obtain Adobe Reader® at no charge from the Adobe® Web site. Adobe Reader® only allows providers to view and print completed PDFs. It does not allow users to save completed fillable PDFs to their computer; however, if Adobe Acrobat® is purchased, providers may save completed PDFs to their computer. Refer to the Adobe® Web site for more information about fillable PDFs.

Selected forms are also available in fillable Microsoft® Word format on the Portal. The fillable Microsoft® Word format allows providers to complete and print the form using Microsoft® Word. To complete a fillable Microsoft® Word form, follow these steps:

- Select a specific form.
- Save the form to the computer.
- Use the "Tab" key to move from field to field.

Note: Providers may save fillable Microsoft® Word documents to their computer by choosing "Save As" from the "File" menu, creating a file name, and selecting "Save" on their desktop.

Telephone or Mail Requests

Providers who do not have Internet access or who need forms that are not available on the ForwardHealth Portal may obtain them by doing either of the following:

- Requesting a paper copy of the form by calling Provider Services. Questions about forms may also be directed to Provider Services.
- Submitting a written request and mailing it to ForwardHealth. Include a return address, the name of the form, and the form number and send the request to the following address:

  ForwardHealth
  Form Reorder
  6406 Bridge Rd

Madison WI 53784-0003

Portal

ASC X12 Version 5010 and NCPDP Version D.0 Implementation Page

ForwardHealth has established a page on the ForwardHealth Portal designed to keep providers and trading partners informed of important dates and information related to the implementation of the new HIPAA ASC X12 version 5010 and NCPDP telecommunication standard version D.0. Providers, trading partners, partners, MCOs, and other interested parties are encouraged to check the 5010 page of the Portal often, as ForwardHealth will post new information regularly.

As information becomes available, ForwardHealth plans to include the following on the version 5010 and version D.0 page of the Portal:

- Questions and answers about the transition to the new standards.
- Companion documents for the new standards.
- External compliance testing schedule and procedures.
- Links to national resources for version 5010 and version D.0 transactions.
- An e-mail address to which providers and trading partners can send their questions (*forwardhealth5010support@wi.gov*).

Claims and Adjustments Using the ForwardHealth Portal

Providers can track the status of their submitted claims, submit individual claims, correct errors on claims, copy claims, and determine what claims are in "pay" status on the ForwardHealth Portal. Providers have the ability to search for and view the status of all their finalized claims, regardless of how they were submitted (i.e., paper, electronic, clearinghouse). If a claim contains an error, providers can correct it on the Portal and resubmit it to ForwardHealth.

Providers can submit an individual claim or adjust a claim through DDE through the secure Portal.

Conducting Recertification Via the ForwardHealth Portal

Providers can conduct recertification online via a secure recertification area of the ForwardHealth Portal.

Cost Share Reports for Long-Term Managed Care Organizations

Individual cost share reports for long-term care MCOs that provide Family Care, Family Care Partnership, and PACE services are available via the secure area of the ForwardHealth Portal and can be downloaded as an Excel file.

Creating a Provider Account

Each provider needs to designate one individual as an administrator of the ForwardHealth Portal account. This user establishes the administrative account once his or her PIN is received. The administrative user is responsible for this provider account and is able to add accounts for other users (clerks) within his or her organization and assign security roles to clerks that have been established. To establish an administrative account after receiving a PIN, the administrative user is required to follow these steps:

1. Go to the ForeardHealth Portal.
2. Click the **Providers** button.
3. Click **Logging in for the first time?**.
4. Enter the Login ID and PIN. The Login ID is the provider's NPI or provider number.
5. Click **Setup Account**.
6. At the Account Setup screen, enter the user's information in the required fields.
7. Read the security agreement and click the checkbox to indicate agreement with its contents.
8. Click **Submit** when complete.

Once in the secure Provider area of the Portal, the provider may conduct business online with ForwardHealth via a secure connection. Providers may also perform the following administrative functions from the Provider area of the Portal:

- Establish accounts and define access levels for clerks.
- Add other organizations to the account.
- Switch organizations.

A user's guide containing detailed instructions for performing these functions can be found on the Portal.

Designating a Trading Partner to Receive 835 Health Care Claim Payment/Advice Transactions

Providers must designate a trading partner to receive their 835 transaction for ForwardHealth interChange.

Providers who wish to submit their 835 designation via the Portal are required to create and establish a provider account to have access to the secure area of the Portal.

To designate a trading partner to receive 835 transactions, providers must first complete the following steps:

- Access the Portal and log into their secure account by clicking the Provider link/button.
- Click on the Designate 835 Receiver link on the right-hand side of the secure home page.
- Enter the identification number of the trading partner that is to receive the 835 in the Trading Partner ID field.
- Click Save.

Providers who are unable to use the Portal to designate a trading partner to receive 835 transactions may call the EDI Helpdesk or submit a paper form.

Electronic Communications

The secure Portal contains a one-way message center where providers can receive electronic notifications and provider publications from ForwardHealth. All new messages display on the provider's main page within the secure Portal.

Enrollment Verification

The secure Portal offers real time member enrollment verification for all ForwardHealth programs. Providers are able to use this tool to determine:

- The health care program(s) in which the member is enrolled.
- Whether or not the member is enrolled in a state-contracted MCO.
- Whether or not the member has any third-party liability, such as Medicare or commercial health insurance.
- Whether or not the member is enrolled in the Pharmacy Services Lock-In Program and the member's Lock-In pharmacy,

primary care provider, and referral providers (if applicable).

Using the Portal to check enrollment may be more effective than calling WiCall or the EVS (although both are available).

Providers are assigned a unique enrollment verification number for each inquiry. Providers can also use the "print screen" function to print a paper copy of enrollment verification inquiries for their records.

ForwardHealth Portal

Providers, members, trading partners, managed care programs, and partners have access to public *and* secure information through the ForwardHealth Portal.

The Portal has the following areas:

- Providers (public and secure).
- Trading Partners.
- Members.
- MCO.
- Partners.

The secure Portal allows providers to conduct business and exchange electronic transactions with ForwardHealth. The public Portal contains general information accessible to all users. Members can access general health care program information and apply for benefits online.

ForwardHealth Portal Helpdesk

Providers and trading partners may call the ForwardHealth Portal Helpdesk with technical questions on Portal functions, including their Portal accounts, registrations, passwords, and submissions through the Portal.

Inquiries to ForwardHealth Via the Portal

Providers are able to contact Provider Services through the ForwardHealth Portal by clicking the Contact link and entering the relevant inquiry information, including selecting the preferred method of response (i.e., telephone call or e-mail). Provider Services will respond to the inquiry by the preferred method of response indicated within five business days.

Internet Connection Speed

ForwardHealth recommends providers have an Internet connection that will provide an upload speed of at least 768 Kbps and a download speed of at least 128 Kbps in order to efficiently conduct business with ForwardHealth via the Portal.

For PES users, ForwardHealth recommends an Internet connection that will provide a download speed of at least 128 Kbps for downloading PES software and software updates from the Portal.

These download speeds are generally not available through a dial-up connection.

Logging in to the Provider Area of the Portal

Once an administrative user's or other user's account is set up, he or she may log in to the Provider area of the Portal to conduct business. To log in, the user is required to click the "Provider" link or button, then enter his or her username and password and click

"Go" in the Login to Secure Site box at the right side of the screen.

Managed Care Organization Portal

Information and Functions Through the Portal

The MCO area of the ForwardHealth Portal allows state-contracted MCOs to conduct business with ForwardHealth. The Public MCO page offers easy access to key MCO information and Web tools. A log-in is required to access the secure area of the Portal to submit or retrieve account and member information which may be sensitive.

The following information is available through the Portal:

- Certified Provider Listing of all Medicaid-certified providers.
- Coordination of Benefits Extract/Insurance Carrier Master List information updated quarterly.
- Data Warehouse, which is linked from the Portal to Business Objects. The Business Objects function allows for access to MCO data for long term care MCOs.
- Electronic messages.
- Enrollment verification by entering a member ID or SSN with date of birth and a "from DOS" and a "to DOS" range. A transaction number is assigned to track the request.
- Member search function for retrieving member information such as medical status code, and managed care and Medicare information.
- Provider search function for retrieving provider information such as address, telephone number, provider ID, and taxonomy code (if applicable), and provider type and specialty.
- HealthCheck information.
- MCO contact information.
- Technical contact information. Entries may be added via the Portal.

Managed Care Organization Portal Reports

The following reports are generated to MCOs through their account on the ForwardHealth MCO Portal:

- Capitation Payment Listing Report.
- Cost Share Report (long-term MCOs only).
- Enrollment Reports.

MCOs are required to establish a Portal account in order to receive reports from ForwardHealth.

Capitation Payment Listing Report

The Capitation Payment Listing Report provides "payee" MCOs with a detailed listing of the members for whom they receive capitation payments. ForwardHealth interChange creates adjustment transaction information weekly and regular capitation transaction information monthly. The weekly batch report includes regular and adjustment capitation transactions. MCOs have the option of receiving both the Capitation Payment Listing Report and the 820 Payroll Deducted and Other Group Premium Payment for Insurance Products transactions.

Initial Enrollment Roster Report

The Initial Enrollment Roster Report is generated according to the annual schedules detailing the number of new and continuing members enrolled in the MCO and those disenrolled before the next enrollment month.

Final Enrollment Roster Report

The Final Enrollment Roster Report is generated the last business day of each month and includes members who have had a change in status since the initial report and new members who were enrolled after the Initial Enrollment Roster Report was generated.

Other Reports

Additional reports are available for BadgerCare Plus HMOs, SSI HMOs, and long-term MCOs. Some are available via the Portal and some in the secure FTP.

Members ForwardHealth Portal

Members can access ForwardHealth information by going to the ForwardHealth Portal. Members can search through a directory of providers by entering a ZIP code, city, or county. Members can also access all member-related ForwardHealth applications and forms. Members can use ACCESS to check availability, apply for benefits, check current benefits, and report any changes.

Obtaining a Personal Identification Number

To establish an account on the ForwardHealth Portal, providers are required to obtain a PIN. The PIN is a unique, nine-digit number assigned by ForwardHealth interChange for the sole purpose of allowing a provider to establish a Portal account. It is used in conjunction with the provider's login ID. Once the Portal account is established, the provider will be prompted to create a username and password for the account, which will subsequently be used to log in to the Portal.

Note: The PIN used to create the provider's Portal account is not the same PIN used for recertification on the Portal. Providers will receive a separate PIN for recertification.

A provider may need to request more than one PIN if he or she is a provider for more than one program or has more than one type of provider certification. A separate PIN will be needed for each provider certification. Health care providers will need to supply their NPI and corresponding taxonomy code when requesting an account. Non-healthcare providers will need to supply their unique provider number.

Providers may request a PIN by following these steps:

1. Go to the Portal.
2. Click on the "Providers" link or button.
3. Click the "Request Portal Access" link from the Quick Links box on the right side of the screen.
4. At the Request Portal Access screen, enter the following information:
    a. Health care providers are required to enter their NPI and click "Search" to display a listing of ForwardHealth certifications. Select the correct certification for the account. The taxonomy code, ZIP+4 code, and financial payer for that certification will be automatically populated. Enter the SSN or TIN.
    b. Non-healthcare providers are required to enter their provider number, financial payer, and SSN or TIN. (This option should only be used by non-healthcare providers who are exempt from NPI requirements).

        The financial payer is one of the following:
        - Medicaid (Medicaid is the financial payer for Wisconsin Medicaid, BadgerCare Plus, and Senior Care).
        - SSI.
        - WCDP.
        - The WWWP.

    c. Click **Submit**.
    d. Once the Portal Access Request is successfully completed, ForwardHealth will send a letter with the provider's PIN to

the address on file.

Online Handbook

The Online Handbook allows providers access to all policy and billing information for Wisconsin Medicaid, BadgerCare Plus, SeniorCare, and WCDP in one centralized place. A secure ForwardHealth Portal account is not required to use the Online Handbook as it is available to all Portal visitors.

Revisions to policy information are incorporated immediately after policy changes have been issued in *ForwardHealth Updates*. The Online Handbook also links to the ForwardHealth Publications page, an archive section that providers can use to research past policy and procedure information.

The Online Handbook, which is available through the public area of the Portal, is designed to sort information based on user-entered criteria, such as program and provider type. It is organized into sections and chapters. Sections within each handbook may include the following:

- Certification.
- Claims.
- Coordination of Benefits.
- Managed Care.
- Member Information.
- Prior Authorization.
- Reimbursement.
- Resources.

Each section consists of separate chapters (e.g, claims submission, procedure codes), which contain further detailed information.

Advanced Search Function

The Online Handbook has an advanced search function, which allows providers to search for a specific word or phrase within a user type, program, service area, or throughout the entire Online Handbook.

Providers can access the advanced search function by following these steps:

1. Go to the Portal.
2. Click the "Online Handbooks" link in the upper left "Providers" box.
3. Complete the two drop-down selections at the right to narrow the search by program and service area, if applicable. This is not needed if providers wish to search the entire Online Handbook.
4. Click "Advanced Search" to open the advanced search options.
5. Enter the word or phrase you would like to search.
6. Select "Search within the options selected above" or "Search all handbooks, programs and service areas."
7. Click the "Search" button.

ForwardHealth Publications Archive Area

The ForwardHealth Publications page of the Online Handbook allows providers to view old *Updates* and previous versions of the Online Handbook.

Providers can access the archive information area by following these steps:

1. Go to the Portal.
2. Click the "Online Handbooks" link in the upper left "Providers" box.

3. Click on the "Updates and Handbooks" link. (This link is below the three drop-down menus.)

Other Business Enhancements Available on the Portal

The secure Provider area of the ForwardHealth Portal enables providers to do the following:

- Verify member enrollment.
- View RAs.
- Designate which trading partner is eligible to receive the provider's 835.
- Update and maintain provider file information. Providers have the choice to indicate separate addresses for different business functions.
- Receive electronic notifications and provider publications from ForwardHealth.
- Enroll in EFT.
- Track provider-submitted PA requests.

Portal Account Administrators

Portal administrators are responsible for requesting, creating, and managing accounts to access these features for their organization.

There must be one administrator assigned for each Portal account and all users established for that account. The responsibilities of the Portal administrator include:

- Ensuring the security and integrity of all user accounts (clerk administrators and clerks) created and associated with their Portal account.
- Ensuring clerks or clerk administrators are given the appropriate authorizations they need to perform their functions for the provider, trading partner, or MCO.
- Ensuring that clerks or clerk administrator accounts are removed/deleted promptly when the user leaves the organization.
- Ensuring that the transactions submitted are valid and recognized by ForwardHealth.
- Ensuring that all users they establish know and follow security and guidelines as required by HIPAA. As Portal administrators establish their Portal account and create accounts for others to access private information, administrators are reminded that all users must comply with HIPAA. The HIPAA privacy and security rules require that the confidentiality, integrity, and availability of PHI are maintained at all times. The HIPAA Privacy Rule provides guidelines governing the disclosure of PHI. The HIPAA Security Rule delineates the security measures to be implemented for the protection of electronic PHI. If Portal administrators have any questions concerning the protection of PHI, visit the Portal for additional information.

Portal administrators have access to all secure functions for their Portal account.

Establish an Administrator Account

All Portal accounts require an administrator account. The administrator is a selected individual who has overall responsibility for management of the account. Therefore, he or she has complete access to all functions within the specific secure area of his or her Portal and are permitted to add, remove, and manage other individual roles.

Portal Clerk Administrators

A Portal administrator may choose to delegate some of the authority and responsibility for setting up and managing the users within their Portal account. If so, the Portal administrator may establish a clerk administrator. An administrator or clerk administrator can create, modify, manage or remove clerks for a Portal account. When a clerk is created, the administrator or clerk administrator must grant permissions to the clerks to ensure they have the appropriate access to the functions they will perform. A clerk administrator can only grant permissions that they themselves have. For example, if an administrator gives a clerk administrator permission only for enrollment verification, then the clerk administrator can only establish clerks with enrollment verification permissions.

Even if a Portal administrator chooses to create a clerk administrator and delegate the ability to add, modify, and remove users from the same account, the Portal administrator is still responsible for ensuring the integrity and security of the Portal account.

Portal Clerks

The administrator (or the clerk administrator if the administrator has granted them authorization) may set up clerks within their Portal account. Clerks may be assigned one or many roles (i.e., claims, PA, enrollment verification). Clerks do not have the ability to establish, modify, or remove other accounts.

Once a clerk account is set up, the clerk account does not have to be established again for a separate Portal account. Clerks can easily be assigned a role for different Portal accounts (i.e., different ForwardHealth certifications). To perform work under a different Portal account for which they have been granted authorization, a clerk can use the "switch org" function and toggle between the Portal accounts to which they have access. Clerks may be granted different authorization in each Portal account (i.e., they may do enrollment verification for one Portal account, and HealthCheck inquires for another).

Public Area of the Provider Portal

The public Provider area of the ForwardHealth Portal offers a variety of important business features and functions that will greatly assist in daily business activities with ForwardHealth programs.

Maximum Allowable Fee Schedules

Within the Portal, all fee schedules for Medicaid, BadgerCare Plus, and WCDP are interactive and searchable. Providers can enter the DOS, along with other information such as procedure code, category of supplies, or provider type, to find the maximum allowable fee. Providers can also download all fee schedules.

Online Handbook

The Online Handbook is the single source for all current policy and billing information for ForwardHealth. The Online Handbook is designed to sort information based on user-entered criteria, such as program and provider type.

Revisions to information are incorporated immediately after policy changes have been issued in *Updates*. The Online Handbook also links to the ForwardHealth Publications page, an archive section where providers can research past policy changes.

ForwardHealth Publications Archive Section

The ForwardHealth Publications page, available via the Quick Links box, lists *Updates*, *Update Summaries*, archives of provider Handbooks and provider guides, and monthly archives of the Online Handbook. The ForwardHealth Publications page contains both current and obsolete information for research purposes only. Providers should use the Online Handbook for current policy and procedure questions. The *Updates* are searchable by provider type or program (e.g., physician or HealthCheck "Other Services") and by year of publication.

Training

Providers can register for all scheduled trainings and view online trainings via the Portal Training page, which contains an up-to-date calendar of all available training. Additionally, providers can view Webcasts of select trainings.

Contacting Provider Services

Providers and other Portal users will have an additional option for contacting Provider Services through the Contact link on the Portal. Providers can enter the relevant inquiry information, including selecting the preferred method of response (i.e., telephone call or e-mail) the provider wishes to receive back from Provider Services. Provider Services will respond to the inquiry within five business days. Information will be submitted via a secure connection.

Online Certification

Providers can speed up the certification process for Medicaid by completing a provider certification application via the Portal. Providers can then track their application by entering their ATN given to them on completion of the application.

Other Business Enhancements Available on the Portal

The public Provider area of the Portal also includes the following features:

- A "What's New?" section for providers that links to the latest provider publication summaries and other new information posted to the Provider area of the Portal.
- Home page for the provider. Providers have administrative control over their Portal homepage and can grant other employees access to specified areas of the Portal, such as claims and PA.
- E-mail subscription service for *Updates*. Providers can sign up to receive notifications of new provider publications via e-mail. Users are able to select, by program and service area, which publication notifications they would like to receive.
- A forms library.

Secure Area of the Provider Portal

Providers can accomplish many processes via the ForwardHealth Portal, including submitting, adjusting, and correcting claims, submitting and amending PA requests, and verifying enrollment.

Claims and Adjustments Using the Portal

Providers can track the status of their submitted claims, submit individual claims, correct errors on claims, and determine what claims are in "pay" status on the Portal. Providers have the ability to search for and view the status of all of their finalized claims, regardless of how they were submitted (i.e., paper, electronic, clearinghouse). If a claim contains an error, providers can correct it on the Portal and resubmit it to ForwardHealth.

Providers can submit an individual claim or adjust a claim via DDE through the secure Portal.

Submitting Prior Authorization and Amendment Requests Via the Portal

Nearly all service areas can submit PAs via the Portal. Providers can do the following:

- Correct errors on PAs or amendment requests via the Portal, regardless of how the PA was originally submitted.
- View all recently submitted and finalized PA and amendment requests.
- View the latest provider review and decision letters.
- Receive messages about PA and amendment requests that have been adjudicated or returned for provider review.

Electronic Communications

The secure Portal contains a one-way message center where providers can receive electronic notifications and provider publications from ForwardHealth. All new messages display on the provider's main page within the secure Portal.

Enrollment Verification

The secure Portal offers real-time member enrollment verification for all ForwardHealth programs. Providers are able to use this tool to determine:

- The health care program(s) in which the member is enrolled.
- Whether or not the member is enrolled in a state-contracted MCO.
- Whether or not the member has any third-party liability, such as Medicare or commercial health insurance.

Using the Portal to check enrollment may be more efficient than calling the AVR system or the EVS (although both are available).

Providers will be assigned a unique enrollment verification number for each inquiry. Providers can also use the "print screen" function to print a paper copy of enrollment verification inquiries for their records.

Other Business Enhancements Available on the Portal

The secure Provider area of the Portal enables providers to do the following:

- Verify member enrollment.
- View RAs.
- Designate which trading partner is eligible to receive the provider's 835.
- Update and maintain provider file information. Providers will have the choice to indicate separate addresses for different business functions.
- Receive electronic notifications and provider publications from ForwardHealth.
- Enroll in EFT.
- Track provider-submitted PA requests.

System and Browser Requirements

The following table lists the recommended system and browser requirements for using the Portal. PES users should note that the Windows-based requirements noted in the table apply; PES cannot be run on Apple-based systems.

<table>
<tr><th>Recommended System Requirements</th><th>Recommended Browser Requirements</th></tr>
<tr><th colspan="2">Windows-Based Systems</th></tr>
<tr><td>Computer with at least a 500Mhz processor, 256 MB of RAM, and 100MB of free disk space</td><td rowspan="2">Microsoft Internet Explorer v. 6.0 or higher, or
Firefox v. 1.5 or higher</td></tr>
<tr><td>Windows XP or higher operating system</td></tr>
<tr><th colspan="2">Apple-Based Systems</th></tr>
<tr><td>Computer running a PowerPC G4 or Intel processor, 512 MB of RAM, and 150MB of free disk space</td><td rowspan="2">Safari, or
Firefox v. 1.5 or higher</td></tr>
<tr><td>Mac OS X 10.2.x or higher operating system</td></tr>
</table>

Trading Partner Portal

The following information is available on the public Trading Partner area of the ForwardHealth Portal:

- Trading partner testing packets.
- Trading Partner Profile submission.
- PES software and upgrade information.

- EDI companion documents.

In the secure Trading Partner area of the Portal, trading partners can exchange electronic transactions with ForwardHealth.

Updates

Full Text Publications Available

Providers may request full-text versions of *ForwardHealth Updates* to be mailed to them by calling Provider Services.

General Information

ForwardHealth Updates are the first source of provider information. *Updates* announce the latest information on policy and coverage changes, PA submission requirements, claims submission requirements, and training announcements.

The *ForwardHealth Update Summary* is distributed on a monthly basis and contains an overview of *Updates* published that month. Providers with a ForwardHealth Portal account will be notified through their Portal mailbox when the *Update Summary* is available on the Portal. Providers without a Portal account will receive a paper copy of the *Update Summary* unless they have opted out of receiving paper publications.

Providers may obtain copies of *Updates* listed in the *Update Summary* from the Portal. A Web address that directly links providers to a list of each month's *Updates* is listed in the *Update Summary*. Providers may then print specific articles to keep on paper as well as navigate to other Medicaid information available on the Portal.

Providers without Internet access may call Provider Services to request a paper copy of an *Update*. To expedite the call, correspondents will ask providers for the *Update* number. Providers should allow seven to 10 business days for delivery.

Revisions to policy information are incorporated into the Online Handbook immediately after policy changes have been issued in *Updates*. The Online Handbook also includes a link to the ForwardHealth Publications page, an archive section where providers can research past changes.

Multiple Ways to Access ForwardHealth Publications

Providers may choose to receive notification on paper via U.S. mail or through a new e-mail subscription service. Providers who have established a ForwardHealth Portal account will automatically receive notification of *ForwardHealth Updates* and the monthly *ForwardHealth Update Summary* in their Portal message box. Providers will receive notification via their Portal accounts or e-mail subscription much sooner than on paper. Certain providers may choose not to receive *Updates* and the monthly *Update Summary*.

ForwardHealth Portal Account

Providers who establish a Portal account will not receive the *Update Summary* on paper through the U.S. mail. Providers are still bound to the program's rules, policies, and regulations even if they do not receive the *Update Summary* through the mail.

Mail

ForwardHealth will mail the monthly *Update Summary* to providers who do not have a Portal account.

E-mail Subscription Service

Providers and other interested parties may sign up on the Portal to receive e-mail notifications of new provider publications. Users are able to select, by program (Wisconsin Medicaid, BadgerCare Plus, or WCDP) and provider type (e.g., physician, hospital, DME

vendor), and which publication notifications they would like to receive. Any number of staff or other interested parties from an organization may sign up for an e-mail subscription. Providers who sign up for an e-mail subscription will continue to receive paper copies of the monthly *Update Summary* unless they have a Portal account or have opted out of receiving paper publications.

Users may sign up for an e-mail subscription by following these steps:

1. Go to the Portal.
2. Click on the "Providers" link or button.
3. Click the "Subscribe to Provider Notifications" link from the Quick Links box on the right side of the screen.
4. Register by supplying e-mail address.

Users may register for additional electronic subscriptions by adding service areas listed under "Available Subscriptions" on the right side of the subscriptions page.

WiCall

Enrollment Inquiries

WiCall is an AVR system that allows providers with touch-tone telephones direct access to enrollment information. A WiCall Quick Reference Guide for Enrollment Inquiries is available.

Information from WiCall will be returned in the following order if applicable to the member's current enrollment:

- Transaction number: A number will be given as a transaction confirmation that providers should keep for their records.
- Benefit enrollment: All benefit plans the member is enrolled in on the DOS or within the DOS range selected for the financial payer.
- County Code: The member's county code will be provided if available. The county code is a two-digit code between 01 and 72 that represents the county in which member resides. If the enrollment response reflects that the member resides in a designated HPSA on the DOS or within the DOS range selected, HPSA information will be given.
- MCO: All information about state-contracted MCO enrollment, including MCO names and telephone numbers (that exists on the DOS or within the DOS range selected), will be listed. This information is applicable to Medicaid and BadgerCare Plus members only.
- Hospice: If the member is enrolled in the hospice benefit on the DOS or within the DOS range that the provider selected, the hospice information will be given. This information is applicable to Medicaid and BadgerCare Plus members only.
- Lock-in: Information about the Pharmacy Services Lock-In Program that exists on the DOS or within the DOS range selected will be provided. This information is applicable to Medicaid, BadgerCare Plus, and SeniorCare members only.
- Medicare: All information about Medicare coverage, including type of coverage and Medicare number, if available, that exists on the DOS or within the DOS range selected will be listed.
- Other Commercial Insurance Coverage: All information about commercial coverage, including carrier names and telephone numbers, if available, that exists on the DOS or within the DOS range selected will be listed.
- Transaction Completed: After the member's enrollment information has been given using the financial payer that was selected, providers will be given the following options:
  - To hear the information again.
  - To request enrollment information for the same member using a different financial payer.
  - To hear another member's enrollment information using the same financial payer.
  - To hear another member's enrollment information using a different financial payer.
  - To return to the main menu.

WiCall is available 24 hours a day, seven days a week. If for some reason the system is unavailable, providers may call Provider Services.

Transaction Number

The AVR system issues a transaction number every time a provider verifies enrollment, even when an individual is *not* enrolled in BadgerCare Plus or Wisconsin Medicaid. The provider should retain this transaction number. It is proof that an inquiry was made about the member's enrollment. If a provider thinks a claim was denied in error, the provider can reference the transaction number to ForwardHealth to confirm the enrollment response that was actually given.

Entering Letters into WiCall

For some WiCall inquries, health care providers are required to enter their taxonomy code with their NPI. Because taxonomy codes are a combination of numbers and letters, telephone key pad combinations, shown in the table below, allow providers to successfully enter taxonomy code letters for WiCall functions (e.g., press *21 to enter an "A," press *72 to enter an "R").

Letter	Key Combination	Letter	Key Combination
A	*21	N	*62
B	*22	O	*63
C	*23	P	*71
D	*31	Q	*11
E	*32	R	*72
F	*33	S	*73
G	*41	T	*81
H	*42	U	*82
I	*43	V	*83
J	*51	W	*91
K	*52	X	*92
L	*53	Y	*93
M	*61	Z	*12

Additionally, providers may select option 9 and press "#" for an automated voice explanation of how to enter letters in WiCall.

Information Available Via WiCall

WiCall, ForwardHealth's AVR system, gathers inquiry information from callers through voice prompts and accesses ForwardHealth interChange to retrieve and "speak" back the following ForwardHealth information:

- Claim status.
- Enrollment verification.
- PA status.
- Provider CheckWrite information.

Note: ForwardHealth releases CheckWrite information to WiCall no sooner than on the first state business day following the financial cycle.

Providers are prompted to enter NPI or provider ID and in some cases, NPI-related data, to retrieve query information.

In all inquiry scenarios, WiCall offers the following options after information is retrieved and reported back to the caller:

- Repeat the information.
- Make another inquiry of the same type.
- Return to the main menu.
- Repeat the options.

Claim Status

Providers may check the status of a specific claim by selecting the applicable program ("financial payer" option, i.e., Wisconsin Medicaid, WCDP, or WWWP by entering their provider ID, member identification number, DOS, and the amount billed.

Note: Claim information for BadgerCare Plus and SeniorCare is available by selecting the Medicaid option.

Enrollment Verification

Providers may request enrollment status for any date of eligibility the member has on file by entering their provider ID and the member ID. If the member ID is unknown, providers may enter the member's date of birth and SSN. Additionally, the provider is prompted to enter the "From DOS" and the "To DOS" for the inquiry. The "From" DOS is the earliest date the provider requires enrollment information and the "To" DOS must be within 365 days of the "From" DOS.

Each time a provider verifies member enrollment, the enrollment verification is saved and assigned a transaction number as transaction confirmation. Providers should note the transaction number for their records.

Prior Authorization Status

Except in certain instances, providers may obtain the status of PA requests for Medicaid and WCDP via WiCall by entering their provider ID and the applicable PA number. If the provider does not know the PA number, there is an option to bypass entering the PA number and the caller will be prompted to enter other PA information such as member ID and type of service (i.e., NDC/procedure code, revenue code, or ICD-9-CM diagnosis code.) When a match is found, WiCall reports back the PA status information, including the PA number for future reference, and the applicable program.

Information on past PAs is retained indefinitely. Paper PAs require a maximum of 20 working days from receipt to be processed and incorporated into WiCall's PA status information.

Note: PA information for BadgerCare Plus and SeniorCare is available by selecting the Medicaid option.

Quick Reference Guide

The WiCall AVR Quick Reference Guide displays the information available for WiCall inquiries.