Claims

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Archive Date:04/01/2013

Claims:Adjustment Requests

Topic #814

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 (Remittance Advice) 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.

Topic #815

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.

Topic #512

Electronic

837 Transaction

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

Provider Electronic Solutions Software

The DHS (Department of Health Services) offers electronic billing software at no cost to providers. The PES (Provider Electronic Solutions) 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 (Electronic Data Interchange) 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.

Topic #513

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 (Electronic Data Interchange) Helpdesk for assistance with electronic adjustment requests.

Topic #515

Paper

Paper adjustment requests must be submitted using the Adjustment/Reconsideration Request (F-13046 (07/12)) form.

Topic #4902

Providers are required to indicate the actual NDC (National Drug Code) 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.

Topic #816

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.

Topic #514

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.

Topic #4857

Submitting Paper Attachments with Electronic Claim Adjustments

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

Drug Utilization Review

Topic #1978

A Comprehensive Overview

The federal OBRA '90 (Omnibus Reconciliation Act of 1990) established program requirements regarding several aspects of pharmacy practice. One of the requirements of OBRA '90 was a DUR (Drug Utilization Review) program for BadgerCare Plus, Medicaid, and SeniorCare members to improve the quality and cost-effectiveness of care.

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

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

Individual pharmacies are responsible for prospective DUR, while BadgerCare Plus, Medicaid, 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 (Department of Health Services) 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 s. 450.01(16)(i), Wis. Stats., for additional information about DUR program requirements.

Topic #12657

Additive Toxicity

The additive toxicity DUR (Drug Utilization Review) 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.

Topic #1983

Alerts and Alert Hierarchy

The DUR (Drug Utilization Review) 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, Medicaid, and SeniorCare by First DataBank, Inc.

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

BadgerCare Plus, Medicaid, and SeniorCare activate alerts that identify the following problems. These alerts are listed in hierarchical order according to the following prospective 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.
- LR — Underuse.
- HD — High dose.
- NS — Insufficient Quantity.

Topic #12618

Drug-Disease Contraindication

The drug-disease contraindication DUR (Drug Utilization Review) 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 — 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.

Topic #12617

Drug-Drug Interaction

The drug-drug interaction DUR (Drug Utilization Review) 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 BadgerCare Plus, Medicaid, and SeniorCare.

Topic #1981

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 (National Drug Code) 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 (Drug Utilization Review). 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.

Topic #1980

Educational Programming

A number of educational programs are generated by the DUR (Drug Utilization Review) Board. 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.

Topic #12660

High Dose

Providers receive the high dose prospective DUR (Drug Utilization Review) 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

Topic #12678

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 insufficient quantity ("NS") prospective DUR (Drug Utilization Review) alert and providers will be required to respond to the alert and resubmit the claim in the POS (Point-of-Sale) system to obtain reimbursement from ForwardHealth.

Topic #12637

Overuse Precaution

The overuse precaution DUR (Drug Utilization Review) 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.

The Prospective Drug Utilization Review System topic includes more information about override policies.

Topic #12620

Pregnancy Alert

The pregnancy DUR (Drug Utilization Review) 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 a diagnosis code.
- A pharmacy claim for a drug that possesses a clinical significance of D, X, or 1 (as assigned by the FDA (Food and Drug Administration) 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.

The pregnancy diagnosis will be deactivated 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.

Topic #1977

Prospective Drug Utilization Review System

To help individual pharmacies comply with their prospective DUR (Drug Utilization Review) responsibility, BadgerCare Plus, Medicaid, 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, Medicaid, and SeniorCare real-time POS (Point-of-Sale) claims submitted to ForwardHealth. Prospective DUR alerts are returned to pharmacy providers as a conflict code. Providers may refer to the ForwardHealth Payer Sheet: (P-00272) NCPDP (National Council for Prescription Drug Programs) Version D.0 for more information about 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, Medicaid, 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 (Omnibus Budget Reconciliation Act of 1990) to perform prospective DUR independently.

Claims for Assisted Living Facility, Group Home, and Nursing Facility Members

Real-time claims for assisted living facility, group home, and nursing facility 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 assisted living facility, group home, or nursing facility pharmacist consultant is responsible for prospective DUR. Although assisted living facility, group home, and nursing facility claims are exempt from denial, an informational alert will be received on POS claims.

Overriding Prospective Drug Utilization Review Alerts

When a claim is processed for a drug that has the potential to cause problems for a member, BadgerCare Plus, Medicaid, 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 (Drug Authorization and Policy Override) 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.

Providers are strongly encouraged to contact their software vendors to ensure that they have access to these necessary fields. Providers may also refer to the payer sheet for information about NCPDP transactions.

Prospective DUR allows pre-overrides if a drug in claims history will activate an alert for a drug that will dispensed from the same pharmacy. Providers may not pre-override claims for certain drugs for which the overuse precaution ("ER") DUR alert will activate.

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.

When pharmacy providers submit noncompound drug claims or reversals with a response to a prospective DUR alert at a minimum, the following fields are required:

- Reason for Service Code (NCPDP field 439-E4).
- Professional Service Code (NCPDP field 440-E5).
- Result of Service Code (NCPDP field 441-E6).

The following table indicates the specific fields that providers are required to submit for prospective DUR claims. The "X" denotes a required field with a prospective DUR claim submission.

Policy Requirements	Drug Utilization Review/PPS Code Counter	Reason for Service Code	Professional Service Code	Result of Service Code
Prospective DUR Override	X	X	X	X

The following table provides additional prospective DUR claim submission examples for when providers submit responses to the prospective DUR alert services in the same transaction.

Example	Reason for Service Code	Professional Service Code	Result of Service Code	Drug Utilization Review or Pharmaceutical Care
A	AT	M0	15	DUR
B	AT	RE	1E	DUR
C	AT	RE	1E	DUR
D	AT	RE	1E	DUR

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

Topic #1982

Prospective Drug Utilization Review and Pharmaceutical Care for DOS Before September 1, 2012

When pharmacy providers submit noncompound drug claims or reversals with a response to a prospective DUR (Drug Utilization Review) alert and submit a claim for a PC (Pharmaceutical Care) dispensing fee on the same claim, at a minimum, the following fields are required:

- Reason for Service Code (NCPDP (National Council for Prescription Drug Programs) field 439-E4).
- Professional Service Code (NCPDP field 440-E5).
- Result of Service Code (NCPDP field 441-E6).
- DUR/PPS Level of Effort (NCPDP field 474-8E).

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

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

Policy Requirements	DUR/PPS Code Counter	Reason for Service Code	Professional Service Code	Result of Service Code	DUR/PPS Level of Effort
PC	X	X	X	X	X
Prospective DUR Override	X	X	X	X	
Prospective DUR and PC	X	X	X	X	X

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

Example	Reason for Service Code	Professional Service Code	Result of Service Code	Prospective DUR/PPS Level of Effort	DUR or PC
A	AT	M0	1E	15	DUR *and* PC
B	AT	RE	1E	Blank	DUR
C	AT	RE	1E	Not sent	DUR
D	AT	RE	1E	Blank	DUR
	SR	M0	1F	11	PC
E	AT	RE	1E	11	PC
	SR	M0	1F	11	Not applicable

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

Topic #1975

Retrospective Drug Utilization Review

Retrospective DURs (Drug Utilization Reviews) are performed by BadgerCare Plus, Medicaid, 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, Medicaid, and SeniorCare pharmacy claims are examined by a software program for potential adverse drug concerns. Criteria are developed by BadgerCare Plus, Medicaid, 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.

Topic #12619

Therapeutic Duplication

The therapeutic duplication DUR (Drug Utilization Review) alert is activated when another drug is present in claims history in the same therapeutic class 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 classes for the duplication alert include:

- Anti-anxiety agents.
- Antidepressants.
- Antihistamines.
- Antihypertensives.
- Antipsychotics.
- Antithrombotics.
- Barbiturates.
- Cardiovascular agents.
- Diuretics.
- Histamine H2 receptor inhibitors.
- Hypoglycemics.
- Narcotic analgesics.
- NSAIDs (nonsteroidal anti-inflammatory drugs) (including COX-2 selective agents).
- Oral contraceptives.
- Platelet aggregation inhibitors.
- PPI (proton pump inhibitor) drugs.
- Sedatives and hypnotics.
- Skeletal muscle relaxants.

Topic #12659

Underuse Precaution

The underuse precaution DUR (Drug Utilization Review) 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 (angiotensin converting enzyme) inhibitor drugs.
- Alpha-blockers.
- Antilipidemics.
- Angiotensin-2 receptor antagonists.
- Anti-arrhythmics.
- Anticonvulsants.
- Antidepressants.
- Antipsychotics.
- Beta-blockers.
- Calcium channel blockers.
- Digoxin.
- Diuretics.
- Oral hypoglycemics.

Good Faith Claims

Topic #518

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 (Express Enrollment) 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 (Enrollment Verification System) 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 (Explanation of Benefits) code, providers should contact Provider Services for assistance.

Topic #1961

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

Topic #528

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.

Topic #532

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-enrolled on the DOS (date of service).
- 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 guide for the appropriate 837 (837 Health Care Claim) transaction when submitting adjustment requests.

Paper Adjustment Requests

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

- Submit an Adjustment/Reconsideration Request (F-13046 (07/12)) 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.

Topic #533

Cash Refunds

When submitting a personal check to ForwardHealth for an overpayment, providers should include a copy of the RA (Remittance Advice) 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 (internal control number), the NPI (National Provider Identifier) (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
313 Blettner Blvd
Madison WI 53784

Topic #531

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 (Remittance Advice).

Topic #530

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.

Topic #10138

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 (internal control numbers) beginning with "67." Overpayments that are adjusted on the Portal will have ICNs that begin with "59."

Pharmaceutical Care

Topic #14457

Pharmaceutical Care Information for DOS before September 1, 2012

ForwardHealth implemented the MTM (Medication Therapy Management) benefit in conjunction with the WPQC (Wisconsin Pharmacy Quality Collaborative). As a result of this implementation, PC (Pharmaceutical Care) services are no longer reimbursable for DOS (dates of service) on or after September 1, 2012.

This topic contains information for PC services for DOS before September 1, 2012.

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, Medicaid, and SeniorCare's PC program provides pharmacists with an enhanced dispensing fee for PC services provided to members. This enhanced fee reimburses pharmacists for additional actions they take beyond the standard dispensing and counseling for a prescription drug.

Reimbursement

There are limitations on PC billing and reimbursement. Responding to prospective DUR (Drug Utilization Review) alerts is not automatically considered a PC service. Not all PC services for which a provider receives a prospective 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.
- Whether the intervention was for safety, efficacy, compliance, or cost savings-only purposes.
- The diagnosis code for the diagnosis, disease, or intended use of the medication involved in the submitted intervention.
- The pharmacist's identity.
- A completed 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 the 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.

Wisconsin Medicaid Pharmaceutical Care Dispensing Fee Documentation

Providers may use any format to document Pharmaceutical Care (PC), but that format must include all the same information as this form.

Patient Name:_____ Medicaid ID No.:_____

Pharmacy Name:_____ Medicaid Provider ID No.:_____

You must establish and document your usual and customary fee structure for PC services billed to non-Medicaid patients.

Indicate your usual and customary non-Medicaid charge for this PC service.

PC Code:_____ **U/C Charge:**_____ **Date PC Completed:** _____

Reason: Provide details about the intervention. Describe problem(s) and rationale or basis for initiating intervention. Include all drugs, Drug Utilization Review alerts, or problems encountered when attempting to dispense the prescription. Document assessment and plan for care.

Action: Provide details about specific action(s) performed to resolve the problem(s), including identification of all contacts.

Result: Provide details about the outcome of the intervention.

Level Prof. Intervention Time:_____ minutes (exclude doc time)
Documentation Time:_____ minutes

Pharmacist's Name:_____

List prescribed drug(s) involved in intervention (include discontinued or unfilled prescriptions).

Drug Name and Strength	Quantity	Refills	ICD-9-CM	Filled-Yes/No

If the PC Result code is 1C, 1D, 1E, 1F, 1K, or 2A, complete the following:

Check all that apply:

☐ Changed dose (before/after) _____ ☐ Changed quantity (before/after)_____
☐ Changed frequency (before/after)_____ ☐ Changed directions (before/after) _____
☐ Discontinued or not-filled order _____ ☐ Other charge, specify _____

List additional service(s), if any, resulting from this PC intervention, e.g., new drug(s), lab service, M.D. office visit, etc.

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 ForwardHealth. 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 PC Worksheet for Payable Codes provides information about allowed combinations of reason, professional service, and result codes.

Billing limitations for PC codes include the following:

- ForwardHealth 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 PC Reason Codes with Billing Information table below 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 members residing in a nursing facility.

Pharmaceutical Care Codes with Billing Information

Providers must maintain a PC profile and include the documentation listed in the allowable PC code and billing information table for DOS before September 1, 2012. Documentation must be made available to ForwardHealth when requested.

Claim Submission

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 through the real-time pharmacy POS (Point-of-Sale) system, using PES (Provider Electronic Solutions) software, on the ForwardHealth Portal, or on paper using the Noncompound Drug Claim (F-13072 (07/12)) form indicating PC codes in the three fields shared with prospective DUR (Drug Utilization Review) and the level of effort field. 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.

Most PC claim submission requires a valid diagnosis code. If the diagnosis code field is left blank, PC for the claim will be denied. The traditional dispensing fee is substituted when the PC code is denied.

Claims for therapeutic interchange do not require a diagnosis code.

Include the usual and customary charge for PC in the "Billed Amount" field along with the usual and customary charge for the drug.

When submitting claims for PC, enter the following:

- The appropriate reason for service code.
- The appropriate professional service code.
- The appropriate result of service code.
- The appropriate level of effort.

If a drug is not dispensed, but a PC service is provided for a covered and payable drug, then the PC may be reimbursed. Submit the claim for the PC in the following way:

- Use the NDC (National Drug Code) of the drug that was not dispensed.
- Indicate the quantity as zero.

- Enter the PC fee as the charge.
- Indicate the appropriate PC information.
- Indicate the number in the days' supply field that reflects the amount that would have been dispensed.

A payable drug is reimbursed even if the PC code is submitted incorrectly.

Wisconsin Medicaid Pharmaceutical Care Worksheet for Payable Codes

Providers may use the following tables to assist in determining billing codes for Pharmaceutical Care (PC) dispensing fees. Not all code combinations are recognized as PC activities and not all recognized PC activities result in allowable PC dispensing fees. Pharmaceutical Care codes are only billable when they represent activity beyond that required under Omnibus Budget Reconciliation Act of 1987 (OBRA '87) and OBRA '90 and when they deal with issues of patient compliance, safety, or efficacy that result in a positive outcome.

Reason for provision of Pharmaceutical Care

☐ AD	(60)	Additional Drug Recommended	☐ LK	(66)	Lock-in Recipient √
☐ AN	(10)	Forgery Possible (Prescription Authentication) √	☐ LR	(25)	Late Refill (Under Use) √
			☐ MN	(30)	Insufficient Duration
			☐ MX	(22)	Excessive Duration √
			☐ NN	(80)	Unnecessary Drug √
☐ AR	(61)	Adverse Drug Reaction √	☐ NS	(32)	Insufficient Quantity
☐ AT	(40)	Additive Toxicity	☐ PS	(17)	Product Selection Opportunity
☐ CD	(71)	Chronic Disease Mgt. — Asthma	☐ RE	(84)	Suspected Environmental Risk (In-home Management)
☐ CS	(63)	Patient Complaint/ Symptom			
☐ DA	(41)	Drug Allergy	☐ SC	(83)	Suboptimal Compliance
☐ DD	(44)	Drug-Drug Interaction	☐ SE	(95)	Side-Effect Precaution (Side Effect) √
☐ DI	(45)	IV Drug Incompatibility			
☐ DM	(65)	Possible Drug Misuse √	☐ SF	(34)	Suboptimal Dose Form
☐ ER	(20)	Early Refill √	☐ SR	(36)	Suboptimal Regimen
☐ EX	(21)	Excessive Quantity	☐ TD	(59)	Therapeutic Duplication
☐ HD	(23)	High Dose	☐ TN	(85)	Lab Test Needed √
☐ LD	(33)	Low Dose	☐	√	**Not Billable For Nursing Home Residents**

Action taken by pharmacist

☐ AS	(20)	Patient Assessment	☐ RT	(30)	Recommend Lab Test
☐ CC	(21)	Coordination of Care	☐ TC	(15)	Payer/Processor Contacted
☐ M0	(22)	MD Contacted (Prescriber Consulted)	☐ TH	(12)	Therapeutic Product Interchange*
☐ MR	(23)	Medication Review			*** Action Requires Prescriber Authorization**
☐ PE	(25)	Patient Education			
☐ R0	(29)	R.Ph. Consult Other Contacted			

Result of action

☐ 1C	(12)	Filled, Different Dose	☐ 2A	(30)	NOT Filled
☐ 1D	(13)	Filled, Different Directions	☐ 3K	(85)	Instructions Understood
			☐ 3M	(80)	Compliance Aid Developed (Distribution System)
☐ 1E	(14)	Filled, Different Drug			
☐ 1F	(15)	Filled, Different Quantity			
☐ 1K	(18)	Filled, Dose Form Change			

Level

☐ 11	0 through 5 minutes
☐ 12	6 through 15 minutes
☐ 13	16 through 30 minutes
☐ 14	31 through 60 minutes
☐ 15	61+ minutes

Use alphanumeric values for real-time and paper claims. Pharmaceutical Care cannot be billed through electronic media claims.

Reimbursement

There are limitations on PC billing and reimbursement. Responding to prospective DUR alerts is not automatically considered a PC service. Not all PC services for which a provider receives a prospective 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.

Pharmaceutical Care Profile

A PC profile must be created and maintained for a 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 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 (over-the-counter) 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. 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 ForwardHealth 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

A professional PC service includes time spent doing the following:

- Resolving a specific drug therapy problem.
- Communicating with the prescriber about a specific member condition and its definition or resolution.
- Communicating with the member, or agent of the member, about a specific therapeutic problem, including its definition or resolution.
- 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.

Time spent in the following activities is not included in the service time:

- Researching a drug therapy problem, including reviewing medical literature or peer-reviewed literature.
- Consulting with another professional (e.g., another pharmacist, medical professional, or poison center) regarding a therapy problem.
- Completing continuing education classes.
- Reviewing PC profiles for drug therapy problems.
- Performing drug regimen reviews and documenting irregularities for nursing home residents.

Responses

Topic #540

An Overview of the Remittance Advice

The RA (Remittance Advice) 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 (text) 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 CSV (comma-separated values) format.

Topic #5091

National Provider Identifier on the Remittance Advice

Health care providers who have a single NPI (National Provider Identifier) that is used for multiple enrollments will receive an RA for each enrollment 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 enrolled in Wisconsin 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.

Topic #4818

Calculating Totals on the Remittance Advice for Adjusted and Paid Claims

The total amounts for all adjusted or paid claims reported on the RA (Remittance Advice) appear at the end of the adjusted claims and paid claims sections. ForwardHealth calculates the total for each section by adding the net amounts for all claims listed in that section. 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 (Explanation of Benefits) codes and will not display an exact dollar amount.

Topic #534

Claim Number

Each claim or adjustment request received by ForwardHealth is assigned a unique claim number (also known as the ICN (internal

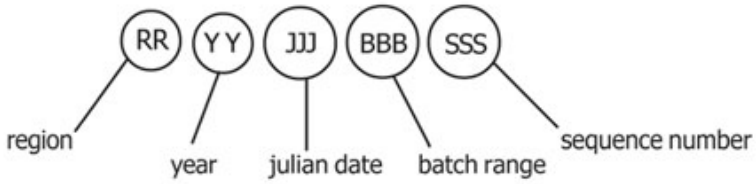
control number)). However, denied real-time compound and noncompound claims are not assigned an ICN, but receive an authorization number. Authorization numbers are not reported to the RA (Remittance Advice) or 835 (835 Health Care Claim Payment/Advice).

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.

Interpreting Claim Numbers

Each claim and adjustment received by ForwardHealth is assigned a unique claim number (also known as the internal control number or ICN). This number identifies valuable information about the claim and adjustment request. The following diagram and table provide detailed information about interpreting the claim number.



Type of Number and Description	Applicable Numbers and Description
Region — Two digits indicate the region. The region indicates how ForwardHealth received the claim or adjustment request.	10 — Paper Claims with No Attachments 11 — Paper Claims with Attachments 20 — Electronic Claims with No Attachments 21 — Electronic Claims with Attachments 22 — Internet Claims with No Attachments 23 — Internet Claims with Attachments 25 — Point-of-Service Claims 26 — Point-of-Service Claims with Attachments 40 — Claims Converted from Former Processing System 45 — Adjustments Converted from Former Processing System 50–59 — Adjustments 80 — Claim Resubmissions 90–91 — Claims Requiring Special Handling
Year — Two digits indicate the year ForwardHealth received the claim or adjustment 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 claim or adjustment request.	For example, February 3 would appear as 034.
Batch range — Three digits indicate the batch range assigned to the claim.	The batch range is used internally by ForwardHealth.
Sequence number — Three digits indicate the sequence number assigned within the batch range.	The sequence number is used internally by ForwardHealth.

Topic #535

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 (Automated Voice Response) system or the 276/277 (276/277 Health Care Claim Status Request and Response) 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.

Topic #4746

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 (Remittance Advice); the detail line EOB (Explanation of Benefits) codes inform providers that an amount was deducted from the total reimbursement but may not indicate the exact amount.

Note: Providers who receive 835 (835 Health Care Claim Payment/Advice) transactions will be able to see all deducted amounts on paid and adjusted claims.

Topic #537

Electronic Remittance Information

Providers are required to access their secure ForwardHealth provider Portal account to obtain their RAs (Remittance Advices). 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 (text) format or from a CSV (comma-separated values) 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 "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 "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.

Refer to the CSV User Guide on the Portal User Guides page of the Portal for 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 (835 Health Care Claim Payment/Advice) 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 real-time compound or noncompound claim 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 (Division of Health Care Access and Accountability) offers electronic billing software at no cost to the provider. The PES (Provider Electronic Solutions) 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 (Electronic Data Interchange) Helpdesk.

Topic #4822

Explanation of Benefit Codes in the Claim Header and

in the Detail Lines

EOB (Explanation of Benefits) 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 (Remittance Advice) 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 (date of service) 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 (text) file.

CSV File

EOB codes are listed in the RA information from the CSV (comma-separated values) file; however, the printed messages corresponding to the codes do not appear in the file. The EOB Code Listing matching standard EOB codes to explanation text is available on the Portal for reference.

Topic #3404

Explanation of Benefits

EOB (Explanation of Benefits) text corresponds to a printed message about the status or action taken on a claim, claim detail, adjustment, or adjustment detail. EOB text may be periodically revised. Providers should occasionally check the EOB text list for revisions.

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.

Topic #13437

ForwardHealth-Initiated Claim Adjustments

There are times when ForwardHealth must initiate a claim adjustment to address claim issues that do not require provider action and do not affect reimbursement.

Claims that are subject to this type of ForwardHealth-initiated claim adjustment will have EOB (Explanation of Benefits) code 8234 noted on the RA (Remittance Advice).

The adjusted claim will be assigned a new claim number, known as an ICN (internal control number). The new ICN will begin with "58." If the provider adjusts this claim in the future, the new ICN will be required when resubmitting the claim.

Topic #4820

Identifying the Claims Reported on the Remittance Advice

The RA (Remittance Advice) reports the first 12 characters of the MRN (medical record number) and/or a PCN (patient control number), 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.

Topic #11537

National Correct Coding Initiative

As part of the federal Patient Protection and Affordable Care Act of 2010, the CMS (Centers for Medicare and Medicaid Services) are required to promote correct coding and control improper coding leading to inappropriate payment of claims under Medicaid. The NCCI (National Correct Coding Initiative) is the CMS response to this requirement. The CMS developed its coding policies based on coding conventions defined in the American Medical Association's CPT (Current Procedural Terminology) manual, national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practices, and a review of current coding practices. The NCCI includes the creation and implementation of claims processing edits to ensure correct coding on claims submitted for Medicaid reimbursement.

ForwardHealth is required to implement the NCCI in order to monitor all professional claims submitted with CPT or HCPCS (Healthcare Common Procedure Coding System) procedure codes for Wisconsin Medicaid, BadgerCare Plus, and Family Planning Only Services for compliance with the following NCCI edits:

- MUE (Medically Unlikely Edits), or units-of-service detail edits, for claims submitted on and after March 21, 2011, regardless of DOS (dates of service).
- Procedure-to-procedure detail edits for claims submitted on and after April 1, 2011, regardless of DOS.

The NCCI editing will occur in addition to/along with current procedure code review and editing completed by McKesson ClaimCheck® and in ForwardHealth interChange.

Medically Unlikely Detail Edits

MUE, or units-of-service detail edits, define for each CPT/HCPCS code the maximum units of service that a provider would report under most circumstances for a single member on a single DOS. If a detail on a claim is denied for MUE, providers will receive an EOB (Explanation of Benefits) code on the RA (Remittance Advice) indicating that the detail was denied due to NCCI.

An example of an MUE would be procedure code 11100 (i.e., biopsy of skin lesion). This procedure is medically unlikely to occur more than once; therefore, if it is billed with units greater than one, the detail will be denied.

Procedure-to-Procedure Detail Edits

Procedure-to-procedure detail edits define pairs of CPT/HCPCS codes that should not be reported together on the same DOS for a variety of reasons. This edit applies across details on a single claim or across different claims. For example, an earlier claim that was paid may be denied and recouped if a more complete code is billed for the same DOS on a separate claim. If a detail on a claim is denied for procedure-to-procedure edit, providers will receive an EOB code on the RA indicating that the detail was denied due to NCCI.

An example of a procedure-to-procedure edit would be procedure code 11451 (i.e., removal of a sweat gland lesion). This is a more complex service than procedure code 93000 (i.e., electrocardiogram) and, therefore, the secondary procedure would be denied.

Quarterly Code List Updates

The CMS will issue quarterly revisions to the table of codes subject to NCCI edits that ForwardHealth will adopt and implement. Refer to the CMS Web site for downloadable code lists.

Claim Details Denied as a Result of National Correct Coding Initiative Edits

Providers should take the following steps if they are uncertain about why particular services on a claim were denied:

- Review ForwardHealth remittance information for the EOB message related to the denial.
- Review the claim submitted to ensure all information is accurate and complete.
- Consult current CPT and HCPCS publications to make sure proper coding instructions were followed.
- Consult current ForwardHealth publications, including the Online Handbook, to make sure current policy and billing instructions were followed.
- Call Provider Services for further information or explanation.

If reimbursement for a claim or a detail on a claim is denied due to an MUE or procedure-to-procedure edit, providers may appeal the denial. Following are instructions for submitting an appeal:

- Complete the Adjustment/Reconsideration Request (F-13046 (07/12)) form. In Element 16, select the "Consultant review requested" checkbox and the "Other/comments" checkbox. In the "Other/comments" text box, indicate "Reconsideration of an NCCI denial."
- Attach notes/supporting documentation.
- Submit a claim, Adjustment/Reconsideration Request, and additional notes/supporting documentation to ForwardHealth for processing.

Topic #539

Obtaining the Remittance Advice

Providers are required to access their secure ForwardHealth provider Portal account to obtain RAs (Remittance Advice). 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 (text) 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 (comma-separated values) 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.

Topic #4745

Overview of Claims Processing Information on the Remittance Advice

The claims processing sections of the RA (Remittance Advice) 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.

Claim Types on the Remittance Advice and Corresponding Provider Types

Claim Types	Provider Types
Dental claims	Dentists, dental hygienists, HealthCheck agencies that provide dental services.
Drug and compound drug claims	Pharmacies and dispensing physicians.
Inpatient claims	Inpatient hospital providers and institutes for mental disease providers.
Long term care claims	Nursing homes.
Medicare crossover institutional claims	Most providers who submit claims on the UB-04.
Medicare crossover professional claims	Most providers who submit claims on the 1500 Health Insurance Claim Form.
Outpatient claims	Outpatient hospital providers and hospice providers.
Professional claims	Ambulance providers, ambulatory surgery centers, anesthesiologist assistants, audiologists, case management providers, certified registered nurse anesthetists, chiropractors, community care organizations, community support programs, crisis intervention providers, day treatment providers, family planning clinics, federally qualified health centers, HealthCheck providers, HealthCheck "Other Services" providers, hearing instrument specialists, home health agencies, independent labs, individual medical supply providers, medical equipment vendors, mental health/substance abuse clinics, nurses in independent practice, nurse practitioners, occupational therapists, opticians, optometrists, personal care agencies, physical therapists, physician assistants, physician clinics, physicians, podiatrists, portable X-ray providers, prenatal care coordination providers, psychologists, rehabilitation agencies, respiratory therapists, rural health clinics, school-based services providers, specialized medical vehicle providers, speech and hearing clinics, speech-language pathologists, therapy groups.

Topic #4914

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 an EOB (Explanation of Benefits) code and an NCPDP (National Council for Prescription Drug Programs) reject code when the variance is exceeded.

Remittance Information

Denied claims will appear on the RA (Remittance Advice) 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 (F-13046 (07/12)).
- If the claim was denied, correct and resubmit the claim.

Topic #4821

Prior Authorization Number on the Remittance Advice

The RA (Remittance Advice) reports PA (prior authorization) numbers used to process the claim. PA numbers appear in the detail lines of claims processing information.

Topic #4418

Reading Non-Claims Processing Sections of the Remittance Advice

Address Page

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

Banner Messages

The Banner Messages section of the RA (Remittance Advice) 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 (comma-separated values) file. Banner messages are posted in the "View Remittance Advices" menu on the provider's secure Portal account.

Explanation of Benefits Code Descriptions

EOB (Explanation of Benefits) code descriptions are listed in the RA information in the TXT file.

EOB codes are listed in the RA information from the CSV file; however, the printed messages corresponding to the codes do not appear in the file.

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 in the "Balance" column.

In the Accounts Receivable section, the "Amount Recouped In Current Cycle" column, when applicable, shows the recoupment amount for the financial cycle as a separate number from the "Recoupment Amount To Date." The "Recoupment Amount To Date" column shows the total amount recouped for each accounts receivable, *including* the amount recouped in the current cycle. The "Total Recoupment" *line* shows the sum of all recoupments to date in the "Recoupment Amount To Date" column and the sum of all recoupments for the current financial cycle in the "Amount Recouped In Current Cycle" column.

For each claim adjustment listed on the RA, a separate accounts receivable will be established and will be listed in the Financial Transactions section. The accounts receivable will be established for the entire amount of the original paid claim. This reflects the way ForwardHealth adjusts claims — by first recouping the entire amount of the original paid claim.

Each new claim adjustment is assigned an identification number called the "Adjustment ICN (internal control number)." 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 (Wisconsin Chronic Disease Program), or WWWP (Wisconsin Well Woman Program)) 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 (Omnibus Budget Reconciliation Act of 1987) 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.

Topic #368

Reading the Claim Adjustments Section of the Remittance Advice

Providers receive a Claim Adjustments section in the RA (Remittance Advice) 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.

To adjust a claim, ForwardHealth recoups the *entire amount* of the original paid claim and calculates a new payment amount for the claim adjustment. ForwardHealth does not recoup the *difference* — or pay the *difference* — between the original claim amount and the claim adjustment amount.

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

The Claim Adjustments section only lists detail lines for a claim adjustment if that claim adjustment has detail line EOBs. This section does not list detail lines for the original paid claim.

Note: For adjusted compound and noncompound 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." The response indicated depends on the difference between the original claim amount and the claim adjustment amount.

If the difference is a positive dollar amount, indicating that ForwardHealth owes additional monies to the provider, then the amount appears in the "Additional Payment" line.

If the difference is a negative dollar amount, indicating that the provider owes ForwardHealth additional monies, then the amount appears in the "Overpayment To Be Withheld" line. 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.

Topic #4824

Reading the Claims Denied Section of the Remittance

Advice

Providers receive a Claims Denied section in the RA (Remittance Advice) 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 (Explanation of Benefits) 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.

Sample Professional Services Claims Denied Section of the Remittance Advice

Remittance Advice — Professional Service Claims Denied Sample

```
REPORT:    CRA-HCDN-R                                FORWARDHEALTH INTERCHANGE                              DATE:  MM/DD/CCYY
  RA#:     999999999                               <Financial Cycle Description>                            PAGE:       9,999
 PAYER:    XXXX                                     PROVIDER REMITTANCE ADVICE
                                                 PROFESSIONAL SERVICE CLAIMS DENIED

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                 PAYEE ID        999999999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                    NPI                  9999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                    CHECK/EFT NUMBER      999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX, XX  XXXXX-XXXX                                                     PAYMENT DATE         MM/DD/CCYY

  --ICN--        PCN          MRN        SERVICE DATES    BILLED          OTH INS         SPENDDOWN
                                          FROM    TO      AMOUNT          AMOUNT          AMOUNT

MEMBER NAME: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX    MEMBER NO.: XXXXXXXXXXXX
RRYYJJJBBBSSS  XXXXXXXXXXXX  XXXXXXXXXXXX  MMDDYY MMDDYY  999,999,999.99   9,999,999.99    999,999.99

HEADER EOBS:  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999

                                 SERVICE DATES                                PA NUMBER
PROC CD  MODIFIERS   ALLW UNITS  FROM    TO      RENDERING PROVIDER           BILLED AMT     DETAIL EOBS
 XXXXX   XX XX XX XX    9999.99  MMDDYY MMDDYY XXX XXXXXXXXXXXXXXX          XXXXXXXXXX     9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                                                               9,999,999.99   9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
 XXXXX   XX XX XX XX    9999.99  MMDDYY MMDDYY XXX XXXXXXXXXXXXXXX          XXXXXXXXXX     9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                                                               9,999,999.99   9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
 XXXXX   XX XX XX XX    9999.99  MMDDYY MMDDYY XXX XXXXXXXXXXXXXXX          XXXXXXXXXX     9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                                                               9,999,999.99   9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
 XXXXX   XX XX XX XX    9999.99  MMDDYY MMDDYY XXX XXXXXXXXXXXXXXX          XXXXXXXXXX     9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                                                               9,999,999.99   9999 9999 9999 9999 9999 9999 9999 9999 9999 9999


            TOTAL PROFESSIONAL SERVICE CLAIMS DENIED:  9,999,999,999.99  99,999,999.99  9,999,999.99
TOTAL NO. DENIED:  999,999
```

Topic #4825

Reading the Claims Paid Section of the Remittance Advice

Providers receive a Claims Paid section in the RA (Remittance Advice) 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 (Explanation of Benefits) 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.

Sample Professional Services Claims Paid Section of the Remittance Advice

Remittance Advice — Professional Service Claims Paid Sample

```
REPORT:   CRA-HCPD-R                                  FORWARDHEALTH INTERCHANGE                        DATE:  MM/DD/CCYY
   RA#:   999999999                                 <Financial Cycle Description>                      PAGE:       9,999
 PAYER:   XXXX                                       PROVIDER REMITTANCE ADVICE
                                                   PROFESSIONAL SERVICE CLAIMS PAID

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                            PAYEE ID      999999999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                               NPI                9999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                               CHECK/EFT NUMBER    999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX, XX   XXXXX-XXXX                                               PAYMENT DATE       MM/DD/CCYY


  --ICN--         PCN           MRN        SERVICE DATES      BILLED AMT      OTH INS AMT    COPAY AMT       PAID AMT
                                           FROM     TO        ALLOWED AMT    SPENDDOWN AMT   CO-INS CB       OUTPAT DED

MEMBER NAME: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX    MEMBER NO.: XXXXXXXXXXXX
RRYYJJJBBBSSS  XXXXXXXXXXXX  XXXXXXXXXXXX  MMDDYY MMDDYY    9,999,999.99     9,999,999.99     999,999.99    9,999,999.99
                                                            9,999,999.99       999,999.99     999,999.99      999,999.99

HEADER EOBS:  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999

                     SERVICE DATES ALLW UNITS RENDERING PROVIDER        PA NUMBER
PROC CD  MODIFIERS   FROM    TO     COPAY AMT  BILLED AMT   ALLOWED AMT  PAID AMT     DETAIL EOBS
 XXXXX  XX XX XX XX  MMDDYY MMDDYY 9999.99     XXX XXXXXXXXXXXXXXX      XXXXXXXXXX   9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                   999,999.99 9,999,999.99 9,999,999.99 9,999,999.99 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
 XXXXX  XX XX XX XX  MMDDYY MMDDYY 9999.99     XXX XXXXXXXXXXXXXXX      XXXXXXXXXX   9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                   999,999.99 9,999,999.99 9,999,999.99 9,999,999.99 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
 XXXXX  XX XX XX XX  MMDDYY MMDDYY 9999.99     XXX XXXXXXXXXXXXXXX      XXXXXXXXXX   9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                   999,999.99 9,999,999.99 9,999,999.99 9,999,999.99 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
 XXXXX  XX XX XX XX  MMDDYY MMDDYY 9999.99     XXX XXXXXXXXXXXXXXX      XXXXXXXXXX   9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                   999,999.99 9,999,999.99 9,999,999.99 9,999,999.99 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999


            TOTAL PROFESSIONAL SERVICE CLAIMS PAID:       99,999,999.99    99,999,999.99   9,999,999.99    99,999,999.99
                                                          99,999,999.99     9,999,999.99   9,999,999.99     9,999,999.99
TOTAL NO. PAID: 999,999
```

Topic #4828

Remittance Advice Financial Cycles

Each financial payer (Medicaid, WCDP (Wisconsin Chronic Disease Program), and WWWP (Wisconsin Well Woman Program)) has separate financial cycles that occur on different days of the week. RAs (Remittance Advices) 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 ForwardHealth 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.

Topic #4827

Remittance Advice Generated by Payer and by Provider Enrollment

RAs (Remittance Advices) 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 (Wisconsin Chronic Disease Program).
- WWWP (Wisconsin Well Woman Program).

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 enrollment. Providers who have a single NPI (National Provider Identifier) that is used for multiple enrollments should be aware that an RA will be generated for each enrollment, 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 enrolled 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.

Topic #6237

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 (National Provider Identifier) and 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 (Remittance Advice).)
- 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
313 Blettner Blvd
Madison WI 53784

Topic #5018

Searching for and Viewing All Claims on the Portal

All claims, including compound, noncompound, 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 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.

Topic #4829

Sections of the Remittance Advice

The RA (Remittance Advice) information in the TXT (text) file includes the following sections:

- Address page.
- Banner messages.
- Paper check information, if applicable.
- Claims processing information.
- EOB (Explanation of Benefits) code descriptions.
- Financial transactions.
- Service code descriptions.
- Summary.

The RA information in the CSV (comma-separated values) 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 (Wisconsin Chronic Disease Program), or WWWP (Wisconsin Well Woman Program)).
- 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 (National Provider Identifier).
- 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.

Topic #544

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

Topic #516

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.

Topic #366

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.

Topic #548

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 (Department of Health Services).
- 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 (General Relief).
- 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.

Topic #547

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 (date of service). 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).

Topic #517

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, ForwardHealth automatically deducts the copayment amount.

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

Submission

Topic #1959

Accuracy in Pharmacy Claims Submission

ForwardHealth monitors pharmacy claims for accuracy. Fields monitored may include:

- Unit dose.
- Days' supply.
- Prescription number.
- Quantity.
- Amount billed.
- DAW (Dispense As Written).
- Brand medically necessary.

A post-pay review of these fields may result in an audit.

Topic #542

Attached Documentation

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

Topic #8577

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 (F-13046 (07/12)) form.

Topic #2605

Claim Submission for Clozapine Management Services

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 (white blood cell) 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 (date of service) may be indicated on the claim. Providers may submit claims for clozapine management only as often as a member's WBC count and ANC (absolute neutrophil count) 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 (837 Health Care Claim: Professional) 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 (place of service) 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

Topic #4403

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 (Division of Health Care Access and Accountability) auditors.

All diagnosis codes indicated on claims (and PA (prior authorization) requests when applicable) must be the most specific ICD-9-CM (International Classification of Diseases, Ninth Revision, Clinical Modification) diagnosis code. Providers are responsible for keeping current with diagnosis code changes. E&M (evaluation and management) 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 (Explanation of Benefits) 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.

Topic #1997

Claims for Non-Preferred Drugs

Pharmacy providers who submit real-time pharmacy claims for non-preferred drugs will receive an EOB (Explanation of Benefits) code and an NCPDP (National Council for Prescription Drug Programs) reject code indicating a denial in the claim response. In addition, as a result of the implementation of NCPDP version D.0, a list of preferred drugs is included in the claim response.

For non-real-time pharmacy claims, providers will receive EOB codes on their RA (Remittance Advice) and reason and remark codes.

Topic #11577

Claims for Package Sizes with Decimals

Noncompound claims for drugs that are pre-packaged in units that are not a whole number will be denied if the quantity indicated on the claim is not equal to the package size or a multiple of the package size.

Providers will receive an EOB (Explanation of Benefits) code on claims where the quantity indicated is not mathematically divisible by the package size.

The policy for claims for packages with decimals does not apply to compound drugs.

Topic #1957

Compound Drugs

Providers may submit claims for compound drugs through the following:

- The real-time POS (Point-of-Sale) system using the NCPDP (National Council for Prescription Drug Programs) Telecommunication Standard.
- On the ForwardHealth Portal.
- Using PES (Provider Electronic Solutions) software.
- On a Compound Drug Claim (F-13073 (07/12)) form.

Providers are required to indicate an NDC (National Drug Code) for each component on claims for compound drugs. Claims for injectible drugs (IV (intravenous), IM (intramuscular), subcutaneous, TPN (total parenteral nutrition) 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 Medicaid 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, Medicaid, 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 providers will be reimbursed 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 (Provider Electronic Solutions) 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. (*Note:* Real-time claims must also adhere to the NCPDP balancing standards.) On Portal claims, indicate the dispensing fee and the cost of the drug ingredients in the "U&CC" field and in the "Charges" fields.

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 a value of "2" in the compound drug 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, the BadgerCare Plus Core Plan, or the BadgerCare Plus Basic Plan.

Topic #5017

Correct Errors on Claims and Resubmit to ForwardHealth on the Portal

Providers can view EOB (Explanation of Benefits) 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.

Topic #10137

Compound and Noncompound Drug Claims

For example, the provider might see on his or her RA (Remittance Advice) 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.

Topic #12977

Days' Supply on Claims

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 or those required to be dispensed in a three-month supply. Pharmacy providers are required to indicate the actual quantity dispensed and the correct days' supply on claims for legend drugs. Claims submitted with an incorrect days' supply are subject to audit and recoupment.

For members with other insurance, pharmacy providers are required to follow ForwardHealth's policies even if the member's other insurance has a different policy.

Topic #4997

Direct Data Entry of Professional and Institutional Claims on the Portal

Providers can submit the following claims to ForwardHealth via DDE (Direct Data Entry) 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.
- Place of service codes.

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

- Type of bill.
- Patient status.
- Visit point of origin.
- Visit priority.
- 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.
- Place of service codes.

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

- Diagnosis codes.
- NDCs (National Drug Codes).
- Place of service 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 (durable medical equipment) or of DMS (disposable medical supplies) who submits noncompound drug claims, may submit these claims via DDE. All claims, including POS (Point-of-Sale) claims, are viewable via DDE.

Topic #4797

Dispense As Written Code

Dispense As Written Code "5"

Pharmacy providers are allowed to indicate DAW (Dispense As Written) code "5" (Substitution Allowed; Brand Drug Dispensed As Generic) on claims for drugs on the State Maximum Allowed Cost List. This will allow a provider who purchases brand name drugs below the state MAC (Maximum Allowed Cost) 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 state 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 state 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 (prior authorization) when submitting a claim for a brand name drug with DAW code "5."

PA is required for prescriptions for brand name drugs on the State Maximum Allowed Cost List if "brand medically necessary" is handwritten on the prescription.

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

Brand Name Drugs for Which Generic Copayment Applies

ForwardHealth generally applies a generic copayment and dispensing fee to a brand name drug when a drug that previously required brand medically necessary PA moves to a preferred drug on the PDL (Preferred Drug List) and the available generic equivalent(s) are non-preferred drugs.

Note: This does not include brand name drugs that were preferred over generic equivalents because the generic equivalents are new to the marketplace and not yet cost-effective when compared with brand pricing (i.e., a MAC rate has not been established).

For drugs determined to be included in this policy, ForwardHealth will automatically apply the generic copayment when a specific brand name drug is preferred over a generic equivalent. Providers do not need to indicate an NCPDP (National Council for Prescription Drug Programs) DAW code on claims to ensure the generic copayment deduction. In addition, ForwardHealth will automatically apply a generic dispensing fee to claims for which a specific brand name drug is preferred over the generic equivalent.

The Preferred Drug List Quick Reference includes the most current list of drugs for which ForwardHealth automatically applies the generic copayment to brand name drugs.

Topic #344

Electronic Claim Submission

Providers are encouraged to submit claims electronically. Electronic claim 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.

Topic #2333

Point-of-Sale Claims

BadgerCare Plus, Medicaid, and SeniorCare use a voluntary pharmacy POS (Point-of-Sale) electronic claims management system. The POS system enables providers to submit electronic pharmacy claims for legend and OTC (over-the-counter) 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 D.0 Telecommunications Standard Claims

BadgerCare Plus, Medicaid, and SeniorCare use the NCPDP (National Council for Prescription Drug Programs)

Telecommunication Standard Format Version D.0. 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 compound drugs.

Cardholder ID

If the member identification number submitted on a claim is not the most current member ID on file with ForwardHealth, the claim will be denied and the Cardholder ID (302-C2) field on the claim response will include the current member ID.

Other Amount Claimed Submitted

ForwardHealth does not reimburse for charges (i.e., postage, shipping, administrative costs) indicated in the Other Amount Claimed Submitted (480-H9) field. Claims will be denied if a provider indicates a charge in the Other Amount Claimed Submitted field.

National Provider Identifier On Compound and Noncompound Claims

Billing Providers

An NPI (National Provider Identifier) is required on compound and noncompound claims. Providers who do not have a unique NPI for each enrollment are required to select one Medicaid enrollment as the "default" enrollment. Claims will be processed using the provider file information from the default enrollment.

Prescriber ID and Prescriber ID Qualifier

An NPI is the only identifier accepted on compound and noncompound 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 (Drug Enforcement Agency) numbers, including "default" DEA numbers, are not accepted for the Prescriber ID on pharmacy claims.

Direct Data Entry of Claims on the Portal

Claims for compound drugs and noncompound drugs may be submitted to ForwardHealth using DDE (Direct Data Entry) 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 (National Drug Codes).
- Place of service 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

(durable medical equipment) or of DMS (disposable medical supplies) who submits noncompound drug claims, may submit these claims via DDE. All claims, including POS claims, are viewable via DDE.

Provider Electronic Solutions Software

The DHS (Department of Health Services) offers electronic billing software at no cost to providers. PES (Provider Electronic Solutions) 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 (Electronic Data Interchange) Helpdesk.

Topic #365

Extraordinary Claims

Extraordinary claims are claims that have been denied by a BadgerCare Plus HMO (health maintenance organization) or SSI (Supplemental Security Income) HMO and should be submitted to fee-for-service.

Topic #4837

HIPAA-Compliant Data Requirements

Procedure Codes

All fields submitted on paper and electronic claims are edited to ensure HIPAA (Health Insurance Portability and Accountability Act of 1996) compliance before being processed. Compliant code sets include CPT (Current Procedural Terminology) and HCPCS (Healthcare Common Procedure Coding System) 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 (National Provider Identifiers) are required in all provider number fields on paper claims and 837 (837 Health Care Claim) transactions, including rendering, billing, referring, prescribing, attending, and "Other" provider fields.

Non-healthcare providers, including personal care providers, SMV (specialized medical vehicle) providers, blood banks, and CCOs (community care organizations) should enter valid provider numbers into fields that require a provider number.

Topic #562

Managed Care Organizations

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

Topic #367

Non-enrolled In-State Providers

Claims from non-enrolled in-state providers must meet additional requirements.

Topic #10837

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 (not otherwise classified), 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 PA (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 (Direct Data Entry) and PES (Provider Electronic Solutions) software when providers submit the following types of claims:

- Professional.
- Institutional.
- Dental.

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

Claims Submitted Via 837 Health Care Claim Transactions

ForwardHealth accepts and utilizes information submitted by providers about NOC procedure codes in certain loops/segments on the 837 (837 Health Care Claim) transactions. Refer to the companion guides for more information.

Topic #2337

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 (Explanation of Benefits) 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 (coordination of benefits) 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.

Topic #1948

Paper Claims Submission

Providers may submit paper claims for pharmacy services to BadgerCare Plus, Medicaid, 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, pharmacy providers should complete either the Noncompound Drug Claim (F-13072 (07/12)) form or a Compound Drug Claim (F-13073 (07/12)) form. Both forms accommodate NCPDP (National Council for Prescription Drug Programs).

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

ForwardHealth
Claims and Adjustments
313 Blettner Blvd
Madison WI 53784

Topic #1956

Pharmacy Special Handling Requests

A Pharmacy Special Handling Request (F-13074 (07/12)) 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.

Topic #10177

Prior Authorization Numbers on Claims

Providers are not required to indicate a PA (prior authorization) number on claims. ForwardHealth interChange matches the claim with the appropriate approved PA request. ForwardHealth's RA (Remittance Advice) and the 835 (835 Health Care Claim Payment/Advice) 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.

Topic #4382

Provider-Administered Drugs

Deficit Reduction Act of 2005

Providers are required to comply with requirements of the federal DRA (Deficit Reduction Act) of 2005 and submit NDCs (National Drug Codes) with HCPCS (Healthcare Common Procedure Coding System) 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 (less-than-effective) 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 (Explanation of Benefits) 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 (dates of service), 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 an EOB code 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 members enrolled in BadgerCare Plus HMOs, Medicaid SSI (Supplemental Security Income) HMOs, and most special managed care programs, BadgerCare Plus and Medicaid fee-for-service, not the member's MCO (managed care organization), 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 (Program for All-Inclusive Care for the Elderly) 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 (total parenteral nutrition)) 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 (Centers for Medicare and Medicaid Services) DRA information page.
- NUBC (National Uniform Billing Committee).
- NUCC (National Uniform Claim Committee).

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

- The FDA (Food and Drug Administration) 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 and the ASP (Average Sales Price) Drug Pricing Files.

Topic #10237

Claims for Provider-Administered Drugs

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

- A 1500 Health Insurance Claim Form.

- The 837P (837 Health Care Claim: Professional) transaction.
- The DDE (Direct Data Entry) on ForwardHealth Portal.
- The PES (Provider Electronic Solutions) 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 (National Uniform Claim Committee) 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 (Electronic Data Interchange) Helpdesk.

Topic #3444

Quantity Limits

Generally, ForwardHealth follows FDA (Food and Drug Administration) 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, the claim will be denied.

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 (Drug Authorization and Policy Override) Center.

Providers may dispense up to the allowed quantity of a drug without contacting the DAPO Center. Pharmacy providers cannot bill intervention-based services or CMR/As (Comprehensive Medication Review and Assessments).

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 POS (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 (F-13074 (07/12)). 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 noncovered. Members do not have appeal rights for noncovered drugs or services.

Topic #12877

Real-Time Claim Submission Requirements for Coordination of Benefits

When submitting claims with information about other insurance or payments to ForwardHealth, providers are required to include specific COB (coordination of benefits) 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 for ForwardHealth.

If a service is covered by other insurance and payment is collected, providers are required to indicate a value of "2" in the Other

Coverage Code field and information in the following NCPDP (National Council for Prescription Drug Programs) fields for each other insurance source:

- 338-5C (Other Payer Coverage Type).
- 339-6C (Other Payer ID Qualifier) with a value of "99."
- 340-7C (Other Payer ID).
- 342-HC (Other Payer Amount Paid Qualifier) with a value of "07."
- 431-DV (Other Payer Amount Paid) with amount paid by other insurance sources.
- 443-E8 (Other Payer Date) with the payment date from other insurance sources.

If a service is covered by other insurance and payment is *not* collected, providers are required to indicate a value of "4" in the Other Coverage Code field and information in the following NCPDP fields for each other insurance source:

- 338-5C (Other Payer Coverage Type).
- 339-6C (Other Payer ID Qualifier) with a value of "99."
- 340-7C (Other Payer ID). Providers may refer to the payer sheet for a list of valid values for the other payer ID field.
- 342-HC (Other Payer Amount Paid Qualifier) with a value of "07."
- 431-DV (Other Payer Amount Paid) with an amount of "0."
- 443-E8 (Other Payer Date) with the date the claim was submitted to other insurance sources.

If a member is covered by SeniorCare and providers indicate a value of "2" or "4" in the Other Coverage Code field, providers are required to indicate information in the following NCPDP fields for each other insurance source:

- 351-NP (Other Payer Patient Responsibility Amount Qualifier) with a value of "06." (Providers are required to indicate the amount [e.g., copayment, deductible] for which a member is responsible to another payer in the Other Payer-Patient Responsibility Amount field. An amount must be indicated in the Other Payer-Patient Responsibility Amount field if another payer's patient pay amount is greater than zero.)
- 352-NQ (Other Payer Patient Responsibility Amount) with the patient responsibility amount reported by the other insurance sources.
- 353-NR (Other Payer Patient Responsibility Amount Count).

If a service is not covered by other insurance, providers are required to indicate a value of "3" in the Other Coverage Code field and information in the following NCPDP fields for each other insurance source:

- 338-5C (Other Payer Coverage Type).
- 339-6C (Other Payer ID Qualifier) with a value of "99."
- 340-7C (Other Payer ID). Providers may refer to the payer sheet for a list of valid values for the other payer ID field.
- 443-E8 (Other Payer Date) with the denial date.
- 471-5E (Other Payer Reject Count) with the number of reject codes following.
- 472-6E (Reject Code) with the reject code(s) provided by the other insurance source.

If other coverage code "2" is indicated, providers are required to indicate the amount reimbursed by commercial health insurance, Medicare Part B, or Medicare Part D in the Other Payer Amount Paid (431-DV) field. If other coverage code "3" is indicated, providers are required to include the Other Payer Reject Code (472-6E) field.

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 (Explanation of Benefits) code 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

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).

Coordination of Benefits Examples for Badger Care Plus and Medicaid

		BadgerCare Plus, Medicaid, and Medicare Part B		BadgerCare Plus, Medicaid, and Commercial Health Insurance		BadgerCare Plus, Medicaid, and Two or More Payers	
NCPDP Fields		PAID	DENIED	PAID	DENIED	PAID	DENIED
Field Number	Field Name						
308-C8	Other Coverage Code	2	3	2	3	2	3
337-4C	Other Payments Count	1	1	1	1	2	2
338-5C	Other Payer Coverage Type	01	01	01	01	01 02	01 02
339-6C	Other Payer ID Qualifier	99	99	99	99	99 99	99 99
340-7C	Other Payer ID	PARTB	PARTB	COMM	COMM	COMM COMM	PARTB COMM
443-E8	Other Payer Date	20111016	20111016	20111016	20111016	20111016 20111016	20111016 20111016
341-HB	Other Payer Amount Paid Count	1		1		1 1	
342-HC	Other Payer Amount Paid Qualifier	07		07		07 07	
426-DQ	Usual And Customary Charge	$100.00	$100.00	$30.00	$30.00	$80.00	$80.00
430-DU	Gross Amount Due	$100.00	$100.00	$30.00	$30.00	$80.00	$80.00
431-DV	Other Payer Amount Paid	$25.00		$14.00		$10.00 $12.50	
471-5E	Other Payer Reject Count		1		2		1 2
472-6E	Other Payer Reject Code		7G		7Z, 8K		7X 78, 7X
353-NR	Other Payer-Patient Responsibility Count						
351-NP	Other Payer-Patient Responsibility Qualifier						
352-NQ	Other Payer-Patient Responsibility						
104-A4	Processor Control Number						

Coordination of Benefits Examples for SeniorCare					
		SeniorCare and Medicare Part D		SeniorCare and Commercial Health Insurance	
NCPDP Fields		PAID	DENIED	PAID	DENIED
Field Number	Field Name				
308-C8	Other Coverage Code	2	3	2	3
337-4C	Other Payments Count	1	1	1	1
338-5C	Other Payer Coverage Type	01	01	01	01
339-6C	Other Payer ID Qualifier	99	99	99	99
340-7C	Other Payer ID	PARTD	PARTD	COMM	COMM
426-DQ	Usual And Customary Charge	$40.00	$40.00	$75.00	$75.00
430-DU	Gross Amount Due	$40.00	$40.00	$75.00	$75.00
443-E8	Other Payer Date	20111016	20111016	20111016	20111016
341-HB	Other Payer Amount Paid Count	1		1	
342-HC	Other Payer Amount Paid Qualifier	07		07	
431-DV	Other Payer Amount Paid	$25.00		$40.00	
471-5E	Other Payer Reject Count		2		2
472-6E	Other Payer Reject Code		7G, 70		7Z,8K
353-NR	Other Payer-Patient Responsibility Count	01		01	
351-NP	Other Payer-Patient Responsibility Qualifier	06		06	
352-NQ	Other Payer-Patient Responsibility	$15.00		$15.00	
104-A4	Processor Control Number	WIPARTD	WIPARTD		

Topic #10637

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 (Explanation of Benefits) 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 RA (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 (F-13073 (07/12)) form.
- Noncompound Drug Claim (F-13072 (07/12)) 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 Acknowledgment of Receipt of Hysterectomy Information (F-1160A (10/08)) form.
  - Sterilization claims must be submitted along with a paper Consent for Sterilization (F-1164 (10/08)) form.
  - Claims submitted to Timely Filing appeals must be submitted on paper with a Timely Filing Appeals Request (F-13047 (07/12)) form.
  - In certain circumstances, drug claims must be submitted on paper with a Pharmacy Special Handling Request (F-13074 (07/12)) form.

Topic #1954

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.

To indicate that repackaging has occurred for non-unit dose drugs, pharmacy providers are required to indicate the appropriate code in the Special Packaging Indicator field. Any other valid value indicated in the special packaging indicator field will not be used to determine reimbursement for repackaging.

If the appropriate code is indicated on the Special Packaging Indicator field for a drug that is not packaged by the manufacturer in individual unit doses, ForwardHealth will add $0.015 per unit billed to the dispensing fee for repackaging.

On claims for which the special packaging indicator is invalid, providers will receive EOB (Explanation of Benefits) code.

Topic #13477

SeniorCare Claim Submissions

Claim submission procedures for SeniorCare are modeled after Wisconsin Medicaid. Pharmacies are required to submit separate claims for Wisconsin Medicaid services and SeniorCare services.

Pharmacies are required under DHS 109.51(5), Wis. Admin. Code, to submit claims to SeniorCare for SeniorCare members at all levels of participation. SeniorCare will not accept receipts for claims submitted by SeniorCare members for reimbursement.

Pharmacy providers may submit claims to SeniorCare using the real-time POS (Point-of-Sale) system, the ForwardHealth Portal, using PES (Provider Eletronic Solutions) software, or on paper.

Topic #1953

Submission Options

Pharmacy providers may submit claims to ForwardHealth via the following:

- Using the real-time POS (Point-of-Sale) system.
- Using DDE (Direct Data Entry).
- Using PES (Provider Electronic Solutions) software.
- On paper by mail.

Pharmacy providers may submit claims for DMS (disposable medical supplies) (except for diabetic supplies) and DME (durable medical equipment) via the following:

- On the 1500 Health Insurance Claim Form.
- On an 837P (837 Health Care Claim: Professional) transaction.
- Using DDE.
- Using PES software.

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

Topic #4817

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 guides 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 (F-13470 (10/08)). Providers are required to indicate an ACN (attachment control number) 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
313 Blettner Blvd
Madison WI 53784

This does not apply to compound and noncompound claims.

Topic #1952

Switch Vendors

Pharmacy providers who submit real-time claims are required to submit electronic NCPDP (National Council for Prescription Drug Programs) transactions using an approved switch vendor. For transmission problems, providers may contact the following sources:

- Emdeon eRx Network.
- RelayHealth — (866) 735.2963.
- QS/1 Data Systems — (800) 231-7776.

Topic #1951

Synagis

Synagis® (palivizumab), a monoclonal antibody, is used to prevent lower respiratory tract diseases caused by RSV (respiratory syncytial virus) 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 (prior authorization) is required for Synagis®.

Synagis® is not part of the provider-administered drugs carve-out policy; therefore, a member's MCO (managed care organization) should reimburse providers for Synagis®.

Professional Claim Submission

Claims for Synagis® must be submitted using the 837P (837 Health Care Claim: Professional) transaction or on the 1500 Health Insurance Claim Form. Prescribers and pharmacy providers are required to indicate CPT (Current Procedural Terminology) procedure code 90378 (Respiratory syncytial virus, monoclonal antibody, recombinant, for intramuscular use, 50 mg, each) and the appropriate unit(s) on each claim submission. To comply with the requirements of the DRA (Deficit Reduction Act), the NDC (National Drug Code) 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.

Topic #1950

Total Parenteral Nutrition and Lipids

For members enrolled in the BadgerCare Plus Standard Plan, Medicaid, and SeniorCare, TPN (total parenteral nutrition) solution and TPN lipids are reimbursed using NDCs (National Drug Codes) from each item used to prepare and administer the TPN. Claims for these NDCs may be submitted using NCPDP (National Council for Prescription Drug Programs) Telecommunication Standard, on the Compound Drug Claim (F-13073 (07/12)) form, using PES (Provider Electronic Solutions) software, or on the ForwardHealth Portal.

Providers should submit claims for DMS (disposable medical supplies) and DME (durable medical equipment) associated with TPNs separately using the 1500 Health Insurance Claim Form or the 837P (837 Health Care Claim: Professional) transaction.

Topic #1949

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 for a quantity of a drug that is greater than the quantity prescribed.
- Billing 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 (over-the-counter) drug without a prescription.
- Submitting a claim with an NDC (National Drug Code) 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, Medicaid, or Wisconsin SeniorCare may suspend or terminate a provider's enrollment 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.

Topic #11677

Uploading Claim Attachments Via the Portal

Providers are able to upload attachments for most claims via the secure Provider area of the ForwardHealth Portal. This allows providers to submit all components for claims electronically.

Providers are able to upload attachments via the Portal when a claim is suspended and an attachment was indicated but not yet received. Providers are able to upload attachments for any suspended claim that was submitted electronically. Providers should note that all attachments for a suspended claim must be submitted within the same business day.

Claim Types

Providers will be able to upload attachments to claims via the Portal for the following claim types:

- Professional.
- Institutional.
- Dental.

The submission policy for compound and noncompound drug claims does not allow attachments.

Document Formats

Providers are able to upload documents in the following formats:

- JPEG (Joint Photographic Experts Group) (.jpg or .jpeg).
- PDF (Portable Document Format) (.pdf).
- Rich Text Format (.rtf).
- Text File (.txt).

JPEG files must be stored with a ".jpg" or ".jpeg" extension; text files must be stored with a ".txt" extension; rich text format files must be stored with a ".rtf" extension; and PDF files must be stored with a ".pdf" extension.

Microsoft Word files (.doc) cannot be uploaded but can be saved and uploaded in Rich Text Format or Text File formats.

Uploading Claim Attachments

Claims Submitted by Direct Data Entry

When a provider submits a DDE (Direct Data Entry) claim and indicates an attachment will also be included, a feature button will appear and link to the DDE claim screen where attachments can be uploaded.

Providers are still required to indicate on the DDE claim that the claim will include an attachment via the "Attachments" panel.

Claims will suspend for 30 days before denying for not receiving the attachment.

Claims Submitted by Provider Electronic Software and 837 Health Care Claim Transactions

Providers submitting claims via 837 (837 Health Care Claim) transactions are required to indicate attachments via the PWK segment. Providers submitting claims via PES (Provider Electronic Solutions) software will be required to indicate attachments via the attachment control field. Once the claim has been submitted, providers will be able to search for the claim on the Portal and upload the attachment via the Portal. Refer to the Implementation Guides for how to use the PWK segment in 837 transactions and the PES Manual for how to use the attachment control field.

Claims will suspend with 30 days before denying for not receiving the attachment.

Timely Filing Appeals Requests

Topic #549

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 (F-13047 (07/12)) form with a paper claim or an Adjustment/Reconsideration Request (F-13046 (07/12)) form to override the submission deadline.

DOS (dates of service) 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.

Topic #551

Resubmission

Decisions on Timely Filing Appeals Requests (F-13047 (07/12)) 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.

Topic #744

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 (F-13047 (07/12)) form for each claim and each adjustment to allow for electronic documentation of individual claims and adjustments submitted to ForwardHealth.
- 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 (place of service) code, etc., as effective for the DOS (date of service). 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 (F-13046 (07/12)) form. The most recent claim number (also known as the ICN (internal control number)) must be indicated on the Adjustment/Reconsideration Request form. This number may be the result of a ForwardHealth-initiated adjustment.	ForwardHealth Timely Filing Ste 50 313 Blettner Blvd Madison WI 53784

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 (Department of Health Services).	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 50 313 Blettner Blvd Madison WI 53784

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 (Express Enrollment) for pregnant women or children identification card.
	  ○ White paper TE (Temporary Enrollment) for Family Planning Only Services identification card.
	  ○ The response received through Wisconsin's EVS (Enrollment Verification System) from a commercial eligibility vendor.
	  ○ The transaction log number received through WiCall.
		ForwardHealth
		Good Faith/Timely Filing
		Ste 50
		313 Blettner Blvd
		Madison WI 53784

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 (Remittance Advice) message. A copy of the RA message that shows the ForwardHealth-initiated adjustment must be submitted with the request.	ForwardHealth Timely Filing Ste 50 313 Blettner Blvd Madison WI 53784

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 (general relief) 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 50 313 Blettner Blvd Madison WI 53784

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 50 313 Blettner Blvd Madison WI 53784

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	ForwardHealth Timely Filing Ste 50 313 Blettner Blvd Madison WI 53784

	remittance information. • A copy of the remittance information showing recoupment for crossover claims when Medicare is recouping payment.	

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 enrollment.	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 claim.	ForwardHealth Timely Filing Ste 50 313 Blettner Blvd Madison WI 53784

Coordination of Benefits

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Archive Date:04/01/2013

Coordination of Benefits:Commercial Health Insurance

Topic #595

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.

Topic #844

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 (prior authorization) before providing the service for covered services that require PA). If the requirements are followed, ForwardHealth may reimburse for the service up to the allowed amount (less any payments made by other health insurance sources).

Topic #598

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.

Topic #599

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 or Wisconsin Medicaid (i.e., state-contracted MCO (managed care organization), 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 and Wisconsin Medicaid 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.

Topic #601

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.

Topic #602

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.

Topic #596

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 (Enrollment Verification System) 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 (F-1159 (10/08)) 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 Medicaid-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 ForwardHealth and commercial health insurance simultaneously. Simultaneous billing may constitute fraud and interferes with ForwardHealth'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 ForwardHealth and the member, the provider is required to return the lesser amount to ForwardHealth.
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.

Topic #2326

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 (health maintenance organizations), all commercial health insurance, and Medicare prior to billing ForwardHealth.

Topic #263

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, ForwardHealth will pay for services covered by both BadgerCare Plus or Medicaid 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 PES (Provider Electronic Solutions) Manual or the appropriate 837 (837 Health Care Claim) companion guide to determine the appropriate other insurance indicator for electronic claims.

Topic #604

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.

Topic #605

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 professional, institutional, or dental 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 (Enrollment Verification System) indicates no commercial health insurance for the DOS (date of service).
- The service does not require other health insurance billing.

- Claim denials from other payers relating to NPI (National Provider Identifier) 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.

Topic #1993

Preferred Drug List Coordination of Benefits

Providers are required to follow BadgerCare Plus, Medicaid, and SeniorCare PA (prior authorization) 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.

Topic #603

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.
- CCS (Comprehensive Community Services).
- Crisis Intervention services.
- CRS (Community Recovery Services).
- CSP (Community Support Program) services.
- Family planning services.
- PNCC (prenatal care coordination) services.
- Preventive pediatric services.
- SMV (specialized medical vehicle) services.

Topic #769

Services Requiring Commercial Health Insurance Billing

If ForwardHealth indicates that the member has other 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 (skilled nursing facility).
- Blood bank services.
- Chiropractic services.
- Dental services.
- DME (durable medical equipment) (rental or purchase), prosthetics, and hearing aids if the billed amount is over $10.00 per item.

- Home health services (excluding PC (personal care) 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 (place of service).
- PT (physical therapy), OT (occupational therapy), and SLP (speech and language pathology) 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 (private duty nursing) services.
- Radiology services.
- RHC (rural health clinic) services.
- Skilled nursing home care, if any DOS (date of service) 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 ForwardHealth indicates the member has other vision coverage, the provider is required to bill the following services to commercial health insurance before submitting claims to ForwardHealth:

- Ophthalmology services.
- Optometrist services.

If ForwardHealth indicates the member has Medicare Supplemental Plan Coverage, 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 surgery 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.

ForwardHealth has identified services requiring Medicare billing.

Medicare

Topic #664

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 (Qualified Medicare Beneficiary-Only) member is required to accept assignment of the member's Medicare Part A benefits. Therefore, Wisconsin Medicaid's total reimbursement for a Medicare Part A-covered inpatient hospital service (i.e., any amount paid by other health insurance sources, any copayment or deductible amounts paid by the member, and any amount paid by Wisconsin Medicaid or BadgerCare Plus) may not exceed the Medicare-allowed amount.

Topic #666

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.

Topic #668

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.

Topic #670

Claims That Do Not Require Medicare Billing

For services provided to dual eligibles, professional, institutional, and dental 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.

Topic #704

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 (Remittance Advice). Claims with an NPI (National Provider Identifier) 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 has not been reported to ForwardHealth or 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 and the ZIP+4 code of the practice location on file with ForwardHealth are required when additional data is needed to identify the provider.

Topic #667

Claims for Services Denied by Medicare

If Medicare denies or recoups payment for services provided to dual eligibles that are covered by BadgerCare Plus or Wisconsin Medicaid, the provider may submit a claim for those services directly to ForwardHealth. To allow payment by ForwardHealth in this situation, providers are encouraged to follow BadgerCare Plus and Medicaid requirements (e.g., request PA (prior authorization) before providing the service for covered services that require PA). If the requirements are followed, ForwardHealth may reimburse for the service up to the allowed amount (less any payments made by other health insurance sources).

Topic #1958

Claims with Medicare-Paid Amounts

Providers should submit drug claims to Medicare prior to sending them to ForwardHealth. 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 compound or noncompound claim. Pharmacies should indicate the appropriate NDC (National Drug Code) 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, Medicaid, and SeniorCare process the Medicare-paid amount like payment from commercial health insurance.

Topic #671

Crossover Claims

A Medicare crossover claim is a Medicare-allowed claim for a dual eligible or QMB-Only (Qualified Medicare Beneficiary-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 (durable medical equipment) 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 (Coordination of Benefits Contractor).

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 (Remittance Advice) 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 or Wisconsin Medicaid at the time the service was submitted to Medicare for payment, but the member was retroactively determined enrolled in BadgerCare Plus or Medicaid.
- 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 (National Provider Identifier) that ForwardHealth has on file for the provider.
- The taxonomy code that ForwardHealth has on file for the provider.
- 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 (Direct Data Entry) through the ForwardHealth Provider Portal.
- 837I (837 Health Care Claim: Institutional) transaction, as applicable.
- 837P (837 Health Care Claim: Professional) transaction, as applicable.
- PES (Provider Electronic Solution) software.
- Paper claim form.

Topic #9077

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 (Healthcare Common Procedure Coding System) 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 (F-13073 (07/12)) form, or a Noncompound Drug Claim (F-13072 (07/12)) form with an NDC (National Drug Code) 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 (Prescription Drug Plan) for information about the PDP's diabetic supply policy.

Topic #672

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 (end-stage renal disease). 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 (physical therapy) services, OT (occupational therapy) services, and some home health services).
- Part C (i.e., Medicare Advantage).
- Part D (i.e., drug benefit).

Topic #684

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- or Medicaid-covered services, even those that are not allowed by Medicare.

Topic #669

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 (F-13046 (07/12)) 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 (Medicare Managed Care)" 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 (F-13047 (07/12)) 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 or Wisconsin Medicaid, 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 ForwardHealth's procedures for submitting crossover claims.

Topic #687

Medicare Advantage

Medicare services may be provided to dual eligibles or QMB-Only (Qualified Medicare Beneficiary-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 (Centers for Medicare and Medicaid Services) 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 (Explanation of Medicare Benefits). This is necessary in order for ForwardHealth to distinguish whether the claim has been processed as commercial managed care or Medicare managed care.

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.

Topic #13737

Disposable Medical Supply and Pharmacy Providers

Crossover claims for Medicare Part B covered drugs for members enrolled in the BadgerCare Plus 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 (F-13074 (07/12)) and a Noncompound Drug Claim (F-13072 (07/12)). 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.

Topic #688

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 ForwardHealth constitutes fraud.

Medicare disclaimer codes identify the status and availability of Medicare benefits. The code allows a provider to be reimbursed correctly by ForwardHealth 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.

Topic #689

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(7), 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 A 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

Medicaid-enrolled provider who is enrolled in Medicare.

Services for Qualified Medicare Beneficiary-Only Members

Because QMB-Only (Qualified Medicare Beneficiary-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 Medicaid-enrolled provider who is enrolled in Medicare.

Topic #8457

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 (American National Standards Institute) 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 (837 Health Care Claim) 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 (Provider Electronic Solutions) 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.

Topic #1946

Medicare Part D Benefits for Dual Eligibles

Providers may verify Medicare Part D enrollment for a dual eligible through Wisconsin's EVS (Enrollment Verification System), the AVR (Automated Voice Response) system, or through WellPoint. The EVS or AVR will state only that a dual eligible is in a Medicare Part D PDP (Prescription Drug Plan). 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 enrolled in Medicare if they provide a Medicare-covered service to a dual eligible. If the provider is not enrolled in Medicare, the provider should refer the dual eligible to another Medicaid-enrolled provider who is also enrolled in Medicare.

Topic #1947

Medicare Part D Claim Submission

BadgerCare Plus and Wisconsin Medicaid deny claims for Medicare Part D-covered drugs for dual eligibles. Claims and PA (prior authorization) requests for Medicare Part D-covered drugs for dual eligibles must be submitted to the appropriate Medicare Part D PDP (Prescription Drug Plan).

Benzodiazepines are Medicare Part D-covered drugs. Claims for benzodiazepines for dual eligibles should be submitted to Medicare Part D.

Barbiturates are Medicare Part D-covered drugs when used for cancer, epilepsy, or chronic mental health disorder diagnoses. Claims for barbiturates for dual eligibles should be submitted to Medicare Part D for members with these diagnoses.

Drugs Excluded from Coverage by 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. 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 (Explanation of Benefits) code for this denial.

Medicare Part D-excluded drugs include barbiturates not used for a diagnosis of cancer, epilepsy, or a chronic mental health disorder; OTC (over-the-counter) 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.

PA requests for drugs covered by Medicare Part D will be denied because these drugs will be covered by a Medicare Part D PDP.

Note: 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.

State-Contacted Managed Care Organizations or HMOs

Drug claims for dual eligibles enrolled in state-contracted MCOs (managed care organizations) or HMOs (health maintenance organizations) should be handled in the same way as claims for dual eligibles who receive drug coverage from fee-for-service.

Claims for the following may be submitted to fee-for-service for dual eligible MCO or HMO enrollees:

- Barbiturates not used for a diagnosis of cancer, epilepsy, or a chronic mental health disorder.
- OTC drugs.
- Agents that are used for the symptomatic relief of cough and cold.
- Prescription vitamins and mineral products (*except* prenatal vitamins and fluoride).
- Weight loss agents.

SeniorCare

Providers are required to submit claims for SeniorCare members who are enrolled in a Medicare Part D PDP to the member's PDP and other health insurance sources before submitting claims to SeniorCare. SeniorCare is the payer of last resort.

Pharmacy providers are required to submit claims to the appropriate PDP for members in all levels of participation. Providers are also required to indicate the outcome of the claim response from the PDP to SeniorCare.

Providers are required to report to SeniorCare any out-of-pocket expenses (i.e., coinsurance, deductible, copayment) determined by the primary insurance. SeniorCare calculates and issues reimbursement, if applicable, for the claim submitted by the pharmacy.

Process

Pharmacy providers should use the following claim submission steps when coordinating benefits for members enrolled in SeniorCare and a Medicare Part D PDP.

1. Submit the claim to the member's PDP. The claim response received from the PDP should include the following:
    - Other health insurance sources that claims may be submitted to after they have been submitted to Medicare Part D.
    - The claim payment amount or the specific claim rejection code(s).
2. Submit the claim to other health insurance sources.
    - If the PDP issued payment and the next health insurance source is not SeniorCare, the claim must be submitted to the next health insurance source before it may be submitted to SeniorCare. When the claim is submitted to SeniorCare, it must include the information indicated in the next bullet.
    - If the PDP issued payment and the next health insurance source is SeniorCare, the claim must include the following information or it will be denied:
        - The other coverage code "2."
        - The PDP paid amount.
        - The patient responsibility.
    - If the SeniorCare member has reached the "donut hole," pharmacy providers should submit the claim to the member's PDP first and then submit the claim to SeniorCare using the other coverage code "4" (Other coverage exists — payment not collected).
    - If the PDP denies the claim, the claim must include the appropriate "other coverage code" with the applicable reason for denial. The following are other coverage codes:
        - "0" Not specified by patient.
        - "1" No other coverage.
        - "3" Other coverage billed — claim not covered.
        - "4" Other coverage exists — payment not collected.

After a claim has been submitted to Medicare Part D, providers may need to change the PCN (processor control number) to WIPARTD before submitting the claim to SeniorCare. (For SeniorCare, this policy applies for members enrolled in levels 2b and 3 only.) Claims received without WIPARTD indicated will be denied.

After a claim has been submitted to Medicare Part D for a member who has reached the "donut hole," pharmacy providers may submit the claim to SeniorCare for the "donut hole" amount with PCN WIPARTD to account for the SeniorCare member's spenddown or deductible amount. After a claim has been submitted to SeniorCare, ForwardHealth will send the pharmacy provider and the TrOOP (true out-of-pocket) facilitator a response that identifies whether the claim was reimbursed or denied.

To determine the specific PDP in which a member is enrolled, providers should first check with the member. If the member does not know the PDP in which he or she is enrolled, providers may send an online eligibility 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 member is enrolled.

True Out-of-Pocket Information

The following claim submission procedures are for SeniorCare members who are in the spenddown or $850 deductible level of participation, regardless of whether or not SeniorCare makes a payment. These procedures apply only to SeniorCare members with incomes over 200 percent of the FPL (Federal Poverty Level).

Claim Submission

Claims submitted to SeniorCare for members who are enrolled in SeniorCare and a Medicare Part D PDP require a BIN (bank identification number) and a PCN. Providers should use the BIN/PCN information received in the claim response from the PDP to submit the claim to SeniorCare for members with incomes over 200 percent of the FPL. For SeniorCare members with incomes over 200 percent of the FPL, the BIN is 610499 and the PCN is WIPARTD. Providers should refer to the PDP's payer sheet for guidance about how to interpret the information contained in the claim response.

After a claim has been submitted to SeniorCare with the BIN/PCN, the pharmacy provider and the TrOOP facilitator will receive a response that identifies whether the claim was reimbursed or denied.

Payments issued by SeniorCare or the member are applied to the member's TrOOP amount. Providers may contact the appropriate PDP for information about a member's TrOOP expenditures or balance. If a claim is submitted in a batch and not through the real-time pharmacy POS (Point-of-Sale) claims processing system, the member's TrOOP cost-sharing amount will still be submitted to the TrOOP facilitator by SeniorCare.

Enrollment

SeniorCare members may be enrolled in both SeniorCare and in a Medicare Part D PDP. SeniorCare members with incomes greater than 200 percent of the FPL who are enrolled in both programs must satisfy their annual TrOOP cost sharing before Medicare Part D catastrophic coverage becomes effective. (Medicare catastrophic coverage reimburses 95 percent of a drug claim's cost.)

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 text on adjustments to previously paid claims.

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.

Topic #690

Medicare Retroactive Eligibility

If a member becomes retroactively eligible for Medicare, the provider is required to refund or adjust any 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.

Topic #895

Modifier for Catastrophe/Disaster-Related Crossover Claims

ForwardHealth accepts modifier "CR" (Catastrophe/disaster related) on Medicare crossover claims (both 837P (837 Health Care Claim: Professional) transactions and 1500 Health Insurance Claim Forms) to accommodate the emergency health care needs of dual eligibles and QMB-Only (Qualified Medicare Beneficiary-Only) members affected by disasters. The CMS (Centers for Medicare and Medicaid Services) Web site contains more information.

Topic #692

Qualified Medicare Beneficiary-Only Members

QMB-Only (Qualified Medicare Beneficiary-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.

Topic #686

Reimbursement for Crossover Claims

Professional Crossover Claims

State law limits reimbursement for coinsurance and copayment of Medicare Part B-covered services provided to dual eligibles and QMB-Only (Qualified Medicare Beneficiary-Only) members.

Total payment for a Medicare Part B-covered 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-covered 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 three examples of how the limitations are applied.

Reimbursement for Coinsurance or Copayment of Medicare Part B-Covered 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 (dates of service) 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.

Inpatient Hospital Services

State law limits reimbursement for coinsurance, copayment and deductible of Medicare Part A-covered inpatient hospital services

for dual eligibles and QMB-Only members.

Wisconsin Medicaid's total reimbursement for a Medicare Part A-covered inpatient hospital service (i.e., any amount paid by other health insurance sources, any copayment or deductible amounts paid by the member, and any amount paid by Wisconsin Medicaid or BadgerCare Plus) may not exceed the Medicare-allowed amount. Therefore, Medicaid reimbursement for coinsurance, copayment, and deductible of a Medicare Part A-covered inpatient hospital service is the *lesser* of the following:

- The difference between the *Medicaid*-allowed amount and the *Medicare*-paid amount.
- The sum of Medicare coinsurance, copayment, and deductible.

The following table provides three examples of how the limitations are applied.

Reimbursement for Medicare Part A-Covered Inpatient Hospital Services Provided To Dual Eligibles			
Explanation	**Example**		
	1	**2**	**3**
Provider's billed amount	$1,200	$1,200	$1,200
Medicare-allowed amount	$1,000	$1,000	$1,000
Medicaid-allowed amount (e.g., diagnosis-related group or per diem)	$1,200	$750	$750
Medicare-paid amount	$1,000	$800	$500
Difference between Medicaid-allowed amount and Medicare-paid amount	$200	($-50)	$250
Medicare coinsurance, copayment and deductible	$0	$200	$500
Medicaid payment	$0	$0	$250

Topic #770

Services Requiring Medicare Billing

If Wisconsin's EVS (Enrollment Verification System) indicates Medicare + Choice, the provider is required to bill the following services to the Medicare Advantage Plan before submitting claims to ForwardHealth:

- Ambulance services.
- Ambulatory surgery center services.
- Chiropractic services.
- Dental anesthesia services.
- Home health services (excluding PC (personal care) services).
- Hospital services, including inpatient or outpatient.
- Medicare-covered services.
- Osteopath services.
- Physician services.

If the EVS indicates Medicare Cost, 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

Topic #4940

After Reporting Discrepancies

After receiving an Other Coverage Discrepancy Report (F-1159 (10/08)), 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 (Enrollment Verification System) that the member's other coverage information has been updated.
- The provider receives a written explanation.

Topic #4941

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.

Topic #609

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.

Topic #610

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 (F-1159 (10/08)) 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.

Topic #14517

Medication Therapy Management Coordination of Benefits

Commercial health insurance and Medicare Part D plans also have MTM (Medication Therapy Management) programs. Coordination of benefits is required for both intervention-based services and CMR/A (Comprehensive Medication Review and Assessment) MTM. If a member is eligible for a commercial health insurance or Medicare Part D MTM program, the pharmacy provider is required to submit the claim to the member's commercial health insurance or PDP (Prescription Drug Plan) before submitting the claim to ForwardHealth.

Refer to the 1500 Health Insurance Claim Form Completion Instructions for Medication Therapy Management Services for information regarding documenting other insurance information.

Pharmacies are responsible for coordination of benefits. ForwardHealth is the payer of last resort.

Topic #7317

Other Coverage for Core Plan and Basic Plan Members

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 or in the HIV (Human Immunodeficiency Virus)/AIDS (Acquired Immune Deficiency Syndrome) drug class for Core Plan or Basic Plan members. Claims for antiretroviral drugs and HIV/AIDS drugs for Core Plan members and Basic Plan members who are also enrolled in the Wisconsin ADAP (AIDS/HIV Drug Assistance Program) 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.

HIRSP Members Enrolled in the Core Plan

Core Plan members may also be enrolled in the HIRSP (Health Insurance Risk Sharing Plan) 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.

Topic #4942

Reporting Discrepancies

Providers are encouraged to report discrepancies to ForwardHealth by submitting the Other Coverage Discrepancy Report (F-1159 (10/08)) 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 (Enrollment Verification System).
- 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 (managed care organization).

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

Topic #660

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 or Wisconsin Medicaid. For example, a provider-based billing claim is created when BadgerCare Plus or Wisconsin Medicaid pays a claim and later discovers that other coverage exists or was made retroactive. Since BadgerCare Plus and Wisconsin Medicaid 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.

Topic #658

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.

Topic #661

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.

Topic #659

Responding to ForwardHealth After 120 Days

If a response is not received within 120 days, the amount originally paid by BadgerCare Plus or Wisconsin Medicaid 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 (dates of service) 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 (Wisconsin's Enrollment Verification System) 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 313 Blettner Blvd Madison WI 53784
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 (F-1159 (10/08)) 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 313 Blettner Blvd Madison WI 53784
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 313 Blettner Blvd Madison WI 53784
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 313 Blettner Blvd Madison WI 53784
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 313 Blettner Blvd Madison WI 53784

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 (F-13047 (07/12)) form according to normal timely filing appeals procedures.	ForwardHealth Timely Filing Ste 50 313 Blettner Blvd Madison WI 53784
The provider discovers that the	• An Other Coverage Discrepancy Report form.	Send the Other Coverage

member's other coverage information (i.e., enrollment dates) reported by the EVS is invalid.	• *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.	Discrepancy Report form to the address indicated on the form. Send the timely filing appeals request to the following address: ForwardHealth Timely Filing Ste 50 313 Blettner Blvd Madison WI 53784
The commercial health insurance carrier reimburses or partially reimburses the provider-based billing claim.	• A claim (do *not* use the prepared provider-based 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.	ForwardHealth Timely Filing Ste 50 313 Blettner Blvd Madison WI 53784
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 50 313 Blettner Blvd Madison WI 53784
The commercial health insurance carrier does not respond to an initial and follow-up provider-based	• A claim (do *not* use the prepared provider-based billing claim). • The appropriate other insurance indicator.	ForwardHealth Timely Filing Ste 50

billing claim.	• A Timely Filing Appeals Request form according to normal timely filing appeals procedures.	313 Blettner Blvd Madison WI 53784

Topic #662

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 (Enrollment Verification System) 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.

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.	• The Provider-Based Billing Summary. • Indication that the EVS no longer reports the member's other coverage.	ForwardHealth Provider-Based Billing PO Box 6220 Madison WI 53716-0220 Fax (608) 221-4567
The provider discovers that the member's other coverage information (i.e., enrollment dates) reported by the EVS is invalid.	• 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.	ForwardHealth Provider-Based Billing PO Box 6220 Madison WI 53716-0220 Fax (608) 221-4567
The other health insurance source reimburses or partially reimburses the provider-based billing claim.	• The Provider-Based Billing Summary. • A copy of the remittance information received from the other health insurance source. • The DOS (date of service), 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	ForwardHealth Provider-Based Billing PO Box 6220 Madison WI 53716-0220 Fax (608) 221-4567

	form.	

The other health insurance source denies the provider-based billing claim.	• 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.
		ForwardHealth
		Provider-Based Billing
		PO Box 6220
		Madison WI 53716-0220
		Fax (608) 221-4567

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

Topic #663

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

Topic #657

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 and Wisconsin Medicaid will not reimburse providers if they receive payment from either of these sources.

The provider may choose a different option for each DOS (date of service). 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.

Topic #829

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 or Wisconsin Medicaid, 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.

Topic #826

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.

Topic #827

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

3

Archive Date:04/01/2013

Covered and Noncovered Services:Codes

Topic #6717

Administration Procedure Codes for Provider-Administered Drugs

For provider-administered drugs administered to members enrolled in BadgerCare Plus HMOs (health maintenance organizations), Medicaid SSI (Supplemental Security Income) HMOs, and most special MCOs (managed care organizations), the CPT (Current Procedural Terminology) 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

Topic #1941

Contraceptive Supply Procedure Codes

Providers are required to submit claims for condoms using the paper 1500 Health Insurance Claim Form or 837P (837 Health Care Claim: Professional) transaction using the following HCPCS (Healthcare Common Procedure Coding System) procedure codes:

- A4267 (Contraceptive supply, condom, male, each).
- A4268 (Contraceptive supply, condom, female, each).

Topic #830

Diagnosis Codes

All diagnosis codes indicated on claims (and PA (prior authorization) requests when applicable) must be the most specific ICD-9-CM (International Classification of Diseases, Ninth Revision, Clinical Modification) 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.

Topic #1943

National Drug Codes

BadgerCare Plus, Medicaid, SeniorCare, and WCDP (Wisconsin Chronic Disease Program) cover FDA (Food and Drug Administration)-approved NDCs (National Drug Codes) 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 not 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 (Healthcare Common Procedure Coding System) crosswalk for a crosswalk of J codes and NDCs to HCPCS and select CPT (Current Procedural Terminology) procedure codes and the ASP (Average Sales Price) Drug Pricing Files.

New National Drug Codes

BadgerCare Plus, Medicaid, and SeniorCare automatically add an NDC of a new drug to the drug file if it meets program guidelines and is produced by a manufacturer participating in the drug rebate program.

Obsolete National Drug Codes

ForwardHealth will no longer reimburse NDCs with an obsolete date of two or more years. The obsolete date is reported by the manufacturer or by the FDA and provides the date the product is not available to the marketplace due to the cessation of marketing, production, or distribution of the product. The obsolete date provided to First DataBank is used to automatically update ForwardHealth.

Topic #12817

Place of Service Codes

POS (place of service) codes identify the place where a drug or service is dispensed or administered. For all compound and noncompound drugs, federal legend drugs, OTC (over-the-counter) drugs, and diabetic supplies, ForwardHealth accepts the following POS code values:

- 01 — Pharmacy: A facility or location where drugs and other medically related items and services are sold, dispensed, or otherwise provided directly to patients.
- 13 — Assisted Living Facility: Congregate residential facility with self-contained living units providing assessment of each resident's needs and on-site support 24 hours a day, 7 days a week, with the capacity to deliver or arrange for services including some health care and other services.

- 14 — Group Home: A residence, with shared living areas, where clients receive supervision and other services such as social and/or behavioral services, custodial service, and minimal services (e.g., medication administration).
- 32 — Nursing Facility: A facility which primarily provides to residents skilled nursing care and related services for the rehabilitation of injured, disabled, or sick persons, or, on a regular basis, health-related care services above the level of custodial care to other than mentally retarded individuals.
- 34 — Hospice: A facility, other than a patient's home, in which palliative and supportive care for terminally ill patients and their families are provided.
- 50 — Federally Qualified Health Center: A facility located in a medically underserved area that provides Medicare beneficiaries preventive primary medical care under the general direction of a physician.
- 65 — End-Stage Renal Disease Treatment Facility: A facility other than a hospital, which provides dialysis treatment, maintenance, and/or training to patients or caregivers on an ambulatory or home-care basis.
- 72 — Rural Health Clinic: An enrolled facility which is located in a rural medically underserved area that provides ambulatory primary medical care under the general direction of a physician.

A complete list of expanded definitions for POS codes is available on the CMS (Centers for Medicare and Medicaid Services) Web site.

Topic #643

Unlisted Procedure Codes

According to the HCPCS (Healthcare Common Procedure Coding System) code book, if a service is provided that is not accurately described by other HCPCS CPT (Current Procedural Terminology) procedure codes, the service should be reported using an unlisted procedure code.

Before considering using an unlisted, or NOC (not otherwise classified), 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 (prior authorization) 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 DDE (Direct Data Entry) through the ForwardHealth Portal, PES (Provider Electronic Solutions) 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.
- Upload claim attachments via the secure Provider area of the Portal.

Covered Services and Requirements

Topic #2331

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 65 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.

Topic #9939

Alpha Hydroxprogesterone (17P) Caproate Compound Injection

The 17P (alpha hydroxyprogesterone caproate) compound injection is a covered service and is reimbursed fee-for-service for members enrolled in the BadgerCare Plus Standard Plan, the BadgerCare Plus Benchmark Plan, and Medicaid, including members enrolled in state-contracted HMOs (health maintenance organizations). The 17P compound must be injected by a medical professional. Members may not self-administer the 17P injection.

Clinical Criteria

The following is clinical criteria for coverage of the 17P compound injection:

- The member must be pregnant with 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 initiated between week 16 to week 20 of gestation and continue through 37 weeks gestation or delivery, whichever is first.
- The member must have a diagnosis of V23.41 (Pregnancy with history of preterm labor.)

Attestation to Administer Alpha Hydroxyprogesterone (17P) Caproate Injections

The Attestation to Administer Alpha Hydroxyprogesterone (17P) Caproate Injections (F-00286 (11/11)) must be completed prior to giving the first injection. The completed Attestation to Administer Alpha Hydroxyprogesterone Caproate (17P) Compound Injection must be kept in the member's medical record.

To be reimbursed for the 17P compound 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 J1725 (Injection, hydroxyprogesterone caproate, 1 mg).
- The NDC and description from the bulk powder used to compound the 17P injection.

The 17P compound 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 compound injection. Claims with other diagnosis codes indicated will be denied.

Reimbursement

The maximum allowable rate for the 17P compound injection is $25.00 per 250 mg injection, which does not include reimbursement for the administration of the drug.

Providers may be reimbursed for the administration of the 17P compound 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 compound injection is $3.31.

Topic #4386

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 (Explanation of Benefits) code and an NCPDP (National Council for Prescription Drug Programs) reject code.

Topic #9358

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 (over-the-counter) drugs.
- Humalog insulin.
- Humalog Mix insulin.
- Lantus insulin.
- Tamiflu.
- Relenza.

Providers may refer to the BadgerCare Plus Basic Plan Product 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 (Explanation of Benefits) 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 (prior authorization) 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 (Drug Utilization Review) and three-month supply initiatives.

Topic #4361

Benchmark Plan Covered Pharmacy Services

The BadgerCare Plus Benchmark Plan covers a broad list of generic drugs and a limited number of OTC (over-the-counter) drugs. The repackaging allowance is also covered by the Benchmark Plan.

The Benchmark Plan only covers drugs listed on the BadgerCare Plus Benchmark Plan Product List.

Certain generic drugs that are non-preferred under the BadgerCare Plus Standard Plan, Medicaid, or SeniorCare may be covered by the Benchmark Plan.

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.

Topic #1940

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. Less-than-effective/identical, related, or similar drugs are drugs that are considered noncovered because the drugs are determined by the CMS (Centers for Medicare and Medicaid Services) to have little therapeutic value, are not medically necessary, or are not cost-effective.

If one ingredient of the compound drug requires PA (prior authorization), the compound drug requires PA. If one ingredient of the compound drug has a diagnosis restriction, the compound drug has the same diagnosis restriction.

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

The Standard Plan, Medicaid, and SeniorCare do not cover a compound drug prescription if a commercial product containing the same ingredients is available.

Drugs contained within a compound prescription must be used for the FDA-approved indication. For example, if the FDA-approved use of an ingredient is for an oral analgesic, this ingredient cannot be used in any compound drug for an intended therapeutic use other than an oral analgesic.

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 (Preferred Drug List) requirements. Prescribers are not required to complete a PA/PDL (Prior Authorization/Preferred Drug List) 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 (National Drug Code) of all ingredients in a compound and submit claims using the following:

- The POS (Point-of-Sale) system.
- PES (Provider Electronic Solutions) software.
- DDE (Direct Data Entry).
- The Compound Drug Claim (F-13073 (07/12)) form.

A member may obtain a compounded medication that is not covered under BadgerCare Plus, Medicaid, or SeniorCare. In these instances, the member is responsible for payment only if the provider informs the member of the following prior to providing the drug:

- BadgerCare Plus, Medicaid, or SeniorCare does not cover the drug.
- The member will be responsible for the cost.

Topic #12357

Contraceptives

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

Pharmacies are required to use the 11-digit NDC (National Drug Code) on the drug package or a HCPCS (Healthcare Common Procedure Coding System) procedure code for all drugs dispensed when submitting pharmacy claims.

Topic #7397

Core Plan Covered Pharmacy Services

The BadgerCare Plus Core Plan has a closed drug formulary. The Core Plan covers certain generic and OTC (over-the-counter) drugs and certain brand name drugs in specific drug classes for all Core Plan members. The BadgerCare Plus Core Plan Brand Name Drugs 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 Product List. Providers may also refer to the Drug Search Tool to search for specific drugs covered by the Core Plan.

The repackaging allowance is covered by the Core Plan.

If a member has not been transitioned from GAMP (General Assistance Medical Program) or GA (general assistance) medical programs, the member will not be grandfathered on drugs he or she is currently taking. Grandfathered drugs for transitioned Core Plan members are indicated on the BadgerCare Plus Core Plan Brand Name Drugs 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 (Explanation of Benefits) 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 PA (prior authorization) requests for diagnosis-restricted drugs for use outside approved diagnoses. PA requests for drugs with a diagnosis outside approved diagnoses will be returned to the provider. 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, unless noted on the Diagnosis Restricted Drugs data table.

Topic #5737

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 (General Assistance Medical Program) and GA (general assistance) 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 (National Drug Code) 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 (selective serotonin reuptake inhibitors).
- Antiparkinson's agents.
- Stimulants and related agents.

PA (prior authorization) 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 (dates of service) 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 State Maximum Allowed Cost List pharmacy data table.

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 (Prior Authorization/Brand Medically Necessary Attachment, F-11083 (07/12)) 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 (Prior Authorization Request Form, F-11018 (07/12)) to ForwardHealth. The PA will be adjudicated using current BadgerCare Plus Standard Plan brand medically necessary policy.

Topic #44

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.

Topic #1939

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 (Explanation of Benefits) text and an NCPDP (National Council for Prescription Drug Programs) reject code.

Pharmacy providers will be required to call the DAPO (Drug Authorization and Policy Override) 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.

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. 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 (F-13074 (07/12)). Providers should check Element 4 (Policy Review Request) 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 4 (Policy Review Request) 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 (Drug Utilization Review) alert and providers will be required to respond to the alert and resubmit the claim in the POS (Point-of-Sale) system to obtain reimbursement from ForwardHealth. Providers will receive EOB text on claims for these drugs.

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.

Unbreakable Pre-Packaged Items

If a claim is submitted for an unbreakable prepackaged item with directions for use that are greater than the allowable maximum of a 34-day supply and the drug is not listed on the Three Month Supply of Drugs data table, use the smallest available package size and indicate a 34-day 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).

Three-Month Supply Intervention-Based Service

Intervention-based services are voluntary face-to-face member assessments and interventions performed by a pharmacist. Three-month supply intervention is one type of intervention-based service. Dispensing a three-month supply of drugs streamlines the prescription filling process for pharmacy providers and members, encourages the use of generic maintenance drugs when medically appropriate for a member, and results in savings to ForwardHealth programs. If the pharmacy contacts the prescriber to amend the prescription, pharmacies are eligible to receive the reimbursement for this service. If the prescription is already prescribed for a three-month supply, pharmacies will not be eligible to receive the reimbursement.

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 enrolled in 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 enrolled in 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 Nursing Facility Members

If a member is in a nursing facility, providers should indicate the appropriate place of service code on the claim. This will exempt the member from the three-month supply of drugs policy. When serving a member in a nursing facility, pharmacy providers are not required to contact the DAPO Center to obtain an override to dispense less than a three-month supply of drugs.

Topic #85

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 (prior authorization) or other program requirements may be waived in emergency situations.
- Non-enrolled in-state providers may be reimbursed for emergency services.
- Non-U.S. citizens may be eligible for covered services in emergency situations.

Topic #1399

Emergency Medication Dispensing

BadgerCare Plus, Wisconsin Medicaid, and SeniorCare strongly encourage 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 (prior authorization) restriction when the prescriber cannot be reached to discuss preferred drug options, therapeutic alternatives, or to complete the necessary PA form and the pharmacist determines that the member should begin taking the medication immediately.

Medications dispensed in emergency situations do not require PA. Coverage of a drug with a PA restriction will continue to require PA. The emergency medication dispensing policy does not guarantee approval of a PA. Members must meet all PA criteria for PA requests to be approved.

This emergency medication dispensing policy applies to members enrolled in the BadgerCare Plus Standard Plan, the BadgerCare Plus Core Plan, Wisconsin Medicaid, and SeniorCare.

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

Emergency medication dispensing is not covered for BadgerCare Plus Benchmark Plan or BadgerCare Plus Basic Plan members.

Policy for Expedited Emergency Supply of Drugs

ForwardHealth has developed an expedited emergency supply process where providers may submit requests for an expedited emergency supply for certain drugs using the STAT-PA (Specialized Transmission Approval Technology-Prior Authorization) system and then submit a claim for the expedited emergency supply electronically. This eliminates the need to submit claims for expedited emergency supply drugs on paper.

Members will be limited to receiving two expedited emergency supply requests of the same drug in 30 days from one pharmacy provider within a six-month time period. A maximum of six expedited emergency supply requests per member regardless of drug or provider may be dispensed in a six-month time period.

Expedited emergency supply requests will generally be granted for up to a 14-day supply; however, for certain drugs, expedited

emergency supply requests may be granted for up to a 34-day supply.

For diagnosis-restricted drugs, an appropriate diagnosis code must be indicated on expedited emergency supply requests and claims. Expedited emergency supply requests submitted without an appropriate diagnosis code will be considered noncovered services.

An approved expedited emergency supply request does not guarantee that a subsequent PA request will be approved. Members must meet all the criteria for a PA request to be approved.

When contacting the prescriber after submitting an expedited emergency supply request, pharmacy providers should discuss the following before submitting a PA request:

- For PDL (Preferred Drug List) drug classes, the pharmacy provider should assist the prescriber in reviewing preferred drugs.
- For brand medically necessary drugs, the pharmacy provider should review therapeutic alternatives with the prescriber.
- For drugs that require clinical PA, the pharmacy provider should review clinical criteria with the prescriber to ensure the member meets the clinical criteria.

The expedited emergency supply request overrides PA policies, including the PDL and brand medically necessary policies. However, other policies, such as the member enrollment, diagnosis restriction, quantity limit, and noncovered services policies continue to apply.

Drugs That Can Be Dispensed in up to a 14-Day Supply

For drugs that require PA that can be dispensed in up to a 14-day expedited emergency supply, a PA is not required to be in process when the first expedited emergency supply request is submitted; however, before a second expedited emergency supply request for the same drug is submitted, a PA request must be submitted to ForwardHealth and be in process of being adjudicated.

If a second expedited emergency supply is necessary for a member, the request must be submitted by the pharmacy that dispensed the first expedited emergency supply. Second expedited emergency supply requests must be for the same drug and strength. Second expedited emergency supply requests will be granted if a PA is in process for the same drug and strength and the PA is submitted by the pharmacy that dispensed the first expedited emergency supply.

Once a PA has been adjudicated, the second expedited emergency supply request will not be granted.

Requests for a second expedited emergency supply must be submitted either on day 15 or day 16 after the initial request was submitted. Second expedited emergency supply requests will not be granted if they are submitted on day 14 and earlier or day 17 and after. For example, if an initial expedited emergency supply request was submitted on March 18, 2011, and a 14-day supply of the drug was dispensed, and a second expedited emergency supply is necessary for the member because the PA request had not yet been adjudicated, the second request must be submitted either on April 1, 2011, or April 2, 2011.

Drugs That Can Be Dispensed in up to a 34-day Supply

For drugs that cannot be dispensed in up to a 14-day expedited emergency supply, pharmacy providers may dispense the quantity indicated on the prescription, up to a 34-day supply, after an expedited emergency supply has been granted; however, only one expedited emergency supply every six months will be allowed for those drugs. Other policies, such as prospective DUR (Drug Utilization Review), the quantity limit, and the early refill policies continue to apply.

Submitting Requests for an Expedited Emergency Supply

Pharmacy providers are required to complete and sign the Expedited Emergency Supply Request (F-00401 (10/11)) before a request for an expedited emergency supply is submitted.

Expedited emergency supply requests may only be submitted using the STAT-PA system. Expedited emergency supply requests cannot be submitted for future or past DOS (dates of service).

The STAT-PA system will notify pharmacy providers if an expedited emergency supply request has been granted. After an expedited emergency supply request has been granted, the pharmacy provider may submit a claim for the drug.

Expedited emergency supply requests cannot be amended.

Claims Submitted for Emergency Medication Dispensing

Pharmacy providers may submit claims for emergency medication supplies of drugs that are not included in the expedited emergency supply process on the Noncompound Drug Claim (F-13072 (07/12)) form with a Pharmacy Special Handling Request (F-13074 (07/12)) form if the prescriber cannot be reached and the pharmacist determines that the member should begin taking a medication immediately.

Providers are required to indicate specific details about why the emergency medication supply is being requested on the Pharmacy Special Handling Request. Providers are encouraged to submit supporting documentation with the request if necessary. Paper claims for emergency medication supplies submitted without detailed information supporting the request will be denied.

Providers should mail completed Noncompound Drug Claim and Pharmacy Special Handling Request forms as indicated on the Pharmacy Special Handling Request. Providers may also submit claims using the ForwardHealth Portal.

Claims for an emergency medication supply cannot be submitted for members who have been previously granted two expedited emergency supply requests for the same drug within a six-month time period.

The emergency medication supply policy overrides PA policies, including the PDL and brand medically necessary policies. However, other policies, such as the member enrollment, diagnosis restriction, quantity limit, and noncovered services policies continue to apply.

A paid emergency medication supply claim does not guarantee that a PA request will be approved for the drug. Members must meet all criteria for a PA request to be approved.

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 dispensing. Completed and detailed information must be indicated on the forms. ForwardHealth is committed to reimbursing providers for emergency medications as long as claims are properly completed and submitted with a Pharmacy Special Handling Request form.

BadgerCare Plus Core Plan Members

The following are the only drugs for which emergency medication dispensing is allowed for all Core Plan members:

- Cytokine and CAM (cell adhesion molecule) antagonist drugs.
- Provigil®.
- Suboxone® film.

Up to a 14-day supply or up to a 34-day supply of a Core Plan-covered medication must be submitted on paper using the Noncompound Drug Claim form and the Pharmacy Special Handling Request form. The expedited emergency supply policy does not apply for Core Plan members.

BadgerCare Plus Benchmark Plan Members

When medically necessary, pharmacy providers are encouraged to dispense a 14-day emergency supply for a covered antipsychotic drug when a child 6 years of age or younger enrolled in the Benchmark Plan receives a prescription for a covered antipsychotic drug without an approved Prior Authorization Drug Attachment for Antipsychotic Drugs for Children 6 Years of Age and Younger and the pharmacist determines that the member should begin taking the medication immediately.

Pharmacy providers may submit claims for emergency medication supplies for covered antipsychotic drugs for children 6 years of age and younger on the Noncompound Drug Claim form, with a Pharmacy Special Handling Request form.

Emergency medication supply requests for drugs other than covered antipsychotic drugs for children 6 years of age and younger are not available for Benchmark Plan members.

A paid emergency medication supply claim does not guarantee that a PA request will be approved for the drug. Members must meet all criteria for a PA request to be approved.

BadgerCare Plus Basic Plan Members

There are no drugs covered by the Basic Plan that require PA; therefore, there is no emergency medication dispensing coverage for members enrolled in the Basic Plan.

Topic #1936

Home Infusion Services

Home IV (intravenous) injections and TPN (total parenteral nutrition) 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 DME (Durable Medical Equipment) and DMS (Disposable Medical Supplies) Indices contain limitations and PA (prior authorization) requirements for supplies and equipment.

Topic #1935

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-enrolled 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).

Topic #12457

Influenza Vaccines

Pharmacy providers may administer influenza vaccines to BadgerCare Plus and Medicaid members age 6 years and older.

Influenza Vaccines Provided to Children

Pharmacy providers may obtain influenza vaccines at no cost to provide to members between 6 years and 18 years of age through the federal VFC (Vaccines for Children) Program.

Pharmacy providers can obtain the influenza vaccine at no cost through the VFC Program; therefore, ForwardHealth reimburses only the administration fee for influenza immunizations provided to BadgerCare Plus and Medicaid members between 6 years and 18 years of age.

In order to receive vaccines at no cost, providers are required to enroll in the VFC Program. For enrollment information, refer to the Wisconsin Immunization Program Web site.

Note: To receive vaccines through the VFC Program for the annual influenza season, providers are required to be enrolled in the VFC Program and place orders no later than February of that year.

Influenza Vaccines Provided to Adults

For influenza vaccines administered to BadgerCare Plus and Medicaid members 19 years of age or older, pharmacy providers should use vaccines from their private stock. When providing influenza vaccine to members 19 years of age or older, ForwardHealth reimburses pharmacy providers for both the vaccine and the administration of the vaccine.

Tracking Influenza Immunizations in the Wisconsin Immunization Registry

Pharmacy providers are strongly encouraged to enter administered influenza immunizations for all clients into the WIR (Wisconsin Immunization Registry). For more information about the WIR, refer to the Wisconsin Immunization Program WIR Web site.

Claim Submission

Wisconsin Medicaid and BadgerCare Plus fee-for-service will reimburse pharmacy providers for influenza immunization services for both children and adult members, even if the member is enrolled in a state-contracted managed care organization. This exception applies to pharmacy providers only.

Pharmacy providers may submit claims for influenza immunization services for both children and adult members via the following:

- The 1500 Health Insurance Claim Form.
- The 837P (837 Health Care Claim: Professional) electronic transaction.
- DDE (Direct Data Entry) on the ForwardHealth Portal.
- PES (Provider Electronic Solutions) claims submission software.

Pharmacy providers may not submit claims for influenza immunization services using the POS (Point-of-Sale) system.

Allowable Procedure Codes

Pharmacy providers are required to indicate the CPT (Current Procedural Terminology) procedure code of the actual vaccine administered, not the administration code, on claims for all influenza immunization services. Pharmacy providers should not separately bill the administration code.

For the most current list of allowable procedure codes for influenza immunization services, refer to the service-specific interactive maximum allowable fee schedules.

Pharmacy providers may not submit claims for influenza immunization services using NDCs (National Drug Codes).

Topic #7357

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 (837 Health Care Claim: Professional) transaction or on the 1500 Health Insurance Claim Form with a HCPCS (Healthcare Common Procedure Coding System) procedure code and an NDC (National Drug Code). An NDC is required on claims to comply with the requirements of the DRA (Deficit Reduction Act of 2005).

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.

Procedure Codes for Injectible Antipsychotic Drugs and Hemophilia Products

The following HCPCS procedure codes are allowable on claims for 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

Topic #1934

Legend Drugs

Most legend drugs and many OTC (over-the-counter) 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 (Food and Drug Administration) 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 (prior authorization); others require an appropriate diagnosis code or have other restrictions for reimbursement.

Topic #1933

Mail Delivery Services

Current Wisconsin law permits Wisconsin Medicaid-enrolled pharmacies to deliver prescriptions to members via the mail. Wisconsin Medicaid-enrolled retail pharmacies may dispense and mail any prescription or OTC (over-the-counter) medication to a member at no additional cost to the member or to ForwardHealth.

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.

Topic #12577

Makena Injections

Makena injections are covered for BadgerCare Plus Standard Plan, BadgerCare Plus Benchmark Plan, and Medicaid members, and are reimbursed fee-for-service for all members, including members enrolled in a state contracted HMO (health maintenance organization).

Makena is a provider-administered drug and must be injected by a medical professional. Members may not self-administer Makena injections.

Attestation to Administer Makena Injections

Makena injections may be covered if all of the following occur:

- Prescribers complete the Attestation to Administer Makena Injections (F-00508 (11/11)) before beginning treatment. If a member has begun treatment with Makena before November 15, 2011, the prescriber should complete the Attestation to Administer Makena Injections before the first Makena injection after November 15, 2011. Prescribers will only be reimbursed for Makena injections administered on and after November 15, 2011.
- Prescribers complete a PA/RF (Prior Authorization Request Form, F-11018 (07/12)) and indicate process type 117.
- Prescribers submit the Attestation to Administer Makena Injections with the PA/RF to ForwardHealth by fax at (608) 221-8616 or by mail to the following address:

  ForwardHealth
  Prior Authorization
  Ste 88
  313 Blettner Blvd
  Madison WI 53784

- Prescribers receive an approved decision notice from ForwardHealth.

The Attestation to Administer Makena Injections is valid for up to a 21 week course of therapy.

Clinical Criteria

The following are clinical criteria for coverage of Makena injections. All the following criteria must be met:

- The member has experienced difficulty with prior use of 17P compound injection or the member has a medical reason that prevents the use of 17P compound injection.
- The member must be pregnant with a singleton pregnancy.
- The member must have had a previous pre-term delivery (i.e., spontaneous birth before 37 weeks gestation).
- The Makena injection treatment must be initiated between week 16 to week 20 of gestation and continue through 37 weeks gestation or delivery, whichever is first.
- The member must have a diagnosis of V23.41 (Pregnancy with history of preterm labor).

Claim Submission

Procedure code J1725 (Injection, hydroxyprogesterone caproate, 1mg), modifier U1, and the NDC (National Drug Code) for Makena injection must be indicated on professional claims for Makena injections. The addition of the U1 modifier identifies the brand Makena injection and will ensure the provider receives a brand reimbursement rate.

One dose of Makena equals 250 mg. Therefore, providers should enter "250" as the quantity. Providers are required to indicate the appropriate unit(s) on each claim submission. Claims for Makena injection may only be submitted if the drug has been administered.

Makena injection is a diagnosis-restricted drug. Diagnosis code V23.41 is the only allowable diagnosis. Claims submitted with other diagnosis other than the allowable diagnosis indicated will be denied.

Reimbursement

The maximum allowable reimbursement rate for Makena injection is $687.50 per 250 mg injection.

Providers may be reimbursed for the administration of Makena injection by indicating procedure code 96372 on the claim.

The rate for administering Makena injection is $3.31.

Topic #1938

Manufacturer Rebate Agreements

In accordance with the OBRA (Omnibus Reconciliation Act) of 1990, also known as the Medicaid Drug Rebate Program, drug manufacturers who choose to participate in BadgerCare Plus, Medicaid, and SeniorCare are required to sign a rebate agreement with the federal government.

BadgerCare Plus, Medicaid, 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.

Claims for provider-administered drugs that do not have a signed manufacturer rebate agreement on file will be denied.

Manufacturer rebates are based on claims data showing the quantity of each NDC (National Drug Code) dispensed to 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.

Drugs by Manufacturers That Did Not Sign Rebate Agreements for 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- (Food and Drug Administration)approved legend drugs through the PA (prior authorization) 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 (Prior Authorization/Drug Attachment, F-11049 (07/12)) to the pharmacy where the drug will be dispensed. Pharmacy providers should complete the PA/RF (Prior Authorization Request Form, F-11018 (07/12)) and submit both forms and any supporting documentation to ForwardHealth. PA requests 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 (F-13072 (07/12)) indicating the actual NDC of the drug with the Pharmacy Special Handling Request (F-13074 (07/12)) form.

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

Drugs by Manufacturers Without a Rebate Agreement for Members

Enrolled in SeniorCare (Levels 2b and 3)

Existing federal Medicaid rebate agreements with drug manufacturers do not cover drugs for SeniorCare members with incomes greater than 200 percent of the FPL (Federal Poverty Level) (levels 2b and 3). For these members, s. 49.688(6), Wis. Stats., requires SeniorCare to cover drugs from only those manufacturers who have signed a separate SeniorCare rebate agreement with the DHS (Department of Health Services). As a result, drugs supplied by manufacturers who have declined to enter into a separate SeniorCare rebate agreement will not be covered for members with incomes greater than 200 percent of the FPL. SeniorCare members in levels 1 or 2a (incomes less than 200 percent of the FPL) are not affected by this.

If a prescription for a drug manufactured by a manufacturer for a member in SeniorCare levels 2b and 3 is changed to a therapeutically equivalent covered drug, pharmacy providers may submit a claim for a PC dispensing fee.

Availability of Covered Drugs

When a drug manufacturer's products are not covered for a member because the manufacturer has not signed a separate SeniorCare rebate agreement, providers who submit claims for a noncovered drug will be denied.

If a covered manufacturer for a drug exists and the member's pharmacy does not carry the drug, providers may choose to either stock the drug or refer the member to another pharmacy that stocks the drug. A pharmacy should not tell a member that the drug is not covered if it is available through another manufacturer.

Availability of Non-Reimbursable Drugs

A member in level 2b or 3 may make the decision to purchase a drug even though the drug is not reimbursable by SeniorCare. If the member chooses to do this, the pharmacy may collect payment from the member for the entire cost of the drug.

Providers and members should understand the following under these circumstances:

- The entire cost of the noncovered drug becomes the member's responsibility.
- If the member is in the spenddown or deductible period, any amount paid for noncovered drugs will not be applied toward the spenddown or deductible.

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

PA is not available for drugs that are not included on the BadgerCare Plus Benchmark Plan Product List, BadgerCare Plus Core Plan Product List, BadgerCare Plus Core Plan Brand Name Drugs Quick Reference, or the BadgerCare Plus Basic Plan Product List. 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.

Topic #84

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.

Topic #86

Member Payment for Covered Services

Under state and federal laws, a Medicaid-enrolled 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 (prior authorization) 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 enrollment.

Topic #5677

Not Otherwise Classified Procedure Codes

Providers who indicate procedure codes such as J3490 (Unclassified drugs), J3590 (Unclassified biologics), or J9999 (Not otherwise classified, antineoplastic drugs) on claims for NOC (not otherwise classified) drugs must also indicate the following on the claim:

- The NDC (National Drug Code) of the drug dispensed.
- The name of the drug.
- The quantity billed.
- The unit of issue (i.e., F2, gr, me, ml, un).

If this information is not included on the claim or if there is a more specific HCPCS (Healthcare Common Procedure Coding System) procedure code for the drug, the claim will be denied. Compound drugs that do not include a drug approved by the FDA (Food and Drug Administration) will be denied.

Providers are required to comply with the requirements of the federal DRA (Deficit Reduction Act) of 2005 and submit NDCs with HCPCS and CPT (Current Procedural Terminology) 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.

Topic #11097

Opioid Monthly Prescription Fill Limit

Opioid drugs are limited to five prescription fills per calendar month for BadgerCare Plus Standard Plan, BadgerCare Plus Benchmark Plan, BadgerCare Plus Core Plan, BadgerCare Plus Basic Plan, Wisconsin Medicaid, and SeniorCare members.

These limits do not affect members who are in a nursing home or hospice care.

The following drugs are exempt from the opioid monthly prescription fill limit:

- Suboxone film and tablet.
- Buprenorphine tablet.
- Methadone solution.
- Opioid antitussive liquid.

Prescriber Responsibilities

If a Standard Plan, Medicaid, and SeniorCare member requires more than five opioid prescription fills in a month, the prescriber may request a policy override through the DAPO (Drug Authorization and Policy Override) 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 override.

When calling the DAPO Center to request a policy override for opioids, the following information must be provided:

- Prescriber's name and NPI (National Provider Identifier).
- Member's name and ID.
- Pharmacy provider'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 Standard Plan, Medicaid, or SeniorCare members, 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 Standard Plan, Medicaid, and SeniorCare members.

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, 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 (F-13072 (07/12)) form, with a Pharmacy Special Handling Request (F-13074 (07/12)) 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.

Topic #1298

Over-the-Counter Drugs

BadgerCare Plus and Wisconsin Medicaid

As required by the OBRA '90 (Omnibus Reconciliation Act of 1990), 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 (over-the-counter) drugs from manufacturers who have signed rebate agreements with CMS (Centers for Medicare and Medicaid Services).

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 WAC (Wholesale Acquisition Cost) as listed by First DataBank Inc., except for state MAC (Maximum Allowed Cost) list and expanded MAC drugs.

As per DHS 107.10(3)(h), Wis. Admin. Code, certain classes of OTC drugs are covered.

BadgerCare Plus Benchmark Plan, Core Plan, Basic Plan, and SeniorCare

The Benchmark Plan, the Core Plan, and the Basic Plan cover a limited number of OTC drugs. The BadgerCare Plus Benchmark Plan Product List and the BadgerCare Plus Core Plan Product 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 (National Drug Code) 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 (prior authorization) 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 (Prior Authorization/Drug Attachment, F-11049 (07/12)) or a copy of the prescription.
- Select the "HealthCheck Other Services" checkbox in Element 1 of the PA/RF (Prior Authorization Request Form, F-11018 (07/12)).
- Fax the form to (608) 221-8616 or mail it to the following address:

  ForwardHealth
  Prior Authorization
  Ste 88
  313 Blettner Blvd
  Madison WI 53784

- If PA is approved, do all of the following:
  - Dispense the medication.
  - Submit a professional claim on an 837P (837 Health Care Claim: Professional) transaction, using PES (Provider Electronic Solutions) software, on the ForwardHealth Portal, or on paper on 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 (F-00020 (10/10)) form.

Topic #11597

Pharmacy Auto Refills

Pharmacy providers may use auto refills as an efficient and effective business practice. Wisconsin Medicaid only reimburses for prescriptions dispensed to members or member representatives. Therefore, pharmacy providers who auto refill prescriptions should ensure that reimbursement for prescriptions not picked up by the member or the member's representative is returned to Medicaid and the medication returned to pharmacy stock.

Topic #2335

Prescriber Requirements

BadgerCare Plus, Medicaid, and SeniorCare cover medically necessary legend drugs and certain OTC (over-the-counter) 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 with a psychiatric specialty.
- Optometrist.
- Physician assistant.
- Podiatrist.

Topic #66

Program Requirements

For a covered service to meet program requirements, the service must be provided by a qualified Medicaid-enrolled provider to an enrolled member. In addition, the service must meet all applicable program requirements, including, but not limited to, medical necessity, PA (prior authorization), claims submission, prescription, and documentation requirements.

Topic #5697

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 (Healthcare Common Procedure Coding System) and CPT (Current Procedural Terminology) procedure codes for provider-administered drugs and reimbursement rates.

For members enrolled in BadgerCare Plus HMOs (health maintenance organizations), Medicaid SSI (Supplemental Security Income) HMOs, and most special managed care programs, BadgerCare Plus and Medicaid fee-for-service, not the member's MCO (managed care organization), 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 (prior authorization), 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 (Program of All-Inclusive Care for the

Elderly) 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.

Topic #3407

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.

Topic #1317

Refills

According to DHS 107.10(3), Wis. Admin. Code, BadgerCare Plus, Medicaid, and 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.

Topic #7897

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 (health maintenance organization).
- 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 (prior authorization) 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.

Topic #13457

SeniorCare Covered Pharmacy Services

SeniorCare covers the following when provided by a Medicaid-enrolled pharmacy:

- Prescription drugs for which there is a signed drug rebate agreement with the manufacturer.
- OTC (over-the-counter) insulin. (Providers should note that SeniorCare does not cover any additional OTC drugs, except for insulin.)
- Compound drugs with at least two ingredients, at least one of which SeniorCare covers.
- Brand-name innovator drugs indentified as "brand medically necessary" on the prescription with a "Dispense As Written" indicator on the drug claim.

SeniorCare members are not eligible for any Wisconsin Medicaid or BadgerCare Plus services.

Topic #824

Services That Do Not Meet Program Requirements

As stated in DHS 107.02(2), Wis. Admin. Code, BadgerCare Plus and Wisconsin Medicaid 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 (Department of Health Services), the PRO (Peer Review Organization) 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 enrollment 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.

Topic #8037

Tamiflu® Suspension is Covered for Children Enrolled in the Benchmark Plan

Tamiflu® suspension is covered for children enrolled in the BadgerCare Plus Benchmark Plan. 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 (Healthcare Common Procedure Coding System) code J3490 (Unclassified drugs) on the 1500 Health Insurance Claim Form.
- Indicate the NDCs (National Drug Codes) 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 (Department of Health Services) 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.

Topic #5657

Tobacco Cessation Drugs

The BadgerCare Plus Standard Plan, the BadgerCare Plus Benchmark Plan, the BadgerCare Plus Core Plan, the BadgerCare Plus Basic Plan, Medicaid, and SeniorCare cover generic legend drugs for tobacco cessation.

Nicotine gum or patches available OTC (over-the-counter) are covered by the Standard Plan, the Benchmark Plan, the Core Plan, the Basic Plan, and Medicaid.

Certain Standard Plan and Benchmark Plan members may be eligible to participate in Striving to Quit Wisconsin Tobacco Quit Line or First Breath initiatives.

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 (prior authorization) is required for uses outside the approved diagnosis.

Diabetic Supplies

Topic #9018

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 (prior authorization) requests.

Topic #8937

Preferred Products

Certain diabetic supplies have preferred products and non-preferred products. Non-preferred products require PA (prior authorization) 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 (National Drug Code):

- Blood glucose calibrator solutions and chips.
- Blood glucose meters.
- Blood glucose test strips.
- Insulin syringes.
- Lancets.
- Lancet devices.
- Pen needles.

Topic #9037

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 (Drug Authorization and Policy Override) 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"

Topic #22

Definition of HealthCheck "Other Services"

HealthCheck is a federally mandated program known nationally as EPSDT (Early and Periodic Screening, Diagnosis, and Treatment). 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 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.

Topic #1

Prior Authorization

To receive PA (prior authorization) 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 (Prior Authorization Request Form, F-11018 (07/12)) (or PA/DRF (Prior Authorization/Dental Request Form, F-11035 (07/12)), or PA/HIAS1 (Prior Authorization Request for Hearing Instrument and Audiological Services 1, F-11020 (07/12)).
  - 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.

Topic #2245

Pharmacy providers should submit a completed PA/DGA (Prior Authorization Drug Attachment, F- 11049 (07/12)) to ForwardHealth to request PA for HealthCheck "Other Services."

Topic #41

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 (prior

authorization) 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.

ForwardHealth 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.

Topic #1401

Covered Over-the-Counter Drugs

All requests for HealthCheck "Other Services" require PA, except for the drugs listed below.

The following OTC (over-the-counter) 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

Medication Therapy Management

Topic #14897

1500 Health Insurance Claim Form Completion Instructions for Medication Therapy Management Services

The following sample 1500 Health Insurance Claim Forms are available for MTM (Medication Therapy Management) services:

- Intervention-Based Services.
- Comprehensive Medication Review and Assessments.

Use the following claim form completion instructions, not the claim form's printed descriptions, to avoid denial or inaccurate claim payment. Complete all required elements as appropriate. Be advised that every code used, even if it is entered in a non-required element, is required to be a valid code. Do not include attachments unless instructed to do so.

Members enrolled in BadgerCare Plus or Medicaid receive a ForwardHealth identification card and SeniorCare members receive a SeniorCare identification card. Always verify a member's enrollment before providing nonemergency services to determine if there are any limitations on covered services and to obtain the correct spelling of the member's name.

When submitting a claim with multiple pages, providers are required to indicate page numbers using the format "Page X of X" in the upper right corner of the claim form.

Submit completed paper claims to the following address:

ForwardHealth
Claims and Adjustments
313 Blettner Blvd
Madison WI 53784

Element 1 — Medicare, Medicaid, TRICARE CHAMPUS, CHAMPVA, Group Health Plan, FECA, Blk Lung, Other
Enter "X" in the Medicaid check box.

Element 1a — Insured's ID Number
Enter the member identification number. Do not enter any other numbers or letters. Use the FowardHealth card or SeniorCare card or Wisconsin's EVS (Enrollment Verification System) to obtain the correct member ID.

Element 2 — Patient's Name
Enter the member's last name, 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 or SeniorCare card and the EVS do not match, use the spelling from the EVS.

Element 3 — Patient's Birth Date, Sex
Enter the member's birth date in MMDDYY format (e.g., February 3, 1955, would be 020355) or in MMDDCCYY format (e.g., February 3, 1955, would be 02031955). Specify whether the member is male or female by placing an "X" in the appropriate box.

Element 4 — Insured's Name
Data are required in this element for OCR (Optical Character Recognition) processing. Any information populated by a provider's computer software is acceptable data for this element (e.g., "Same"). If computer software does not automatically complete this element, enter information such as the member's last name, first name, and middle initial.

Element 5 — Patient's Address
Enter the complete address of the member's place of residence, if known.

Element 6 — Patient Relationship to Insured (not required)

Element 7 — Insured's Address (not required)

Element 8 — Patient Status (not required)

Element 9 — Other Insured's Name
Commercial health insurance must be billed prior to submitting claims to ForwardHealth, unless the service does not require commercial health insurance billing as determined by ForwardHealth.

If the EVS indicates that the member has dental ("DEN") insurance only, is enrolled in a Medicare Advantage Plan only, or has no commercial health insurance, leave Element 9 blank.

If the EVS indicates that the member has any other commercial health insurance, and the service requires other insurance billing, one of the following three OI (other insurance) explanation codes must be indicated in the first box of Element 9. If submitting a multiple-page claim, providers are required to indicate OI explanation codes on the *first page* of the claim.

The description is not required, nor is the policyholder, plan name, group number, etc. (Elements 9a, 9b, 9c, and 9d are not required.)

Code	Description
OI-P	PAID in part or in full by commercial health insurance or commercial HMO. In Element 29 of this claim form, indicate the amount paid by commercial health insurance to the provider or to the insured.
OI-D	DENIED by commercial health insurance or commercial HMO following submission of a correct and complete claim, or payment was applied towards the coinsurance and deductible. Do not use this code unless the claim was actually billed to the commercial health insurer.
OI-Y	YES, the member has commercial health insurance or commercial HMO coverage, but it was not billed for reasons including, but not limited to, the following: • The member denied coverage or will not cooperate. • The provider knows the service in question is not covered by the carrier. • The member's commercial health insurance failed to respond to initial and follow-up claims. • Benefits are not assignable or cannot get assignment. • Benefits are exhausted.

Note: The provider may not use OI-D or OI-Y if the member is covered by a commercial HMO and the HMO denied payment because an otherwise covered service was not rendered by a designated provider. Services covered by a commercial HMO are not reimbursable by ForwardHealth except for the copayment and deductible amounts. Providers who receive a capitation payment from the commercial HMO may not bill ForwardHealth for services that are included in the capitation payment.

Element 9a — Other Insured's Policy or Group Number (not required)

Element 9b — Other Insured's Date of Birth, Sex (not required)

Element 9c — Employer's Name or School Name (not required)

Element 9d — Insurance Plan Name or Program Name (not required)

Element 10a-10c — Is Patient's Condition Related to: (not required)

Element 10d — Reserved for Local Use (not required)

Element 11 — Insured's Policy Group or FECA Number
If an EOMB (Explanation of Medicare Benefits) indicates that the member is enrolled in a Medicare Advantage Plan and the claim is being billed as a crossover, enter "MMC" in the upper right corner of the claim, indicating that the other insurance is a Medicare Advantage Plan and the claim should be processed as a crossover claim.

Use the first box of this element only. (Elements 11a, 11b, 11c, and 11d are not required.) Element 11 should be left blank when one or more of the following statements are true:

- Medicare never covers the procedure in any circumstance.
- ForwardHealth indicates the member does not have any Medicare coverage, including a Medicare Advantage Plan, for the service provided. For example, the service is covered by Medicare Part A, but the member does not have Medicare Part A.
- ForwardHealth indicates that the provider is not Medicare enrolled.
- Medicare has allowed the charges. In this case, attach the EOMB, but do not indicate on the claim form the amount Medicare paid.

If none of the previous statements are true, a Medicare disclaimer code is necessary. If submitting a multiple-page claim, indicate Medicare disclaimer codes on the *first page* of the claim. The following Medicare disclaimer codes may be used when appropriate.

Code	Description
M-7	Medicare disallowed or denied payment. This code applies when Medicare denies the claim for reasons related to policy (not billing errors), or the member's lifetime benefit, spell of illness, or yearly allotment of available benefits is exhausted. *For Medicare Part A, use M-7 in the following instances (all three criteria must be met):* • The provider is identified in ForwardHealth files as enrolled in Medicare Part A. • The member is eligible for Medicare Part A. • The service is covered by Medicare Part A but is denied by Medicare Part A due to frequency limitations, diagnosis restrictions, or exhausted benefits. *For Medicare Part B, use M-7 in the following instances (all three criteria must be met):* • The provider is identified in ForwardHealth files as enrolled in Medicare Part B. • The member is eligible for Medicare Part B. • The service is covered by Medicare Part B but is denied by Medicare Part B due to frequency limitations, diagnosis restrictions, or exhausted benefits.
M-8	Noncovered Medicare service. This code may be used when Medicare was not billed because the service is not covered in this circumstance. *For Medicare Part A, use M-8 in the following instances (all three criteria must be met):*

- The provider is identified in ForwardHealth files as enrolled in Medicare Part A.
- The member is eligible for Medicare Part A.
- The service is usually covered by Medicare Part A but not in this circumstance (e.g., member's diagnosis).

For Medicare Part B, use M-8 in the following instances (all three criteria must be met):

- The provider is identified in ForwardHealth files as enrolled in Medicare Part B.
- The member is eligible for Medicare Part B.
- The service is usually covered by Medicare Part B but not in this circumstance (e.g., member's diagnosis).

Element 11a — Insured's Date of Birth, Sex (not required)

Element 11b — Employer's Name or School Name (not required)

Element 11c — Insurance Plan Name or Program Name (not required)

Element 11d — Is there another Health Benefit Plan? (not required)

Element 12 — Patient's or Authorized Person's Signature (not required)

Element 13 — Insured's or Authorized Person's Signature (not required)

Element 14 — Date of Current Illness, Injury, or Pregnancy (not required)

Element 15 — If Patient Has Had Same or Similar Illness (not required)

Element 16 — Dates Patient Unable to Work in Current Occupation (not required)

Element 17 — Name of Referring Provider or Other Source (required if the member was referred for services by a provider)

Element 17a (not required)

Element 17b — NPI (required if the member was referred for services by a provider)

Element 18 — Hospitalization Dates Related to Current Services (not required)

Element 19 — Reserved for Local Use (not required)

Element 20 — Outside Lab? $Charges (not required)

Element 21 — Diagnosis or Nature of Illness or Injury
Enter a valid ICD-9-CM (International Classification of Diseases, Ninth Revision, Clinical Modification) diagnosis code for each symptom or condition related to the services provided. The required use of valid diagnosis codes includes the use of the most specific diagnosis codes. List the primary diagnosis first. Etiology ("E") and manifestation ("M") codes may not be used as a primary diagnosis. The diagnosis description is not required.

ForwardHealth accepts up to eight diagnosis codes. To enter more than four diagnosis codes:

- Enter the fifth diagnosis code in the space *between* the first and third diagnosis codes.
- Enter the sixth diagnosis code in the space *between* the second and fourth diagnosis codes.

- Enter the seventh diagnosis code in the space to the right of the third diagnosis code.
- Enter the eighth diagnosis code in the space to the right of the fourth diagnosis code.

When entering fifth, sixth, seventh, and eighth diagnosis codes, do *not* number the diagnosis codes (e.g., do not include a "5." before the fifth diagnosis code).

Family Planning Services

Indicate the appropriate ICD-9-CM diagnosis code from the V25 series for services and supplies that are only contraceptive management related.

Element 22 — Medicaid Resubmission (not required)

Element 23 — Prior Authorization Number (not required)

Element 24
The six service lines in Element 24 have been divided horizontally. Enter service information in the bottom, unshaded area of the six service lines. The horizontal division of each service line is not intended to allow the billing of 12 lines of service.

Element 24A-24G (shaded area) (not required)

Element 24A — Date(s) of Service
Enter the DOS (dates of service) in MMDDYY or MMDDCCYY format. Enter the date under "From." Leave "To" blank or re-enter the "From" date.

The DOS is defined as the date the medication was dispensed, if applicable (e.g., for a cost-effectiveness intervention), or the date the member received the MTM service (e.g., for a medication deletion intervention).

Element 24B — Place of Service
Enter the appropriate two-digit POS (place of service) code for each item used or service performed.

Element 24C — EMG (not required)

Element 24D — Procedures, Services, or Supplies
Enter the single most appropriate five-character procedure code. ForwardHealth denies claims received without an appropriate procedure code.

Modifiers
Enter the appropriate (up to four per procedure code) modifier(s) in the "Modifier" column of Element 24D.

Element 24E — Diagnosis Pointer
Enter the number(s) that corresponds to the appropriate ICD-9-CM diagnosis code(s) listed in Element 21. Up to four diagnosis pointers per detail may be indicated. Valid diagnosis pointers, digits 1 through 8, should *not* be separated by commas or spaces.

Element 24F — $ Charges
Enter the total charge for each line item.

Enter the dollar amount right justified in the dollar area of the field. Do not use commas when reporting dollar amounts. Dollar signs should not be entered. Enter "00" in the cents area if the amount is a whole number.

Providers are to bill ForwardHealth their usual and customary charge. The usual and customary charge is the provider's charge for providing the same service to persons not entitled to ForwardHealth benefits.

Element 24G — Days or Units
Enter the number of days or units. Only include a decimal when billing fractions (e.g., 1.50).

Element 24H — EPSDT/Family Plan (not required)

Element 24I — ID Qual (not required)

Element 24J — Rendering Provider ID. # (not required)

Element 25 — Federal Tax ID Number (not required)

Element 26 — Patient's Account No. (not required)

Element 27 — Accept Assignment? (not required)

Element 28 — Total Charge
Enter the total charges for this claim. If submitting a multiple-page claim, enter the total charge for the claim (i.e., the sum of all details from all pages of the claim) *only on the last page of the claim*.

Enter the dollar amount right justified in the dollar area of the field. Do not use commas when reporting dollar amounts. Dollar signs should not be entered. Enter "00" in the cents area if the amount is a whole number.

Element 29 — Amount Paid
Enter the actual amount paid by commercial health insurance. If submitting a multiple-page claim, indicate the amount paid by commercial health insurance only on the *first page* of the claim.

Enter the dollar amount right justified in the dollar area of the field. Do not use commas when reporting dollar amounts. Dollar signs should not be entered. Enter "00" in the cents area if the amount is a whole number.

If a dollar amount indicated in Element 29 is greater than zero, "OI-P" must be indicated in Element 9. If the commercial health insurance denied the claim, enter "000." Do not enter Medicare-paid amounts in this field.

Element 30 — Balance Due
Enter the balance due as determined by subtracting the amount paid in Element 29 from the amount in Element 28. If submitting a multiple-page claim, enter the balance due for the claim (i.e., the sum of all details from all pages of the claim minus the amount paid by commercial insurance) *only on the last page of the claim*.

Enter the dollar amount right justified in the dollar area of the field. Do not use commas when reporting dollar amounts. Dollar signs should not be entered. Enter "00" in the cents area if the amount is a whole number.

Element 31 — Signature of Physician or Supplier, Including Degrees or Credentials
The provider or authorized representative must sign in Element 31. The month, day, and year the form is signed must also be entered in MMDDYY or MMDDCCYY format.

Note: The signature may be a computer-printed or typed name and date or a signature stamp with the date.

Element 32 — Service Facility Location Information (not required)

Element 32a — NPI (not required)

Element 32b (not required)

Element 33 — Billing Provider Info & Ph #

Enter the name of the provider submitting the claim and the practice location address. The minimum requirement is the provider's name, street, city, state, and ZIP+4 code. Do not enter a Post Office Box or a ZIP+4 code associated with a PO Box. The practice location address entered must correspond with the NPI listed in Element 33a and match the practice location address on the provider's file maintained by ForwardHealth.

Element 33a — NPI
Enter the NPI of the billing provider.

Element 33b
Enter qualifier "ZZ" followed by the appropriate 10-digit provider taxonomy code on file with ForwardHealth. Do not include a space between the qualifier "ZZ" and the provider taxonomy code.

Note: Providers should use qualifier "PXC" when submitting an electronic claim using the 837P (837 Health Care Claim: Professional) transaction. For further instructions, refer to the companion guide for the 837P transaction.

Sample 1500 Health Insurance Claim Form for Intervention-Based Services

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA | PICA

CARRIER

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) [X] | TRICARE CHAMPUS (Sponsor's SSN) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 1234567890

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): MEMBER, IM A

3. PATIENT'S BIRTH DATE MM DD YY: MM DD YY — SEX M [X] F

4. INSURED'S NAME (Last Name, First Name, Middle Initial): SAME

5. PATIENT'S ADDRESS (No., Street): 609 WILLOW ST

6. PATIENT RELATIONSHIP TO INSURED: Self | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street)

CITY: ANYTOWN — STATE: WI

8. PATIENT STATUS: Single | Married | Other

CITY | STATE

ZIP CODE: 55555 — TELEPHONE (Include Area Code): (444) 444-4444

Employed | Full-Time Student | Part-Time Student

ZIP CODE | TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES | NO

a. INSURED'S DATE OF BIRTH MM DD YY — SEX M | F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY — SEX M | F

b. AUTO ACCIDENT? YES | NO — PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES | NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES | NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED ____ DATE ____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED ____

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: MM DD YY — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM ____ TO ____

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE — 17a. — 17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM ____ TO ____

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES | NO — $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 250 . 01
2. ____ . ____
3. ____ . ____
4. ____ . ____

22. MEDICAID RESUBMISSION CODE — ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	09	15	12						99605	U1	1	XX XX	1		NPI	
2	09	15	12						99607	U1	1	0 00	1		NPI	
3	09	15	12						99605	U2	1	XX XX	1		NPI	
4	09	15	12						99605	U2	1	XX XX	1		NPI	
5															NPI	
6															NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.: 1234JED

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES | NO

28. TOTAL CHARGE: $ XX XX

29. AMOUNT PAID: $

30. BALANCE DUE: $ XX XX

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

I. M. Provider — 09302012

SIGNED — DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

I.M. PROVIDER
1 W WILLIAMS ST
ANYTOWN WI 55555-1234

a. 0222222220 b. ZZ123456789X

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

Sample 1500 Health Insurance Claim Form for Comprehensive Medication Review and Assessments

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) / MEDICAID (Medicaid #) X / TRICARE CHAMPUS (Sponsor's SSN) / CHAMPVA (Member ID#) / GROUP HEALTH PLAN (SSN or ID) / FECA BLK LUNG (SSN) / OTHER (ID)	1a. INSURED'S I.D. NUMBER (For Program in Item 1): 1234567890
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): MEMBER, IM A	3. PATIENT'S BIRTH DATE MM DD YY: MM DD YY; SEX: M X F
4. INSURED'S NAME (Last Name, First Name, Middle Initial): SAME	
5. PATIENT'S ADDRESS (No., Street): 609 WILLOW ST	6. PATIENT RELATIONSHIP TO INSURED: Self Spouse Child Other
7. INSURED'S ADDRESS (No., Street)	
CITY: ANYTOWN; STATE: WI	8. PATIENT STATUS: Single Married Other; Employed Full-Time Student Part-Time Student
CITY; STATE	
ZIP CODE: 55555; TELEPHONE (Include Area Code): (444) 444-4444	
ZIP CODE; TELEPHONE (Include Area Code): ( )	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:
11. INSURED'S POLICY GROUP OR FECA NUMBER	
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES NO
a. INSURED'S DATE OF BIRTH MM DD YY; SEX M F	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY; SEX M F	b. AUTO ACCIDENT? YES NO PLACE (State)
b. EMPLOYER'S NAME OR SCHOOL NAME	
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES NO
c. INSURANCE PLAN NAME OR PROGRAM NAME	
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.	

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED _____

14. DATE OF CURRENT: MM DD YY; ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY: FROM TO	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. ; 17b. NPI
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY: FROM TO	
19. RESERVED FOR LOCAL USE	20. OUTSIDE LAB? YES NO; $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line): 1. L 250 . 00; 2. ; 3. ; 4.	22. MEDICAID RESUBMISSION CODE; ORIGINAL REF. NO.
	23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	09 16 12			99605	UA	1	XX XX	1		NPI	
2	09 16 12			99607	UA	1	0 00	2		NPI	
3	09 16 12			99605	U1	1	XX XX	1		NPI	
4	09 16 12			99605	U1	1	XX XX	1		NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.: 1234JED	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO	28. TOTAL CHARGE $ XXX XX
29. AMOUNT PAID $	30. BALANCE DUE $ XXX XX		
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) I.M. Provider 09302012 SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION a. NPI b.	33. BILLING PROVIDER INFO & PH # ( ) I.M. PROVIDER 1 W WILLIAMS ST ANYTOWN WI 55555-1234 a. 0222222220 b. ZZ123456789X	

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

Topic #14477

An Overview of Medication Therapy Management

ForwardHealth implemented the MTM (Medication Therapy Management) benefit in conjunction with the WPQC (Wisconsin

Pharmacy Quality Collaborative). The MTM benefit consists of the following types of services:

- **Intervention-based services.** These are focused interventions between a pharmacist and a member. All Medicaid-enrolled pharmacies are eligible to provide these services to members. Certification by the WPQC is *not* required to perform and receive reimbursement for intervention-based services.
- **CMR/A (Comprehensive Medication Review and Assessment) services.** These are private consultations between a pharmacist and a member to review the member's drug regimen. The member must be approved by ForwardHealth as a patient who is at high risk of experiencing medical complications due to his or her drug regimen to receive the CMR/A. The pharmacy requests approval to perform the CMR/A by calling the DAPO (Drug Authorization and Policy Override) Center. In addition to Medicaid enrollment, WPQC certification is required to perform and receive reimbursement for CMR/A services.

As a result of this implementation, PC (Pharmaceutical Care) services are no longer reimbursable for DOS (dates of service) on and after September 1, 2012.

Topic #15177

Claims for SeniorCare Members with Spenddowns and Deductibles

State law limits what pharmacies may charge SeniorCare members for covered MTM (Medication Therapy Management) services. Regardless of a member's level of participation in SeniorCare, pharmacies should always submit their usual and customary charge for MTM services, including services billed with procedure code 99607, if applicable. SeniorCare will track and maintain the member spenddown or deductible amounts for claims for MTM services. SeniorCare will inform the pharmacy of the amount to charge the member through the remittance information.

A pharmacy provider should never charge a member more than the amount indicated by SeniorCare, according to s. 49.688(5)(a), Wis. Stats. If a SeniorCare member pays an amount greater than the amount on the remittance, the provider is required to refund the difference to the member.

Until a member meets any required spenddown, pharmacies may charge the member no more than their usual and customary rate for covered MTM services. Until a member meets any required deductible, pharmacies may charge the member no more than the ForwardHealth rate for covered MTM services.

Providers may obtain deductible and spenddown information for a specific member through the following sources:

- Remittance information.
- Enrollment Verification on the ForwardHealth Portal.
- Provider Services.

SeniorCare Members at Level 2a (Deductible) Participation

Under level 2a (deductible) participation, a member is required to pay a $500 deductible in each of the following situations:

- Upon applying for SeniorCare, if the member meets the income limits for level 2a.
- Subsequent to applying for SeniorCare, if the member meets the SeniorCare spenddown requirement.

Until a member meets the required deductible, pharmacies may charge the member no more than the ForwardHealth rate for covered MTM services.

Dollars applied toward the deductible are not carried over into the next benefit period. After the member meets the deductible

amount, the pharmacy may be reimbursed by ForwardHealth for covered MTM services.

SeniorCare Members at Level 2b (Deductible) Participation

Under level 2b (deductible) participation, a member is required to pay an $850 deductible in each of the following situations:

- Upon applying for SeniorCare, if the member meets the income limits for level 2b.
- Subsequent to applying for SeniorCare, if the member meets the SeniorCare spenddown requirement.

Until a member meets the required deductible, pharmacies may charge the member no more than the ForwardHealth rate for covered MTM services.

Dollars applied toward the deductible are not carried over into the next benefit period. After the member meets the deductible amount, the pharmacy may be reimbursed by ForwardHealth for covered MTM services.

SeniorCare Members at Level 3 (Spenddown) Participation

Under level 3 (spenddown) participation, members are required to pay a spenddown equal to the amount that their income exceeds 240 percent of the FPL (Federal Poverty Level). For households in which only one individual is eligible for SeniorCare, the member's spenddown amount is based on the individual's income. If the individual is married and living with his or her spouse, however, SeniorCare eligibility is based on the income of both spouses.

If both spouses are eligible for SeniorCare, the spenddown amount is based on the total of both members' incomes. SeniorCare-covered MTM services for either member will be applied to satisfy the spenddown amount.

Until a member meets any required spenddown, pharmacies may charge the member no more than their usual and customary rate for covered MTM services.

Dollars applied toward spenddown are not carried over into the next benefit period. After the member meets the spenddown amount, he or she must then meet the $850 deductible. Once the deductible is met, the pharmacy may be reimbursed by ForwardHealth for covered MTM services.

Topic #15178

Claims for Tablet Splitting for SeniorCare Members

SeniorCare members are eligible for a reduced brand drug copayment when they have their tablets split. To ensure SeniorCare members receive the reduced copayment, pharmacy providers are required to submit claims for tablet splitting on a noncompound claim using the tablet splitting PC (Pharmaceutical Care) code. If a cost-effectiveness intervention also occurred, the provider should submit a separate professional claim for the MTM (Medication Therapy Management) service.

The following fields are required in the DUR (Drug Use Review)/PPS (Professional Pharmacy Services) segment of noncompound claims for tablet splitting for SeniorCare members:

- The Reason for Service Code (NCPDP (National Council for Prescription Drug Programs) field 439-E4) must be SR (Suboptimal Regimen).
- The Professional Service Code (NCPDP field 440-E5) must be M0 (Prescriber Consulted).
- The Result of Service Code (NCPDP field 441-E6) should be 1D (Filled, with Different Directions) or 1F (Filled, with Different Quantity).
- The DUR/PPS Level of Effort (NCPDP field 474-8E) value must be between 11 and 15.

In addition, a diagnosis code must be included on the claim. If tablet splitting is indicated for a covered brand name drug and the member is a SeniorCare member at Level 1 (copayment) participation, the maximum copayment rate that may be deducted on the claim is $7.50.

For SeniorCare members, the following information should be indicated on professional claims for cost-effectiveness interventions for tablet splitting:

- The appropriate CPT (Current Procedural Terminology) procedure code for a new or established patient.
- Modifier U1 (cost-effectiveness intervention) with a quantity of 1.

If a cost-effectiveness intervention lasts longer than 15 minutes, pharmacy providers should indicate CPT procedure code 99607 with modifier U1 for each additional 15 minutes on a separate detail.

Topic #14677

Comprehensive Medication Review and Assessments

ForwardHealth implemented the MTM (Medication Therapy Management) benefit in conjunction with the WPQC (Wisconsin Pharmacy Quality Collaborative). The MTM benefit consists of intervention-based services and CMR/As (Comprehensive Medication Review and Assessments).

The CMR/A services are voluntary medication reviews for members performed by a pharmacist. CMR/As may include one or more of the following analytical, consultative, educational, and monitoring services, provided by a pharmacist to help members get the best results from medications through enhancing consumer understanding of medication therapy, increasing adherence to medications, controlling costs, and preventing drug complications, conflicts and interactions.

An initial face-to-face CMR/A identifies, resolves, and prevents medication-related problems, including adverse drug events, or can include performing medication reconciliation for a member discharged from a hospital or long-term care setting.

A follow up CMR/A monitors and evaluates the member's response to therapy, including safety and effectiveness of target medications.

Certification Requirements for Providing Comprehensive Medication Review and Assessments

To perform and be reimbursed for CMR/As, the pharmacists and the pharmacy at which a pharmacist is performing the CMR/A are required to be certified by an approved MTM program. Currently, the only approved MTM certification program is offered by the WPQC. The PSW (Pharmacy Society of Wisconsin) manages the WPQC training and certification process, and has established rates for WPQC certification.

Note: A separate WPQC certification is not required to perform and receive reimbursement for intervention-based services.

Conducting a Comprehensive Medication Review and Assessment

The CMR/A services may include the following value-added professional services provided by a pharmacist:

- Obtaining the necessary assessments of the member's health status.
- Formulating a medication treatment plan for the member.
- Providing an updated personal medication record and medication action plan for the member following each CMR/A visit.
- Providing information, support services and resources designed to enhance member adherence with the therapeutic regimen.

- Providing verbal education and training designed to enhance the member's understanding and appropriate use of the medication.
- Documenting the care delivered and communicating essential information to the member's primary care providers.
- Referring to an appropriate health care provider if necessary.
- Coordinating and integrating medication management services within the broader health care system.
- Notifying appropriate prescribers of each comprehensive care review and assessment service provided and sending a copy of the personal medication record and medication action plan. If authorizations to change specific medications are needed, the specific prescriber will be notified.

Qualifying Criteria

A CMR/A service may be provided to a member who is at a high risk of experiencing medical complications due to his or her drug regimen. A high-risk member meets one of the following criteria:

- Takes four or more prescription medications to treat or prevent two or more chronic conditions, one of which must be hypertension, asthma, chronic kidney disease, congestive heart failure, dyslipidemia, COPD (Chronic Obstructive Pulmonary Disease), or depression.
- Has diabetes.
- Requires coordination of care due to multiple prescribers.
- Has been discharged from the hospital or long-term care setting within the past 14 days.
- Has health literacy issues as determined by the pharmacist.
- Has been referred for the MTM services by the prescriber.

Members residing in a nursing home are not eligible for CMR/As.

If the member meets at least one of the aforementioned criteria, the pharmacy must call the DAPO (Drug Authorization and Policy Override) Center to request approval to provide CMR/A services. The CMR/A approval covers the initial and up to three follow-up CMR/As.

Comprehensive Medication Review and Assessment Process

The following is a step-by-step process for providing a CMR/A:

- The pharmacist identifies an opportunity or receives a prescriber referral to perform a CMR/A.
- The pharmacy contacts the member about the CMR/A opportunity and the member accepts services.
- The pharmacy calls the DAPO Center to request approval to schedule a CMR/A.
- If approved, the pharmacist schedules an appointment with the member to perform the CMR/A.
- The pharmacist performs the CMR/A, which may include the following:
    - Meeting with the member.
    - Consulting with the prescriber if needed.
    - Documenting the intervention.
- The pharmacy submits a professional claim for the CMR/A.

Coordination of Benefits

Commercial health insurance and Medicare Part D plans also have MTM programs. If a member is eligible for a commercial health insurance or Medicare Part D MTM program, the pharmacy provider is required to submit the claim to the member's commercial health insurance or Medicare Part D plan before submitting the claim to ForwardHealth.

Pharmacies are responsible for MTM COB (coordination of benefits). ForwardHealth is the payer of last resort.

A sample 1500 Health Insurance Claim Form depicting a scenario in which other health insurance was billed is available.

Sample 1500 Health Insurance Claim Form for Medication Therapy Management Services, with Other Insurance

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) / MEDICAID (Medicaid #) [X] / TRICARE CHAMPUS (Sponsor's SSN) / CHAMPVA (Member ID#) / GROUP HEALTH PLAN (SSN or ID) / FECA BLK LUNG (SSN) / OTHER (ID)	1a. INSURED'S I.D. NUMBER (For Program in Item 1): 1234567890
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): MEMBER, IM A	3. PATIENT'S BIRTH DATE MM DD YY: MM DD YY; SEX: M [X] F [ ]
4. INSURED'S NAME (Last Name, First Name, Middle Initial): SAME	
5. PATIENT'S ADDRESS (No., Street): 609 WILLOW ST	6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]
7. INSURED'S ADDRESS (No., Street)	
CITY: ANYTOWN; STATE: WI	8. PATIENT STATUS: Single [ ] Married [ ] Other [ ]; Employed [ ] Full-Time Student [ ] Part-Time Student [ ]
CITY; STATE	
ZIP CODE: 55555; TELEPHONE (Include Area Code): (444) 444-4444	
ZIP CODE; TELEPHONE (Include Area Code): ( )	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): OI-P	10. IS PATIENT'S CONDITION RELATED TO:
11. INSURED'S POLICY GROUP OR FECA NUMBER	
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES [ ] NO [ ]
a. INSURED'S DATE OF BIRTH MM DD YY; SEX M [ ] F [ ]	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY; SEX M [ ] F [ ]	b. AUTO ACCIDENT? YES [ ] NO [ ] PLACE (State)
b. EMPLOYER'S NAME OR SCHOOL NAME	
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES [ ] NO [ ]
c. INSURANCE PLAN NAME OR PROGRAM NAME	
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] *If yes*, return to and complete item 9 a-d.	
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____	13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____
14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY	
19. RESERVED FOR LOCAL USE	20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. 250.01 2. 3. 4.	22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.
	23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	09 15 12				99605	U1	1	XX XX	1		NPI	
2	09 15 12				99607	U1	1	0 00	1		NPI	
3											NPI	
4											NPI	
5											NPI	
6											NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.: 1234JED	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [ ] NO [ ]	28. TOTAL CHARGE $ XX XX
29. AMOUNT PAID $ XX XX	30. BALANCE DUE $ XX XX		
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) I.M. Provider SIGNED 09302012 DATE	32. SERVICE FACILITY LOCATION INFORMATION a. NPI b.	33. BILLING PROVIDER INFO & PH # ( ) I.M. PROVIDER 1 W WILLIAMS ST ANYTOWN WI 55555-1234 a. 0222222220 b. ZZ123456789X	

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

Topic #14757

Comprehensive Medication Review and Assessments — Claim Submission

Claims for CMR/As (Comprehensive Medication Review and Assessments) must be submitted fee-for-service on a professional claim. In order to be reimbursed for a CMR/A, the pharmacy must submit a professional claim using a valid CPT (Current Procedural Terminology) code and modifier via one of the following claim submission methods:

- 837 (837 Health Care Claim: Professional) transaction.
- PES (Provider Electronic Solutions) software.
- DDE (direct data entry) on the FowardHealth Portal.
- 1500 Health Insurance Claim Form.

ForwardHealth reduces reimbursement on most claims submitted to ForwardHealth on paper. Most paper claims are subject to up to a $1.10 reimbursement reduction per claim.

To ensure that members receive their CMR/A services in a timely manner, pharmacy providers are encouraged to schedule, perform, and submit claims for CMR/A services as soon as possible following approval of the CMR/A request. The submission of the claim is the indication to ForwardHealth that the service has been performed. The DAPO (Drug Authorization and Policy Override) Center may inactivate the approval for a CMR/A service if it is not billed within the 60-day approval window.

Quantity on Claims for Initial and Follow-up Comprehensive Medication Reviews and Assessments

When submitting claims for an initial CMR/A, pharmacies should indicate CPT code 99605 with the modifier "UA," with a quantity of "1" for the first 15 minutes. If the initial CMR/A lasts longer than 15 minutes, pharmacies should also indicate CPT code 99607 with modifier "UA" for each additional 15 minutes.

When submitting claims for a follow-up CMR/A, pharmacies should indicate CPT code 99606 with modifier "UB," with a quantity of "1" for the first 15 minutes. If a follow-up CMR/A lasts longer than 15 minutes, pharmacies should indicate CPT code 99607 with modifier "UB" for each additional 15 minutes.

Pharmacies should note the following when submitting claims for each additional 15 minutes of a CMR/A using CPT code 99607:

- Procedure code 99607 must be listed on a separate detail line from the primary service code on claims for CMR/A services.
- Each claim detail must include the appropriate modifier.
- On the claim detail, each 15 minutes is equal to one unit (e.g., 30 minutes equals two units, 45 minutes equals three units, etc.). Providers should round up to the nearest 15 minutes when determining the number of units to bill. For example, if a CMR/A lasts 21 minutes, pharmacies should round to 30 minutes on the claim.
- The claim detail should be submitted with a zero dollar amount. (Claim details for procedure code 99607 are paid $0 since reimbursement for CMR/A services occurs with procedure code 99605 or 99606.)

Claim details for procedure code 99607 that are billed with a zero dollar amount are placed in a "pay" status with an amount paid of $0.

Although procedure code 99607 will be reimbursed at zero dollars, pharmacies must submit details with the correct quantities to comply with correct coding practices.

Determination of New or Established Patient Status

When submitting claims for MTM services, pharmacies should note that a new patient is one who has *not* received any MTM services from the pharmacy within the past three years. An established patient is one who has received MTM services from the pharmacy within the past three years. The CPT procedure code that a provider uses to bill the first 15 minutes of an MTM service indicates whether the member is a new (procedure code 99605) or an established (procedure code 99606) patient.

Providers billing multiple MTM services for any one member on the same DOS (date of service) are reminded to use the appropriate CPT procedure code for that DOS. Claims will be denied if the member is indicated as both a new patient and an established patient on the same DOS.

Note: The DOS is defined as the date the medication was dispensed, if applicable (e.g., for a cost-effectiveness intervention), or the date the member received the MTM service (e.g., for a medication deletion intervention).

Multiple Medication Therapy Management Services of the Same Type on the Same Day for the Same Member

When a pharmacy performs the same type of MTM service more than once for the same member on the same day, the services must be listed as separate claim details. For example, if a pharmacist converts two of a member's prescriptions to a three-month supply on the same day, the pharmacist would list each three-month supply conversion as a separate claim detail, as shown on the sample 1500 Health Insurance Claim Form.

Sample 1500 Health Insurance Claim Form for Intervention-Based Services

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) / MEDICAID (Medicaid #) X / TRICARE CHAMPUS (Sponsor's SSN) / CHAMPVA (Member ID#) / GROUP HEALTH PLAN (SSN or ID) / FECA BLK LUNG (SSN) / OTHER (ID)	1a. INSURED'S I.D. NUMBER (For Program in Item 1): 1234567890
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): MEMBER, IM A	3. PATIENT'S BIRTH DATE MM DD YY: MM DD YY; SEX M X F
4. INSURED'S NAME (Last Name, First Name, Middle Initial): SAME	
5. PATIENT'S ADDRESS (No., Street): 609 WILLOW ST	6. PATIENT RELATIONSHIP TO INSURED: Self / Spouse / Child / Other
7. INSURED'S ADDRESS (No., Street)	
CITY: ANYTOWN; STATE: WI	8. PATIENT STATUS: Single / Married / Other; Employed / Full-Time Student / Part-Time Student
CITY; STATE	
ZIP CODE: 55555; TELEPHONE (Include Area Code): (444) 444-4444	
ZIP CODE; TELEPHONE (Include Area Code): ( )	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:
11. INSURED'S POLICY GROUP OR FECA NUMBER	
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES / NO
a. INSURED'S DATE OF BIRTH MM DD YY; SEX M / F	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY; SEX M / F	b. AUTO ACCIDENT? YES / NO; PLACE (State)
b. EMPLOYER'S NAME OR SCHOOL NAME	
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES / NO
c. INSURANCE PLAN NAME OR PROGRAM NAME	
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES / NO *If yes*, return to and complete item 9 a-d.	

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED _____

14. DATE OF CURRENT: MM DD YY; ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY: FROM TO	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. ; 17b. NPI
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY: FROM TO	
19. RESERVED FOR LOCAL USE	20. OUTSIDE LAB? YES / NO; $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line): 1. 250.01	22. MEDICAID RESUBMISSION CODE; ORIGINAL REF. NO.
2. ; 3. ; 4.	23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	09 15 12			99605	U1	1	XX XX	1		NPI	
2	09 15 12			99607	U1	1	0 00	1		NPI	
3	09 15 12			99605	U2	1	XX XX	1		NPI	
4	09 15 12			99605	U2	1	XX XX	1		NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER; SSN EIN	26. PATIENT'S ACCOUNT NO.: 1234JED	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES / NO	28. TOTAL CHARGE $ XX XX
29. AMOUNT PAID $	30. BALANCE DUE $ XX XX		
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) I.M. Provider 09302012 SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION a. NPI b.	33. BILLING PROVIDER INFO & PH # ( ) I.M. PROVIDER 1 W WILLIAMS ST ANYTOWN WI 55555-1234 a. 0222222220 b. ZZ123456789X	

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Topic #14697

Comprehensive Medication Review and Assessments — Documentation Requirements

The following documentation is required for CMR/A (Comprehensive Medication Review and Assessment) services and must be maintained by the pharmacy in the member's file or on the prescription:

- Member information.
  - Member name.
  - Member identification number.
  - Whether or not the member resides in a nursing home.
- Pharmacist name and NPI (National Provider Identifier).
- Pharmacy name and NPI.
- Description of the need for the CMR/A.
- Indication if the member has other insurance. If so, indicate whether or not the member is enrolled in the other insurance's MTM (Medication Therapy Management) program.
- Indication of how the member meets the criteria to receive a CMR/A.
- Date of the CMR/A.
- Member consent for the CMR/A, indicated by the member's signature and date.
- Indication that DAPO (Drug Authorization and Policy Override) approval was received for the CMR/A.
- Indication if this was the initial assessment or a follow-up assessment.
- Description of what was discussed in the CMR/A.
- Face-to-face start and end time of the CMR/A.
- Total time spent providing the CMR/A, including administrative time (however, administrative time should not be billed and will not be reimbursed).
- Pharmacist signature and date on the documentation.

Pharmacies may use any format to document CMR/As, but that format must include all of the aforementioned elements. Documentation must be made available to ForwardHealth upon request. Refer to the sample of acceptable documentation for CMR/A.

Comprehensive Medication Review and Assessment Approval Process

Pharmacies are required to receive DAPO approval before scheduling a CMR/A with a member. Pharmacies may contact the DAPO (Drug Authorization and Policy Override) Center from 8:00 a.m. to 5:30 p.m. (Central Standard Time), Monday through Friday, except holidays.

When calling the DAPO Center for approval to schedule the CMR/A, the following information, similar to the documentation requirements, must be provided:

- Member information.
- Pharmacy and pharmacist information.
- Reason for the CMR/A.
- Whether or not the member is enrolled in Medicare Part D.
- Member's qualifying criteria.
- Whether or not member consent was obtained.

The member's verbal consent is required before calling the DAPO Center to request approval to schedule a CMR/A. The member's written consent (i.e., his or her signature) must be obtained before performing the CMR/A. If the member is a child or has physical or cognitive impairments that preclude the member from managing his or her own medications, a caregiver (e.g., caretaker relative, legal guardian, power of attorney, licensed health professional) may provide verbal or written consent on the member's behalf.

Generally DAPO Center staff will approve the CMR/A request by the end of the call based on the information provided by the caller. The pharmacy then must schedule, perform, and submit the claim for the CMR/A within 60 days following the approval. If the CMR/A is not provided within 60 days of approval, a new approval may be granted for a new pharmacy. The CMR/A

approval is for the initial CMR/A and the three follow-up CMR/As.

If a pharmacy calls the DAPO Center to request CMR/A approval and the information provided does not qualify, the pharmacy will be informed that the request is not approved.

COMPREHENSIVE MEDICATION REVIEW AND ASSESSMENT DOCUMENTATION EXAMPLE

SECTION I — MEMBER INFORMATION

Name — Member (Last, First, Middle Initial)
Ima M. Ember

Member Identification Number
0123456789

Is the member currently residing in a nursing home?
☐ Yes ☒ No

SECTION II — PHARMACY INFORMATION

Pharmacist Name Jane Doe Pharmacist NPI 03333333330
Pharmacy Name: Doe Pharmacy Pharmacy NPI 0222222222

SECTION III —COMPREHENSIVE MEDICATION REVIEW AND ASSESSMENT

Describe the need for the CMR/A: Member is taking 5 different medications for Hypertension and Dyslipidemia; adherence is questionable

Does the member have other insurance?
☐ Yes ☒ No

Is the member covered by the other insurance MTM Services?
☐ Yes ☒ No

The patient meets the following criteria (check all that apply):

- ☒ Take four or more prescription medications to treat or prevent two or more chronic conditions. Chronic conditions include at least one of the following:
  - ☒ Hypertension
  - ☐ Asthma
  - ☐ Chronic Kidney Disease
  - ☐ Congestive Heart Failure
  - ☒ Dyslipidemia
  - ☐ COPD
  - ☐ Depression
- ☐ Have Diabetes
- ☐ Coordination of care issue identified due to multiple prescribers
- ☐ Discharge from the hospital or long term care setting within the past 14 days
- ☐ Experience health literacy issues as determined by the pharmacist
- ☐ Prescriber referral
- ☐ Other referral

Date of CMR/A
10/15/2012

Member consent obtained? ☒ Yes ☐ No

SIGNATURE — Member
Im A. Member

Date Signed
9/1/2012

Override Approved? ☒ Yes ☐ No

SECTION II — SERVICE PERFORMED

Type of Service

☒ Initial Assessment Date 10/15/2012

❑ Follow-Up Assessment (1) Date _____ (2) Date _____ (3) Date _____

Describe what was discussed in the CMR/A. The dosing Schedule and reasons for taking each medication was discussed with the member. Barriers to adherence were also discussed, and the member has agreed to use a pill reminder.

Start Time	End Time	Total Time Spent on Service (In Minutes)
1:00 p.m.	1:45 p.m.	45 minutes

SIGNATURE — Pharmacist	Date Signed
Jane Doe	10/15/2012

Topic #14717

Comprehensive Medication Review and Assessments — Limitations

In most cases, a CMR/A (Comprehensive Medication Review and Assessment) is limited to one initial assessment and three follow-up assessments per rolling year.

Policy Override to Exceed Comprehensive Medication Review and Assessment Limitations

If a member requires more than the one initial and three follow-up CMR/As per rolling year (for example, a member is discharged from the hospital, released from long-term care, or has moved), pharmacies must contact the DAPO (Drug Authorization and Policy Override) Center to request a policy override.

Intervention-Based Services That Occur During a Comprehensive Medication Review and Assessment

If an intervention-based service is completed during the CMR/A, pharmacies should not bill and will not be reimbursed for the intervention-based service in addition to the CMR/A. Additionally, the focused adherence intervention or medication device instruction intervention will not be reimbursed on the same DOS (date of service) as a CMR/A. Claims submitted for the focused adherence intervention or medication device instruction submitted on the same DOS as a CMR/A will be denied.

Intervention-based services that are i*dentified* during a CMR/A but are not *completed* until after the CMR/A are separately reimbursable, with the exception of focused adherence interventions and medication device instruction interventions.

In-Home Medication Management and Comprehensive Medication Review and Assessment

If the pharmacist must conduct a CMR/A in the member's home because the member is unable to visit the pharmacy, the pharmacy may be reimbursed for an in-home medication management intervention in conjunction with a CMR/A.

Topic #14737

Comprehensive Medication Review and Assessments — Procedure Codes and Modifiers

Claims submitted for CMR/As (Comprehensive Medication Review and Assessment) must be submitted with at least one of the following CPT codes:

- 99605—Medication therapy management service(s) provided by a pharmacist, individual, face-to-face with patient, with assessment and intervention if provided; initial 15 minutes, new patient.
- 99606—Medication therapy management service(s) provided by a pharmacist, individual, face-to-face with patient with assessment and intervention if provided; initial 15 minutes, established patient.
- 99607—Medication therapy management service(s) provided by a pharmacist, individual, face-to-face with patient, with assessment and intervention if provided; each additional 15 minutes (List separately in addition to code for primary service).

Procedure codes submitted for CMR/As must be submitted with one of the following modifiers:

- UA—The initial assessment of a member who is at high risk of experiencing medical complications due to their drug regimen.
- UB—Follow-up assessment of a member who experiencing medical complications due to their drug regimen and has already received an initial assessment by the pharmacy. The follow-up assessment will not be reimbursed unless the initial assessment has been reimbursed.

Pharmacists should submit one procedure code and modifier per detail line. Claim details without the appropriate modifier will be denied.

Comprehensive Medication Review and Assessment Procedure Codes and Modifiers

Type of Comprehensive Medication Review and Assessment	Description	Modifier	CPT Code for New Patient	CPT Code for Established Patient	Reimbursement	Payable for nursing home residents?	Limit
CMR/A — Initial Assessment	This is an initial assessment of a member who is at a high risk of experiencing medical complications due to his drug regimen.	UA	99605 for first 15 minutes; 99607 for each additional 15 minutes	99606 for first 15 minutes; 99607 for each additional 15 minutes	$75	No	1/member/ rolling year
CMR/A — Follow-Up Assessment	This is a follow-up assessment of a member who is at a high risk of experiencing medical complications due to the drug regimen and has already received an initial assessment by the pharmacy.	UB	N/A	99606 for first 15 minutes; 99607 for each additional 15 minutes	$35	No	3/member/ rolling year

Topic #14777

Comprehensive Medication Review and Assessments — Reimbursement

Pharmacies will be reimbursed at $75 for the initial CMR/A (Comprehensive Medication Review and Assessment) and $35 for follow-up CMR/A.

For SeniorCare members, pharmacies are reimbursed directly for CMR/As 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 is reimbursed by the member. As a reminder, the pharmacy must obtain member consent for the CMR/A prior to providing the service.

Note: For a pharmacy to receive reimbursement for a CMR/A, the member must be enrolled in one of the covered programs on the DOS (date of service). Pharmacies are responsible for verifying the member's enrollment.

Topic #14557

Intervention-Based Services

ForwardHealth implemented an MTM (Medication Therapy Management) benefit in conjunction with the WPQC (Wisconsin Pharmacy Quality Collaborative). The MTM benefit consists of intervention-based services and CMR/As (Comprehensive Medication Review and Assessments).

Intervention-based services are voluntary face-to-face member assessments and interventions performed by a pharmacist. These services are provided to the member to optimize the member's response to medications or to manage treatment-related medication interactions or complications for both compound and noncompound drugs. Intervention-based services require prescriber approval before the service is performed, with the exception of focused adherence, medication device instruction, and in-home medication management.

Note: Only verbal consent from a member is required for intervention-based services; the member's signature is not required. If the member is a child or has physical or cognitive impairments that preclude the member from managing his or her own medications, a caregiver (e.g., caretaker relative, legal guardian, power of attorney, licensed health professional) may provide verbal consent on the member's behalf.

Intervention-based services may be any of the following types:

- Cost-effectiveness intervention — A cost-effectiveness intervention may be one or more of the following: formulary interchange, therapeutic interchange, tablet splitting opportunity, conversion to an OTC (over-the-counter) product, or dose consolidation.

- Three-month Supply intervention — Dispensing a three-month supply of drugs streamlines the prescription filling process for pharmacy providers and members, encourages the use of generic, maintenance drugs when medically appropriate for a member, and results in savings to ForwardHealth programs. If the pharmacy contacts the prescriber to amend the prescription, pharmacies are eligible to receive the reimbursement for this service. If the prescription is already prescribed for a three-month supply, pharmacies will not be eligible to receive the reimbursement. Providers may refer to the Three Month Supply Drugs data table for a list of drugs that may be dispensed in a three-month supply.

- Dose/dosage form/duration change intervention — Provides the opportunity to change the member's dose, dosage form, or duration of therapy based upon manufacturer recommended dose, organ function or age-appropriateness of dose;

insufficient or excessive duration or quantity of medication prescribed; sub-optimal dosage form prescribed; drug-drug interaction or drug-food interaction.

- Focused-adherence intervention — Consultation with a member regarding a significant lack of adherence in order to enhance the member's understanding of his or her medication regimen. An adherence tool or referral for a CMR/A may be provided if applicable. A focused adherence intervention may address possible drug misadministration, inability to correctly split tablets, presence of adverse drug reactions, misunderstanding of prescribed instructions, sharing of unauthorized medications, presence of an uncontrolled disease state, prescription of an inappropriate dosage form, concern relating to health literacy or another concern as determined by the pharmacist, and follow-up consultations on focused adherence for a member who has already received a focused adherence intervention. As a reminder, blister and pill card packaging will be reimbursed at the repackaging allowance rate.

  Providers are encouraged to follow up with members who have received a focused adherence intervention by calling them on the telephone to ensure they understand what was discussed during the service. These telephone calls are not separately reimbursable.

- Medication addition intervention — Recommendation of the addition of a medication based on clinical guidelines, indications, adverse drug reaction, contraindication, black box warning or FDA (Food and Drug Administration) safety alert, additive toxicity, drug-drug interaction, drug-food interaction, drug allergy, or other reason as determined by the pharmacist.

- Medication deletion intervention — Recommendation of the deletion of a medication based on clinical guidelines, indications, adverse drug reaction, contraindication, black box warning or FDA safety alert, additive toxicity, drug-drug interaction, drug-food interaction, drug allergy, or other reason as determined by the pharmacist.

- Medication device instruction intervention — Intensive pharmacist consultation lasting more than five minutes on any device associated with a medication and subsequent patient or caregiver demonstration of the device's use. This includes instructing a member to use a new medication device, correcting technique, patient or prescriber request for instruction, or another reason as determined by the pharmacist.

- In-home Medication Management — Provided for members who, due to a physical or mental health condition, are not able to pick up their medication and do not have a family or friend who can pick up the medication, and the medication cannot be mailed to the member's residence, requiring pharmacy staff to travel to the member's home to provide the medication. Examples of medication eligible for this type of intervention include pre-filled syringes, medication that must be refrigerated, or medication that must be stabilized. This intervention may also be used to assist members with device management in the home, such as automated medication dispensing devices. In-home medication management can only be reimbursed in conjunction with a focused adherence, medication device instruction intervention-based service, or a CMR/A. Claims submitted for In-Home Medication Management without a focused adherence intervention, medication device instruction intervention, or a CMR/A will be denied.

Three-month supply and in-home medication management are specific interventions only covered by ForwardHealth. Other WPQC participating payers do not include these services at this time.

Reimbursement

Reimbursement for MTM intervention-based services 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 ForwardHealth. Positive outcomes include increasing patient compliance or preventing potential adverse drug reactions. This fee reimburses pharmacists for additional actions they take beyond the standard dispensing and counseling for a prescription drug.

Coordination of Benefits

Commercial health insurance and Medicare Part D plans also have MTM programs. If a member is eligible for a commercial health insurance or Medicare Part D MTM program, the pharmacy provider is required to submit the claim to the member's commercial health insurance or Medicare Part D program before submitting the claim to ForwardHealth.

Pharmacies are responsible for COB (coordination of benefits). ForwardHealth is the payer of last resort.

A sample 1500 Health Insurance Claim Form depicting a scenario in which other health insurance was billed is available.

Sample 1500 Health Insurance Claim Form for Medication Therapy Management Services, with Other Insurance

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) X TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)	1a. INSURED'S I.D. NUMBER (For Program in Item 1): 1234567890
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): MEMBER, IM A	3. PATIENT'S BIRTH DATE MM DD YY: MM DD YY SEX M X F
4. INSURED'S NAME (Last Name, First Name, Middle Initial): SAME	
5. PATIENT'S ADDRESS (No., Street): 609 WILLOW ST	6. PATIENT RELATIONSHIP TO INSURED: Self Spouse Child Other
7. INSURED'S ADDRESS (No., Street)	
CITY: ANYTOWN STATE: WI	8. PATIENT STATUS: Single Married Other; Employed Full-Time Student Part-Time Student
CITY STATE	
ZIP CODE: 55555 TELEPHONE (Include Area Code): (444) 444-4444	ZIP CODE TELEPHONE (Include Area Code): ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): OI-P	10. IS PATIENT'S CONDITION RELATED TO:
11. INSURED'S POLICY GROUP OR FECA NUMBER	
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES NO
a. INSURED'S DATE OF BIRTH MM DD YY SEX M F	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F	b. AUTO ACCIDENT? YES NO PLACE (State)
b. EMPLOYER'S NAME OR SCHOOL NAME	
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES NO
c. INSURANCE PLAN NAME OR PROGRAM NAME	
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.	
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED DATE	13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED
14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY	
19. RESERVED FOR LOCAL USE	20. OUTSIDE LAB? YES NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line): 1. 250.01 3. 2. 4.	22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.
	23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	09 15 12				99605	U1	1	XX XX	1		NPI	
2	09 15 12				99607	U1	1	0 00	1		NPI	
3											NPI	
4											NPI	
5											NPI	
6											NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.: 1234JED	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO	28. TOTAL CHARGE $ XX XX
29. AMOUNT PAID $ XX XX	30. BALANCE DUE $ XX XX		
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) I.M. Provider SIGNED 09302012 DATE	32. SERVICE FACILITY LOCATION INFORMATION a. NPI b.	33. BILLING PROVIDER INFO & PH # ( ) I.M. PROVIDER 1 W WILLIAMS ST ANYTOWN WI 55555-1234 a. 0222222220 b. ZZ123456789X	

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

Topic #14637

Intervention-Based Services — Claim Submission

Claims for intervention-based services must be submitted fee-for-service on a professional claim by the pharmacy. In order to be

reimbursed for intervention-based services, the pharmacy must submit a professional claim using a valid CPT (Current Procedural Terminology) code and modifier via one of the following claims submission methods:

- 837 (837 Health Care Claim) transaction.
- PES (Provider Electronic Solutions) software.
- DDE (Direct Data Entry) Professional Claim.
- Paper 1500 Health Insurance Claim Form.

ForwardHealth reduces reimbursement on most claims submitted to ForwardHealth on paper. Most paper claims are subject to up to a $1.10 reimbursement reduction per claim.

Note: Cost-effectiveness, dose/dosage form/duration change, medication addition, medication deletion, and three-month supply intervention-based services are the only intervention-based services covered for members residing in a nursing facility.

Reimbursement limits for MTM (Medication Therapy Management) services are applied per member (not per pharmacy). Pharmacy providers are encouraged to submit claims for intervention-based services as soon as possible after provision of the service.

Quantity on Claims for New and Established Patients for Intervention-Based Services

When submitting claims for intervention-based services for a new patient, pharmacies should indicate CPT code 99605 with the appropriate modifier, with a quantity of "1" for the first 15 minutes. If an intervention-based service lasts longer than 15 minutes, pharmacies should indicate CPT code 99607, with the appropriate modifier on a separate detail, for each additional 15 minutes.

When submitting claims for intervention-based services for an established patient, pharmacies should indicate CPT code 99606 with the appropriate modifier, with a quantity of "1" for the first 15 minutes. If an intervention-based service lasts longer than 15 minutes, pharmacies should indicate 99607, with the appropriate modifier, for each additional 15 minutes.

Pharmacies should note the following when submitting claims for each additional 15 minutes of an intervention-based service using CPT code 99607:

- Procedure code 99607 must be listed on a separate detail line from the primary service code on claims for intervention-based services.
- Each claim detail must include the appropriate modifier.
- On the claim detail, each 15 minutes is equal to one unit (e.g., 30 minutes equals two units, 45 minutes equals three units, etc.). Providers should round up to the nearest 15 minutes when determining the number of units to bill. For example, if an intervention-based service lasts 21 minutes, pharmacies should round to 30 minutes on the claim.
- The claim detail should be submitted with a zero dollar amount. (Claim details for procedure code 99607 are paid $0 since reimbursement for intervention-based services occurs with procedure code 99605 or 99606.)

Claim details for procedure code 99607 that are billed with a zero dollar amount are placed in a "pay" status with an amount paid of $0.

Although procedure code 99607 will be reimbursed at zero dollars, pharmacies must submit details with the correct quantities to comply with correct coding practices.

Determination of New or Established Patient Status

When submitting claims for MTM services, pharmacies should note that a new patient is one who has *not* received any MTM services from the pharmacy within the past three years. An established patient is one who has received MTM services from the pharmacy within the past three years. The CPT procedure code that a provider uses to bill the first 15 minutes of an MTM service

indicates whether the member is a new (procedure code 99605) or an established (procedure code 99606) patient.

Providers billing multiple MTM services for any one member on the same DOS (date of service) are reminded to use the appropriate CPT procedure code for that DOS. Claims will be denied if the member is indicated as both a new patient and an established patient on the same DOS.

Note: The DOS is defined as the date the medication was dispensed, if applicable (e.g., for a cost-effectiveness intervention), or the date the member received the MTM service (e.g., for a medication deletion intervention).

Multiple Medication Therapy Management Services of the Same Type on the Same Day for the Same Member

When a pharmacy performs the same type of MTM service more than once for the same member on the same day, the services must be listed as separate claim details. For example, if a pharmacist converts two of a member's prescriptions to a three-month supply on the same day, the pharmacist would list each three-month supply conversion as a separate claim detail, as shown on the sample 1500 Health Insurance Claim Form.

Medication Addition and Deletion Interventions

If a medication addition intervention and a medication deletion intervention occur at the same time *and* one medication is replacing another, providers should submit a claim only for the medication addition.

If a medication addition intervention and a medication deletion intervention occur at the same time *but* are unrelated, providers may bill separately for the interventions, either on separate detail lines or on separate claims.

Sample 1500 Health Insurance Claim Form for Intervention-Based Services

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) MEDICAID [X] (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)	1a. INSURED'S I.D. NUMBER (For Program in Item 1): 1234567890
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): MEMBER, IM A	3. PATIENT'S BIRTH DATE MM DD YY: MM DD YY; SEX: M [X] F [ ]
4. INSURED'S NAME (Last Name, First Name, Middle Initial): SAME	
5. PATIENT'S ADDRESS (No., Street): 609 WILLOW ST	6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]
7. INSURED'S ADDRESS (No., Street)	
CITY: ANYTOWN; STATE: WI	8. PATIENT STATUS: Single [ ] Married [ ] Other [ ]; Employed [ ] Full-Time Student [ ] Part-Time Student [ ]
CITY; STATE	
ZIP CODE: 55555; TELEPHONE (Include Area Code): (444) 444-4444	
ZIP CODE; TELEPHONE (Include Area Code): ( )	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:
11. INSURED'S POLICY GROUP OR FECA NUMBER	
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES [ ] NO [ ]
a. INSURED'S DATE OF BIRTH MM DD YY; SEX M [ ] F [ ]	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY; SEX M [ ] F [ ]	b. AUTO ACCIDENT? YES [ ] NO [ ] PLACE (State)
b. EMPLOYER'S NAME OR SCHOOL NAME	
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES [ ] NO [ ]
c. INSURANCE PLAN NAME OR PROGRAM NAME	
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] *If yes*, return to and complete item 9 a-d.	
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____	13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____
14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. ; 17b. NPI
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY	
19. RESERVED FOR LOCAL USE	20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. L 250 . 01 3. _____ 2. _____ 4. _____	22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.
	23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 09 15 12			99605	U1	1	XX XX	1		NPI	
2 09 15 12			99607	U1	1	0 00	1		NPI	
3 09 15 12			99605	U2	1	XX XX	1		NPI	
4 09 15 12			99605	U2	1	XX XX	1		NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [ ] NO [ ]	28. TOTAL CHARGE $ XX XX	29. AMOUNT PAID $	30. BALANCE DUE $ XX XX
	1234JED				

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # ( )
I. M. Provider 09302012 SIGNED DATE	a. NPI b.	I.M. PROVIDER 1 W WILLIAMS ST ANYTOWN WI 55555-1234 a. 0222222220 b. ZZ123456789X

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

Topic #14577

Intervention-Based Services — Documentation Requirements

The following documentation is required for intervention-based services and must be maintained by the pharmacy in the member's file or on the prescription:

- Member information.
  - Member name.
  - Does the member currently reside in a nursing home?
- Prescriber name and NPI (National Provider Identifier).
- Prescription number.
- DOS (Date of service) for the intervention-based service. The DOS is defined as the date the medication was dispensed, if applicable (e.g., for a cost-effectiveness intervention), or the date the member received the MTM (Medication Therapy Management) service (e.g., for a medication deletion intervention).
- Member consent for the service, indicated by the member's signature and date.
- Indication of whether or not the prescriber was contacted.
- If yes, the date the prescriber was contacted.
- Indication of the time spent on service (in minutes). Include the time spent providing and documenting the service. (Pharmacies are required to document both face-to-face and administrative time for intervention-based services in their records; however, providers may only bill for face-to-face time on claims.)
- Pharmacist signature and date on the documentation.

Pharmacies are required to document the following information specific to intervention types:

- Cost-effectiveness intervention — Identify the assessment performed, the current therapy, and the recommended therapy. Did the prescriber accept the change?
- Three-month supply intervention — Name of the drug. Did the prescriber accept or decline?
- Dose/dosage form/duration change intervention.
  - Name of the drug involved.
  - Dose — The strength was changed from, the strength was changed to, and the reason for the change.
  - Dosage Form — The dosage form of drug was changed from, the dosage form of drug was changed to, and the reason for change.
  - Duration Change — Duration of drug therapy was changed from and the duration to which the drug therapy was changed.
  - Reason for the change.
  - Did the prescriber accept the change?
- Focused adherence intervention.
  - Name of the drug(s) involved.
  - What is the adherence issue (e.g., late or early refill) and the adherence intervention or education provided?
- Medication addition intervention.
  - Name of the drug added.
  - Reason for the drug addition?
  - Did the prescriber accept the addition?
- Medication deletion intervention.
  - Name of the drug deleted.
  - Reason for the drug deletion.
  - Did the prescriber accept the deletion?
- Medication device instruction intervention — Name of drug or device the member was trained to use.
- In-home medication management intervention — Reason for the service.

When applicable, providers should include the post-intervention prescription number in documentation.

Pharmacies may use any format to document intervention-based services, but that format must include all of the aforementioned elements. Documentation must be made available to ForwardHealth upon request. Refer to the Intervention-Based Service Documentation example for a sample of acceptable documentation.

INTERVENTION-BASED SERVICE DOCUMENTATION EXAMPLE

SECTION I — MEMBER INFORMATION

Name — Member (Last, First, Middle Initial)
Ima M. Ember

Member Identification Number	Is the member currently residing in a nursing home?
0123456789	❑ Yes ☒ No

SECTION II — PRESCRIPTION INFORMATION

Prescriber Name	Prescriber National Provider Identifier
Dr. John Smith	02222222220
RX Number	Intervention-Based Date of Service
0000000001	September 2, 2012

Was member consent obtained? ☒ Yes ❑ No

Was the prescriber contacted? ☒ Yes ❑ No

If yes, date the prescriber was contacted: September 15, 2012.

SECTION III —INTERVENTION-BASED SERVICE PERFORMED (CHECK ONE)

☒ Cost-Effectiveness

Agent Switched from Nexium 40mg to pantoprazole 40mg.

Did the prescriber accept the changes? ☒ Yes ❑ No

❑ Three-Month Supply (Limited to One Override, Per Drug, Per Rolling Year)

Name of Drug: _____.

_____.

Did the prescriber accept the changes? ❑ Yes ❑ No

❑ Dose/Dosage Form/ Duration Change

Drug Involved _____

❑ Dosage strength changed from _____ to _____.

❑ Dosage form of drug changed from _____ to _____.

❑ Duration of drug therapy changed from _____to _____.

Reason for Change _____

Did the prescriber accept the changes ❑ Yes ❑ No

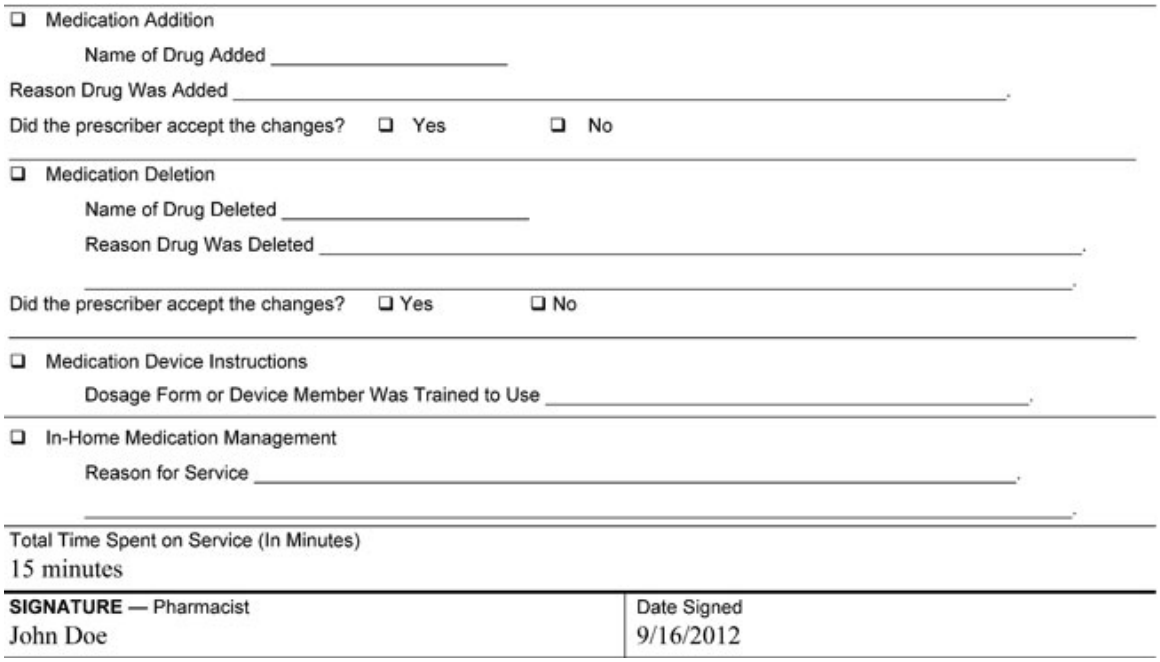
❑ Focused Adherence

Drug(s) Involved _____

Adherence Issue _____

Adherence Intervention / Education Provided _____

_____



❑ Medication Addition

Name of Drug Added _____

Reason Drug Was Added _____.

Did the prescriber accept the changes? ❑ Yes ❑ No

❑ Medication Deletion

Name of Drug Deleted _____

Reason Drug Was Deleted _____.

_____.

Did the prescriber accept the changes? ❑ Yes ❑ No

❑ Medication Device Instructions

Dosage Form or Device Member Was Trained to Use _____.

❑ In-Home Medication Management

Reason for Service _____.

_____.

Total Time Spent on Service (In Minutes)

15 minutes

SIGNATURE — Pharmacist	Date Signed
John Doe	9/16/2012

Topic #14597

Intervention-Based Services — Limitations

Intervention-based services have the following limits:

- Four of the same intervention-based services are reimbursable per member, per rolling year, with the exception of the cost-effectiveness intervention and three-month supply intervention. Claims for intervention-based services exceeding the limit will be denied.
- The cost-effectiveness intervention does not have a service limitation.
- Three-month supply interventions are limited to one intervention, per drug, per rolling year.
- Cost-effectiveness, dose/dosage form/duration change intervention, medication addition, medication deletion, and three-month supply are the only intervention-based services covered for members residing in nursing homes.

Policy Override to Exceed Intervention-Based Service Limitations

If a member requires more than four of the same intervention-based services per rolling year, pharmacies must contact the DAPO (Drug Authorization and Policy Override) Center to request a policy override.

The pharmacy may be granted a policy override to exceed the limit for an intervention-based service if the pharmacy demonstrates that the member has an appropriate medical need. Examples of when an intervention-based service override request may be approved through the DAPO Center include, but are not limited to, the following:

- The member is unable to fill his or her insulin syringes, does not have a caregiver who can fill the syringes, and the insulin is not available in a pen. The pharmacy provides the member with pre-filled syringes under the focused adherence intervention, but the member has met the limit of four times per rolling year for this intervention and requires additional assistance. The pharmacy may request a policy override to exceed the four times per rolling year limit for the focused adherence intervention.
- The pharmacy learns that the prescriber has prescribed an excessive quantity of a medication for a child, and the pharmacy would like to perform the Dose/Dosage Form/Duration Change Intervention to change the child's dose, but the member has

already met his limit of four Dose/Dosage Form/Duration Change Intervention services per rolling year for this intervention. The pharmacy may request a policy override to exceed the yearly limit in order to provide this service.

When calling the DAPO Center to request an intervention-based service limitation override, pharmacies should have the following information, similar to the documentation requirements, on hand:

- Member information.
- Pharmacy information.
- Service requested.
- Drugs involved.
- Reason for the override request.
- Number of services beyond the yearly limit that are required.

If the DAPO Center denies the policy override, the intervention-based service is considered a noncovered service. 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.

Topic #14617

Intervention-Based Services-Procedure Codes and Modifiers

Claims submitted for intervention-based services must be submitted with one of the following CPT (Current Procedural Terminology) codes:

- 99605 — Medication therapy management service(s) provided by a pharmacist, individual, face-to-face with patient, with assessment and intervention if provided; initial 15 minutes, new patient.
- 99606 — Medication therapy management service(s) provided by a pharmacist, individual, face-to-face with patient with assessment and intervention if provided; initial 15 minutes, established patient.
- 99607 — Medication therapy management service(s) provided by a pharmacist, individual, face-to-face with patient, with assessment and intervention if provided; each additional 15 minutes (list separately in addition to code for primary service).

Procedure codes submitted for intervention-based services must be submitted with one of the following modifiers:

- U1 — Cost Effectiveness Intervention.
- U2 — Three Month Supply Intervention.
- U3 — Dose/Dosage form/Duration Change Intervention.
- U4 — Focused Adherence Intervention.
- U5 — Medication Addition Intervention.
- U6 — Medication Deletion Interventions.
- U7 — Medication Device Instruction Intervention.
- U8 — In-home Medication Management Intervention.

Pharmacies should submit one procedure code and modifier per detail line. Claim details without the appropriate modifier will be denied.

CPT Code	Description

99605	Medication therapy management service(s) provided by a pharmacist, individual, face-to-face with patient, with assessment and intervention if provided; initial 15 minutes, new patient
99606	initial 15 minutes, established patient
99607	each additional 15 minutes (List separately in addition to code for primary service)

Intervention-Based Procedure Codes and Modifiers

Type of Intervention	Description	Modifier	CPT Code for New Patient	CPT Code for Established Patient	Reimbursement Rate	Payable for nursing home residents?	Limit
Cost-Effectiveness	Formulary interchange, therapeutic interchange, conversion to an over-the-counter product; tablet splitting opportunity; dose consolidation.	U1	99605 for first 15 minutes; 99607 for each additional 15 minutes	99606 for first 15 minutes; 99607 for each additional 15 minutes	$30	Yes	Unlimited
Three-Month Supply	Switching from one-month supply to three-month supply.	U2	99605 for first 15 minutes; 99607 for each additional 15 minutes	99606 for first 15 minutes; 99607 for each additional 15 minutes	$10	Yes	1/ drug/ rolling year
Dose/Dosage Form/Duration Change Intervention	Opportunity to change patient's dose, dosage form, or duration of therapy based on manufacturer recommended dose, organ function or age-appropriateness of dose; insufficient or excessive duration or quantity of medication prescribed; sub-optimal dosage form prescribed; drug-drug interaction or drug-food interaction.	U3	99605 for first 15 minutes; 99607 for each additional 15 minutes	99606 for first 15 minutes; 99607 for each additional 15 minutes	$30	Yes	4/member/ rolling year
Focused Adherence Intervention	Consultation with a patient regarding a significant lack of adherence in order to enhance the patient's understanding of his or her medication regimen.	U4	99605 for first 15 minutes; 99607 for each additional 15 minutes	99606 for first 15 minutes; 99607 for each additional 15 minutes	$30	No	4/member/ rolling year
Medication Additions Intervention	Adding a drug based on clinical concerns.	U5	99605 for first 15 minutes; 99607 for	99606 for first 15 minutes; 99607 for	$30	Yes	4/member/ rolling year

			each additional 15 minutes	each additional 15 minutes			
Medication Deletions Interventions	Deletion of a drug based on clinical concerns.	U6	99605 for first 15 minutes; 99607 for each additional 15 minutes	99606 for first 15 minutes; 99607 for each additional 15 minutes	$30	Yes	4/member/ rolling year
Medication Device Instruction Intervention	Intensive pharmacist consultation lasting more than five minutes on any device associated with a medication and subsequent patient or caregiver demonstration of the device's use.	U7	99605 for first 15 minutes; 99607 for each additional 15 minutes	99606 for first 15 minutes; 99607 for each additional 15 minutes	$30	No	4/member/ rolling year
In-Home Medication Management	Provided to assist members who, due to a physical or mental health condition, are not able to pick up their medication and do not have family members or friends who can pick up medication, or require device management. In-home medication management can only be reimbursed in conjunction with a focused adherence or medication device instruction, intervention-based service, or CMR/A (Comprehensive Medication Review and Assessment).	U8	99605 for first 15 minutes; 99607 for each additional 15 minutes	99606 for first 15 minutes; 99607 for each additional 15 minutes	$10	No	4/member/ rolling year

Topic #14657

Intervention-Based Services — Reimbursement

All intervention-based services, with the exception of in-home medication management and three-month supply, will be reimbursed at $30 per intervention. In-home medication management and three-month supply intervention will be reimbursed at $10 per intervention.

Note: In order for pharmacies to receive reimbursement for an intervention-based service, the member must be enrolled in one of the covered programs on the DOS (date of service). Pharmacies are responsible for verifying the member's enrollment. The DOS is defined as the date the medication was dispensed, if applicable (e.g., for a cost-effectiveness intervention), or the date the member received the MTM (Medication Therapy Management) service (e.g., for a medication deletion intervention).

For SeniorCare members, pharmacies are reimbursed directly for intervention-based services 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 is reimbursed by the member. As a reminder, the pharmacy must obtain member consent for the intervention-based service prior to providing the service.

Reimbursement for Three-Month Supply Interventions

Pharmacy providers will only receive reimbursement for three-month supply interventions if the intervention resulted in conversion of the prescription to a three-month supply. If the pharmacy provider contacted the prescriber to amend the prescription, but the prescription was not converted to a three-month supply, the pharmacy provider is not eligible to receive reimbursement for the intervention.

Topic #14537

Medication Therapy Management Coordination

Pharmacies are responsible for COB (coordination of benefits) for both intervention-based services and CMR/A (Comprehensive Medication Review and Assessment) MTM (Medication Therapy Management) services.

Topic #15199

Medication Therapy Management Services — Face-to-Face with Member or Caregiver

MTM (Medication Therapy Management) services must be provided face-to-face with the member whenever possible. If the member is a child or has physical or cognitive impairments that preclude the member from managing his or her own medications, MTM services may be provided face-to-face to a caregiver (e.g., caretaker relative, legal guardian, power of attorney, licensed health professional) on the member's behalf.

Topic #15198

Medication Therapy Management Services — Member Eligibility

The MTM (Medication Therapy Management) benefit is covered for members enrolled in the following programs:

- The BadgerCare Plus Standard Plan.
- The BadgerCare Plus Benchmark Plan.
- The BadgerCare Plus Core Plan.
- The BadgerCare Plus Basic Plan.
- SeniorCare.
- Wisconsin Medicaid.

Note: MTM services are reimbursed fee-for-service for all eligible members, including those enrolled in state-contracted managed care organizations. Pharmacy providers should submit fee-for-service claims directly to ForwardHealth for reimbursement.

Topic #14797

Medication Therapy Management Services — Place of Service Codes

The following POS (place of service) codes are allowed for intervention-based and CMR/A (Comprehensive Medication Review and Assessment) services:

- 01 — Pharmacy.
- 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.
- 13 — Assisted Living Facility.
- 14 — Group Home.
- 16 — Temporary Lodging.
- 17 — Walk-in Retail Health Clinic.
- 22 — Outpatient Hospital.**
- 31 — Skilled Nursing Facility.*
- 32 — Nursing Facility.*
- 49 — Independent Clinic.
- 50 — Federally Qualified Health Center.
- 54 — Intermediate Care Facility/Mentally Retarded.*
- 56 — Psychiatric Residential Treatment Center.
- 57 — Non-residential Substance Abuse Treatment Facility.
- 71 — Public Health Clinic.
- 72 — Rural Health Clinic.

* These POS codes are only allowed for cost effectiveness, dose/dosage form/duration change, medication addition, medication deletion, and three-month supply intervention-based services.

** When a pharmacist performs a CMR/A service in an outpatient hospital setting, ForwardHealth does not reimburse the facility charge.

Topic #15197

Medication Therapy Management Services — Referrals

Any licensed health professional who is Medicaid-enrolled and authorized to prescribe drugs can be a referring provider for covered MTM (Medication Therapy Management) services.

Noncovered Services

Topic #10917

"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.

Topic #9337

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.
- CRS (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 (private duty nursing)).
- Inpatient mental health and substance abuse treatment services.
- Non-emergency transportation (i.e., common carrier, SMV (specialized medical vehicle)).
- Nursing home.
- Obstetrical care and delivery.
- Outpatient mental health and substance abuse services.
- PNCC (prenatal care coordination).
- Provider-administered drugs.
- Routine vision examinations billed with CPT (Current Procedural Terminology) 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 (school-based services).
- 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.

Topic #68

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.

Topic #9397

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.

Topic #5717

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 (prior authorization) is not available for drugs that are not included on the BadgerCare Plus Benchmark Plan Product List, the BadgerCare Plus Core Plan Product List, or the BadgerCare Plus Core Plan Brand Name Drugs Quick Reference. 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 an intervention-based service 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 with questions and concerns about drug coverage to Member Services.

Topic #104

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 (Centers for Medicare and Medicaid Services) 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 for NEMT (non-emergency medical transportation) services. Most members may receive NEMT services through LogistiCare. Refer to the NEMT service area for more information.
- 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

Topic #8997

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 (prior authorization) 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.

Topic #7117

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

Topic #9797

Excluded Pharmaceutical Care Codes

Certain PC (Pharmaceutical Care) codes on the PC Worksheet for Payable Codes and the PC Reason Codes and Billing Information are excluded for members in nursing facilities.

Wisconsin Medicaid Pharmaceutical Care Worksheet for Payable Codes

Providers may use the following tables to assist in determining billing codes for Pharmaceutical Care (PC) dispensing fees. Not all code combinations are recognized as PC activities and not all recognized PC activities result in allowable PC dispensing fees. Pharmaceutical Care codes are only billable when they represent activity beyond that required under Omnibus Budget Reconciliation Act of 1987 (OBRA '87) and OBRA '90 and when they deal with issues of patient compliance, safety, or efficacy that result in a positive outcome.

Reason for provision of Pharmaceutical Care

☐ AD	(60)	Additional Drug Recommended	☐ LK	(66)	Lock-in Recipient √
☐ AN	(10)	Forgery Possible (Prescription Authentication) √	☐ LR	(25)	Late Refill (Under Use) √
			☐ MN	(30)	Insufficient Duration
			☐ MX	(22)	Excessive Duration √
			☐ NN	(80)	Unnecessary Drug √
☐ AR	(61)	Adverse Drug Reaction √	☐ NS	(32)	Insufficient Quantity
☐ AT	(40)	Additive Toxicity	☐ PS	(17)	Product Selection Opportunity
☐ CD	(71)	Chronic Disease Mgt. — Asthma	☐ RE	(84)	Suspected Environmental Risk (In-home Management)
☐ CS	(63)	Patient Complaint/ Symptom			
☐ DA	(41)	Drug Allergy	☐ SC	(83)	Suboptimal Compliance
☐ DD	(44)	Drug-Drug Interaction	☐ SE	(95)	Side-Effect Precaution (Side Effect) √
☐ DI	(45)	IV Drug Incompatibility			
☐ DM	(65)	Possible Drug Misuse √	☐ SF	(34)	Suboptimal Dose Form
☐ ER	(20)	Early Refill √	☐ SR	(36)	Suboptimal Regimen
☐ EX	(21)	Excessive Quantity	☐ TD	(59)	Therapeutic Duplication
☐ HD	(23)	High Dose	☐ TN	(85)	Lab Test Needed √
☐ LD	(33)	Low Dose	☐	√	**Not Billable For Nursing Home Residents**

Action taken by pharmacist

☐ AS	(20)	Patient Assessment	☐ RT	(30)	Recommend Lab Test
☐ CC	(21)	Coordination of Care	☐ TC	(15)	Payer/Processor Contacted
☐ M0	(22)	MD Contacted (Prescriber Consulted)	☐ TH	(12)	Therapeutic Product Interchange*
☐ MR	(23)	Medication Review			*** Action Requires Prescriber Authorization**
☐ PE	(25)	Patient Education			
☐ R0	(29)	R.Ph. Consult Other Contacted			

Result of action

☐ 1C	(12)	Filled, Different Dose	☐ 2A	(30)	NOT Filled
☐ 1D	(13)	Filled, Different Directions	☐ 3K	(85)	Instructions Understood
			☐ 3M	(80)	Compliance Aid Developed (Distribution System)
☐ 1E	(14)	Filled, Different Drug			
☐ 1F	(15)	Filled, Different Quantity			
☐ 1K	(18)	Filled, Dose Form Change			

Level

☐ 11	0 through 5 minutes
☐ 12	6 through 15 minutes
☐ 13	16 through 30 minutes
☐ 14	31 through 60 minutes
☐ 15	61+ minutes

Use alphanumeric values for real-time and paper claims. Pharmaceutical Care cannot be billed through electronic media claims.

Topic #2011

Nursing Facility Daily Rate Covered Items

Providers may find a list of items covered in the nursing facility daily rate in the Methods of Implementation For Wisconsin Medicaid Nursing Home Payment Rates. Wisconsin Medicaid retains authority under s. 49.45(10), Wis. Stats., to amend, modify, or delete items on the list.

Lists of OTC (over-the-counter) drugs and diabetic supplies included in the nursing home daily rate are available.

Topic #2010

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, Medicaid, or SeniorCare. Wisconsin Medicaid retains 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 (prior authorization) *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).

Topic #2009

Purchasing Items for Nursing Facility Members

There are three ways pharmacy items can be purchased for members 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 or Wisconsin Medicaid pharmacy claim — Claims for prescribed, covered drugs and certain OTC (over-the-counter) products (except OTCs included in the nursing facility daily rate) must be submitted using the POS (Point-of-Sale) system, using PES (Provider Electronic Solutions) software, on the ForwardHealth Portal, or on paper.

  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 (prior authorization) for a specific member.
  - Sundry items such as cough drops, cigarettes, candy, and alcoholic beverages.

Topic #2008

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 (date of service) (e.g., July 14).

Topic #2007

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, 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 $5.00 per prescription. Pharmacies may not accept returned medications from nursing facilities unless they credit all reusable medications. BadgerCare Plus, Medicaid, 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 ForwardHealth 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 (F-13046 (07/12)) to change the quantity on the allowed claim.

Pharmacy providers who choose not to reverse or adjust the original claim must refund ForwardHealth by check. If this option is chosen, the pharmacy must remit a check to ForwardHealth 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
313 Blettner Blvd
Madison WI 53784

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 (internal control numbers) 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.

Managed Care

4

Archive Date:04/01/2013

Managed Care:Claims

Topic #385

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 (health maintenance organization) or SSI (Supplemental Security Income) 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 (F-12022 (03/09)) 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.

Topic #384

Appeals to HMOs and SSI HMOs

Providers are required to first file an appeal directly with the BadgerCare Plus HMO (health maintenance organization) or Medicaid SSI (Supplemental Security Income) 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.

Topic #386

Claims Submission

BadgerCare Plus HMOs (health maintenance organizations) and Medicaid SSI (Supplemental Security Income) 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.

Topic #387

Extraordinary Claims

Extraordinary claims are BadgerCare Plus or Medicaid claims for a BadgerCare Plus HMO (health maintenance organization) or Medicaid SSI (Supplemental Security Income) 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

Topic #388

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 (health maintenance organization) or Medicaid SSI (Supplemental Security Income) 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.

Topic #389

Provider Appeals

When a BadgerCare Plus HMO (health maintenance organization) or Medicaid SSI (Supplemental Security Income) 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 HMO 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

Topic #390

Covered Services

HMOs

HMOs (health maintenance organizations) are required to provide at least the same benefits as those provided under fee-for-service arrangements. Although ForwardHealth requires contracted HMOs and Medicaid SSI (Supplemental Security Income) 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.

Topic #391

Noncovered Services

The following are not covered by BadgerCare Plus HMOs (health maintenance organizations) or Medicaid SSI (Supplemental Security Income) HMOs but are provided to enrollees on a fee-for-service basis provided the member's fee-for-service plan covers the service:

- CRS (Community Recovery Services).
- CSP (Community Support Program) benefits.
- Crisis intervention services.
- Environmental lead inspections.
- CCC (child care coordination) services.
- Pharmacy services and diabetic supplies.
- PNCC (prenatal care coordination) services.
- Provider-administered drugs, including all "J" codes, drug-related "Q" codes, and a limited number of related administration codes.
- SBS (school-based services).
- Targeted case management services.
- NEMT (non-emergency medical transportation) services for most Wisconsin Medicaid and BadgerCare Plus members. Wisconsin Medicaid and BadgerCare Plus members who are enrolled in an HMO in Milwaukee, Waukesha, Washington, Ozaukee, Kenosha, and Racine counties receive NEMT services from their respective HMOs.
- DOT (directly observed therapy) and monitoring for TB-Only (Tuberculosis-Only Related Services).

Topic #13877

Striving to Quit Initiative — First Breath

Background Information

According to the CDC (Centers for Disease Control and Prevention), almost one million individuals in Wisconsin smoke every day. While the smoking rate for adults overall in the state is about 20 percent, the rate is higher — about 33 percent — for BadgerCare Plus members. Wisconsin Medicaid has received a five-year $9.2 million grant from the CMS (Centers for Medicare and Medicaid Services) to help BadgerCare Plus members enrolled in participating HMOs (health maintenance organizations) to quit smoking through the Striving to Quit initiative. Striving to Quit includes the following separate, evidence-based programs:

- Wisconsin Tobacco Quit Line (i.e., Quit Line), which offers telephone counseling to eligible members who smoke.
- First Breath, which targets eligible pregnant women who smoke by connecting them to trained tobacco cessation counselors for face-to-face tobacco cessation counseling.

First Breath

The First Breath program offers eligible pregnant women who smoke (or who have quit smoking in the last six months) face-to-face tobacco cessation counseling during their prenatal care visits and up to five face-to-face counseling visits plus additional telephone calls for support during the postpartum phase. To participate in the First Breath program, members may be referred to First Breath by their prenatal care provider or may independently call First Breath without a referral at (800) 448-5148. Members who participate in First Breath via Striving to Quit may be eligible to receive financial incentives of up to $160.00 for participation in treatment and for quitting smoking.

Enrollment Criteria

To be eligible to receive enhanced services from the First Breath program via Striving to Quit, BadgerCare Plus members must meet the following criteria:

- Be enrolled in the BadgerCare Plus Standard Plan or the BadgerCare Plus Benchmark Plan.
- Be a pregnant smoker.
- Express an interest in quitting smoking.
- Be enrolled in one of the following HMOs:
    - Children's Community Health Plan.
    - CommunityConnect HealthPlan.
    - Managed Health Services.
    - MercyCare Health Plans.
    - Molina Health Care.
    - Network Health Plan.
    - Physicians Plus Insurance Corporation.
    - Unity Health Plans Insurance Corporation.
- Reside in one of the following counties:
    - Dane.
    - Kenosha.
    - Milwaukee.
    - Racine.
    - Rock.

Covered Services

The following services are covered by Striving to Quit via First Breath:

- Up to 10 one-on-one counseling sessions during regular prenatal care appointments by First Breath providers.
- Five one-on-one counseling sessions with a trained First Breath Health Educator following delivery.
- Up to six telephone calls with the First Breath Health Educator following delivery.

Provider Responsibilities

Providers are responsible for screening pregnant BadgerCare Plus HMO members for smoking and enrolling them in the First Breath program or referring members to the First Breath program.

Clinics that currently provide First Breath services are responsible for the following:

- Screening for smoking and enrolling members in First Breath.
- Encouraging members to enroll in Striving to Quit.
- Providing regular First Breath counseling during prenatal care visits.
- Completing First Breath data forms and submitting the forms via fax to (608) 251-4136 or mail to the following address:

  Wisconsin Women's Health Foundation
  2503 Todd Dr
  Madison WI 53713

Clinics that do not currently provide First Breath smoking cessation services should refer members to First Breath.

Screening and Making Referrals

For clinics that currently provide First Breath services, there are no changes to current procedures.

The following language is suggested for providers to use to encourage members to enroll in First Breath:

> One of the benefits of enrolling in First Breath now is that you may be eligible to participate in a stop smoking study that provides free counseling services to help you quit and will pay you for taking part in certain activities. You can learn more about the program when someone from the First Breath office calls you or when you call them.

Clinics that do not currently provide First Breath services should encourage pregnant BadgerCare Plus members to seek help to quit by using the above language. Clinic staff or the member may call the First Breath program at (800) 448-5148, extension 112, for help in finding a First Breath provider in the member's area. Members may also visit the First Breath Web site to locate a First Breath provider.

Becoming a First Breath Site

Clinics not currently providing First Breath services may become First Breath sites by calling the First Breath Coordinator at (800) 448-5148, extension 112, or by visiting the First Breath Web site. Providers will need to complete four hours of training to provide First Breath services. Training is free and provided by First Breath coordinators on site. Becoming a First Breath site allows all pregnant BadgerCare Plus and Medicaid members to be served during their regular prenatal care visits.

After becoming a First Breath site, clinics will need to do the following:

- Provide evidence-based cessation counseling during regular prenatal care.
- Complete enrollment and other data forms.
- Distribute small, non-cash gifts supplied by the First Breath program.

For More Information

For more information about Striving to Quit, providers should contact their HMO representative, visit the ForwardHealth Portal, or e-mail Striving to Quit at *dhsstqinfo@wisconsin.gov*.

For more information or for technical assistance questions regarding the Quit Line, providers may visit the UW-CTRI (University

of Wisconsin Center for Tobacco Research and Intervention) Web site.

For more information or for technical assistance questions regarding First Breath, providers may call First Breath at (800) 448-5148, extension 112, or visit the First Breath Web site.

Topic #13857

Striving to Quit Initiative — Wisconsin Tobacco Quit Line

Background Information

According to the CDC (Centers for Disease Control and Prevention), almost one million individuals in Wisconsin smoke every day. While the smoking rate for adults overall in the state is about 20 percent, the rate is higher — about 33 percent — for BadgerCare Plus members. Wisconsin Medicaid has received a five-year $9.2 million grant from the CMS (Centers for Medicare and Medicaid Services) to help BadgerCare Plus members enrolled in participating HMOs (health maintenance organizations) to quit smoking through the Striving to Quit initiative. Striving to Quit includes the following separate, evidence-based programs:

- Wisconsin Tobacco Quit Line (i.e., Quit Line), which offers telephone counseling to eligible members who smoke.
- First Breath, which targets eligible pregnant women who smoke by connecting them to trained tobacco cessation counselors for face-to-face tobacco cessation counseling.

Wisconsin Tobacco Quit Line

Striving to Quit offers eligible members who smoke enhanced tobacco cessation treatment from the Quit Line. Members who participate in Striving to Quit qualify for at least five smoking cessation counseling calls from the Quit Line and appropriate tobacco cessation medications covered by Wisconsin Medicaid. To participate in Striving to Quit, members may be referred to the Quit Line by their provider or may independently call the Quit Line without a referral at (800) QUIT-NOW (784-8669).

Striving to Quit members using the Quit Line may be eligible to receive financial incentives of up to $120.00 for participation in treatment and for quitting smoking. Striving to Quit requires members who participate in Quit Line treatment services to take a biochemical test to confirm smoking status at initial enrollment, six months post-enrollment, and 12 months after enrollment in the initiative.

Enrollment Criteria

To be eligible to receive enhanced services from the Quit Line via Striving to Quit, members must meet the following criteria:

- Be enrolled in BadgerCare Plus Standard Plan or BadgerCare Plus Benchmark Plan.
- Be 18 years of age and older.
- Be a smoker and express an interest in quitting smoking.
- Be enrolled in one of the following HMOs:
    - Children's Community Health Plan.
    - Compcare.
    - Group Health Cooperative of Eau Claire.
    - Managed Health Services.
    - MercyCare Health Plans.
    - Molina Health Care.
    - Network Health Plan.
    - Physicians Plus Insurance Corporation.

- UnitedHealthcare Community Plan.
- Unity Health Plans Insurance Corporation.
- Reside in one of the following counties:
    - Dodge.
    - Fond du Lac.
    - Jefferson.
    - Sheboygan.
    - Calumet.
    - Columbia.
    - Door.
    - Florence.
    - Grant.
    - Green.
    - Iowa.
    - Kewaunee.
    - Lafayette.
    - Manitowoc.
    - Marinette.
    - Menominee.
    - Oconto.
    - Rock.
    - Sauk.
    - Walworth.
    - Waupaca.
    - Brown.
    - Dane.
    - Outagamie.
    - Winnebago.

Covered Drugs and Services

The following drugs and services are covered by Striving to Quit or Medicaid:

- Up to five cessation counseling calls to the Quit Line plus additional calls initiated by the member are covered by Striving to Quit.
- Tobacco cessation medications and biochemical testing to confirm smoking status are covered by Medicaid.

Provider Responsibilities

For members seeking Striving to Quit services from the Quit Line, providers are responsible for the following:

- Screening for smoking and referring potentially eligible members who smoke to the Quit Line.
- Conducting biochemical tests (i.e., urine cotinine tests).
- Writing prescriptions for tobacco cessation drugs for members, as appropriate.
- Working with the Quit Line, completing Striving to Quit referral forms for member referrals, writing tobacco cessation prescriptions, and faxing biochemical test results and forms to the Quit Line.
- Identifying one or two key staff members in a clinic or practice who will serve as points of contact for Striving to Quit and assist with coordinating the biochemical tests and other tasks as needed.

Screening and Making Referrals

The following language is suggested for providers to use to encourage members who smoke to agree to a referral or to call the

Quit Line themselves:

> One of the benefits of calling the Quit Line now is that you may be eligible to participate in a stop smoking study that provides free counseling services to help you quit and will pay you for taking part in certain activities. I would be happy to make a referral for you. If you are interested, all we need to do is a simple urine test to confirm that you smoke. After I send the paperwork, someone from the Quit Line will call you to tell you more about the study or you can call them directly at the number on the card. If you do not want to be in the study, you may still get some services from the Quit Line.

Providers should ask HMO members living in targeted counties if they may refer the member to the Quit Line. If a member is referred to the Quit Line, providers should submit a Striving to Quit Referral form signed by the member to the Quit Line via fax at (877) 554-6643. Striving to Quit Referral forms are available on the UW-CTRI's (University of Wisconsin Center for Tobacco Research and Intervention) Striving to Quit Web site or on the ForwardHealth Portal. A representative from the Quit Line will call the member within three business days to begin the enrollment process.

Outreach Specialists for the UW-CTRI will provide technical assistance to clinics and providers about how to make Striving to Quit referrals. A short training video about Striving to Quit procedures is available on UW-CTRI's Web site. A link to the training video is also on the Portal.

Biochemical Testing

As part of Striving to Quit, HMO members are required to have a urine cotinine test to confirm smoking status. This test should be conducted by providers in the member's HMO network using NicCheck® I testing strips. NicCheck® I testing strips (item MA-500-001) may be ordered online or by calling (888) 882-7739.

Urine cotinine test results should be faxed to the Quit Line at (877) 554-6643. Claims for urine cotinine testing should be submitted to the member's HMO.

BadgerCare Plus members may be tested on a walk-in basis at any participating clinic in the member's HMO network. Members who need assistance finding a participating clinic should contact their HMO.

Prescriptions

For HMO members identified as smokers who express an interest in quitting and agree to a referral to the Quit Line, providers should discuss the use of tobacco cessation medications. Research indicates that the use of tobacco cessation medications in combination with evidence-based counseling almost doubles the likelihood of a successful quit attempt. The following types of tobacco cessation medications are covered by Wisconsin Medicaid for BadgerCare Plus members:

- OTC (over-the-counter) nicotine gum and patches.
- Legend products (i.e., bupropion SR, Chantix, Nicotrol spray).

Providers may use the Drug Search Tool to determine the most current covered drugs. Providers may also refer to the benefit plan-specific product lists for the most current list of covered drugs.

An allowable diagnosis code must be indicated on claims for covered tobacco cessation medications. Tobacco cessation medications are not covered for uses outside the allowable diagnosis code.

If tobacco cessation medications are appropriate for members, prescriptions for tobacco cessation medications should be sent to the member's pharmacy. On the Striving to Quit Referral form sent to the Quit Line, the tobacco cessation medication prescription box should be checked either yes or no.

For HMO members who independently call the Quit Line and are enrolled in Striving to Quit, staff at the Quit Line will provide a suggested prescription to a provider within the member's HMO network. The provider will determine the adequacy of the

prescription and approve as appropriate. The provider is required to send the following:

- The prescription to the pharmacy where it will be filled (e-prescribing is preferred).
- The approval or disapproval of the prescription to the Quit Line on the Striving to Quit Referral form via fax at (877) 554-6643.

For More Information

For more information about Striving to Quit, providers should contact their HMO representative, visit the Portal, or e-mail Striving to Quit at *dhsstqinfo@wisconsin.gov*.

For more information or for technical assistance questions regarding the Quit Line, providers may visit the UW-CTRI (University of Wisconsin Center for Tobacco Research and Intervention) Web site.

Enrollment

Topic #392

Disenrollment and Exemptions

In some situations, a member may be exempt from enrolling in a BadgerCare Plus HMO (health maintenance organization) or Medicaid SSI (Supplemental Security Income) 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 (Department of Health Services) and the HMO or SSI HMO provide more detail on the exemption and disenrollment requirements.

Topic #393

Enrollee Grievances

Enrollees have the right to file grievances about services or benefits provided by a BadgerCare Plus HMO (health maintenance organization) or Medicaid SSI (Supplemental Security Income) 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 (Department of Health Services) and the HMO or SSI HMO describes the responsibilities of the HMO or SSI HMO and the DHS regarding enrollee grievances.

Topic #397

Enrollment Eligibility

BadgerCare Plus HMOs

Members enrolled in the BadgerCare Plus Standard Plan, BadgerCare Plus Benchmark Plan, and the BadgerCare Plus Core Plan are eligible for enrollment in a BadgerCare Plus HMO (health maintenance organization).

An individual who receives the TB-Only (Tuberculosis-Related Services-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 (Enrollment Verification System) or the ForwardHealth Portal.

SSI HMOs

Members of the following subprograms are eligible for enrollment in a Medicaid SSI (Supplemental Security Income) 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 (managed care organization).

Topic #394

Enrollment Periods

HMOs

Members are sent enrollment packets that explain the BadgerCare Plus HMOs (health maintenance organizations) 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 (Supplemental Security Income) HMO's enrollment process and provide contact 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.

Topic #395

Enrollment Specialist

The Enrollment Specialist provides objective enrollment, education, outreach, and advocacy services to BadgerCare Plus HMO (health maintenance organization) and Medicaid SSI (Supplemental Security Income) 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.

Topic #398

Member Enrollment

HMOs

BadgerCare Plus HMO (health maintenance organization) 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 (Supplemental Security Income) 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.

Topic #396

Ombudsman Program

The Ombudsmen, or Ombuds, are resources for enrollees who have questions or concerns about their BadgerCare Plus HMO (health maintenance organization) or Medicaid SSI (Supplemental Security Income) HMO. Ombuds provide advocacy and assistance to help enrollees understand their rights and responsibilities in the grievance and appeal process.

Ombuds can be contacted at the following address:

BadgerCare Plus HMO/Medicaid SSI HMO Ombudsmen
PO Box 6470
Madison WI 53716-0470

Topic #399

Release of Billing or Medical Information

ForwardHealth supports BadgerCare Plus HMO (health maintenance organization) and Medicaid SSI (Supplemental Security Income) HMO enrollee rights regarding the confidentiality of health care records. ForwardHealth has specific standards regarding the release of an HMO or SSI HMO enrollee's billing information or medical claim records.

Managed Care Information

Topic #401

BadgerCare Plus HMO Program

An HMO (health maintenance organization) 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 ForwardHealth (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 (prior authorization), claims submission, adjudication procedures, etc., which may differ from fee-for-service policies and procedures. BadgerCare Plus HMO network providers should contact their HMO for more information about its policies and procedures.

Topic #405

Managed Care

Managed Care refers to the BadgerCare Plus HMO (health maintenance organization) program, the Medicaid SSI (Supplemental Security Income) 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.

Topic #402

Managed Care Contracts

The contract between the DHS (Department of Health Services) and the BadgerCare Plus HMO (health maintenance organization) or Medicaid SSI (Supplemental Security Income) 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.

Topic #404

SSI HMO Program

Medicaid SSI (Supplemental Security Income) HMOs (health maintenance organizations) 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 (prior authorization) 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.

Topic #403

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 (Program of All-Inclusive Care for the Elderly), 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

Topic #400

Prior Authorization Procedures

BadgerCare Plus HMOs (health maintenance organizations) and Medicaid SSI (Supplemental Security Income) HMOs may develop PA (prior authorization) 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

Topic #406

Copayments

Providers cannot charge Medicaid SSI (Supplemental Security Income) HMO (health maintenance organization) 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.

Topic #407

Emergencies

Non-network providers may provide services to BadgerCare Plus HMO (health maintenance organization) and Medicaid SSI (Supplemental Security Income) HMO enrollees in an emergency without authorization or in urgent situations when authorized by the HMO or SSI HMO. The contract between the DHS (Department of Health Services) 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.

Topic #408

Non-network Providers

Providers who do not have a contract with the enrollee's BadgerCare Plus HMO (health maintenance organization) or Medicaid SSI (Supplemental Security Income) 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 (Department of Health Services) 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.

Topic #409

Out-of-Area Care

BadgerCare Plus HMOs (health maintenance organizations) and Medicaid SSI (Supplemental Security Income) 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.

Topic #410

Provider Participation

Providers interested in participating in a BadgerCare Plus HMO (health maintenance organization) or Medicaid SSI (Supplemental Security Income) 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.

Topic #411

Referrals

Non-network providers may at times provide services to BadgerCare Plus HMO (health maintenance organization) and Medicaid SSI (Supplemental Security Income) 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.

Topic #412

Services Not Provided by HMOs or SSI HMOs

If an enrollee's BadgerCare Plus HMO (health maintenance organization) or Medicaid SSI (Supplemental Security Income) HMO benefit package does not include a covered service, such as chiropractic or dental services, any Medicaid-enrolled provider may provide the service to the enrollee and submit claims to fee-for-service.

Member Information

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Archive Date:04/01/2013

Member Information:Birth to 3 Program

Topic #792

Administration and Regulations

In Wisconsin, Birth to 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 (Department of Health Services) monitors, provides technical assistance, and offers other services to county Birth to 3 agencies.

The enabling federal legislation for the Birth to 3 Program is 34 CFR Part 303. The enabling state legislation is s. 51.44, Wis. Stats., and the regulations are found in DHS 90, Wis. Admin. Code.

Providers may contact the appropriate county Birth to 3 agency for more information.

Topic #790

Enrollment Criteria

A child from birth up to (but not including) age 3 is eligible for Birth to 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 Birth to 3 information because many children enrolled in the Birth to 3 Program are also BadgerCare Plus members.

Topic #791

Individualized Family Service Plan

A Birth to 3 member receives an IFSP (Individualized Family Service Plan) 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 Birth to 3 services must be identified in the child's IFSP.

Topic #788

Requirements for Providers

Title 34 CFR Part 303 for Birth to 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 Birth to 3 services. These children must be referred to the appropriate county Birth to 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 Birth to 3 program for evaluation. (Providers are encouraged to explain the need for the Birth to 3 referral to the child's parents or guardians.)
- Cooperate and participate with Birth to 3 service coordination as indicated in the child's IFSP (Individualized Family Services Plan). Birth to 3 services must be provided by providers who are employed by, or under agreement with, a Birth to 3 agency to provide Birth to 3 services.
- Deliver Birth to 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 enrollment as a therapy group to be reimbursed for these therapy services.)
- Assist parents or guardians of children receiving Birth to 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.

Topic #789

Services

The Birth to 3 Program covers the following types of services when they are included in the child's IFSP (Individualized Family Services Plan):

- Evaluation and assessment.
- Special instruction.
- OT (occupational therapy).
- PT (physical therapy).
- SLP (speech and language pathology).
- 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

Topic #785

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 (prior authorization) 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).

Topic #9297

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 (health maintenance organizations).

As of March 19, 2011, new enrollment into the Basic Plan ended. The Basic Plan will continue for members already enrolled in the Basic Plan.

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 BadgerCare Plus Standard Plan, the BadgerCare Plus Benchmark Plan, or the Core Plan.
- Becomes incarcerated or becomes institutionalized in an IMD (institution for mental disease).
- 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 (Wisconsin Chronic Disease Program), 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 (Health Insurance Risk-Sharing Plan) 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.

Alternatives to the BadgerCare Plus Basic Plan

Before enrolling in the BadgerCare Plus Basic Plan, you should consider two other insurance options available to some Wisconsin residents. Enrolling in BadgerCare Plus Basic will make you ineligible for coverage under the Federal Pool option described below.

Option 1: Health Insurance Risk-Sharing Plan (HIRSP)

You may qualify for HIRSP if:

1. You recently lost your employer-sponsored insurance coverage; or
2. You have been rejected for coverage in the private insurance market; or
3. You have HIV/AIDS; or
4. You have Medicare because of a disability.

HIRSP offers comprehensive medical and pharmacy benefits including coverage of brand name drugs and $150 of first dollar coverage on routine/preventive services. HIRSP will not cover medical services for a preexisting condition for the first six months of coverage. The preexisting condition waiting period does not apply to drug coverage. The medical services preexisting condition waiting period does not apply if you qualify for HIRSP because you have recently lost your employer-sponsored coverage.

If your annual household income is below $33,000, you may be entitled to a premium and deductible subsidy. For example, a 25 year old man with an annual income of less than $10,000 would pay $89 per month for a $2,500 deductible insurance plan.

HIRSP members can also be enrolled in the BadgerCare Plus Basic or Core Plan.

Option 2: Federal Temporary High Risk Insurance Pool

You may qualify for the new Federal Pool if:

1. You are a citizen or national of the United States, or are lawfully present;
2. You have a preexisting medical condition; and
3. You have been uninsured for at least 6 months before applying for coverage.

The Federal Pool will offer the same medical and drug benefits as HIRSP. There is no preexisting condition waiting period under the Federal Pool.

In most cases, the Federal Pool premium will be lower than the HIRSP premium.
Enrollment is expected to begin in July 2010, for coverage beginning August 1, 2010.

If you enroll in BadgerCare Plus Basic or HIRSP now, you will not be eligible for the Federal Pool. You should determine which program best serves your needs. For more information about HIRSP or the Federal Pool and your insurance options, please contact HIRSP Customer Service at 1.800.828.4777 or visit *www.hirsp.org*

Topic #5557

BadgerCare Plus Core Plan

The BadgerCare Plus Core Plan covers basic health care services including primary care, preventive care, certain generic and OTC (over-the-counter) 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 the TB-Only (Tuberculosis-Related Services Only) Benefit.
- Is not eligible for or enrolled in Medicare.
- Has a monthly gross income that does not exceed 200 percent of the FPL (Federal Poverty Level).
- 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

Individuals who wish to enroll may apply for the Core Plan using the ACCESS tool online or via the ESC (Enrollment Services Center). 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-enrolled providers cannot pay the $60.00 application processing fee on behalf of Core Plan applicants. An offer by a Medicaid-enrolled 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 (Department of Justice) and the Department of HHS (Health and Human Services') OIG (Office of the Inspector General).

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 (institution for mental disease).
- 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 (Department of Health Services) 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 (Wisconsin Chronic Disease Program), 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 (Health Insurance Risk Sharing Plan) 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.

Topic #225

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 are enrolled in BadgerCare Plus HMOs (health maintenance organizations). In those areas of Wisconsin where HMOs are not available, services will be reimbursed on a fee-for-service basis.

Topic #6917

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 (Federal Poverty Level). 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 (over-the-counter) 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.

Topic #230

Express Enrollment for Children and Pregnant Women

The EE (Express Enrollment) 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.

The EE for Children Benefit allows certain members through 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.

Topic #226

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 (physical therapy) 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 (sexually transmitted disease), 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 (temporary enrollment) 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 (Federal Poverty Level).

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.

Topic #4757

ForwardHealth and ForwardHealth interChange

ForwardHealth brings together many DHS (Department of Health Services) 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 (Wisconsin Chronic Disease Program).
- WIR (Wisconsin Immunization Registry).
- Wisconsin Medicaid.
- Wisconsin Well Woman Medicaid.
- WWWP (Wisconsin Well Woman Program).

ForwardHealth interChange is supported by the state's fiscal agent, HP (Hewlett-Packard).

Topic #229

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 (Express Enrollment) for Children.
- EE for Pregnant Women.
- Family Planning Only Services, including TE (Temporary Enrollment) for Family Planning Only Services.
- QDWI (Qualified Disabled Working Individuals).
- QI-1 (Qualifying Individuals 1).
- QMB Only (Qualified Medicare Beneficiary Only).
- SLMB (Specified Low-Income Medicare Beneficiary).
- TB-Only (Tuberculosis-Related Services-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 (Wisconsin's Enrollment Verification System) 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.

Topic #228

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 (Wisconsin Medical Assistance Program), MA (Medical Assistance), 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 (Supplemental Security Income).
- WWWP (Wisconsin Well Woman Program).

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 (Social Security Administration) 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 (managed care organizations).

Topic #10217

Members Enrolled in the Wisconsin Well Woman

Program and the BadgerCare Plus Basic Plan

Women may be enrolled in the WWWP (Wisconsin Well Woman Program) and the BadgerCare Plus 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 (Wisconsin Well Woman Medicaid) 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.

Topic #232

Qualified Disabled Working Individual Members

QDWI (Qualified Disabled Working Individual) 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 (Federal Poverty Level).
- Be entitled to, but not necessarily enrolled in, Medicare Part A.
- Have income or assets too high to qualify for QMB-Only (Qualified Medicare Beneficiary-Only) and SLMB (Specified Low-Income Medicare Beneficiaries).

Topic #234

Qualified Medicare Beneficiary-Only Members

QMB-Only (Qualified Medicare Beneficiary-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 (Federal Poverty Level).
- Be entitled to, but not necessarily enrolled in, Medicare Part A.

Topic #235

Qualifying Individual 1 Members

QI-1 (Qualifying Individual 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 (Federal Poverty Level).
- Be entitled to, but not necessarily enrolled in, Medicare Part A.

Topic #1208

SeniorCare

SeniorCare is a prescription drug assistance program for Wisconsin residents who are 65 years of age or older who meet enrollment criteria.

SeniorCare is administered by the DHS (Department of Health Services). Within the DHS, the DHCAA (Division of Health Care Access and Accountability) is directly responsible for managing SeniorCare.

Individuals enrolled in SeniorCare are called members. When a member receives a prescription, the pharmacist will know that a member is eligible for 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.

Levels of Participation

SeniorCare has three levels of program participation based on the income of a member. Each level has different out-of-pocket expense requirements:

- Copayment — Level 1.
- Deductible — Level 2a.
- Deductible — Level 2b.
- Spenddown — Level 3.

State law limits what pharmacies may charge SeniorCare members for covered drugs. Regardless of the level of participation, pharmacies should always submit their usual and customary charge. Based on the level of participation, SeniorCare will track and maintain the member spenddown or deductible amounts for claims submitted by pharmacies and provide the copayment amount as applicable. SeniorCare will inform the pharmacy of the amount to charge the member during all levels through the real-time pharmacy POS (Point-of-Sale) system response and remittance information. A provider should never charge a member more than the amount indicated by SeniorCare, according to s. 49.688(5)(a), Wis. Stats. If a SeniorCare member pays an amount greater than the amount on the SeniorCare claim response during any level of participation, the provider is required to refund the difference to the member.

Until members meet any required spenddown, pharmacies may charge members no more than their usual and customary charge. Until members meet any required deductible, pharmacy may charge participants no more than the SeniorCare rate, which equals the Medicaid ingredient rate plus 5 percent, plus the applicable Medicaid dispensing fee.

Providers may obtain deductible and spenddown information for a specific member through the following sources:

- The POS system.
- Remittance information.
- Provider Services.

The following table lists the four levels of participation in SeniorCare.

SeniorCare participation levels

SeniorCare level	FPL (Federal Poverty Level)
1	Less than or equal to 160 percent of the FPL
2a	Greater than 160 and less than or equal to 200 percent of the FPL
2b	Greater than 200 and less than or equal to 240 percent of the FPL
3	Greater than 240 percent of the FPL

Level 1

A member must pay a copayment in each of the following situations:

- Upon applying for SeniorCare, if the member meets the income limits for level 1 (copayment).
- Subsequent to applying for SeniorCare, if the member meets the SeniorCare spenddown or deductible requirements.

Copayment amounts are the following:

- A $5 copayment on each generic prescription drug and compound drug.
- A copayment for each brand-name prescription drug and insulin.

When a member is required to pay a copayment, pharmacies are required to collect the copayment from the member; SeniorCare will reimburse the remainder of the prescription cost up to the SeniorCare rate. The copayment must be paid at the time the drug is dispensed. If the member does not pay the copayment, the pharmacist can choose not to dispense the drug.

There is no limit on the total amount of copayments a member may be required to pay during his or her SeniorCare enrollment. Unlike BadgerCare Plus, SeniorCare does not make exemptions for copayment.

Level 2a

A member is required to pay a $500 deductible in each of the following situations:

- Upon applying for SeniorCare, if the member meets the income limits for level 2a (deductible).
- Subsequent to applying for SeniorCare, if the member meets the SeniorCare spenddown requirement.

Until a member meets the required deductible, pharmacies may charge the member no more than the SeniorCare rate, which equals the Medicaid reimbursement rate plus 5 percent, plus the applicable Medicaid dispensing fee.

Dollars applied toward the deductible are not carried over into the next benefit period. After the member meets the deductible amount, he or she will be able to purchase drugs at the copayment amounts.

Level 2b

A member is required to pay an $850 deductible in each of the following situations:

- Upon applying for SeniorCare, if the member meets the income limits for level 2b (deductible).
- Subsequent to applying for SeniorCare, if the member meets the SeniorCare spenddown requirement.

Until a member meets the required deductible, pharmacies may charge the participant no more than the SeniorCare rate, which equals the Medicaid reimbursement rate plus 5 percent, plus the applicable Medicaid dispensing fee.

Dollars applied toward the deductible are not carried over into the next benefit period. After the member meets the deductible amount, he or she will be able to purchase drugs at the copayment amounts.

Level 3

Under SeniorCare income requirements, members are required to pay a spenddown equal to the amount their income exceeds 240 percent of the FPL. For households in which only one individual is eligible for SeniorCare, the member's spenddown amount is based on the individual's income. If the individual is married and living with his or her spouse, however, SeniorCare eligibility is based on the income of both spouses.

If both spouses are eligible for SeniorCare, the spenddown amount is based on the total of both members' incomes. SeniorCare-covered drugs for either member will be applied to satisfy the spenddown amount. For example, a spenddown of $1,200 has been determined for a couple. One spouse could pay $700 for prescription drugs and the other could pay $500 to meet the total spenddown amount of $1,200. Once the spenddown is satisfied, each spouse will be required to satisfy a $500 deductible.

Members eligible for level 3 pay the retail price for drugs while meeting this spenddown. Until members meet their required spenddown, pharmacies may charge members no more than their usual and customary charge.

Dollars applied toward spenddown are not carried over into the next benefit period. After the member meets the spenddown amount, he or she must then meet the $500 deductible. Once the deductible is met, he or she may purchase drugs at the copayment amounts.

Qualifying Individuals

Individuals with prescription drug coverage from other health insurance sources may enroll in SeniorCare. Seniors who are Wisconsin Medicaid or BadgerCare members may not enroll for SeniorCare, except for the following:

- Qualified Medicare Beneficiaries.
- Qualifying Individuals (QI-1 or QI-2).
- SLMB (Specified Low-Income Medicare Beneficiaries).
- Members receiving TB-Only (Tuberculosis-Related Services-Only) services.
- Members with an unmet Medicaid deductible.

Topic #236

Specified Low-Income Medicare Beneficiaries

SLMB (Specified Low-Income Medicare Beneficiary) 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 (Federal Poverty Level).
- Be entitled to, but not necessarily enrolled in, Medicare Part A.

Topic #11977

Transitioned BadgerCare Plus Core Plan Members

Transitioned BadgerCare Plus Core Plan members are individuals previously enrolled in Milwaukee County's GAMP (General Assistance Medical Program) and other counties' GA (general assistance) medical programs who are now enrolled in the Core Plan.

Topic #262

Tuberculosis-Related Services-Only Benefit

The TB-Only (Tuberculosis-Related Services-Only) Benefit is a limited benefit category that allows individuals with TB (tuberculosis) infection or disease to receive covered TB-related outpatient services.

Topic #240

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 (Wisconsin Well Woman Program) 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 WWWMA (Wisconsin 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 are eligible to be enrolled in WWWMA. 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-enrolled 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.

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. 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.

Enrollment Responsibilities

Topic #241

General Information

Members have certain responsibilities per DHS 104.02, Wis. Admin. Code, and the ForwardHealth Enrollment and Benefits (P-00079 (10/11)) booklet.

Topic #243

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 and Medicaid 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 (Enrollment Verification System) or the ForwardHealth Portal prior to providing each service, even if an approved PA (prior authorization) request is obtained for the service.

Topic #707

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.

Topic #269

Members Should Present Card

It is important that providers determine a member's enrollment and other insurance coverage *prior to* each DOS (date of service) 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 (durable medical equipment) 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.

Topic #244

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.

Topic #245

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

Topic #246

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 (Division of Hearings and Appeals).

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 (DHA-28 (08/09)) 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
313 Blettner Blvd
Madison WI 53784

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.

Topic #247

Freedom of Choice

Members may receive covered services from *any* willing Medicaid-enrolled provider, unless they are enrolled in a state-contracted MCO (managed care organization) or assigned to the Pharmacy Services Lock-In Program.

Topic #248

General Information

Members are entitled to certain rights per DHS 103, Wis. Admin. Code.

Topic #250

Notification of Discontinued Benefits

When the DHS (Department of Health Services) 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.

Topic #252

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.

Topic #254

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 (Qualified Medicare Beneficiary-Only) members.

Identification Cards

Topic #9357

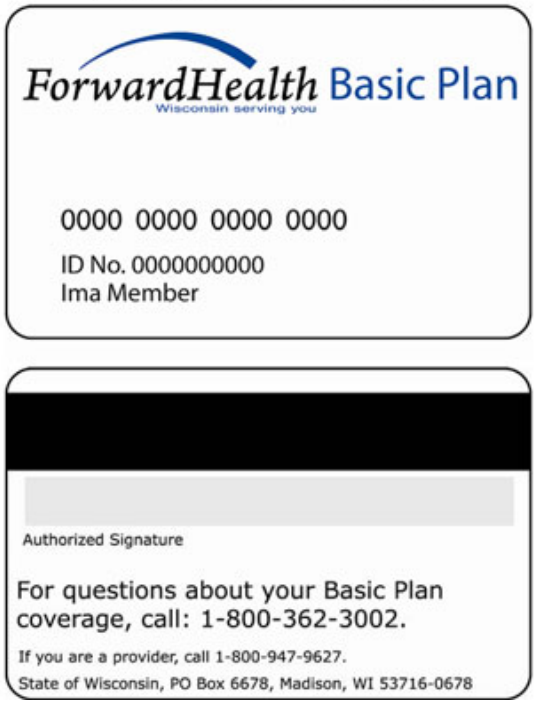
ForwardHealth Basic Plan Identification Cards

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 (270/271 Health Care Eligibility/Benefit Inquiry and Information Response) 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.

Sample ForwardHealth Basic Plan Card



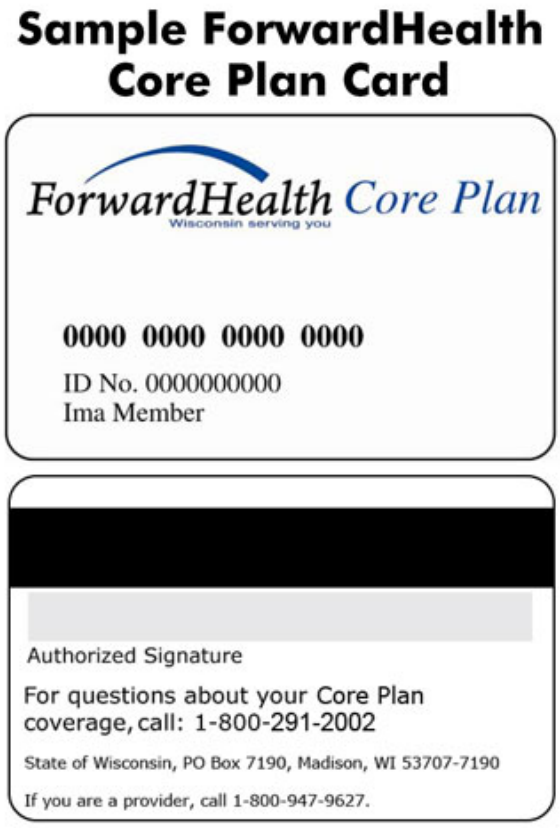
Topic #6977

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 Member Services with questions about enrollment criteria, HMO (health maintenance organization) enrollment, and covered services.

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.



Topic #266

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 (Enrollment Verification System).

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 (Automated Voice Response).

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 (managed care organization) 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.

Topic #268

Temporary Enrollment for Family Planning Only Services Identification Cards

Qualified providers may issue white paper TE (Temporary Enrollment) for Family Planning Only Services identification cards for members to use temporarily until they receive a ForwardHealth identification card. The identification card is included with the TE for Family Planning Only Services Application (F-10119).

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.

Topic #267

Temporary Express Enrollment Cards

There are two types of temporary EE (Express Enrollment) 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 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. A beige paper identification card is attached to the last page of the application and provided to the woman after she completes the enrollment process.

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 (Enrollment Verification System) to verify enrollment for DOS (dates of service) after those printed on the card. Providers are encouraged to keep a photocopy of the card.

Sample Express Enrollment Cards

Which benefit?	Status of your benefits?
BadgerCare Plus temporary enrollment for pregnant women	You applied for BadgerCare Plus Express Enrollment on **06/26/2008**. You are temporarily enrolled in BadgerCare Plus for outpatient pregnancy-related services. Your enrollment will end on or before **07/31/2008**. To learn more, see your Rights and Responsibilities. To get regular BadgerCare Plus or Wisconsin Medicaid, you must apply online, by mail or in person: • Online at http://access.wi.gov • By mail or in person at: Dane County Job Center 1819 Aberg Ave. Madison, WI 53704 (608) 242-7400
To learn more, see your Rights and Responsibilities.	

To the Provider

The individual listed has been temporarily enrolled through BadgerCare Plus Express Enrollment in accordance with Wis. Stat. s. 49.471. This card entitles this individual to receive pregnancy related outpatient care including pharmacy services through BadgerCare Plus from any certified BadgerCare Plus provider for the period specified on this card. (See card effective dates.) For additional information, call Provider Services at (800) 947-9627 or see the All Provider Handbook.

NOTE:

It is important to provide services when this card is presented. Providers who render services based on the enrollment dates on this card will receive payment for those services as long as other reimbursement requirements are met. All policies regarding covered services apply during the temporary enrollment period, including the prohibition against billing recipients. Refer to the All Provider Handbook for further information regarding this temporary ID card. Providers are encouraged to keep a photocopy of this card.

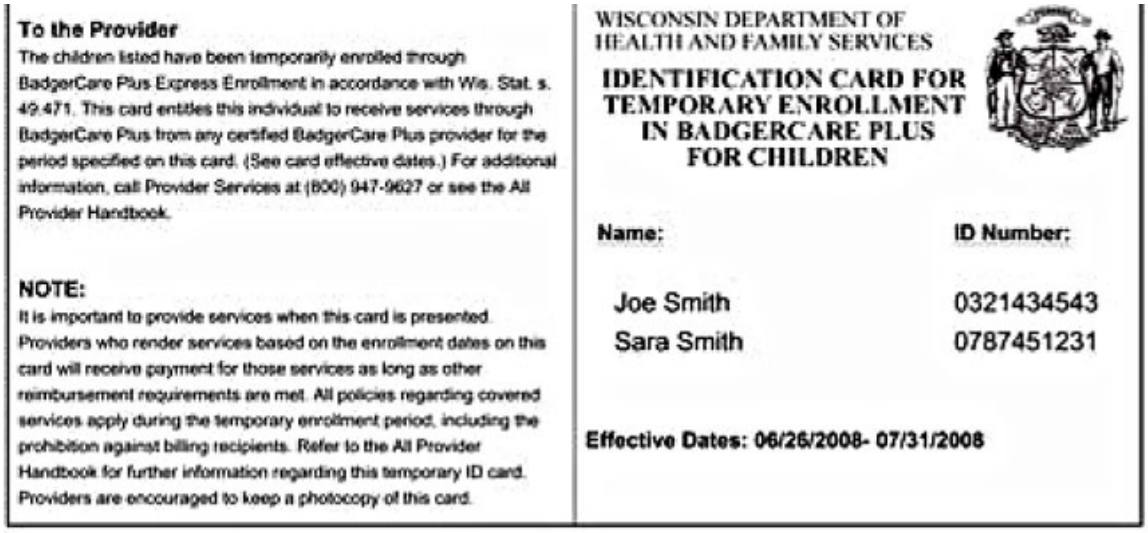
WISCONSIN DEPARTMENT OF HEALTH AND FAMILY SERVICES

IDENTIFICATION CARD FOR TEMPORARY ENROLLMENT IN BADGERCARE PLUS FOR PREGNANT WOMEN

Name:	ID Number:
Jane Smith	0454782131

Effective Dates: 06/26/2008- 07/31/2008

Which benefit?	Status of your benefits?
BadgerCare Plus temporary enrollment for children	You applied for BadgerCare Plus Express Enrollment on **06/26/2008**. The following individual(s) is/are temporarily enrolled in BadgerCare Plus: • **Joe Smith** • **Sara Smith** This temporary enrollment will end on or before **07/31/2008**. To learn more, see your Rights and Responsibilities. In order to continue receiving BadgerCare Plus you must apply through one of the following methods: • Online at http://access.wi.gov • By mail or in person at: Dane County Job Center 1819 Aberg Ave. Madison, WI 53704 (608) 242-7400
To learn more, see your Rights and Responsibilities.	



To the Provider

The children listed have been temporarily enrolled through BadgerCare Plus Express Enrollment in accordance with Wis. Stat. s. 49.471. This card entitles this individual to receive services through BadgerCare Plus from any certified BadgerCare Plus provider for the period specified on this card. (See card effective dates.) For additional information, call Provider Services at (800) 947-9627 or see the All Provider Handbook.

NOTE:

It is important to provide services when this card is presented. Providers who render services based on the enrollment dates on this card will receive payment for those services as long as other reimbursement requirements are met. All policies regarding covered services apply during the temporary enrollment period, including the prohibition against billing recipients. Refer to the All Provider Handbook for further information regarding this temporary ID card. Providers are encouraged to keep a photocopy of this card.

WISCONSIN DEPARTMENT OF HEALTH AND FAMILY SERVICES

IDENTIFICATION CARD FOR TEMPORARY ENROLLMENT IN BADGERCARE PLUS FOR CHILDREN

Name:	ID Number:
Joe Smith	0321434543
Sara Smith	0787451231

Effective Dates: 06/26/2008- 07/31/2008

Topic #1435

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.
- White plastic SeniorCare cards.
- Paper printout temporary card for EE (Express Enrollment) for children.
- Paper printout temporary card for EE for pregnant women.
- Beige paper temporary card for EE for pregnant women.
- White paper TE (Temporary Enrollment) for Family Planning Only Services cards.

Misuse and Abuse of Benefits

Topic #271

Examples of Member Abuse or Misuse

Examples of member abuse or misuse are included in DHS 104.02(5), Wis. Admin. Code.

Topic #274

Pharmacy Services Lock-In Program

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 for controlled substances. 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.

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.

The Pharmacy Services Lock-In Program applies to members in fee-for-service as well as members enrolled in Medicaid SSI (Supplemental Security Income) HMOs (health maintenance organizations) 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.

Members enrolled in the Pharmacy Services Lock-In Program will be locked into one pharmacy where prescriptions for restricted medications must be filled and one prescriber who will prescribe restricted medications. Restricted medications are most controlled substances, carisoprodol, and tramadol. Referrals will be required only for restricted medication services.

Fee-for-service members enrolled in the Pharmacy Services Lock-In Program may choose physicians and pharmacy providers from whom to receive prescriptions and medical services not related to restricted medications. Members enrolled in an HMO must comply with the HMO's policies regarding care that is not related to restricted medications.

Referrals of members as candidates for lock-in are received from retrospective DUR (Drug Utilization Review), 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.

Excluded Drugs

The following scheduled drugs will be excluded from monitoring by the Pharmacy Services Lock-In Program:

- Anabolic steroids.
- Barbiturates used for seizure control.
- Lyrica®.
- Provigil® and Nuvigil®.
- Weight loss drugs.

Pharmacy Services Lock-In Program Administrator

The Pharmacy Services Lock-In Program is administered by HID (Health Information Designs, Inc.). HID may be contacted by telephone at (800) 225-6998, extension 3045, by fax at (800) 881-5573, or by mail at the following address:

Pharmacy Services Lock-In Program
c/o Health Information Designs
391 Industry Dr
Auburn AL 36832

Pharmacy Services Lock-In Prescribers Are Required to Be Enrolled in Wisconsin Medicaid

To prescribe restricted medications for Pharmacy Services Lock-In Program members, prescribers are required to be enrolled in Wisconsin Medicaid. Enrollment for the Pharmacy Services Lock-In Program is not separate from enrollment in Wisconsin Medicaid.

Role of the Lock-In Prescriber and Pharmacy Provider

The Lock-In prescriber determines what restricted medications are medically necessary for the member, prescribes those

medications using his or her professional discretion, and designates an alternate prescriber if needed. If the member requires an alternate prescriber to prescribe restricted medications, the primary prescriber should complete the Pharmacy Services Lock-In Program Designation of Alternate Prescriber for Restricted Medication Services (F-11183 (12/10)) form and return it to the Pharmacy Services Lock-In Program and to the member's HMO, if applicable.

To coordinate the provision of medications, the Lock-In prescriber may also contact the Lock-In pharmacy to give the pharmacist(s) guidelines as to which medications should be filled for the member and from whom. The primary Lock-In prescriber should also coordinate the provision of medications with any other prescribers he or she has designated for the member.

The Lock-In pharmacy fills prescriptions for restricted medications that have been written by the member's Lock-In prescriber(s) and works with the Lock-In prescriber(s) to ensure the member's drug regimen is consistent with the overall care plan. The Lock-In pharmacy may fill prescriptions for medications from prescribers other than the Lock-In prescriber only for medications not on the list of restricted medications. If a pharmacy claim for a restricted medication is submitted from a provider who is not a designated Lock-In prescriber, the claim will be denied.

Designated Lock-In Pharmacies

The Pharmacy Services Lock-In Program pharmacy fills prescriptions for restricted medications that have been written by the member's Lock-In prescriber(s) and works with the Lock-In prescriber(s) to ensure the member's drug regimen is consistent with the overall care plan. The Lock-In pharmacy may fill prescriptions for medications from prescribers other than the Lock-In prescriber only for medications not on the list of restricted medications. If a pharmacy claim for a restricted medication is submitted from a provider who is not a designated Lock-In prescriber, the claim will be denied.

Alternate Providers for Members Enrolled in the Pharmacy Services Lock-In Program

Members enrolled in the Pharmacy Services Lock-In Program do not have to visit their Lock-In prescriber to receive medical services unless an HMO requires a primary care visit. Members may see other providers to receive medical services; however, other providers cannot prescribe restricted medications for Pharmacy Services Lock-In Program members unless specifically designated to do so by the primary Lock-In prescriber. For example, if a member sees a cardiologist, the cardiologist may prescribe a statin for the member, but the cardiologist may not prescribe restricted medications unless he or she has been designated by the Lock-In prescriber as an alternate provider.

A referral to an alternate provider for a Pharmacy Services Lock-In Program member is necessary only when the member needs to obtain a prescription for a restricted medication from a provider other than his or her Lock-In prescriber or Lock-In pharmacy.

If the member requires alternate prescribers to prescribe restricted medications, the primary Lock-In prescriber 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 Service Lock-In Program and the member's HMO.

Designated alternate prescribers are required to be enrolled in Wisconsin Medicaid.

Claims from Providers Who Are Not Designated Pharmacy Services Lock-In Providers

If the member brings a prescription for a restricted medication from a non-Lock-In prescriber to the designated Lock-In pharmacy, the pharmacy provider cannot fill the prescription.

If a pharmacy claim for a restricted medication is submitted from a provider who is not the designated Lock-In prescriber, alternate prescriber, Lock-In pharmacy, or alternate pharmacy, the claim will be denied. If a claim is denied because the

prescription is not from a designated Lock-In prescriber, the Lock-In pharmacy provider cannot dispense the drug or collect a cash payment from the member because the service is a nonreimbursable service. However, the Lock-In pharmacy provider may contact the Lock-In prescriber to request a new prescription for the drug, if appropriate.

To determine if a provider is on file with the Pharmacy Services Lock-In Program, the Lock-In pharmacy provider may do one of the following:

- Speak to the member.
- Call HID.
- Call Provider Services.
- Use the ForwardHealth Portal.

Claims are not reimbursable if the designated Lock-In prescriber, alternate Lock-In prescriber, Lock-In pharmacy, or alternate Lock-In pharmacy provider is not on file with the Pharmacy Services Lock-In Program.

Exceptions

Certain exceptions will be made regarding Pharmacy Services Lock-In Program requirements. The following are exempt from Pharmacy Services Lock-In Program requirements:

- Out-of-state providers who are not enrolled in Wisconsin Medicaid.
- Administration of drugs during an emergency room visit.

If a member enrolled in the Pharmacy Services Lock-In Program presents a prescription for a restricted medication from an emergency room visit or an out-of-state provider, the pharmacist at the Lock-In pharmacy must attempt to contact the Lock-In prescriber to verify the appropriateness of filling the prescription. If the pharmacy provider is unable to contact the Lock-In prescriber, the pharmacist should use his or her professional judgment to determine whether or not the prescription should be filled. If the prescription is filled, the claim must be submitted on paper using the Pharmacy Special Handling Request (F-13074 (07/12)) form.

The ForwardHealth emergency medication dispensing policy does not apply to the Pharmacy Services Lock-In Program. Drugs dispensed in an emergency to Pharmacy Services Lock-In Program members are nonreimbursable services except as noted above. Providers cannot collect payment from Pharmacy Services Lock-In Program members for nonreimburseable services.

For More Information

Providers may call HID with questions about the Pharmacy Services Lock-In Program. Pharmacy providers may also refer to the list of restricted medications data table or call Provider Services with questions about the following:

- Drugs that are restricted for Pharmacy Services Lock-In Program members.
- A member's enrollment in the Pharmacy Services Lock-In program.
- A member's designated Lock-In prescriber or Lock-In pharmacy.

Topic #273

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.

Topic #275

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

Topic #276

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.

Topic #279

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 and Wisconsin Medicaid cover 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 (prior authorization) 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 enrolled 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.

Topic #277

Non-U.S. Citizens — Emergency Services

Certain non-U.S. citizens who are not qualified aliens are eligible for services only in cases of acute emergency medical conditions. Providers should use the appropriate 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 and Wisconsin Medicaid do 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 (continuously eligible newborn) option. However, babies born to women with incomes over 300 percent of the FPL (Federal Poverty Level) 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 (F-1162 (02/09)) 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.

Topic #278

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.

Topic #280

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-enrolled provider for a covered service during the period of retroactive enrollment, according to DHS 104.01(11), Wis. Admin. Code. A Medicaid-enrolled 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 (prior authorization) 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 (date of service) 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 (Enrollment Verification System) (if the services provided during the period of retroactive enrollment were covered).

Topic #281

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 (date of service) 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 (F-10109 (07/08)) 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

6

Archive Date:04/01/2013

Prior Authorization:Brand Medically Necessary Drugs

Topic #2019

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 (Prior Authorization/Brand Medically Necessary Attachment, F-11083 (07/12)). Criteria for approval of a PA (prior authorization) 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 (Preferred Drug List) 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.

Topic #2020

Approval Criteria for Narrow Therapeutic Index Drugs

The clinical criteria for approval of a PA (prior authorization) request for NTI (narrow therapeutic index) 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 (Prior Authorization/Brand Medically Necessary Attachment, F-11083 (07/12)) must include the prescriber's belief that switching the member to a generic drug is likely to cause an adverse reaction.

Topic #2322

Brand Medically Necessary Amendments

Pharmacy providers should amend a PA (prior authorization) 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 (Prior Authorization Request Form, F-11018 (07/12)).
- Indicate the new NDC (National Drug Code), 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 (Prior Authorization/Brand Medically Necessary Attachment, F-11083 (07/12)) 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.

Topic #13177

Brand Medically Necessary Prior Authorizations for Antipsychotic Drugs for Children 6 Years of Age and Younger

Brand name antipsychotic drugs prescribed to children 6 years of age and younger that are brand medically necessary require a prescription with "Brand Medically Necessary" written in the prescriber's own handwriting, a Prior Authorization Drug Attachment for Antipsychotic Drugs for Children 6 Years of Age and Younger, *and* a PA/BMNA (Prior Authorization/Brand Medically Necessary Attachment, F-11083 (07/12)). For example, if a prescription is written for Risperdal, the prescriber is required to complete the Prior Authorization Drug Attachment for Antipsychotic Drugs for Children 6 Years of Age and Younger *and* a PA/BMNA and a prescription with "Brand Medically Necessary" written in the prescriber's own handwriting.

Two unique PA (prior authorization) numbers will be assigned for a brand medically necessary antipsychotic drug. One PA number will be assigned to the Prior Authorization Drug Attachment for Antipsychotic Drugs for Children 6 Years of Age and Younger, and the other will be assigned to the PA/BMNA.

Topic #4419

Documentation Requirements

BadgerCare Plus must receive adequate documentation on the PA/BMNA (Prior Authorization/Brand Medically Necessary Attachment, F-11083 (07/12)) or attached to the PA request for the pharmacist consultant to make a determination about the request. The following are documentation requirements for PA (prior authorization) 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.

Topic #4420

Medical Necessity

All brand medically necessary PA (prior authorization) 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 ForwardHealth 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.

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.

Topic #2017

Pharmacy Provider Requirements for Brand Medically Necessary Drugs

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 (Prior Authorizaton Request Form, F-11018 (07/12)) to be submitted with the PA/BMNA (Prior Authorization/Brand Medically Necessary Attachment, F-11083 (07/12)), completed by the prescriber.
- Obtain Brand Medically Necessary PA (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.

Topic #2016

Prescriber Requirements for Brand Medically Necessary Drugs

To assist pharmacy providers in obtaining PA (prior authorization) 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 (Prior Authorization/Brand Medically Necessary Attachment, F-11083 (07/12)). 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 (Prior Authorization Request Form, F-11018 (07/12)) and submit the PA/BMNA, the PA/RF, and a copy of the prescription to ForwardHealth.

Topic #2014

Prior Authorization/Brand Medically Necessary Attachment

A PA/BMNA (Prior Authorization/Brand Medically Necessary Attachment, F-11083 (07/12)) 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 (prior authorization). 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 (Prior Authorization/Request Form, F-10118 (07/12)) 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 (Food and Drug Administration)-approved generic equivalent if medically appropriate for the member.

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.

Topic #2012

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 (Prior Authorization/Brand Medically Necessary Attachment, F-11083 (07/12)) 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 (National Drug Codes) of all requested strengths of the drug on the PA/RF (Prior Authorization Request Form, F-11018 (07/12)).

Decisions

Topic #4617

An Overview

ForwardHealth will make a decision regarding 24-hour PA (prior authorization) 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.

Topic #424

Approved Requests

PA (prior authorization) 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.

Topic #4437

Once a PA request is approved, a member may go to any enrolled pharmacy provider to obtain the prior authorized drug. The member's PA does not need to be enddated when the member changes pharmacies.

Topic #4724

Communicating Prior Authorization Decisions

ForwardHealth will make a decision regarding a provider's PA (prior authorization) 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.

Topic #5038

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 (prior authorization) request or amendment request via the Portal to ForwardHealth for processing.

Topic #5037

Decision Notice Letters and Returned Provider Review Letters on the Portal

Providers can view PA (prior authorization) 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.

Topic #425

Denied Requests

When a PA (prior authorization) 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 (Prior Authorization Request Form, F-11018 (07/12)), PA/DRF (Prior Authorization/Dental Request Form, F-11035 (07/12)), or PA/HIAS1 (Prior Authorization for Hearing Instrument and Audiological Services 1, F-11020 (07/12)).
- 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.

Sample Notice of Appeal Rights Letter

<Month DD, CCYY>
<sequence number>
<RecipName>
<RecipAddressLine1>
<RecipAddressLine2>
<RecipCity> <RecipStateZip>

Member Identification Number:
<XXX-XX-XXXXX>
Local County or Tribal Agency
Telephone Number: <AgencyPhone>

<PROGRAM NAME> Notice of Appeal Rights

Appeal Date: <AppealDate>

In <PROGRAM NAME>, certain services and products must be reviewed and approved before payment can be made for them. This review process is called prior authorization (PA). The purposes of this letter are to notify you that <PROGRAM NAME> has either denied or modified a request for prior authorization of a service or product that was submitted on your behalf and to inform you of your right to appeal that decision.

Your provider <ProviderName> requested prior authorization for the following service(s):

Service Code	Modifier	Service Description	Unit	Dollar
XXXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX.XX	XXXXX.XX
XXXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX.XX	XXXXX.XX

<ServiceNN>

That prior authorization request, PA number <PANumber>, was reviewed by <PROGRAM NAME> medical consultants. Based on that review, the following services have been denied or modified as follows.

Denied Services

Service Code	Modifier	Service Description	Unit	Dollar
XXXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX.XX	XXXXX.XX
XXXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX.XX	XXXXX.XX

<DeniedServiceNN>

Modified Services

Service Code	Modifier	Service Description	Unit	Dollar
XXXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX.XX	XXXXX.XX
XXXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX.XX	XXXXX.XX

<ModifiedServiceNN>

<PROGRAM NAME>'s denial or modification of the services requested was made for the following reasons:

(Denial/modify code(s) will be inserted here)

<PROGRAM NAME> bases its decisions on criteria found in the Wisconsin Administrative Code. <PROGRAM NAME> may modify or deny a prior authorization request if one or more of the criteria are not supported by documentation submitted by your provider. The specific regulation(s) that supports the reason for the denial/modification of your provider's request for services is found in the following Wisconsin Administrative Code:

(Wis. Admin. Code Regulation(s) will be inserted here)

We have sent your provider the denied/modified prior authorization request. We encourage you to contact <Provider Name> to review the prior authorization request and the reasons for the decision.

Your Rights and Responsibilities

You or your designated representative may appeal this decision in accordance with state and federal law within <RecipientDays> days. To file an appeal, you may do one of the following:

1) Call your local county or tribal agency at the telephone number listed on the first page of this letter for an appeal form and/or assistance in completing it.

2) Write a letter requesting an appeal to the Division of Hearings and Appeals at the following address:

   Division of Hearings and Appeals
   Department of Administration
   PO Box 7875
   Madison WI 53707-7875

The appeal form or letter should include all of the following:

- The name, address, and telephone number of the <PROGRAM NAME> member for whom the appeal is being made.
- The member identification number.
- The prior authorization number <PANumber> of the denied/modified request.
- The reason you think the denial or modification of the prior authorization is wrong.

REMEMBER: You must mail or deliver your appeal to your local county or tribal agency or the Division of Hearings and Appeals so it is received by the <RecipientDays>-day deadline, which is <AppealDate>.

You will lose your right to an appeal if your request to appeal is not received by the local county or tribal agency or the Division of Hearings and Appeals by <AppealDate>.

If you file an appeal, you may expect the following to occur:

- The state Division of Health Care Access and Accountability will be required to explain, in writing, the reason(s) for the denial or modification of the services your provider requested. This explanation will be mailed to you.
- The Division of Hearings and Appeals will schedule a hearing to consider your appeal and will notify you of the time and place by mail. Hearings are generally held at your local county or tribal agency. You may want to ask your local county or tribal agency if there is free legal help available in your area.
- At that hearing, you (or you may choose a friend, relative, attorney, provider, etc., to represent you) will have an opportunity to explain your need for the service to a hearing officer. Division of Health Care Access and Accountability staff may also appear in person or participate by telephone.
- Based on all the information available, the hearing officer will make a decision on your appeal, notify you of the decision by mail, and advise you of any additional appeal rights.

Whether or not you appeal, <PROGRAM NAME> will pay for any services it has approved. After the hearing officer makes a decision on your appeal, <PROGRAM NAME> will continue to pay for the approved services plus any additional services the hearing officer directs <PROGRAM NAME> to pay.

If you need information about accommodation for a disability or for language translation, please call 1-608-266-3096 (voice) or 1-608-264-9853 (TTY) immediately so arrangements can be made. The staff at these numbers will not be able to provide you with information about the reasons for Wisconsin <PROGRAM NAME>'s decision to deny or modify the prior authorization request. These telephone numbers at the Division of Hearings and Appeals should only be used for questions about the hearing process.

F-11194 (10/08)

Topic #12837

Pharmacy Providers

If a PA is denied during adjudication, providers may submit a new request for the service using the P4 transaction; however, they are required to submit the original denied PA request, additional supporting clinical documentation, and medical justification via the Portal, fax, or mail following the submission guidelines.

Topic #426

Modified Requests

Modification is a change in the services originally requested on a PA (prior authorization) 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.

Sample Notice of Appeal Rights Letter

<Month DD, CCYY>
<sequence number>
<RecipName>
<RecipAddressLine1>
<RecipAddressLine2>
<RecipCity> <RecipStateZip>

Member Identification Number:
<XXX-XX-XXXXX>
Local County or Tribal Agency
Telephone Number: <AgencyPhone>

<PROGRAM NAME> Notice of Appeal Rights

Appeal Date: <AppealDate>

In <PROGRAM NAME>, certain services and products must be reviewed and approved before payment can be made for them. This review process is called prior authorization (PA). The purposes of this letter are to notify you that <PROGRAM NAME> has either denied or modified a request for prior authorization of a service or product that was submitted on your behalf and to inform you of your right to appeal that decision.

Your provider <ProviderName> requested prior authorization for the following service(s):

Service Code	Modifier	Service Description	Unit	Dollar
XXXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX.XX	XXXXX.XX
XXXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX.XX	XXXXX.XX

<ServiceNN>

That prior authorization request, PA number <PANumber>, was reviewed by <PROGRAM NAME> medical consultants. Based on that review, the following services have been denied or modified as follows.

Denied Services

Service Code	Modifier	Service Description	Unit	Dollar
XXXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX.XX	XXXXX.XX
XXXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX.XX	XXXXX.XX

<DeniedServiceNN>

Modified Services

Service Code	Modifier	Service Description	Unit	Dollar
XXXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX.XX	XXXXX.XX
XXXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX.XX	XXXXX.XX

<ModifiedServiceNN>

<PROGRAM NAME>'s denial or modification of the services requested was made for the following reasons:

(Denial/modify code(s) will be inserted here)

<PROGRAM NAME> bases its decisions on criteria found in the Wisconsin Administrative Code. <PROGRAM NAME> may modify or deny a prior authorization request if one or more of the criteria are not supported by documentation submitted by your provider. The specific regulation(s) that supports the reason for the denial/modification of your provider's request for services is found in the following Wisconsin Administrative Code:

(Wis. Admin. Code Regulation(s) will be inserted here)

We have sent your provider the denied/modified prior authorization request. We encourage you to contact <Provider Name> to review the prior authorization request and the reasons for the decision.

Your Rights and Responsibilities

You or your designated representative may appeal this decision in accordance with state and federal law within <RecipientDays> days. To file an appeal, you may do one of the following:

1) Call your local county or tribal agency at the telephone number listed on the first page of this letter for an appeal form and/or assistance in completing it.

2) Write a letter requesting an appeal to the Division of Hearings and Appeals at the following address:

   Division of Hearings and Appeals
   Department of Administration
   PO Box 7875
   Madison WI 53707-7875

The appeal form or letter should include all of the following:

- The name, address, and telephone number of the <PROGRAM NAME> member for whom the appeal is being made.
- The member identification number.
- The prior authorization number <PANumber> of the denied/modified request.
- The reason you think the denial or modification of the prior authorization is wrong.

REMEMBER: You must mail or deliver your appeal to your local county or tribal agency or the Division of Hearings and Appeals so it is received by the <RecipientDays>-day deadline, which is <AppealDate>.

You will lose your right to an appeal if your request to appeal is not received by the local county or tribal agency or the Division of Hearings and Appeals by <AppealDate>.

If you file an appeal, you may expect the following to occur:

- The state Division of Health Care Access and Accountability will be required to explain, in writing, the reason(s) for the denial or modification of the services your provider requested. This explanation will be mailed to you.
- The Division of Hearings and Appeals will schedule a hearing to consider your appeal and will notify you of the time and place by mail. Hearings are generally held at your local county or tribal agency. You may want to ask your local county or tribal agency if there is free legal help available in your area.
- At that hearing, you (or you may choose a friend, relative, attorney, provider, etc., to represent you) will have an opportunity to explain your need for the service to a hearing officer. Division of Health Care Access and Accountability staff may also appear in person or participate by telephone.
- Based on all the information available, the hearing officer will make a decision on your appeal, notify you of the decision by mail, and advise you of any additional appeal rights.

Whether or not you appeal, <PROGRAM NAME> will pay for any services it has approved. After the hearing officer makes a decision on your appeal, <PROGRAM NAME> will continue to pay for the approved services plus any additional services the hearing officer directs <PROGRAM NAME> to pay.

If you need information about accommodation for a disability or for language translation, please call 1-608-266-3096 (voice) or 1-608-264-9853 (TTY) immediately so arrangements can be made. The staff at these numbers will not be able to provide you with information about the reasons for Wisconsin <PROGRAM NAME>'s decision to deny or modify the prior authorization request. These telephone numbers at the Division of Hearings and Appeals should only be used for questions about the hearing process.

F-11194 (10/08)

Topic #1324

Response Time

For most drugs, ForwardHealth responds by fax or telephone to the provider's paper PA (prior authorization) 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, ForwardHealth makes an attempt to notify the provider by telephone or fax within 24 hours.
- If the request is received after 1 p.m. central time, ForwardHealth makes an attempt to notify the provider by telephone or fax on the next regular business day.

Exceptions to the 24-Hour Response

ForwardHealth respond within 24 hours except when:

- The PA request contains insufficient, incorrect, or illegible information so that ForwardHealth 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.

ForwardHealth makes three attempts to contact the provider by telephone or fax within 24 hours of receiving the PA request.

Topic #4737

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 (prior authorization) 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.

Topic #427

Returned Requests

A PA (prior authorization) 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 and dental models will be returned once the PA is finalized.

Photographs submitted to ForwardHealth as additional supporting clinical documentation for PA requests will not be returned to providers and will be disposed of securely.

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.

Emergent and Urgent Situations

Topic #429

Emergency Services

In emergency situations, the PA (prior authorization) 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.

Topic #430

Urgent Services

Telephone consultations with DHCAA (Division of Health Care Access and Accountability) staff regarding a prospective PA (prior authorization) 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 Quality Assurance and Appropriateness Review Section 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

Topic #4738

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. The method ForwardHealth will use to communicate decisions regarding PA (prior authorization) amendment requests will depend on how the *PA request* was originally submitted (not how the amendment request was submitted) and whether the provider has a ForwardHealth Portal account:

- If the PA request was originally submitted via the Portal, the decision notice letter or returned amendment provider review letter will be sent to the provider via the Portal.
- If the PA request was originally submitted 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 PA request was originally submitted via mail or fax and the provider does *not* have a Portal account, the decision notice letter or returned amendment provider review letter will be sent by mail 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 or amendment request.

Topic #431

Amendments

Providers are required to use the Prior Authorization Amendment Request (F-11042 (07/12)) to amend an approved or modified PA (prior authorization) 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 member's ForwardHealth 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.

Topic #432

Appeals

If a PA (prior authorization) 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 (Division of Hearings and Appeals). 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.

To file an appeal, members may complete and submit a Request for Fair Hearing (DHA-28 (08/09)) 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
313 Blettner Blvd
Madison WI 53784

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
313 Blettner Blvd
Madison WI 53784

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.

Sample Notice of Appeal Rights Letter

<Month DD, CCYY>
<sequence number>
<RecipName>
<RecipAddressLine1>
<RecipAddressLine2>
<RecipCity> <RecipStateZip>

Member Identification Number:
<XXX-XX-XXXXX>
Local County or Tribal Agency
Telephone Number: <AgencyPhone>

<PROGRAM NAME> Notice of Appeal Rights

Appeal Date: <AppealDate>

In <PROGRAM NAME>, certain services and products must be reviewed and approved before payment can be made for them. This review process is called prior authorization (PA). The purposes of this letter are to notify you that <PROGRAM NAME> has either denied or modified a request for prior authorization of a service or product that was submitted on your behalf and to inform you of your right to appeal that decision.

Your provider <ProviderName> requested prior authorization for the following service(s):

Service Code	Modifier	Service Description	Unit	Dollar
XXXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX.XX	XXXXX.XX
XXXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX.XX	XXXXX.XX

<ServiceNN>

That prior authorization request, PA number <PANumber>, was reviewed by <PROGRAM NAME> medical consultants. Based on that review, the following services have been denied or modified as follows.

Denied Services

Service Code	Modifier	Service Description	Unit	Dollar
XXXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX.XX	XXXXX.XX
XXXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX.XX	XXXXX.XX

<DeniedServiceNN>

Modified Services

Service Code	Modifier	Service Description	Unit	Dollar
XXXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX.XX	XXXXX.XX
XXXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX.XX	XXXXX.XX

<ModifiedServiceNN>

<PROGRAM NAME>'s denial or modification of the services requested was made for the following reasons:

(Denial/modify code(s) will be inserted here)

<PROGRAM NAME> bases its decisions on criteria found in the Wisconsin Administrative Code. <PROGRAM NAME> may modify or deny a prior authorization request if one or more of the criteria are not supported by documentation submitted by your provider. The specific regulation(s) that supports the reason for the denial/modification of your provider's request for services is found in the following Wisconsin Administrative Code:

(Wis. Admin. Code Regulation(s) will be inserted here)

We have sent your provider the denied/modified prior authorization request. We encourage you to contact <Provider Name> to review the prior authorization request and the reasons for the decision.

Your Rights and Responsibilities

You or your designated representative may appeal this decision in accordance with state and federal law within <RecipientDays> days. To file an appeal, you may do one of the following:

1) Call your local county or tribal agency at the telephone number listed on the first page of this letter for an appeal form and/or assistance in completing it.

2) Write a letter requesting an appeal to the Division of Hearings and Appeals at the following address:

   Division of Hearings and Appeals
   Department of Administration
   PO Box 7875
   Madison WI 53707-7875

The appeal form or letter should include all of the following:

- The name, address, and telephone number of the <PROGRAM NAME> member for whom the appeal is being made.
- The member identification number.
- The prior authorization number <PANumber> of the denied/modified request.
- The reason you think the denial or modification of the prior authorization is wrong.

REMEMBER: You must mail or deliver your appeal to your local county or tribal agency or the Division of Hearings and Appeals so it is received by the <RecipientDays>-day deadline, which is <AppealDate>.

You will lose your right to an appeal if your request to appeal is not received by the local county or tribal agency or the Division of Hearings and Appeals by <AppealDate>.

If you file an appeal, you may expect the following to occur:

- The state Division of Health Care Access and Accountability will be required to explain, in writing, the reason(s) for the denial or modification of the services your provider requested. This explanation will be mailed to you.
- The Division of Hearings and Appeals will schedule a hearing to consider your appeal and will notify you of the time and place by mail. Hearings are generally held at your local county or tribal agency. You may want to ask your local county or tribal agency if there is free legal help available in your area.
- At that hearing, you (or you may choose a friend, relative, attorney, provider, etc., to represent you) will have an opportunity to explain your need for the service to a hearing officer. Division of Health Care Access and Accountability staff may also appear in person or participate by telephone.
- Based on all the information available, the hearing officer will make a decision on your appeal, notify you of the decision by mail, and advise you of any additional appeal rights.

Whether or not you appeal, <PROGRAM NAME> will pay for any services it has approved. After the hearing officer makes a decision on your appeal, <PROGRAM NAME> will continue to pay for the approved services plus any additional services the hearing officer directs <PROGRAM NAME> to pay.

If you need information about accommodation for a disability or for language translation, please call 1-608-266-3096 (voice) or 1-608-264-9853 (TTY) immediately so arrangements can be made. The staff at these numbers will not be able to provide you with information about the reasons for Wisconsin <PROGRAM NAME>'s decision to deny or modify the prior authorization request. These telephone numbers at the Division of Hearings and Appeals should only be used for questions about the hearing process.

F-11194 (10/08)

Topic #1106

Enddating

Providers are required to use the Prior Authorization Amendment Request (F-11042 (07/12)) to enddate most PA (prior authorization) 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 (Specialized Transmission Approval Technology-Prior Authorization) 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.

Topic #4739

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 (prior authorization) 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 and dental models will be returned once the amendment request is finalized.

Photographs submitted to ForwardHealth as additional supporting clinical documentation for PA requests will not be returned to providers and will be disposed of securely.

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.

Topic #5039

Searching for Previously Submitted Prior Authorization Requests on the Portal

Providers will be able to search for all previously submitted PA (prior authorization) 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

Topic #960

An Overview

Depending on the service being requested, most PA (prior authorization) requests must be comprised of the following:

- The PA/RF (Prior Authorization Request Form, F-11018 (07/12)), PA/DRF (Prior Authorization/Dental Request Form, F-11035 (07/12)), or PA/HIAS1 (Prior Authorization for Hearing Instrument and Audiological Services 1, F-11020 (07/12)).
- A service-specific PA attachment(s).
- Additional supporting clinical documentation.

Topic #446

Attachments

In addition to the PA/RF (Prior Authorization Request Form, F-11018 (07/12)), PA/HIAS1 (Prior Authorization for Hearing Instrument and Audiological Services 1, F-11020 (07/12)), or PA/DRF (Prior Authorization/Dental Request Form, F-11035 (07/12)), a service-specific PA (prior authorization) 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.

Topic #447

Obtaining Forms and Attachments

Providers may obtain paper versions of all PA (prior authorization) 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
313 Blettner Blvd
Madison WI 53784

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 (Portable Document Format) and fillable Microsoft® Word formats.

Web Prior Authorization Via the Portal

Certain providers may complete the PA/RF (Prior Authorization Request Form, F-11018 (07/12)) 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.

Topic #4620

Pharmacy Prior Authorization Forms

PA/PDL (Prior Authorization/Preferred Drug List) forms, PA (prior authorization) drug attachment forms, and the PA/DGA (Prior Authorization/Drug Attachment, F-11049 (07/12)) are available on the Forms page of the ForwardHealth Portal.

Topic #448

Prior Authorization Request Form

The PA/RF (Prior Authorization Request Form, F-11018 (07/12)) is used by ForwardHealth and is mandatory for most providers when requesting PA (prior authorization). 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 the claim for prior authorized services.

Topic #4619

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 (prior authorization) requests, or processing provider claims for reimbursement. The use of the PA/RF (Prior Authorization

Request Form, F-11018 (07/12)) 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, via the ForwardHealth Portal, by fax to ForwardHealth at (608) 221-8616, or by mail to the following address:

ForwardHealth
Prior Authorization
Ste 88
313 Blettner Blvd
Madison WI 53784

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 (Wisconsin Chronic Disease Program) 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 (National Provider Identifier) 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 (Enrollment Verification System) 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 (International Classification of Diseases, Ninth Revision, Clinical Modification) 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 (date of service) 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 (National Drug Code) 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 place of service 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 (Department of Health Services).

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).

DEPARTMENT OF HEALTH SERVICES
Division of Health Care Access and Accountability
F-11018 (10/08)

STATE OF WISCONSIN
HFS 106.03(4), Wis. Admin. Code
HFS 152.06(3)(h), 153.06(3)(g), 154.06(3)(g), Wis. Admin. Code

FORWARDHEALTH
PRIOR AUTHORIZATION REQUEST FORM (PA/RF)

Providers may submit prior authorization (PA) requests by fax to ForwardHealth at (608) 221-8616 or by mail to: ForwardHealth, Prior Authorization, Suite 88, 6406 Bridge Road, Madison, WI 53784-0088. **Instructions:** Type or print clearly. Before completing this form, read the service-specific Prior Authorization Request Form (PA/RF) Completion Instructions.

SECTION I — PROVIDER INFORMATION

1. Check only if applicable	2. Process Type	3. Telephone Number — Billing Provider
❑ HealthCheck "Other Services" ❑ Wisconsin Chronic Disease Program (WCDP)	**131**	**(XXX) XXX-XXXX**

4. Name and Address — Billing Provider (Street, City, State, ZIP+4 Code)	5a. Billing Provider Number	5b. Billing Provider Taxonomy Code
I.M. Billing Provider **609 Willow St** **Anytown WI 55555-1234**	**0222222220**	**123456789X**

SECTION II — MEMBER INFORMATION

6. Member Identification Number	7. Date of Birth — Member	8. Address — Member (Street, City, State, ZIP Code)
0123456789	**MM/DD/CCYY**	**322 Ridge St** **Anytown WI 55555**

9. Name — Member (last, first, middle initial)	10. Gender — Member
Member, Im A.	❑ MALE ☒ FEMALE

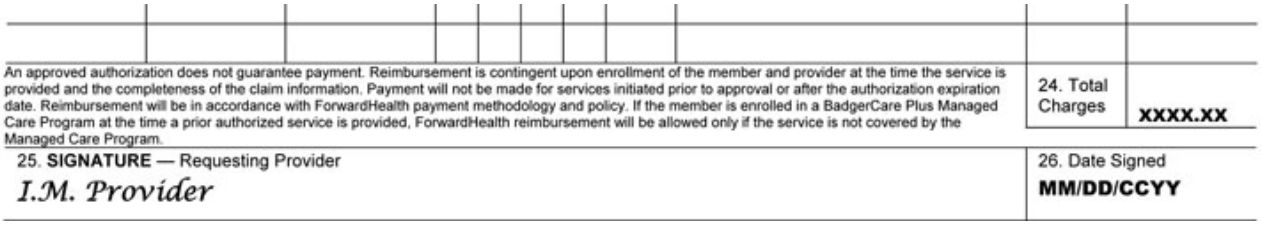
SECTION III — DIAGNOSIS / TREATMENT INFORMATION

11. Diagnosis — Primary Code and Description	12. Start Date — SOI	13. First Date of Treatment — SOI
427.31 — atrial fibrillation		

14. Diagnosis — Secondary Code and Description	15. Requested PA Start Date
	MM/DD/CCYY

16. Rendering Provider Number	17. Rendering Provider Taxonomy	18. Service Code	19. Modifiers 1	2	3	4	20. POS	21. Description of service	22. QR	23. Charge
1234567890	**234567890X**	**00056-0172-70**					**00**	**coumadin 5mg tablet**	**365**	**XXXX.XX**

Sample Prior Authorization Request Form for Pharmacy Services and Diabetic Supplies



Topic #7797

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 (prior authorization) 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, via the ForwardHealth Portal, by fax to ForwardHealth at (608) 221-8616, or by mail to the following address:

ForwardHealth
Prior Authorization
Ste 88
313 Blettner Blvd
Madison WI 53784

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 (Wisconsin Chronic Disease Program) if the services requested on the PA/RF (Prior Authorization Request Form, F-11018 (07/12)) are for a WCDP member.

Element 2 — Process Type
Enter process type 117 — Physician Services. 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 enrolled in Wisconsin Medicaid should indicate their telephone number as the billing provider on PA requests. Prescribers who are not enrolled in Wisconsin Medicaid should indicate the telephone number of the Medicaid-enrolled 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 enrolled in Wisconsin Medicaid should indicate their name and address as the billing provider on PA requests. Prescribers who are not enrolled in Wisconsin Medicaid should indicate the name and address of the Medicaid-enrolled billing provider (e.g., clinic) with which they are affiliated on PA requests.

Element 5a — Billing Provider Number
Enter the NPI (National Provider Identifier) of the billing provider. The NPI in this element must correspond with the provider name listed in Element 4.

Note: Prescribers who are enrolled in Wisconsin Medicaid should indicate their provider number as the billing provider on PA requests. Prescribers who are not enrolled in Wisconsin Medicaid should indicate the provider number of the Medicaid-enrolled 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 enrolled in Wisconsin Medicaid should indicate their taxonomy code as the billing provider on PA requests. Prescribers who are not enrolled in Wisconsin Medicaid should indicate the taxonomy code of the Medicaid-enrolled 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 (Enrollment Verification System) 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 (International Classification of Diseases, Ninth Revision, Clinical Modification) 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 (date of service) 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 appropriate place of service code designating where the requested item would be provided/performed/dispensed.

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).

Topic #449

Supporting Clinical Documentation

Certain PA (prior authorization) 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 dental models will be returned to providers.

Photographs submitted to ForwardHealth as additional supporting clinical documentation for PA requests will not be returned to providers and will be disposed of securely.

General Information

Topic #4402

An Overview

The PA (prior authorization) review process includes 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.

Topic #434

Communication with Members

ForwardHealth recommends that providers inform members that PA (prior authorization) 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.

Topic #435

Definition

PA (prior authorization) 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.

Topic #5098

Designating an Address for Prior Authorization Correspondence

Correspondence related to PA (prior authorization) 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 dental models.

Photographs submitted to ForwardHealth as additional supporting clinical documentation for PA requests will not be returned to providers and will be disposed of securely.

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 (F-01181 (07/12)) form.

Topic #2334

Drugs

Wisconsin Medicaid has the authority to require PA (prior authorization) 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 (Specialized Transmission Approval Technology-Prior Authorization) system, on the ForwardHealth Portal, using an NCPDP (National Council for Prescription Drug Programs) transaction, or on paper by fax or mail.

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.

Drug PAs are not provider specific. Once the PA request is approved, the member may go to any Medicaid-enrolled 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.

SeniorCare

Regardless of the member's level of participation, SeniorCare requires PA for certain drugs so that the pharmacy provider may receive reimbursement.

Topic #4383

Prior Authorization Numbers

Upon receipt of the PA/RF (Prior Authorization Request Form, F-11018 (07/12)), ForwardHealth will assign a PA (prior authorization) 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 (Specialized Transmission Approval Technology-Prior Authorization); 4 = STAT-PA; 5 = Portal; 6 = Portal; 7 = NCPDP (National Council for Prescription Drug Programs) transaction or 278 (278 Health Care Services Review - Request for Review and Response) transaction; 9 = MedSolutions
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.

Topic #8578

Prior Authorization and Day Supply

Drug PAs (prior authorization) 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.

Topic #436

Reasons for Prior Authorization

Only about four percent of all services covered by Wisconsin Medicaid require PA (prior authorization). 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 (Department of Health Services).

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.

Topic #437

Referrals to Out-of-State Providers

PA (prior authorization) may be granted to non-enrolled 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-enrolled provider, the referring provider should refer the out-of-state provider to the ForwardHealth Portal or Provider Services to obtain appropriate enrollment 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.

Topic #438

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 (prior authorization) 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 enrolled in 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.

Topic #1268

Sources of Information

Providers should verify that they have the most current sources of information regarding PA (prior authorization). 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.

Topic #812

Status Inquiries

Providers may inquire about the status of a PA (prior authorization) request through one of the following methods:

- Accessing WiCall, ForwardHealth's AVR (Automated Voice Response) system.
- Calling Provider Services.

Providers should have the 10-digit PA number available when making inquiries.

Topic #13697

Third-Party Web Sites

The ForwardHealth Portal allows providers access to all policy and billing information for BadgerCare Plus, Medicaid, SeniorCare, and WCDP (Wisconsin Chronic Disease Program) in one centralized place. PA (prior authorization) request forms and information about ForwardHealth's policies should be obtained from the Portal or Provider Services. Third-party Web sites are not affiliated with or endorsed by ForwardHealth.

Grant and Expiration Dates

Topic #439

Backdating

Backdating an initial PA (prior authorization) request or SOI (spell of illness) 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.

Topic #440

Expiration Date

The expiration (end) date of an approved or modified PA (prior authorization) 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.

Topic #441

Grant Date

The grant (start) date of an approved or modified PA (prior authorization) 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.

Topic #442

Renewal Requests

To prevent a lapse in coverage or reimbursement for ongoing services, all renewal PA (prior authorization) 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

Topic #443

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 (Enrollment Verification System) before the services are provided at each visit.
- When the PA (prior authorization) 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.

Topic #444

Retroactive Disenrollment from State-Contracted MCOs

Occasionally, a service requiring fee-for-service PA (prior authorization) is performed during a member's enrollment period in a state-contracted MCO (managed care organization). 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 (date of service). 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.

Topic #445

Retroactive Enrollment

If a service(s) that requires PA (prior authorization) 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

Topic #1999

A Comprehensive Overview

PDL (Preferred Drug List) recommendations are made to the Wisconsin Medicaid Pharmacy PA (prior authorization) 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 Preferred Drug List Quick Reference 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. New drugs are automatically added to existing drug classes on the PDL as non-preferred drugs prior to the PA Advisory Committee meeting.

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 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 (cell adhesion molecule) 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.

Before a non-preferred drug is prescribed, members are required to experience a treatment failure on at least one preferred drug in the same drug class as the non-preferred drug.

For all PA requests, prescribers are required to complete, physically sign, and date the appropriate PA/PDL form. Prescribers are required to submit the appropriate PA form along with any supporting documentation to the pharmacy where the prescription will be filled. 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 (Prior Authorization/Preferred Drug List Exemption Request, F-11075 (10/11)) for non-preferred drugs that do not have specific clinical criteria requirements. Prescribers and pharmacy providers are required to keep a completed and signed copy of the PA form.

If drugs change from a preferred to non-preferred status or vice versa, the status change may impact whether or not a drug is covered by the Benchmark Plan, the Core Plan, and the Basic Plan.

Clinical Criteria

Clinical criteria for approval of a non-preferred drug must be documented by the prescriber on the appropriate PA/PDL (Prior Authorization/Preferred Drug List) 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, Medicaid, 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 (Specialized Transmission Approval Technology-Prior Authorization) 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 (Point-of-Sale) system, using PES (Provider Electronic Solutions) software, on the ForwardHealth Portal, or on a Noncompound Drug Claim (F-13072 (07/12)) form.

For PA requests submitted using the STAT-PA system, providers are required to enter information into STAT-PA exactly as it is written on the 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, physically sign, date, and submit to ForwardHealth a PA/RF (Prior Authorization Request Form, F-11018 (07/12)) with the appropriate PA/PDL form and supporting documentation from the prescriber.

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/RF 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.

Topic #13597

Acne Agents, Topical

In the acne agents, topical drug class on the Preferred Drug List Quick Reference, ForwardHealth lists only the preferred federal legend generic and brand name drugs. Federal legend non-preferred drugs in the acne agents, topical drug class will not be listed.

Drugs not listed in the acne agents, topical drug class on the Preferred Drug List Quick Reference are one of the following:

- Considered to be non-preferred drugs and require PA (prior authorization) for BadgerCare Plus Standard Plan, Medicaid, and SeniorCare members.
- Noncovered for the Standard Plan, Medicaid, and SeniorCare (e.g., OTC (over-the-counter) drugs, drugs without signed manufacturer rebate agreements, convenience or combination packaged drugs, drugs terminated by the CMS (Centers for Medicare and Medicaid Services)).

Providers may use the claim response or the Drug Search Tool to determine the most current covered drugs.

For BadgerCare Plus Benchmark Plan, BadgerCare Plus Core Plan, and BadgerCare Plus Basic Plan members, providers may refer to the benefit plan-specific product lists for the most current list of covered acne agents, topical.

Convenience and combination packaged drugs are not covered by ForwardHealth.

Topic #15037

Alzheimer's Agents

Namenda is an N-methyl-D-aspartate receptor antagonist in the Alzheimer's agents drug class. Namenda is used in the treatment of Alzheimer's disease and dementia-related disorders. (*Note:* There are no adequate and well-controlled trials documenting the safety and efficacy of Namenda in any illness occurring in children.)

Namenda is a preferred drug; however, PA (prior authorization) is required for Namenda for members who are 44 years of age or younger. For members 45 years of age or older, PA is not required for Namenda.

Namenda is covered without PA for members enrolled in the BadgerCare Plus Standard Plan, the BadgerCare Plus Core Plan, and Medicaid who are 44 years of age or younger *and* have a Namenda claim in history between August 15, 2012, and February 15, 2013.

PA requests for Namenda for members who are 44 years of age or younger and who are not currently taking Namenda should be submitted on paper using the PA/DGA (Prior Authorization/Drug Attachment, F-11049 (07/12)) and the PA/RF (Prior Authorization Request Form, F-11018 (07/12)). Clinical documentation supporting an Alzheimer's disease or dementia indication for members who are 44 years of age or younger must be submitted with the PA request.

Namenda is a noncovered drug for members enrolled in the BadgerCare Plus Benchmark Plan and the BadgerCare Plus Basic Plan.

Topic #9837

Antibiotics, Inhaled

Tobi is a preferred drug and Cayston is a non-preferred drug that requires PA (prior authorization) in the antibiotics, inhaled drug class. Providers should submit PA requests for Cayston on paper using the PA/DGA (Prior Authorization/Drug Attachment, F-11049 (07/12)) and the PA/RF (Prior Authorization Request Form, F-11018 (07/12)). Clinical documentation supporting the use of Cayston must be submitted with each PA request.

Cayston

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 (forced expiratory volume in 1 second) 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.

Topic #13617

Anticoagulants

Xarelto 10 mg

Xarelto 10 mg is a preferred drug for members enrolled in the BadgerCare Plus Standard Plan, the BadgerCare Plus Core Plan, Medicaid, and SeniorCare. Quantity limits apply for Xarelto 10 mg. Members will be limited to 35 tablets per rolling year. If a member is prescribed 35 tablets of Xarelto 10 mg for 35 days of treatment, providers may dispense 35 tablets and ForwardHealth will accept and reimburse claims for a quantity of 35 with a 35-day supply. If it is medically appropriate for a member to exceed the quantity limit, pharmacy providers may request a quantity limit policy override.

Xarelto 10 mg is a noncovered drug for members enrolled in the BadgerCare Plus Benchmark Plan and the BadgerCare Plus Basic Plan.

Xarelto 15 mg and 20 mg

Xarelto 15 mg and 20 mg are preferred drugs for members enrolled in the Standard Plan, the Core Plan, Medicaid, and SeniorCare. Quantity limits apply. If it is medically appropriate for a member to exceed the quantity limit, pharmacy providers may request a quantity limit policy override.

Xarelto 15 mg and 20 mg are noncovered drugs for members enrolled in the Benchmark Plan and the Basic Plan.

Topic #8377

Antiemetics, Cannabinoids

PA (prior authorization) is required for all antiemetic, cannabinoid drugs. To request PA, prescribers are required to complete and submit the PA/PDL for Antiemetics, Cannabinoids (Prior Authorization/Preferred Drug List for Antiemetics, Cannabinoids, F-00194 (10/11)) 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®

Members who are prescribed Marinol® for the treatment of appetite/weight loss caused by HIV (Human Immunodeficiency Virus) or AIDS (Acquired Immune Deficiency Syndrome) 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 (Specialized Transmission Approval Technology-Prior Authorization) 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®.

Clinical Criteria

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®).

Topic #8837

Bladder Relaxants

Oxybutynin ER is a non-preferred drug; however, PA (prior authorization) 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.

Quantity limits apply to certain bladder relaxant preparations.

Topic #8838

Bronchodilators, Beta Agonists

Albuterol 1.25 mg/3mL (0.042 percent) for inhalation is a non-preferred drug; however, PA (prior authorization) 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.

Topic #15057

Cough and Cold — Narcotic Liquids

In the cough and cold — narcotic liquids drug class on the Preferred Drug List Quick Reference, ForwardHealth lists only the preferred legend and OTC (over-the-counter) drugs by active ingredient name.

Drugs not listed in the cough and cold — narcotic liquids drug class on the Preferred Drug List Quick Reference are those that are one of the following:

- Considered to be non-preferred drugs and require PA (prior authorization) for BadgerCare Plus Standard Plan, Medicaid, and SeniorCare members.
- Noncovered by the Standard Plan, Medicaid, and SeniorCare (e.g., certain OTC drugs, drugs without signed manufacturer rebate agreements, drugs terminated by the CMS (Centers for Medicare and Medicaid Services)).

Providers may use the claim response or the Drug Search Tool to determine the most current covered drugs.

For BadgerCare Plus Benchmark Plan, BadgerCare Plus Core Plan, and BadgerCare Plus Basic Plan members, providers may refer to the benefit plan-specific product lists for the most current list of covered cough and cold — narcotic liquids.

Topic #4417

Cytokine and Cell Adhesion Molecule Antagonist Drugs

Clinical PA (prior authorization) is required for all cytokine and CAM (cell adhesion molecule) antagonist drugs, including preferred cytokine and CAM antagonist drugs.

Clinical criteria for approval of a PA request for preferred cytokine and CAM antagonist drugs for BadgerCare Plus Core Plan members are the same as the clinical criteria for members enrolled in the BadgerCare Plus Standard Plan, Medicaid, and SeniorCare. Only preferred cytokine and CAM antagonist drugs are covered for Core Plan members.

The drugs in the cytokine and CAM antagonist drug class are not covered for members enrolled in the BadgerCare Plus Benchmark Plan or the BadgerCare Plus Basic Plan.

All PA requests for non-preferred cytokine and CAM antagonist drugs must be submitted by fax or by mail. PA requests for non-preferred cytokine and CAM antagonist drugs may not be submitted using the STAT-PA (Specialized Transmission Approval Technology-Prior Authorization) system.

Initial PA requests for non-preferred cytokine and CAM antagonist drugs will be approved for up to 183 days. Renewal PA requests for non-preferred cytokine and CAM antagonist drugs will be approved for up to one year.

PA requests for cytokine and CAM antagonist drugs will only be approved for use to treat the following identified clinical

conditions:

- Ankylosing spondylitis.
- Crohn's disease.
- Plaque psoriasis.
- Psoriatic arthritis.
- Rheumatoid arthritis and polyarticular juvenile RA.
- Ulcerative colitis.

Clinical Criteria for Cytokine and Cell Adhesion Molecule Antagonist Drugs for Ankylosing Spondylitis

Enbrel® and Humira® are preferred drugs in the cytokine and CAM antagonist drug class used 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 have taken **two** preferred cytokine and CAM antagonist drugs for at least **three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction.

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.
- At least **one** of the following is true:
    - The member has moderate to severe axial symptoms of ankylosing spondylitis.
    - 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:
        - Leflunomide.
        - Methotrexate.
        - An NSAID (Nonsteroidal Anti-inflammatory Drug) or COX-2 (cyclooxygenase) inhibitor drug.
        - Oral corticosteroids.
        - Sulfasalazine.

PA requests for drugs for ankylosing spondylitis must be submitted on the PA/PDL for Cytokine and CAM Antagonist Drugs for Ankylosing Spondylitis (Prior Authorization/Preferred Drug List for Cytokine and Cell Adhesion Molecule Antagonist Drugs for Ankylosing Spondylitis, F-11304 (12/12)).

Clinical Criteria for Cytokine and Cell Adhesion Molecule Antagonist Drugs for Crohn's Disease

Cimzia® and Humira® are preferred drugs in the cytokine and CAM antagonist drug class used 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.
- Methotrexate.
- Oral corticosteroids.
- 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 (Prior Authorization/Preferred Drug List for Cytokine and Cell Adhesion Molecule Antagonist Drugs for Crohn's Disease, F-11305 (12/12)).

Clinical Criteria for Cytokine and Cell Adhesion Molecule Antagonist Drugs for Plaque Psoriasis

Enbrel® and Humira® are preferred drugs in the cytokine and CAM antagonist drug class used 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 is true:
  - 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 palmoplantar psoriasis.
- The prescription is written by a dermatologist or through a dermatology consultation.
- The member has received **two or more** of the following drugs and received each drug for at least **one** month and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction:
  - Calcipotriene.
  - Tazarotene.
  - Topical corticosteroids.
- 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 (Prior Authorization/Preferred Drug List for Cytokine and Cell Adhesion Molecule Antagonist Drugs for Plaque Psoriasis, F-11306 (12/12)).

Clinical Criteria for Cytokine and Cell Adhesion Molecule Antagonist Drugs for Psoriatic Arthritis

Enbrel® and Humira® are preferred drugs in the cytokine and CAM antagonist drug class used 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 have taken **two** preferred cytokine and CAM antagonist drugs for at least **three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction.

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.
- At least **one** of the following is true:
  - The member has moderate to severe axial symptoms of psoriatic arthritis.
  - 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.
    - Cyclosporine.
    - Hydroxychloroquine.
    - Leflunomide.
    - Methotrexate.
    - An NSAID (Nonsteroidal Anti-inflammatory Drug) or COX-2 (cyclooxygenase) inhibitor drug.
    - Oral corticosteroids.

PA requests for drugs for psoriatic arthritis must be submitted on the PA/PDL for Cytokine and CAM Antagonist Drugs for Psoriatic Arthritis (Prior Authorization/Preferred Drug List for Cytokine and Cell Adhesion Molecule Antagonist Drugs for Psoriatic Arthritis, F-11307 (12/12)).

Clinical Criteria for Cytokine and Cell Adhesion Molecule Antagonist Drugs for Rheumatoid Arthritis

Cimzia®, Enbrel®, and Humira® are preferred drugs in the cytokine and CAM antagonist drug class used to treat RA (rheumatoid arthritis). Enbrel and Humira are preferred drugs in the cytokine and CAM antagonist drug class used to treat polyarticular juvenile RA.

Kineret®, Orencia, Simponi™, and Xeljanz are non-preferred drugs used to treat RA. For PA requests for Kineret®, Orencia, and Simponi™, the member must meet **all** clinical criteria below and have taken **two** preferred cytokine and CAM antagonist drugs for at least **three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction. For PA requests for Simponi™, members must also continue to take methotrexate in combination with Simponi™.

PA requests for drugs for RA (except Xeljanz) must be submitted on the PA/PDL for Cytokine and CAM Antagonist Drugs for RA and Polyarticular Juvenile RA (Prior Authorization/Preferred Drug List for Cytokine and Cell Adhesion Molecule Antagonist Drugs for Rheumatoid Arthritis and Polyarticular Juvenile RA, F-11308 (12/12)).

Clinical Criteria for Rheumatoid Arthritis

Clinical criteria for approval of a PA request for cytokine and CAM antagonist drugs (except Xeljanz) 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.
  - Cyclosporine.

- Hydroxychloroquine.
- Leflunomide.
- Methotrexate.
- An NSAID (Nonsteroidal Anti-inflammatory Drug) or COX-2 (cyclooxygenase) inhibitor drug.
- Oral corticosteroids
- Penicillamine.
- Sulfasalazine.

Clinical Criteria for Xeljanz to Treat Rheumatoid Arthritis

Clinical criteria that must be documented for approval of a PA request for Xeljanz to treat RA are **all** of the following:

- The member has a diagnosis of RA.
- The member is 18 years of age or older.
- The member has moderate to severe symptoms of RA.
- The prescription is written by a rheumatologist or through a rheumatology consultation.
- The member has taken methotrexate for at least **three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction.
- The member has taken **one or more** of the following drugs for at least **three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction:
  - Azathioprine.
  - Cyclosporine.
  - Hydroxychloroquine.
  - Leflunomide.
  - An NSAID (Nonsteroidal Anti-inflammatory Drug) or COX-2 (cyclooxygenase) inhibitor drug.
  - Oral corticosteroids.
  - Penicillamine.
  - Sulfazalazine.
- The member has taken **two** preferred cytokine and CAM antagonist drugs for at least **three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction.

Quantity limits apply to Xeljanz. Members will be limited to 68 tablets of Xeljanz per month.

Xeljanz is a noncovered drug for members enrolled in the Benchmark Plan, the Core Plan, and the Basic Plan.

PA requests for Xeljanz must be submitted on the PA/DGA (Prior Authorization/Drug Attachment, F-11049 (07/12)) and the PA/RF (Prior Authorization Request Form, F-11018 (07/12)). PA requests for Xeljanz must include documentation supporting that all of the clinical criteria have been met.

Initial PA requests for Xeljanz will be approved for up to 183 days. Renewal PA requests for Xeljanz will be approved for up to one year.

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.
  - Cyclosporine.

- Hydroxychloroquine.
- Leflunomide.
- Methotrexate.
- An NSAID (Nonsteroidal Anti-inflammatory Drug) or COX-2 (cyclooxygenase) inhibitor drug.
- Oral corticosteroids.
- Penicillamine.
- Sulfasalazine.

Clinical Criteria for Cytokine and Cell Adhesion Molecule Antagonist Drugs for Ulcerative Colitis

Enbrel® is a preferred drug in the Cytokine and CAM Antagonist drug class used to treat ulcerative colitis.

Clinical criteria for approval of a PA request for Humira® to treat ulcerative colitis are **all** of the following:

- The member has a diagnosis of ulcerative colitis.
- The member has moderate to severe symptoms of ulcerative colitis.
- The prescription is written by a gastroenterologist or through a gastroenterology consultation.
- The member has taken **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:
  - 6-mercaptopurine (6MP).
  - Azathioprine.
  - Oral aminosalicylates (balsalazide, mesalamine, olsalazine, or sulfasalazine).
  - Oral corticosteroids.

PA requests for Humira® for ulcerative colitis must be submitted on the PA/PDL for Cytokine and CAM Antagonist Drugs for Ulcerative Colitis (Prior Authorization/Preferred Drug List for Cytokine and Cell Adhesion Molecule Antagonist Drugs for Ulcerative Colitis, F-00694 (12/12)).

PA requests for Humira® for ulcerative colitis may be initially approved for up to three months. PA requests may be approved for up to one year if the member has been using Humira® for ulcerative colitis for at least two consecutive months and the member has shown signs of clinical remission. For ongoing PA renewal requests, the member must continue to show evidence of clinical remission.

Topic #9877

Fentanyl Mucosal Agents

PA (prior authorization) requests for the following non-preferred fentanyl mucosal agents must be submitted on the PA/PDL for Fentanyl Mucosal Agents (Prior Authorization/Preferred Drug List for Fentanyl Mucosal Agents, F-00281 (10/11)):

- 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.

Topic #3509

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 Maximum Allowed Cost List pharmacy data table.

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 (prior authorization) 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 (Prior Authorization/Brand Medically Necessary Attachment, F-11083 (07/12)), the prescription with "Brand Medically Necessary" handwritten on it, and all of the appropriate supporting documentation. The pharmacy provider completes a PA/RF (Prior Authorization Request Form, F-11018 (07/12)) 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.

Topic #12897

Grandfathering for Alzheimer's Agents

Galantamine tablets, galantamine solution, and galantamine ER will be grandfathered for BadgerCare Plus Standard Plan, Medicaid, and SeniorCare members currently taking the drug as long as galantamine tablets, galantamine solution, and galantamine ER are non-preferred. PA (prior authorization) is required for galantamine tablets, galantamine solution, and galantamine ER for members who are not grandfathered on the drug.

Galantamine tablets, galantamine solution, and galantamine ER are covered for BadgerCare Plus Benchmark Plan, BadgerCare Plus Core Plan, and BadgerCare Plus Basic Plan members.

Topic #12917

Grandfathering for Anticonvulsants

Equetro is a non-preferred anticonvulsant drug; however, BadgerCare Plus Standard Plan, Core Plan, Medicaid, and SeniorCare members who are currently taking Equetro will be grandfathered until a generic becomes available. PA (prior authorization) is required for Equetro for Standard Plan, Medicaid, and SeniorCare members who are not grandfathered on the drug.

Equetro is a noncovered drug for BadgerCare Plus Core Plan members who are not grandfathered on the drug.

Equetro is a noncovered drug for BadgerCare Plus Benchmark Plan and BadgerCare Plus Basic Plan members.

Topic #10658

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 (prior authorization) 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.

Topic #10659

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 (Prior Authorization Advisory Committee) 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.

Topic #10977

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.

Topic #11837

Grandfathering for HIV/AIDS Drugs

Non-preferred drugs in the HIV (Human Immunodeficiency Virus)/AIDS (Acquired Immune Deficiency Syndrome) drug class will be grandfathered until the generic becomes available for BadgerCare Plus Standard Plan, Medicaid, and SeniorCare members who are currently taking the drugs. After the generic becomes available, grandfathering of non-preferred HIV/AIDs drugs will end for all members.

Certain preferred, generic HIV/AIDS drugs are covered by the Benchmark Plan.

Topic #8839

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.

Topic #10661

Grandfathering for Pancreatic Enzymes

Creon

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.

Pancreaze

Pancreaze is a non-preferred drug; however, Standard Plan, Core Plan, Medicaid, and SeniorCare members who are currently taking Pancreaze will be grandfathered until a generic becomes available. After the generic becomes available, grandfathering of Pancreaze will end for all members.

For Standard Plan, Medicaid, and SeniorCare members, providers should begin working with prescribers to either switch a member's prescription if medically appropriate to a preferred drug in the pancreatic enzymes drug classes or request PA for a non-preferred drug.

For Core Plan members who have not previously taken Pancreaze, the drug will be a noncovered drug.

Pancreaze is a noncovered drug for Benchmark Plan and Basic Plan members.

Topic #8737

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.

Topic #11857

Grandfathering for Pulmonary Arterial Hypertension Drugs

Tracleer

Members currently taking Tracleer are grandfathered and may remain on the drug indefinitely without PA (prior authorization) until a generic is available.

Revatio

Revatio is a non-preferred drug; however, BadgerCare Plus Standard Plan, BadgerCare Plus Core Plan, Medicaid, and SeniorCare members who are currently taking Revatio will be grandfathered until a generic becomes available. After the generic becomes available, grandfathering of Revatio will end for all members.

For Standard Plan, Medicaid, and SeniorCare members, providers should begin working with prescribers to either switch a member's prescription if medically appropriate to a preferred drug in the pulmonary arterial hypertension drug class or request PA for a non-preferred drug.

For Core Plan members who have not previously taken Revatio, the drug will be a noncovered drug. Providers should begin working with prescribers to switch a member's prescription if medically appropriate to a preferred drug in the pulmonary arterial hypertension drug class.

Topic #10662

Grandfathering for Stimulants and Related Agents

Methylphenidate solution is a non-preferred drug; however, BadgerCare Plus Standard Plan, Medicaid, SeniorCare, and transitioned BadgerCare Plus Core Plan members who are currently taking methylphenidate solution will be grandfathered.

PA (prior authorization) is required for methylphenidate solution for Standard Plan, Medicaid, and SeniorCare members who have not previously taken the drug.

Methylphenidate solution continues to be diagnosis-restricted. Members must have one of the allowable diagnosis codes for PA requests to be approved.

Methylphenidate solution continues to be a noncovered drug for Benchmark Plan and Basic Plan members. For all Core Plan members except transitioned Core Plan members, methylphenidate solution is a noncovered drug.

Topic #1988

Growth Hormone Drugs

All growth hormone drugs require clinical PA (prior authorization) for BadgerCare Plus Standard Plan, Medicaid, and SeniorCare members.

Prescribers are required to provide clinical documentation on the PA/PDL for Growth Hormone Drugs (Prior Authorization/Preferred Drug List for Growth Hormone Drugs, F-11092 (10/11)) 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 (Specialized Transmission Approval Technology-Prior Authorization) 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 (Prior Authorization Request Form, F-11018 (07/12)), PA/PDL for Growth Hormone Drugs form, and all supporting documentation.

Growth hormone drugs are noncovered drugs for BadgerCare Plus Benchmark Plan, BadgerCare Plus Core Plan, and BadgerCare Plus Basic Plan members.

Serostim

ForwardHealth covers Serostim with PA for BadgerCare Plus Standard Plan, Medicaid, and SeniorCare members with a diagnosis of AIDS (Acquired Immune Deficiency Syndrome) wasting disease or cachexia.

PA requests for Serostim must be submitted on the PA/PDL for Growth Hormone Drugs.

Zorbtive

ForwardHealth covers Zorbtive with PA for Standard Plan, Medicaid, and SeniorCare members with a diagnosis of short bowel syndrome. Members are limited to a 28-day course of the drug to reduce dependence on intravenous parenteral nutrition. Clinical documentation, including medical records that demonstrate the medical need for Zorbtive, should be submitted with each PA request.

PA requests for Zorbtive must be submitted on the PA/PDL for Growth Hormone Drugs.

Allowable Indications for Growth Hormone Drugs

ForwardHealth covers growth hormone drugs for the following indications:

- Pediatric members with growth failure or short stature associated with chronic renal insufficiency and growth hormone treatment is pre-transplant.
- Pediatric members with growth failure or short stature associated with growth hormone deficiency confirmed with growth hormone stimulation testing demonstrating a growth hormone response of less than 10 ng/mL.
- Pediatric members with growth failure or short stature associated with Noonan's syndrome.
- Pediatric members with growth failure or short stature associated with Prader Willi syndrome.
- Pediatric members with growth failure or short stature associated with SHOX (short stature homeobox-containing) gene deficiency.
- Pediatric members with growth failure or short stature associated with Turner syndrome.
- Pediatric members born small for gestational age that are two years of age or older with a height that remains two standard deviations below the mean for chronological age.
- Adult members with growth hormone deficiency confirmed with an appropriate growth hormone stimulation test.
- Pediatric and adult members with hypothalamic-pituitary structural lesions and evidence of panhypopituitarism involving at least three pituitary hormone deficiencies.

ForwardHealth does not cover growth hormone drugs for members with the following conditions:

- Closed epiphyses.
- A growth rate that falls to less than 2 cm/year.
- Noncompliance.

PA requests submitted for these conditions will be returned as a noncovered service. Members do not have appeal rights for noncovered services.

Note: For adult members with growth hormone deficiency confirmed with an appropriate growth hormone stimulation test and pediatric and adult members with hypothalamic-pituitary structural lesions and evidence of panhypopituitarism involving at least three pituitary hormone deficiencies, the previous bullets regarding returned PA requests do not apply.

For members 18 years of age or older, PA requests for growth hormone drugs must be submitted to ForwardHealth on paper. On PA requests for growth hormone drugs, include the appropriate clinical and medical documentation for the PA consultant to make a determination about the request. Documentation may include the following:

- Bone age results.
- Growth charts and growth percentiles.
- Growth plate results.
- Growth hormone stimulation test results.
- Imaging results.

- Lab testing.
- Medical office notes.

Noncovered Diagnosis

ForwardHealth will no longer cover growth hormone drugs for members with a diagnosis of ISS (idiopathic short stature). ISS is a growth failure or short stature not associated with growth hormone deficiency or disease state.

PA requests submitted for a diagnosis of ISS will be returned to providers and the drug will be a noncovered drug; however, current, approved PAs will be honored until their expiration date. Members do not have appeal rights for noncovered drugs.

Topic #11838

HIV/AIDS Drugs

Although the HIV (Human Immunodeficiency Virus)/AIDS (Acquired Immune Deficiency Syndrome) drug class is split into multiple subclasses on the Preferred Drug List Quick Reference, ForwardHealth monitors the HIV/AIDS drug subclasses as a single drug class. Members must experience a treatment failure on a preferred drug in any subclass before PA (prior authorization) may be requested for a non-preferred drug in any subclass. For example, a member must experience a treatment failure on a preferred protease inhibitor drug before PA may be requested for a non-preferred fusion inhibitor drug.

Topic #12937

Hepatitis C Agents, Protease Inhibitors

Information is available for DOS (dates of service) before April 1, 2012.

Incivek and Victrelis are preferred hepatitis C agents that require clinical PA (prior authorization) for BadgerCare Plus Standard Plan, BadgerCare Plus Core Plan, Medicaid, and SeniorCare members. PA requests for Incivek and Victrelis must be submitted on the Prior Authorization Drug Attachment for Incivek and Victrelis (F-00583 (03/12)).

PA requests for Incivek and Victrelis may be submitted on the ForwardHealth Portal or on paper by fax or mail. ForwardHealth will make a decision about PA requests for Incivek and Victrelis within one business day of receipt of all necessary information.

Incivek and Victrelis are noncovered drugs for BadgerCare Plus Benchmark Plan and BadgerCare Plus Basic Plan members.

Clinical Criteria for Incivek and Victrelis

Clinical criteria for approval of a PA request for Incivek and Victrelis are all of the following:

- The member has a diagnosis of chronic hepatitis C genotype 1 HCV (hepatitis C virus).
- The member is 18 years of age or older.
- The member is not pregnant.
- The member has not had a liver transplant.
- The member has not received a prior course of therapy with a treatment regimen that includes the requested agent or any other HCV NS3/4A protease inhibitor.
- The member's treatment includes concurrent use of pegylated interferon and ribavirin.
- The member has compensated liver disease.
- The member is not taking any contraindicated drugs.

Clinical Criteria for Victrelis

For PA requests for Victrelis, in addition to the previously listed clinical criteria, the member's treatment must include a four-week lead-in period with pegylated interferon and ribavirin before starting Victrelis therapy.

Documentation Requirements

All clinical criteria must be documented on the PA requests for Incivek and Victrelis. In addition, the following must also be documented on the PA request:

- For initial PA requests, the initial HCV-RNA (hepatitis C virus ribonucleic acid) level before therapy began and the date the level was obtained.
- For renewal PA requests for Incivek, the HCV-RNA level at treatment week 4 and the date the level was obtained.
- For renewal PA requests for Victrelis, the HCV-RNA level and the date the level was obtained at the following appropriate intervals indicated in the Victrelis RGT (Response-Guided Therapy) guidelines:
    - Treatment week 8 (i.e., at 4 weeks taking Victrelis) (for members who are naive to treatment with pegylated interferon and ribavirin prior to current treatment with Victrelis).
    - Treatment week 12 (i.e., at 8 weeks taking Victrelis).
    - Treatment week 24 (i.e., at 20 weeks taking Victrelis).

If the member is coinfected with hepatitis B or HIV (Human Immunodeficiency Virus), prescribers are required to document the following on PA requests for Incivek and Victrelis:

- The prescriber's medical specialty.
- The prescriber's experience with prescribing and managing HCV NS3/4 protease inhibitors in coinfected members.
- Why treatment with an HCV NS3/4 protease inhibitor is clinically appropriate for the member.

Prior Authorization Requests

For Incivek, initial PA requests may be approved for up to a maximum of eight weeks. PA requests may be renewed for up to an additional four weeks if the member's HCV-RNA is 1,000 IU/ml or less at treatment week 4. Treatment with Incivek may be approved for up to a maximum treatment period of 12 weeks. Treatment with Incivek should be discontinued at treatment week 4 if the member's HCV-RNA is greater than 1,000 IU/ml.

If treatment with pegylated interferon or ribavirin is discontinued for any reason, treatment with Incivek must be discontinued.

For Victrelis, initial PA requests may be approved for up to a maximum of 12 weeks. PA requests may be renewed for up to an additional 12 weeks if the member's HCV-RNA is less than 100 IU/ml at treatment week 12 (i.e., at 8 weeks taking Victrelis). A final renewal request may be approved for up to an additional 20 weeks if the member's HCV-RNA is undetectable at treatment week 24 (i.e., at 20 weeks taking Victrelis). Treatment with Victrelis may be approved for up to a maximum period of 44 weeks. The maximum approval period for PA requests for Victrelis is based on the Victrelis RGT guidelines. If the member's HCV-RNA is greater than or equal to 100 IU/ml at treatment week 12 or if the member's HCV-RNA is detectable at treatment week 24, treatment with Victrelis should be discontinued.

If treatment with pegylated interferon or ribavirin is discontinued for any reason, treatment with Victrelis must be discontinued.

Submitting Prior Authorization Requests

PA requests for Incivek and Victrelis must be submitted on the Prior Authorization Drug Attachment for Incivek and Victrelis.

PA requests for Incivek and Victrelis may be submitted on the Portal or on paper by fax or mail. ForwardHealth will make a decision about PA requests for Incivek and Victrelis within one business day of receipt of all necessary information.

The Prior Authorization Drug Attachment for Incivek and Victrelis should be completed for initial PA requests and renewal PA requests.

For initial PA requests for Incivek or Victrelis, prescribers should complete Sections I, II, III, and VI of the Prior Authorization Drug Attachment for Incivek and Victrelis and submit the form to the pharmacy where the prescription will be filled. Pharmacy providers are required to submit to ForwardHealth the completed Prior Authorization Drug Attachment for Incivek and Victrelis and a completed PA/RF (Prior Authorization Request Form, F-11018 (07/12)) for initial PA requests.

For renewal PA requests for Incivek and Victrelis, prescribers are required to complete Sections I, II, IV or V, and VI of the Prior Authorization Drug Attachment for Incivek and Victrelis form and submit the form to the pharmacy where the prescription will be filled. Pharmacy providers are required to submit to ForwardHealth the completed Prior Authorization Drug Attachment for Incivek and Victrelis and a completed Prior Authorization Amendment Request (F-11042 (07/12)) for renewal PA requests.

Topic #8858

Hypoglycemics, GLP-1 Agents

Byetta is a preferred drug that requires clinical PA (prior authorization) for BadgerCare Plus Standard Plan, Medicaid, and SeniorCare members. Bydureon and Victoza are non-preferred drugs for Standard Plan, Medicaid, and SeniorCare members.

PA requests for GLP-1 (glucagon-like peptide) agents must be submitted on the Prior Authorization Drug Attachment for Glucagon-Like Peptide (GLP-1) Agents (F-00238 (06/12)).

PA requests for Byetta may be submitted using the STAT-PA (Specialized Transmission Approval Technology-Prior Authorization) system, on the ForwardHealth Portal, or on paper by fax or mail.

PA requests for Bydureon and Victoza may be submitted on the Portal or on paper by fax or mail. PA requests for Bydureon and Victoza cannot be submitted using the STAT-PA system.

PA requests for GLP-1 agents may be initially approved for up to six months. PA requests may be approved for up to one year if the member has been using a GLP-1 agent for at least six months and the member's HbA1c (hemoglobin) decreases by at least 0.5 percent from the member's initial HbA1c or if the member's HbA1c was above seven percent and the HbA1c drops below seven percent. For ongoing PA renewal requests, the member must continue to maintain the improved HbA1c value.

An allowable diagnosis code must be indicated on claims and PA requests for GLP-1 agents. GLP-1 agents are noncovered drugs for uses outside the allowable diagnosis codes.

Bydureon, Byetta, and Victoza are noncovered drugs for BadgerCare Plus Benchmark Plan, BadgerCare Plus Core Plan, and BadgerCare Plus Basic Plan members.

Clinical Criteria for Byetta

Clinical criteria for approval of a PA request for Byetta are all of the following:

- The member has Type II diabetes mellitus.
- The member is 18 years of age or older.
- The member is not currently being treated with insulin other than Lantus insulin.
- 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's HbA1c was measured within the past six months.

- If the member is not currently using a GLP-1 agent, his or her most recent HbA1c is 6.5 percent or greater.
- If the member is not being treated with Lantus insulin, one of the following applies to the member:
    - The member has been taking the maximum effective dose of metformin for the past three months and will continue to take metformin, and the member has been taking the maximum effective dose of a sulfonylurea for the past three months and will continue to take a sulfonylurea.
    - The member has been taking the maximum effective dose of metformin for the past three months and will continue to take metformin, and the member is unable to take the maximum effective dose of a sulfonylurea.
    - The member is unable to take the maximum effective dose of metformin, and the member has been taking the maximum effective dose of a sulfonylurea for the past three months and will continue to take a sulfonylurea.
    - The member is unable to take the maximum effective dose of metformin, and the member is unable to take the maximum effective dose of a sulfonylurea, or
- If the member is being treated with Lantus insulin, one of the following applies to the member:
    - The member has been taking the maximum effective dose of metformin for the past three months and will continue to take metformin.
    - The member is unable to take the maximum effective dose of metformin.

Clinical Criteria for Bydureon

Clinical criteria for approval of a PA request for Bydureon are all of the following:

- The member has Type II diabetes mellitus.
- The member is 18 years of age or older.
- The member is not currently being treated with insulin.
- 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's HbA1c was measured within the past six months.
- If the member is not currently using a GLP-1 agent, his or her most recent HbA1c is 6.5 percent or greater.
- One of the following applies to the member:
    - The member has been taking the maximum effective dose of metformin for the past three months and will continue to take metformin, and the member has been taking the maximum effective dose of a sulfonylurea for the past three months and will continue to take a sulfonylurea.
    - The member has been taking the maximum effective dose of metformin for the past three months and will continue to take metformin, and the member is unable to take the maximum effective dose of a sulfonylurea.
    - The member is unable to take the maximum effective dose of metformin, and the member has been taking the maximum effective dose of a sulfonylurea for the past three months and will continue to take a sulfonylurea.
    - The member is unable to take the maximum effective dose of metformin, and the member is unable to take the maximum effective dose of a sulfonylurea.

For PA requests for Bydureon, members must have taken the maximum dose of Byetta for at least three consecutive months within the last year and failed to achieve at least a 0.5 percent decrease in HbA1c or experienced a clinically significant adverse drug reaction within the last year.

PA requests for Bydureon will not be approved if the member is using any insulin, including basal insulin. Only members who are not taking insulin may qualify for Bydureon.

Clinical Criteria for Victoza

Clinical criteria for approval of a PA request for Victoza are all of the following:

- The member has Type II diabetes mellitus.
- The member is 18 years of age or older.

- The member is not currently being treated with insulin other than basal insulin.
- 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's HbA1c was measured within the past six months.
- If the member is not currently using a GLP-1 agent, his or her most recent HbA1c is 6.5 percent or greater.
- If the member is not being treated with basal insulin, one of the following applies to the member:
    - The member has been taking the maximum effective dose of metformin for the past three months and will continue to take metformin, and the member has been taking the maximum effective dose of a sulfonylurea for the past three months and will continue to take a sulfonylurea.
    - The member has been taking the maximum effective dose of metformin for the past three months and will continue to take metformin, and the member is unable to take the maximum effective dose of a sulfonylurea.
    - The member is unable to take the maximum effective dose of metformin, and the member has been taking the maximum effective dose of a sulfonylurea for the past three months and will continue to take a sulfonylurea.
    - The member is unable to take the maximum effective dose of metformin, and the member is unable to take the maximum effective dose of a sulfonylurea, or
- If the member is being treated with basal insulin, one of the following applies to the member:
    - The member has been taking the maximum effective dose of metformin for the past three months and will continue to take metformin.
    - The member is unable to take the maximum effective dose of metformin.

For PA requests for Victoza, members must have taken the maximum dose of Byetta for at least three consecutive months within the last year and failed to achieve at least a 0.5 percent decrease in HbA1c or experienced a clinically significant adverse drug reaction within the last year.

PA requests for Victoza will not be approved if the member is using bolus insulin (i.e., meal-time insulin).

Topic #12197

Hypoglycemics, Symlin

Clinical Criteria for Hypoglycemics, Symlin

Symlin is a non-preferred drug that requires clinical PA (prior authorization). PA requests for Symlin must be submitted on the PA/PDL for Symlin (Prior Authorization/Preferred Drug List for Symlin, F-00080 (10/11)). PA requests for Symlin may be submitted using the STAT-PA (Specialized Transmission Approval Technology-Prior Authorization) system, on the ForwardHealth 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 (hemoglobin) is less than 9 percent.

Topic #10597

Hypoglycemics, Thiazolidinediones

Effective for DOS (dates of service) on and after September 27, 2010, as a result of FDA (Food and Drug Administration) safety concerns, Avandia, Avandamet, and Avandaryl are non-preferred drugs that require PA (prior authorization) 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, BadgerCare Plus Basic Plan members, and SeniorCare members in levels 2b and 3.

Avandia, Avandamet, and Avandaryl continue to be covered without PA for members taking the drugs as of September 27, 2010, who were grandfathered at that time.

PA is required for Standard Plan, Medicaid, and SeniorCare members who have not previously taken Avandia, Avandamet, or Avandaryl. PA requests for Avandia, Avandamet, and Avandaryl should be submitted on the PA/PDL Exemption Request (Prior Authorization/Preferred Drug List Exemption Request, F-11075 (10/11)).

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.

Topic #10660

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 (prior authorization) is required for those members.

Topic #8657

Leukotriene Modifiers

Information is available for DOS (dates of service) before September 1, 2012.

For DOS on and after September 1, 2012, PA (prior authorization) is not required for Singulair® for BadgerCare Plus Core Plan members.

Topic #9879

Lipotropics, Other

Zetia and Vytorin are non-preferred drugs that require PA (prior authorization). PA requests for Zetia and Vytorin for BadgerCare Plus Standard Plan, Medicaid, and SeniorCare members must be submitted on the PA/PDL for Zetia or Vytorin (Prior Authorization/Preferred Drug List for Zetia or Vytorin, F-00279 (10/11)).

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 LDL (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, 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.

Clinical Criteria for Vytorin

Clinical criteria for approval of a PA request for Vytorin are the following:

- The member is being treated for an elevated total cholesterol level, or
- The member is being treated for an elevated LDL cholesterol level, and
- The member is stabilized on Vytorin and achieving a measureable therapeutic response, or
- The member is stabilized on simvastatin plus Zetia as two separate drugs and achieving a measureable therapeutic response, and
- The member has a medical condition that prevents him or her from taking simvastatin plus Zetia as two separate drugs. Clinical reasons do not include member preference or member copayment.

Topic #11839

Lipotropics, Statins

As a result of an association between 80 mg simvastatin and an increased risk of myopathy, the FDA (Food and Drug Administration) announced safety changes that restrict use of what is currently the highest approved dose of simvastatin.

Simvastatin 80 mg is a preferred drug. The FDA recommends that no new members be prescribed 80 mg of simvastatin. Members who have been taking the dose for a year or more are recommended to continue taking it, provided they have not experienced any muscle toxicity. In addition, the FDA states that the labeling features new contraindications and dose limitations for when simvastatin is taken with certain other medications.

Topic #11917

Migraine Agents, Injectable

PA (prior authorization) requests for non-preferred injectable migraine agents must be submitted on the PA/PDL for Migraine Agents, Injectable (Prior Authorization/Preferred Drug List for Migraine Agents, Injectable, F-00622 (06/12)).

Clinical Criteria for Non-Preferred Migraine Agents, Injectable

Clinical criteria for approval of a PA request for non-preferred injectable migraine agent drugs are the following:

- The member has experienced an unsatisfactory therapeutic response or a clinically significant adverse drug reaction to an oral sumatriptan product, or
- The member has a medical condition(s) that prevents him or her from using an oral sumatriptan product, and
- The member has experienced an unsatisfactory therapeutic response or a clinically significant adverse drug reaction to a nasal sumatriptan product, or
- The member has a medical condition(s) that prevents him or her from using a nasal sumatriptan product, and
- The member has used a preferred injectable sumatriptan product and experienced an unsatisfactory therapeutic response or a clinically significant adverse drug reaction, or
- The member has a medical condition(s) that prevents him or her from using a preferred injectable sumatriptan product, and
- Member preference is not the reason why the member is unable to use a preferred injectable sumatriptan product.

Topic #9878

Migraine Agents, Other

PA (prior authorization) requests for migraine agents must be submitted on the PA/PDL for Migraine Agents, Other (Prior Authorization/Preferred Drug List for Migraine Agents, Other, F-00280 (06/12)).

Clinical Criteria for Non-Preferred Migraine Agents, Other

Clinical criteria for approval of a PA request for a non-preferred oral migraine agent are all of the following:

- The member has previously taken any formulation of a sumatriptan product (i.e., injection, nasal, tablet) and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction.
- The member has previously taken a naratriptan product and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction.
- The member has previously taken an eletriptan product and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction.

Clinical Criteria for Cambia

Clinical criteria for approval of a PA request for Cambia are the following:

- The member has previously taken any formulation of a sumatriptan product (i.e., injection, nasal, tablet) and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction, and
- The member has previously taken a naratriptan product and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction, and
- The member has previously taken an eletriptan product and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction, or
- There is a clinically significant drug interaction between another medication the member is taking and a serotonin 5-HT1 receptor agonist agent (i.e., triptan), and
- The member has experienced an unsatisfactory therapeutic response or a clinically significant adverse drug reaction to two preferred, generic nonsteroidal anti-inflammatory drugs, and
- The member has not experienced an unsatisfactory therapeutic response or a clinically significant adverse drug reaction to diclofenac.

Topic #10997

Multiple Sclerosis Agents, Immunomodulators

Aubagio® and Gilenya™ are non-preferred drugs in the multiple sclerosis agents, immunomodulators drug class that require PA (prior authorization) for members enrolled in the BadgerCare Plus Standard Plan, Medicaid, and SeniorCare. Providers are required to submit PA requests for Aubagio® and Gilyena™ by fax or by mail using the PA/DGA (Prior Authorization/Drug Attachment, F-11049 (07/12)) and the PA/RF (Prior Authorization Request Form, F-11018 (07/12)). Clinical documentation supporting that all of the clinical criteria have been met for the use of Aubagio® or Gilenya™ must be submitted with each PA request.

Aubagio® and Gilenya™ are noncovered drugs for members enrolled in the BadgerCare Plus Benchmark Plan, the BadgerCare Plus Core Plan, and the BadgerCare Plus Basic Plan.

Clinical Criteria for Aubagio®

Clinical criteria that must be documented for approval of a PA request for Aubagio® are **all** of the following:

- The type of MS (multiple sclerosis) 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.
- Clinical information about why the member cannot use a preferred drug and why it is medically necessary that the member receive Aubagio® instead of a preferred MS immunomodulator drug, including **at least one** of the following:
    - The member has experienced an unsatisfactory therapeutic response with a preferred drug(s). If the member has experienced an unsatisfactory therapeutic response, indicate the preferred drug(s) and dose, specific details about the unsatisfactory therapeutic response, and the approximate dates the preferred drug(s) was taken.
    - The member has a medical condition(s) that prevents the use of a preferred drug(s). If the member has a medical condition(s) that prevents the use of a preferred drug(s), indicate the member's medical condition(s) and the preferred drug(s).
    - The member is taking a medication(s) with a clinically significant drug interaction with a preferred drug(s). If the member is taking a medication(s) with a clinically significant drug interaction, indicate the medication(s), the drug interaction(s), and the preferred drug(s).
    - The member has experienced a clinically significant adverse drug reaction with a preferred drug(s). If the member

has experienced a clinically significant adverse drug reaction, indicate the preferred drug(s) and dose, specific details about the clinically signification adverse drug reaction, and the approximate dates the preferred drug(s) was taken.
- Documentation of reliable birth control for women of childbearing age and for men with female partners of childbearing age.

PA requests for Aubagio® must include documentation supporting that all of the clinical criteria have been met.

PA requests for Aubagio® will only be approved for relapsing types of MS. Initial PA requests for Aubagio® may be approved for up to 183 days. Renewal PA requests for Aubagio® may be approved for up to one year.

Clinical Criteria for Gilenya™

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 receive Gilenya™ instead of a preferred drug.

Topic #9857

Multiple Sclerosis Agents, Other

Ampyra is a non-preferred drug that requires clinical PA (prior authorization) in the multiple sclerosis agents, other drug class. Providers should submit PA requests for Ampyra on paper using the PA/DGA (Prior Authorization/Drug Attachment, F-11049 (07/12)) and the PA/RF (Prior Authorization Request Form, F-11018 (07/12)). 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 (multiple sclerosis) 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.

Topic #2328

Nonsteroidal Anti-Inflammatory Drugs

Clinical Criteria for Nonsteroidal Anti-Inflammatory Drugs

The clinical criterion for approval of a PA (prior authorization) request for a non-preferred NSAID (nonsteroidal anti-inflammatory drug), *excluding* COX-2 (cyclooxygenase) inhibitors and Celebrex®, is that the member has experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction with **at least two** preferred NSAIDs (the two preferred NSAIDs cannot be ibuprofen or naproxen).

Clinical criteria for approval of a PA request for Celebrex® require **one** of the following:

- The member has experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction with **at least two** preferred NSAIDS (the two preferred NSAIDS cannot be ibuprofen or naproxen).
- The member has a history of FAP (familial adenomatous polyposis).
- The member has medical record documentation of thrombocytopenia or platelet dysfunction.
- The member has medical record documentation of peptic ulcer disease, a history of GI (gastrointestinal) 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 (Prior Authorization/Preferred Drug List for Non-Steroidal Anti-Inflammatory Drugs, Including Cyclo-oxygenase Inhibitors, F-11077 (12/12)) form.

Topic #8917

Opioid Dependency Agents

Effective for DOS (dates of service) on and after February 1, 2011, PAs (prior authorizations) 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. 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 (Prior

Authorization/Preferred Drug List for Suboxone and Buprenorphine, F-00081 (10/11)).

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 (Specialized Transmission Approval Technology-Prior Authorization) 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.

Topic #10937

Pharmacy Provider Responsibilities for Prior

Authorization for Preferred Drug List Drugs

Pharmacy providers should review the Preferred Drug List Quick Reference for the most current list of preferred and non-preferred drugs.

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 (prior authorization) form.

Pharmacy providers are required to submit the PA request using the PA form received from the prescriber and using the PA request submission option most appropriate for the drug. Pharmacy providers may submit the PA request using the STAT-PA (Specialized Transmission Approval Technology-Prior Authorization) system, on the ForwardHealth Portal, or on paper by fax or mail.

Pharmacy providers are required to retain a completed, signed, and dated copy of the PA form and any supporting documentation received from the prescriber.

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, claims for the drug may be submitted to BadgerRx Gold.

Topic #1987

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. The clinical criteria for PA (prior authorization) approval of a non-preferred drug are the following, unless drug class-specific clinical criteria have been established and published by ForwardHealth:

- A clinically significant drug interaction between another medication the member is taking and the preferred drug(s).
- A clinically significant adverse drug reaction while taking a preferred drug(s).
- An unsatisfactory therapeutic response with a preferred drug(s) in the same drug class as the non-preferred drug.
- A medical condition(s) that prevents the use of a preferred drug(s).

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 the appropriate PA form for the drug. Prescribers are required to send the PA form 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. The PA form 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 PA form to submit a PA request to ForwardHealth. Prescribers should not submit the PA form to ForwardHealth.

Prescribers are required to retain a completed, signed, and dated copy of the PA form and any supporting documentation.

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.

Topic #8877

Proton Pump Inhibitor Drugs

PA (prior authorization) requests for PPI (proton pump inhibitor) drugs may be submitted on the PA/PDL for PPI Capsules and Tablets (Prior Authorization/Preferred Drug List for Proton Pump Inhibitor Capsules and Tablets, F-11078 (10/11)) or the PA/PDL for PPI Suspensions and Orally Disintegrating Tablets (Prior Authorization/Preferred Drug List for Proton Pump Inhibitor Suspensions and Orally Disintegrating Tablets, F-00433 (10/11)).

Lansoprazole solutab 15 mg is a non-preferred drug; however, PA is not required for lansoprazole solutab 15 mg for members who are 12 years of age and younger. For members 13 years of age or older, PA is required. An age restriction no longer applies to Nexium 10 mg suspension or Nexium 20 mg suspension; therefore, PA is required for Nexium 10 mg suspension and Nexium 20 mg suspension regardless of the member's age.

Clinical Criteria for Non-preferred Capsules and Tablets

Clinical criteria for approval of a PA request for non-preferred PPI capsules and tablets are the following:

- The member experienced an unsatisfactory therapeutic response to omeprazole, or
- The member experienced a clinically significant adverse drug reaction to or drug interaction with omeprazole, and
- The member experienced an unsatisfactory therapeutic response to pantoprazole, or
- The member experienced a clinically significant adverse drug reaction to or drug interaction with pantoprazole, and
- The member experienced an unsatisfactory therapeutic response to rabeprazole, or
- The member experienced a clinically significant adverse drug reaction to or drug interaction with rabeprazole.

Note: Members are required to try and fail omeprazole, pantoprazole, and rabeprazole before a PA request may be approved for a non-preferred PPI capsule or tablet.

Clinical Criteria for Non-preferred Suspensions

Clinical criteria for approval of a PA request for non-preferred PPI suspensions are the following:

- The member has a swallowing condition that prevents him or her from swallowing a tablet or capsule, and
- The member experienced an unsatisfactory therapeutic response on any dosage form of omeprazole, or
- The member experienced a clinically significant adverse drug reaction to or drug interaction with any dosage form of omeprazole, or
- The member experienced an unsatisfactory therapeutic response on any dosage form of pantoprazole, or
- The member experienced a clinically significant adverse drug reaction to or drug interaction with any dosage form of pantoprazole.

Note: Members are required to have a swallowing condition that prevents them from swallowing a tablet or capsule and they are required to try and fail omeprazole or pantoprazole before a PA request may be approved for a non-preferred suspension.

Clinical Criteria for Non-preferred Orally Disintegrating Tablets

Clinical criteria for approval of a PA request for non-preferred PPI orally disintegrating tablets are the following:

- The member has a swallowing condition that prevents him or her from swallowing a tablet or capsule, and
- The member has a medical condition that prevents him or her from taking a PPI suspension. Clinical reasons that prevent members from taking a PPI suspension cannot include member preference.

OR

Clinical criteria for approval of a PA request for non-preferred PPI orally disintegrating tablets are the following:

- The member has a swallowing condition that prevents him or her from swallowing a tablet or capsule, and
- The member experienced an unsatisfactory therapeutic response on any dosage form of omeprazole, or
- The member experienced a clinically significant adverse drug reaction to or drug interaction with any dosage form of omeprazole, and
- The member experienced an unsatisfactory therapeutic response on any dosage form of pantoprazole, or
- The member experienced a clinically significant adverse drug reaction to or drug interaction with any dosage form of pantoprazole.

  Note: Members are required to have a swallowing condition that prevents them from swallowing a tablet or capsule and they are required to try and fail omeprazole and pantoprazole before a PA request may be approved for a non-preferred orally disintegrating tablet.

Topic #6660

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 (Other chronic pulmonary heart diseases) are required on claims and PA (prior authorization) requests for all pulmonary arterial hypertension drugs.

Quantity limits apply to Adcirca for BadgerCare Plus Standard Plan, BadgerCare Plus Core Plan, Medicaid, and SeniorCare members.

Topic #8897

Stimulants and Related Agents

Drugs in this class are diagnosis restricted. An allowable diagnosis code must be indicated on claims (and PA (prior authorization) requests when applicable) for all stimulant and related agent drugs, except for modafinil and Nuvigil®.

Strattera® is a preferred drug for members enrolled in the BadgerCare Plus Standard Plan, Medicaid, and SeniorCare.

Strattera® is a noncovered drug for members enrolled in the BadgerCare Plus Benchmark Plan and the BadgerCare Plus Basic Plan.

For PA requests for non-preferred stimulants and related agents, except for modafanil and Nuvigil®, providers should complete the section of the PA/PDL for Stimulants and Related Agents (Prior Authorization/Preferred Drug List for Stimulants and Related Agents, F-11097 (12/12)) form appropriate to the drug being requested.

Clinical Criterion for Non-preferred Stimulants

The clinical criterion for approval of a PA request for a non-preferred stimulant is the member has experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction with **at least two** preferred stimulants.

Clinical Criteria for Kapvay™

Kapvay™ is a non-preferred drug in the stimulants and related agents drug class.

Clinical criteria for approval of a PA request for Kapvay™ require **one** of the following:

- The member will take Kapvay™ in combination with a preferred stimulant.
- The member has experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction with a preferred stimulant.
- The member has a medical condition(s) 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.

Clinical Criteria for Modafinil

PA requests for modafinil for members enrolled in the Standard Plan, the BadgerCare Plus Core Plan, Medicaid, and SeniorCare should be submitted using the Prior Authorization Drug Attachment for Modafinil and Nuvigil® (F-00079 (12/12)).

Pharmacy providers may submit PA requests for modafinil by fax or mail. PA requests for modafinil cannot be submitted through the STAT-PA (Specialized Transmission Approval Technology-Prior Authorization) system.

Clinical criteria for approval of a PA request for modafinil 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 (polysomnogram) has been performed for the member. (*Note:* Test results for the PSG must be submitted with the PA request.)
  - An MSLT (multiple sleep latency test) 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 (obstructive sleep apnea/hypopnea syndrome):
  - The member has tried a CPAP (continuous positive airway pressure) 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 AHI (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.

Clinical criteria for approval of a PA request for modafinil for members with a diagnosis of ADD (attention deficit disorder) or ADHD (attention deficit hyperactivity disorder) are the following:

- The member is at least 16 years of age.
- The member is not currently taking any other stimulants.
- **At least one** of the following is true:
  - The member has experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse

drug reaction with **at least two** preferred stimulants.
    - The member has a medical history of substance abuse or misuse.
    - The member has a serious risk of drug diversion.
- The member has experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction with Strattera®.

A dose limit applies to modafinil. The dose limit for modafinil is 200 mg per day; any dose that exceeds the daily dose limit is a noncovered service.

Initial PA requests for modafinil may be approved for up to 183 days. Renewal PA requests for modafinil may be approved for up to one year.

Modafinil is not covered for Benchmark Plan or Basic Plan members.

Clinical Criteria for Nuvigil®

PA requests for Nuvigil® for members enrolled in the Standard Plan, Medicaid, and SeniorCare should be submitted using the Prior Authorization Drug Attachment for Modafinil and Nuvigil® (F-00079 (12/12)).

Pharmacy providers may submit PA requests for Nuvigil® by fax or mail. PA requests for Nuvigil® cannot be submitted through the STAT-PA system.

Members are required to have taken modafinil before PA may be requested for Nuvigil®. A member must have taken modafinil and experienced an unsatisfactory therapeutic response or had a clinically significant adverse drug reaction and be diagnosed with either narcolepsy, OSAHS, or shift work sleep disorder before PA may be requested for Nuvigil®.

Clinical criteria for approval of a PA request for 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.)
    - An 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 AHI 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.

A dose limit applies to Nuvigil®. The dose limit for Nuvigil® is 250 mg per day; any dose that exceeds the daily dose limit is a noncovered service.

Initial PA requests for Nuvigil® may be approved for up to 183 days. Renewal PA requests for Nuvigil® may be approved for up to one year.

Nuvigil® is not covered for Benchmark Plan, Basic Plan, or Core Plan members.

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 (Prior Authorization/Drug Attachment, F-11049 (07/12)) and a PA/RF (Prior Authorization Request Form, F-11018 (07/12)).

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.
    - Modafinil 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.

Topic #8857

Topical Immunomodulators

Clinical Criteria for Elidel and Protopic

Clinical critieria for approval of a PA (prior authorization) 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® (Prior Authorization/Preferred Drug List for Elidel and Protopic, F-11303 (10/11)) 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 (Specialized Transmission Approval Technology-Prior Authorization) 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.

Review Process

Topic #450

Clerical Review

The first step of the PA (prior authorization) request review process is the clerical review. The provider, member, diagnosis, and treatment information indicated on the PA/RF (Prior Authorization Request Form, F-11018 (07/12)), PA/HIAS1 (Prior Authorization for Hearing Instrument and Audiological Services 1, F-11020 (07/12)), and PA/DRF (Prior Authorization/Dental Request Form, F-11035 (07/12)) 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-enrolled.
- 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.

Topic #451

Clinical Review

Upon verifying the completeness and accuracy of clerical items, the PA (prior authorization) 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. DHS 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 (Department of Health Services).
- Standards of practice.
- Professional knowledge.
- Scientific literature.

Services Requiring Prior Authorization

Topic #10277

Alpha-1 Proteinase Inhibitor Drugs

Although pharmacy providers are responsible for obtaining PA (prior authorization) for drugs that are on the brand medically necessary list or the PDL (Preferred Drug List), prescribers may be asked to provide clinical information to support the medical necessity for alpha-1 proteinase inhibitor drugs (Prolastin and Aralast).

Topic #1414

Drugs That Require Paper Prior Authorization

Paper PA (prior authorization) 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 (Department of Health Services) and the manufacturer; however, these drug products may be covered for BadgerCare Plus or Wisconsin Medicaid members if a paper PA request is submitted.

Submitting Paper Prior Authorization Requests

Paper PA requests that are faxed to ForwardHealth 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 ForwardHealth and for ForwardHealth 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 ForwardHealth may be approved, returned, or denied.

When a PA request is approved:

- The "approved" box on the PA/RF (Prior Authorization Request Form, F-11018 (07/12)) 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.

Topic #13678

Fertility and Impotence Drugs

According to DHS 107.10(2)(f) and 107.10(2)(g), Wis. Admin. Code, the following drugs require PA (prior authorization):

- Drugs identified by the DHS (Department of Health Services) that are sometimes used to enhance the prospect of fertility in males or females, when proposed to be used for treatment of a condition not related to fertility.
- Drugs identified by the DHS that are sometimes used to treat impotence, when proposed to be used for the treatment of a condition not related to impotence.

These types of drugs are not covered unless a paper PA request is submitted on the PA/DGA (Prior Authorization/Drug Attachment, F-11049 (07/12)) and the drug is being used to treat a condition unrelated to fertility or impotence.

Topic #13677

Kalydeco

Kalydeco (ivacaftor) requires PA (prior authorization) and is only indicated for the treatment of a rare form of cystic fibrosis with a G551D mutation in the CFTR (cystic fibrosis transmembrane conductance regulator) gene. Providers should submit PA requests for Kalydeco on paper using the PA/DGA (Prior Authorization/Drug Attachment, F-11049 (07/12)) and the PA/RF (Prior Authorization Request Form, F-11018 (07/12)). Clinical documentation supporting the use of Kalydeco must be submitted with each PA request.

Clinical criteria for approval of a PA request for Kalydeco are the following:

- The member has a diagnosis of cystic fibrosis.
- The member is 6 years of age or older.
- The prescriber has confirmed the member has a G551D mutation in the CFTR gene. (*Note:* A copy of the test results should be included with an initial PA request.)

- The prescriber has confirmed the member does not have a homozygous F508del mutation in the CFTR gene.
- The prescriber has confirmed liver function testing is being periodically monitored. (*Note:* A copy of the test results completed within the last 90 days should be included with initial and renewal PA requests.)

PA requests for Kalydeco may be approved for a maximum approval period of 365 days.

Kalydeco is a noncovered drug for BadgerCare Plus Benchmark Plan, BadgerCare Plus Core Plan, and BadgerCare Plus Basic Plan members.

Topic #7877

Prior Authorization Requests and Amendments for Synagis

Synagis® requires PA (prior authorization). 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.

When requesting PA for Synagis®, the prescribing provider must identify the name and NPI (National Provider Identifier) of the provider who intends to submit a claim for reimbursement for Synagis® (i.e., the billing provider).

If the prescribing provider intends to submit the claim, the prescribing provider must list his or her name and NPI on the PA request as the billing provider.

If the prescribing provider's clinic or group intends to submit the claim, the prescribing provider must list the clinic or group's name and NPI on the PA request as the billing provider.

If, instead, a pharmacy provider intends to submit the claim, the prescribing provider must list the pharmacy provider's name and NPI on the PA request as the billing provider. In this case, it is the prescribing provider's responsibility to acquire the pharmacy provider's name and NPI.

Prescribers or their designees must request PA for Synagis® using only one of the following options:

- DAPO (Drug Authorization and Policy Override) Center.
- ForwardHealth 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 (Prior Authorization Request Form, F-11018 (07/12)) for physician services.
- Prior Authorization Drug Attachment for Synagis (F-00142 (10/09)).
- Supporting documentation, as appropriate.

The Prior Authorization Fax Cover Sheet (F-01176 (12/11)) is available for providers submitting the forms and documentation by fax.

Prior Authorization Amendments

Prescribing providers and billing providers may amend approved PAs for Synagis® if a member's weight changes, resulting in an increase in Synagis® units during a treatment season. Providers have 30 days from the date of administering each dose change to amend an approved PA for Synagis®.

If the prescribing provider is not also the billing provider, the prescribing provider may only amend the PA by contacting the DAPO Center.

Billing providers may amend PA requests through the following:

- By calling the DAPO Center.
- On the Portal.
- By submitting a PA/RF by mail or fax.

To amend a PA request for Synagis®, providers are required to provide the following information:

- The member's most recent weight and the date it was measured.
- The member's weight at the time the dose change occurred and the date it was measured.
- The requested start date for the dose change.
- The new Synagis® dose calculation.

Change in Billing Provider

If during the course of Synagis® treatment the billing provider changes, the prescribing provider (i.e., the provider who submitted the original PA request) is responsible for amending the PA. To amend the billing provider information, the prescribing provider must call the DAPO Center. The prescribing provider will be required to give the new billing provider's name and NPI.

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 (respiratory syncytial virus) 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 (severe combined immunodeficiency) or advanced AIDS (Acquired Immunodeficiency Syndrome)). 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 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.

Topic #7837

Prior Authorization for Anti-Obesity Drugs

PA (Prior authorization) requests for the following anti-obesity drugs may be submitted on the Prior Authorization Drug Attachment for Anti-Obesity Drugs (F-00163 (12/12)):

- Benzphetamine.
- Diethylpropion.
- Phentermine.
- Phendimetrazine.
- Qysmia.
- Xenical®.

Note: Anti-obesity drugs are not covered by the BadgerCare Plus Benchmark Plan, the BadgerCare Plus Core Plan, or the BadgerCare Plus Basic Plan.

Anti-obesity drugs are covered for dual eligibles enrolled in a Medicare Part D PDP (Prescription Drug Plan).

A 34-day supply is the maximum amount of any anti-obesity drug that may be dispensed each month.

Clinical Criteria for Anti-obesity Drugs

Clinical criteria for approval of a PA request for anti-obesity drugs require **one** of the following:

- The member has a BMI (body mass index) 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 drugs if an FDA (Food and Drug Administration)-approved generic equivalent is available. ForwardHealth does not cover any brand name innovator phentermine products. In addition, ForwardHealth does not cover OTC (over-the-counter) anti-obesity drugs.

ForwardHealth will return PA requests for OTC and brand name anti-obesity drugs with generic equivalents and brand name phentermine products 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, or if the member has completed six months of continuous benzphetamine, diethylpropion, phendimetrazine, or phentermine treatment, the member must wait six months before PA can be requested for Qysmia, benzphetamine, diethylpropion, phendimetrazine, or phentermine.

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.

Qysmia

If clinical criteria for anti-obesity drugs are met, initial PA requests for Qysmia will be approved for six months. If the member meets a weight loss goal of at least five percent of his or her weight from baseline, PA may be requested for an additional six months of treatment. PA requests for Qysmia may be approved for a maximum treatment period of 12 continuous months of drug therapy.

If the member does not meet a weight loss goal of at least five percent of his or her weight from baseline during the initial six-month approval, or if the member has completed 12 months of continuous Qysmia treatment, the member must wait six months before PA can be requested for Qysmia, benzphetamine, diethylpropion, phendimetrazine, or phentermine.

ForwardHealth allows only two weight loss attempts with Qysmia 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 for anti-obesity drugs are met, initial PA requests for Xenical® will be approved for six months. 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.

If the member does not meet a weight loss goal of at least 10 pounds during the initial six-month approval, if the member's weight increases during any renewal period, or if the member has completed 24 months of continuous Xenical® treatment, the member must wait six months before PA can be requested for Xenical®.

ForwardHealth allows only two weight loss attempts with Xenical® during a member's lifetime. Additional PA requests will not be approved. ForwardHealth will return additional PA requests to the provider as noncovered services.

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 enrolled in Wisconsin Medicaid to submit PA requests to ForwardHealth. Prescribers who are enrolled in Wisconsin Medicaid should indicate their name and NPI (National Provider Identifier) as the billing provider on PA requests. Prescribers who are not enrolled in Wisconsin Medicaid should indicate the name and NPI of the Wisconsin Medicaid-enrolled billing provider (e.g., clinic) with which they are affiliated on PA requests.

Prescribers are encouraged to submit PA requests for anti-obesity drugs through the DAPO (Drug Authorization and Policy Override) Center. PA requests for anti-obesity drugs may also be submitted on the Portal or by fax or mail.

Note: Pharmacy providers cannot request PA for anti-obesity drugs using the STAT-PA (Specialized Transmission Approval Technology-Prior Authorization) 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."

Prior Authorization Requests Submitted by Fax or Mail

Prescribers may 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
313 Blettner Blvd
Madison WI 53784

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 (Prior Authorization Request Form, F-11018 (07/12)) for prescribers for drugs.

- Prior Authorization Drug Attachment for Anti-Obesity Drugs.
- Supporting documentation, as appropriate.

The Prior Authorization Fax Cover Sheet (F-01176 (12/11)) is available for providers submitting the forms and documentation by fax.

PA 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.

Topic #13157

Prior Authorization for Antipsychotic Drugs for Children 6 Years of Age and Younger

All antipsychotic drugs prescribed for oral use for all children 6 years of age and younger require PA (prior authorization).

PA requests must meet the criteria for children 6 years of age and younger to maintain coverage of an antipsychotic drug.

PA requests for antipsychotic drugs for children 6 years of age and younger must be submitted on the Prior Authorization Drug Attachment for Antipsychotic Drugs for Children 6 Years of Age and Younger (F-00556 (01/12)).

Claims submitted for an antipsychotic drug for children 6 years of age and younger without an approved Prior Authorization Drug Attachment for Antipsychotic Drugs for Children 6 Years of Age and Younger on file will be denied.

Providers should refer to the Preferred Drug List Quick Reference for a list of covered antipsychotic drugs for members enrolled in the BadgerCare Plus Standard Plan or Medicaid. Prescribers are encouraged to write prescriptions for preferred antipsychotic drugs.

Providers should refer to the BadgerCare Plus Benchmark Plan Product List for a list of covered antipsychotic drugs for BadgerCare Plus Benchmark Plan members. Antipsychotic drugs that are not on the BadgerCare Plus Benchmark Plan Product List are noncovered. If a noncovered antipsychotic drug is necessary for a Benchmark Plan member, the prescriber should inform the member the drug is not covered and instruct the member to work with his or her pharmacy provider to determine whether or not the drug is covered by BadgerRx Gold.

Prescriber Responsibilities for Antipsychotic Drugs for Children 6 Years of Age and Younger

Prescribers should determine the ForwardHealth benefit plan in which a member is enrolled before writing a prescription for an antipsychotic drug.

If the child is 6 years of age or younger and requires an antipsychotic drug, the prescriber is required to complete the Prior Authorization Drug Attachment for Antipsychotic Drugs for Children 6 Years of Age and Younger. PA requests and prescriptions must be faxed, mailed, or sent with the member to the pharmacy provider.

The pharmacy provider will use the completed form to submit a PA request to ForwardHealth. Prescribers should not submit the Prior Authorization Drug Attachment for Antipsychotic Drugs for Children 6 Years of Age and Younger form directly to ForwardHealth.

PA requests for covered antipsychotic drugs for children 6 years of age and younger are approved at the active ingredient level. Therefore, an approved PA request allows any covered NDC (National Drug Code) drug with the same active ingredient of the

prior authorized drug to be covered with the same PA. For example, if a member has an approved PA request for risperidone 1 mg tablet and the prescriber orders a new prescription for risperidone 2 mg tablet, an amended PA request or new PA request is not required.

Pharmacy Responsibilities for Antipsychotic Drugs for Children 6 Years of Age and Younger

Pharmacy providers should ensure that they have received the completed Prior Authorization Drug Attachment for Antipsychotic Drugs for Children 6 Years of Age and Younger from the prescriber. Pharmacy providers should determine the ForwardHealth benefit plan in which the member is enrolled. After the benefit plan is confirmed, pharmacy providers should review the program-specific covered drug or product list. For Standard Plan and Medicaid members, pharmacy providers should review the Preferred Drug List Quick Reference for the most current list of preferred and non-preferred drugs. For Benchmark Plan members, pharmacy providers should review the BadgerCare Plus Benchmark Plan Product List.

If a Standard Plan or Medicaid member presents a prescription for a non-preferred antipsychotic 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 antipsychotic drug, if medically appropriate for the member.

For Benchmark Plan members, if an antipsychotic drug is a noncovered drug, claims for the drug may be submitted to BadgerRx Gold.

It is important that pharmacy providers work with prescribers to ensure that members are given appropriate assistance regarding coverage information and the PA request submission process for antipsychotic drugs. Pharmacy providers are responsible for the submission of the Prior Authorization Drug Attachment for Antipsychotic Drugs for Children 6 Years of Age and Younger to ForwardHealth. Pharmacy providers are required to retain a completed and signed copy of the PA form.

Required Documentation

The following factors will be considered for the approval of a PA request for antipsychotics for children 6 years of age and younger and should be documented on the PA request:

- Diagnoses — There are appropriate indications for the use of antipsychotic medications in young children with certain diagnoses including autism spectrum disorders, psychotic disorders, tic disorders, and severe agitation or aggression that may accompany severe mood and developmental disorders.
- Prescriber's credentials — When ForwardHealth reviews a particular PA request, the prescriber's credentials are considered as one's area of expertise that may or may not include familiarity with the antipsychotic class of medications.
- Target symptoms — To appropriately prescribe and track the use of antipsychotic medications, the prescriber needs to carefully identify the primary target symptom so that the family, mental health clinicians, teachers, and all involved adults can help clarify and determine the efficacy of the medication.
- Polypharmacy — There are many concerns regarding the use of multiple psychoactive medications in children. The Prior Authorization Drug Attachment for Antipsychotic Drugs for Children 6 Years of Age and Younger requires the notation of any psychoactive medications, concurrent medications, and previous medication trials in the preceding 12 months.
- Mental health resources — The available resources for evaluating and treating a child and family are critical for understanding the clinical approach and role of medication in a child's treatment plan. Noting the involvement of resources (such as Birth to 3, in-home therapy, family therapy, child psychiatry consultation, outpatient contacts, hospitalization, acute/chronic medical needs) will help the PA consultants understand the clinical resources available to a particular child and family.
- BMI (Body Mass Index) — Antipsychotic medications can have profoundly adverse effects on weight, glucose, and lipids. Because of these well-documented side effects, the Prior Authorization Drug Attachment for Antipsychotic Drugs for Children 6 Years of Age and Younger requires the submission of a BMI measurement with each PA request. A BMI calculator is available and may be found on the Centers for Disease Control and Prevention Web site at http://apps.nccd.cdc.gov/dnpabmi/.

- Foster placement — Several studies have shown that children in foster care have a relatively high incidence of receiving antipsychotic medications. Indicate whether or not the child is currently placed in foster care.
- PDL (Preferred Drug List) — If the prescriber is requesting a non-preferred antipsychotic medication, clinical justification must be provided (e.g., failed trials of preferred medications including doses, length of treatment, clinical response, side effects, target symptoms). PA requests for brand medically necessary drugs must be submitted separately with clinical justification that the brand name drug is medically necessary.

Psychiatrists board-certified in child psychiatry developed the PA criteria and they are consulting with ForwardHealth to review the PA requests. A PA request may be returned for additional information prior to adjudication, so it is important that contact information for the prescriber or the prescriber's office be accurate to facilitate the adjudication process. The child psychiatrist consultants will be available to review specific questions about a particular PA request after the PA request is received by ForwardHealth.

Prior Authorization Request Submission Methods

Pharmacy providers are encouraged to submit all PA requests for antipsychotic drugs for Standard Plan and Medicaid members 6 years of age and younger using the STAT-PA (Specialized Transmission Approval Technology-Prior Authorization) system. The STAT-PA submission allows ForwardHealth to capture and use information to monitor prescribing of antipsychotic drugs for children under the DUR (Drug Utilization Review) program.

If the PA request is not approved through the STAT-PA system or if the PA request is for a brand medically necessary antipsychotic drug, pharmacy providers are required to submit the Prior Authorization Drug Attachment for Antipsychotic Drugs for Children 6 Years of Age and Younger form via one of the following:

- The ForwardHealth Portal.
- Fax.
- Mail.

For Benchmark Plan members, all Prior Authorization Drug Attachment for Antipsychotic Drugs for Children 6 Years of Age and Younger forms must be submitted on either the Portal or by fax or mail.

PA requests for all antipsychotic drugs submitted via the Portal or by fax or mail to ForwardHealth must include the following:

- A PA/RF (Prior Authorization Request Form, F-11018 (07/12)).
- The Prior Authorization Drug Attachment for Antipsychotic Drugs for Children 6 Years of Age and Younger.
- Any additional supporting documentation from the prescriber.

Approved Prior Authorization Requests for Antipsychotic Drugs for Children 6 Years of Age and Younger

PA requests for all antipsychotic drugs for children 6 years of age and younger will be approved at the ingredient level.

Neither a new PA request nor a PA amendment is needed if the antipsychotic drug the child is taking has changed and the new drug contains the same active ingredient as the original drug approved or if the child is taking multiple strengths of the same drug.

PA decision letters for antipsychotic drugs for children 6 years of age and younger will include a message stating: "The prior authorization for this drug has been approved at the active ingredient level instead of the drug strength and dosage form level. Additional PAs are not needed for a different strength of this same drug."

Topic #7077

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 (prior authorization) is required for all Core Plan members:

- Cytokine and CAM (cell adhesion molecule) 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.

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.

Topic #10897

Prior Authorization for Diagnosis Restricted Diabetic Supplies

Some diabetic supplies may be used to treat or monitor conditions related to diabetes. PA (prior authorization) requests may be approved for blood glucose meters, blood glucose strips, control solutions, lancets, and lancet devices if a 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 (Prior Authorization Request Form, F-11018 (07/12)).
- A PA/DGA (Prior Authorization/Drug Attachment, F-11049 (07/12)).
- 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.

Topic #12997

Prior Authorization for Drugs Outside Approved Diagnoses

PA (prior authorization) requests for drugs outside approved diagnoses must be submitted on paper using a PA/RF (Prior Authorization Request Form, F-11018 (07/12)) and a PA/DGA (Prior Authorization/Drug Attachment, F-11049 (07/12)). 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.

Submission of peer-reviewed medical literature to support the proven efficacy of the requested use of a drug is required for PA requests outside diagnosis restrictions.

Topic #7817

Prior Authorization for Lovaza

Lovaza® is a preferred drug that requires clinical PA (prior authorization). To request PA for Lovaza®, prescribers are required to complete and submit to ForwardHealth the Prior Authorization Drug Attachment for Lovaza (F-00162 (07/12)).

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 enrolled in Wisconsin Medicaid to submit PA requests to ForwardHealth. Prescribers who are enrolled in Wisconsin Medicaid should indicate their name and NPI (National Provider Identifier) as the billing provider on PA requests. Prescribers who are not enrolled in Wisconsin Medicaid should indicate the name and NPI of the Wisconsin Medicaid-enrolled billing provider (e.g., clinic) with which they are affiliated on PA requests.

PA requests for Lovaza® may be submitted through the following:

- DAPO (Drug Authorization and Policy Override) Center.
- Fax.

- Mail.

Note: Pharmacy providers cannot request PA for Lovaza® using the STAT-PA (Specialized Transmission Approval Technology-Prior Authorization) 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
313 Blettner Blvd
Madison WI 53784

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 (Prior Authorization Request Form, F-11018 (07/12)) for prescribers for drugs.
- Prior Authorization Drug Attachment for Lovaza.
- Supporting documentation, as appropriate.

The Prior Authorization Fax Cover Sheet (F-01176 (12/11)) 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.

Topic #8977

Prior Authorization for Non-Preferred Diabetic Supplies

Providers may submit PA (prior authorization) requests for non-preferred diabetic supplies. To receive PA for non-preferred products, members are required to try and fail on at least one product by each of the preferred manufacturers.

Providers must submit PA requests using the Prior Authorization Drug Attachment for Diabetic Supplies (F-00239 (04/10)). 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 Request Form, F-11018 (07/12)).
- Prior Authorization Drug Attachment for Diabetic Supplies.
- Any supporting documentation.

Once the PA request is approved, the member may go to any enrolled 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.

Topic #13017

Types of Drugs that Require Prior Authorization

The following are types of drugs that require PA (prior authorization):

- Brand medically necessary drugs.
- Diagnosis-restricted drugs.
- Drugs outside approved diagnoses.
- PDL (Preferred Drug List) drugs.

Situations Requiring New Requests

Topic #5197

Changes to Member Enrollment Status

Changes to a member's enrollment status may affect PA (prior authorization) 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.

Topic #5417

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.

Topic #454

Services Not Performed Before Expiration Date

Generally, a new PA (prior authorization) 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

Topic #12597

278 Health Care Services Review — Request for Review and Response Transaction

Providers may request PA (prior authorization) electronically using the 278 (278 Health Care Services Review — Request for Review and Response) transaction, the standard electronic format for health care service PA requests.

Compliance Testing

Trading partners may conduct compliance testing for the 278 transaction.

After receiving an "accepted" 999 (999 Functional Acknowledgment) for a test 278 transaction, trading partners are required to call the EDI (Electronic Data Interchange) Helpdesk to request the production 278 transaction set be assigned to them.

Submitting Prior Authorization Requests

Submitting an initial PA request using the 278 transaction does not result in a real-time approval and cannot be used to request PA for drugs and diabetic supplies.

After submitting a PA request via a 278 transaction, providers will receive a real-time response indicating whether the transaction is valid or invalid. If the transaction is invalid, the response will indicate the reject reason(s), and providers can correct and submit a new PA request using the 278 transaction. A real-time response indicating a valid 278 transaction will include a PA number and a pending status. The PA request will be placed in a status of "Pending - Fiscal Agent Review."

The 278 transaction does not allow providers to submit supporting clinical information as required to adjudicate the PA request.

Trading partners cannot submit the 278 transaction through PES (Provider Electronic Solutions). In order to submit the 278 transaction, trading partners will need to use their own software or contract with a software vendor.

Topic #7857

Drug Authorization and Policy Override Center

The DAPO (Drug Authorization and Policy Override) Center is a specialized drug helpdesk for prescribers, their designees, and pharmacy providers to submit PA (prior authorization) 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.

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 enrolled in Wisconsin Medicaid to submit PA requests to ForwardHealth. Prescribers who are enrolled in Wisconsin Medicaid should indicate their name and NPI (National Provider Identifier) as the billing provider on PA requests. Providers who are not enrolled in Wisconsin Medicaid should indicate the name and NPI of the Wisconsin Medicaid-enrolled 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 (registered nurse), 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 up 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 (Prior Authorization Request Form, F-11018 (07/12)) 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.

Topic #455

Fax

Faxing of all PA (prior authorization) requests to ForwardHealth may eliminate one to three days of mail time. The following are recommendations to avoid delays when faxing PA requests:

- Providers should 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 (F-01176 (12/11)) 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) 224-6124.

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 (Prior Authorization Request Form, F-11018 (07/12)) or the PA/HIAS1 (Prior Authorization for Hearing Instrument and Audiological Services 1, F-11020

(07/12)) 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) 224-6124, 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 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.

Topic #458

ForwardHealth Portal Prior Authorization

Providers can use the PA (prior authorization) features on the ForwardHealth Portal to do the following:

- Submit PA requests and amendments for all services that require PA.
- Save a partially completed PA request and return at a later time to finish completing it.
- Upload PA attachments and additional supporting clinical documentation for PA requests.
- Receive decision notice letters and returned provider review letters.
- Correct returned PA requests and PA amendment requests.
- Change the status of a PA request from "Suspended" to "Pending."
- Submit additional supporting documentation for a PA request that is in "Suspended" or "Pending" status.
- Search and view previously submitted PA requests or saved 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 (National Provider Identifier) requirements, NPI and related data are required on PA requests 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 PA requests with a status of "Approved" or "Approved with Modifications."

Saving Partially Completed Prior Authorization Requests

Providers do not have to complete PA requests in one session; they can save partially completed PA requests at any point after the Member Information page has been completed by clicking on the Save and Complete Later button, which is at the bottom of each page. There is no limit to how many times PA requests can be saved.

Providers can complete partially saved PA requests at a later time by logging in to the secure Provider area of the Portal, navigating to the Prior Authorization home page, and clicking on the Complete a Saved PA Request link. This link takes the provider to a Saved PA Requests page containing all of the provider's PA requests that have been saved.

Once on the Saved PA Requests page, providers can select a specific PA request and choose to either continue completing it or delete it.

Note: The ability to save partially completed PA requests is only applicable to new PA requests. Providers cannot save partially completed PA amendments or corrections to returned PA requests or amendments.

30 Calendar Days to Submit or Re-Save Prior Authorization Requests

Providers must submit or re-save PA requests within 30 calendar days of the date the PA request was last saved. After 30 calendar days of inactivity, a PA request is automatically deleted, and the provider has to re-enter the entire PA request.

The Saved PA Requests page includes a list of deleted PA requests. This list is for information purposes only and includes saved PA requests that have been deleted due to inactivity (it does *not* include PA requests deleted by the provider). Neither providers nor ForwardHealth are able to retrieve PA requests that have been deleted.

Submitting Completed Prior Authorization Requests

ForwardHealth's initial receipt of a PA request occurs when the PA request is submitted on the Portal. Normal backdating policy applies based on the date of initial receipt, not on the last saved date. Providers receive a confirmation of receipt along with a PA number once a PA request is submitted on the Portal.

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 (Prior Authorization/"J" Code Attachment, F-11034 (07/12)) and display the form for the provider to complete. Certain PA attachments cannot be completed online or uploaded.

Providers may also upload an electronically completed version of the paper PA attachment form. However, when submitting a PA attachment electronically, ForwardHealth recommends completing the PA attachment online as opposed to uploading an electronically completed version of the paper attachment form to reduce the chances of the PA request being returned for clerical errors.

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 (F-11159 (10/08)) 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 (Prior Authorization Request Form, F-11018 (07/12)) that was completed on the Portal.

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 request 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 providers.

Additional Supporting Clinical Documentation

ForwardHealth accepts additional supporting clinical documentation when the information cannot be indicated on the required PA request forms and is pertinent for processing the PA request or PA amendment request. Providers have the following options for submitting additional supporting clinical information for PA requests or PA amendment requests:

- Upload electronically.
- Mail.
- Fax.

Providers can choose to upload electronic supporting information through the Portal in the following formats:

- JPEG (Joint Photographic Experts Group) (.jpg or .jpeg).
- PDF (Portable Document Format) (.pdf).
- Rich Text Format (.rtf).
- Text File (.txt).
- OrthoCAD™ (.3dm) (for dental providers).

JPEG files must be stored with a ".jpg" or ".jpeg" extension; text files must be stored with a ".txt" extension; rich text format files must be stored with an ".rtf" extension; and PDF files must be stored with a ".pdf" extension. Dental OrthoCAD™ files are stored

with a ".3dm" extension.

Microsoft Word files (.doc) cannot be uploaded but can be saved and uploaded in Rich Text Format or Text File formats.

In addition, providers can also upload additional supporting clinical documentation via the Portal when:

- Correcting a PA request or PA amendment request that is in a "Returned — Provider Review" status.
- Submitting a PA amendment request.

If submitting supporting clinical information via mail or fax, 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.

ForwardHealth will return PA requests and PA amendments requests when the additional documentation could have been indicated on the PA/RF and PA attachments or when the pertinent information is difficult to find.

"Suspended" Prior Authorization Requests

For PA requests in a "Suspended" status, the provider has the option to:

- Change a PA request status from "Suspended" to "Pending."
- Submit additional documentation for a PA request that is in "Suspended" or "Pending" status.

Changing a Prior Authorization Request from "Suspended" to "Pending"

The provider has the option of changing a PA request status from "Suspended — Provider Sending Info" to "Pending" if the provider determines that additional information will not be submitted. Changing the status from "Suspended — Provider Sending Info" to "Pending" will allow the PA request to be processed without waiting for additional information to be submitted. The provider can change the status by searching for the suspended PA request, checking the box indicating that the PA request is ready for processing without additional documentation, and clicking the Submit button to allow the PA request to be processed by ForwardHealth. There is an optional free form text box, which allows providers to explain or comment on why the PA request can be processed.

Submitting Additional Supporting Clinical Documentation for a Prior Authorization Request in "Suspended" or "Pending" Status

There is an Upload Documents for a PA link on the PA home page in the provider secured Home Page. By selecting that link, providers have the option of submitting additional supporting clinical documentation for a PA request that is in "Suspended" or "Pending" status. When submitting additional supporting clinical documentation for a PA request that is in "Suspended" status, providers can choose to have ForwardHealth begin processing the PA request or to keep the PA request suspended. Prior authorization requests in a "Pending" status are processed regardless.

Note: When the PA request is in a "Pending" status and the provider uploads additional supporting clinical documentation, there may be up to a four-hour delay before the documentation is available to ForwardHealth in the system. If the uploaded information was received after the PA request was processed and the PA request was returned for missing information, the provider may resubmit the PA request stating that the missing information was already uploaded.

Topic #456

Mail

Any type of PA (prior authorization) 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
313 Blettner Blvd
Madison WI 53784

Providers are encouraged to retain copies of all PA requests and supporting documentation before submitting them to ForwardHealth.

Topic #4618

NCPDP Transactions

ForwardHealth accepts the following NCPDP (National Council for Prescription Drug Programs) Telecommunication Standard Version D.0 PA (prior authorization) 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 Payer Sheet: National Council for Prescription Drug Programs Version D.0.

The following are descriptions and/or requirements for each type of NCPDP PA transaction:

P2 Reversal

To reverse a PA (i.e., change the PA to an inactive status) using the P2 transaction, all of the following must be true:

- The provider is the original provider who submitted the PA.
- The PA is in one of the following statuses:
  - Approved — The PA request was approved.
  - 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 — State Review: The PA request is being reviewed by the state.
  - Suspended — 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.
- None of the services on an approved PA have been used.

P3 Inquiry

Providers may inquire about PAs they have previously submitted and receive PA information from ForwardHealth by submitting a P3 inquiry transaction. ForwardHealth recommends indicating the PA number, if known, when submitting a P3 inquiry. If a PA number is not included on the P3 inquiry, the most recent matching PA number will be reported.

P4 Request

Providers may submit an initial PA request using the P4 request transaction; however, this will not result in a real-time approval. The P4 request transaction does not allow providers to submit the required clinical information needed to adjudicate the PA

request.

After submitting a PA request via the P4 transaction, providers will receive a real-time response indicating whether the transaction is accepted or rejected. If the transaction is rejected, the response will indicate a reject reason(s), and providers can correct and submit a new PA request using the P4 transaction.

An accepted P4 transaction with a captured response status will include a PA number. The PA request will be placed in a status of "Pending — Fiscal Agent Review."

Uploading Additional Documentation

Once providers receive the PA number, they may upload additional documentation (e.g., the PA attachment, supporting clinical information) for the pending PA through the Portal.

After receiving the additional documentation, ForwardHealth will adjudicate the PA request and send the provider either a decision notice or a returned provider review letter.

Returned Provider Review Letter

Once the PA request is in a Pending — Fiscal Agent Review status, ForwardHealth will review the request and, if the additional documentation has not been submitted, will send providers a returned provider review letter indicating the information required to adjudicate the request. PA requests cannot be adjudicated until ForwardHealth receives the additional information.

After receiving a returned provider review letter, providers should submit the additional information through the Portal, fax, or mail if they have not already done so. Providers have 30 calendar days from the date on the returned provider review letter to submit the additional information or the PA request will become inactive. After a PA request has become inactive, providers can submit a new request using the P4 transaction.

Topic #457

STAT-PA

Providers can submit STAT-PA (Specialized Transmission Approval Technology-Prior Authorization) 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 (prior authorization) requests.

NPI (National Provider Identifier) 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.

Topic #1416

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 (National Council for Prescription Drug Programs) transaction, or on paper.

A STAT-PA Quick Reference Guide includes information about STAT-PA inquiries.

The STAT-PA system allows enrolled 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 using the STAT-PA System Instructions (F-11055, 10/11) 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.

For STAT-PA requests that are approved, providers receive verbal confirmation of the approval at the end of the transaction. The verbal confirmation includes the following information:

- A PA number.
- The grant date and expiration date.
- The allowable days' supply.

Providers are encouraged to write this information in the applicable fields of the PA drug attachment.

(*Note:* When a STAT-PA request is approved, the claim may be submitted immediately.)

For STAT-PA requests that are returned, providers receive the following information at the end of the transaction:

- A PA number.
- The reason for the return.
- A statement to submit the PA request with complete clinical documentation.

Providers also receive a returned provider review letter by mail.

Reconsideration of a STAT-PA Request

Submit the following on paper for reconsideration of a STAT-PA request:

- A PA/RF (Prior Authorization Request Form, F-11018 (07/12)). 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

Providers may enddate PAs using the STAT-PA system according to the following requirements:

- 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 end date must be after the grant date and before the expiration date.
- The PA must *not* have been previously amended.
- The end date must be within 14 days of the current date.
- The end date must be within 29 days of the services (days' supply) that are already used on the PA. (For PAs for Suboxone, the end date must be within 10 days.)

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.

For STAT-PA amendment requests that are approved, providers receive verbal confirmation of the approval at the end of the transaction, as well as by mail.

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.

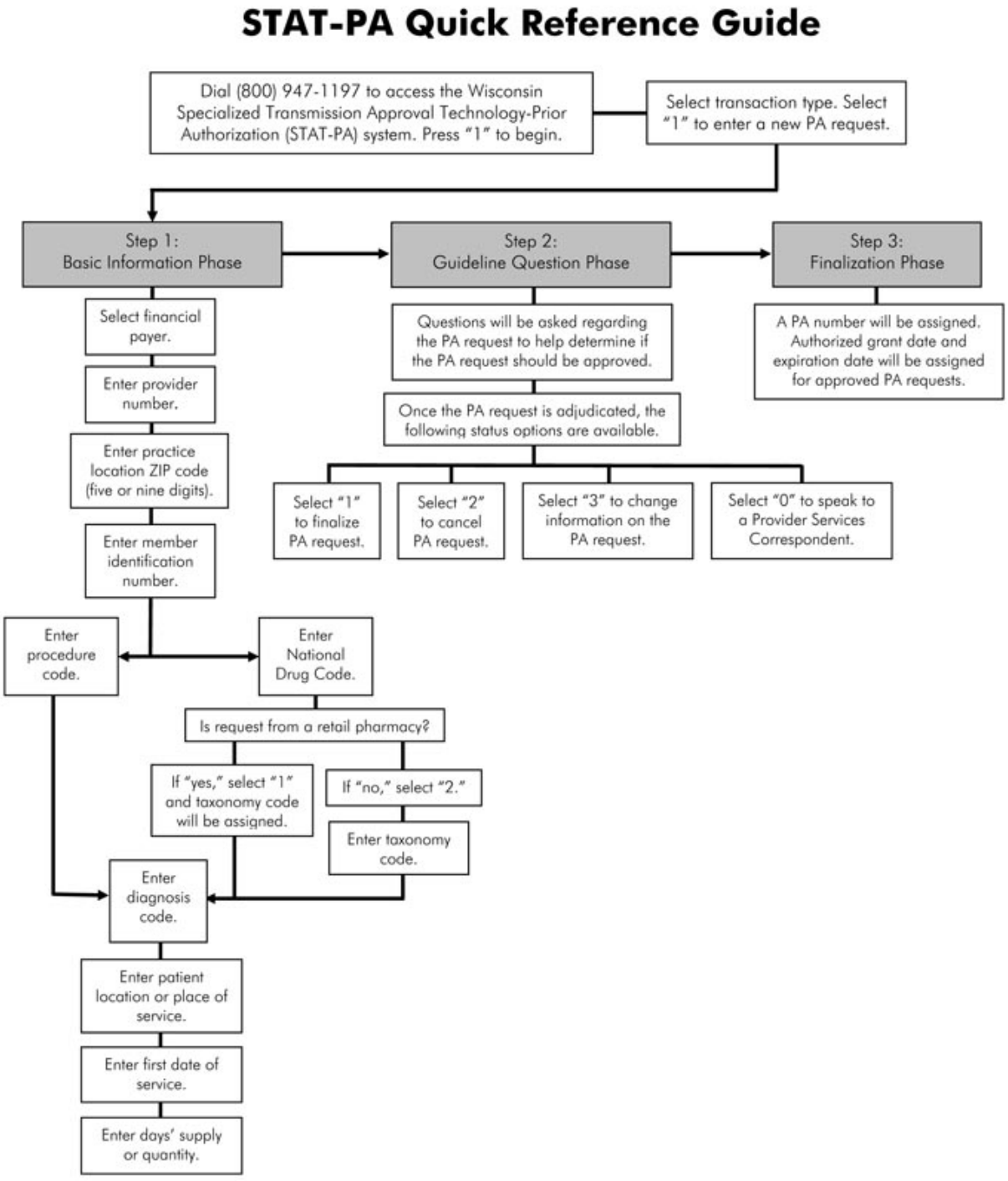
Dispensing STAT-PA Drugs When STAT-PA Is Unavailable

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:

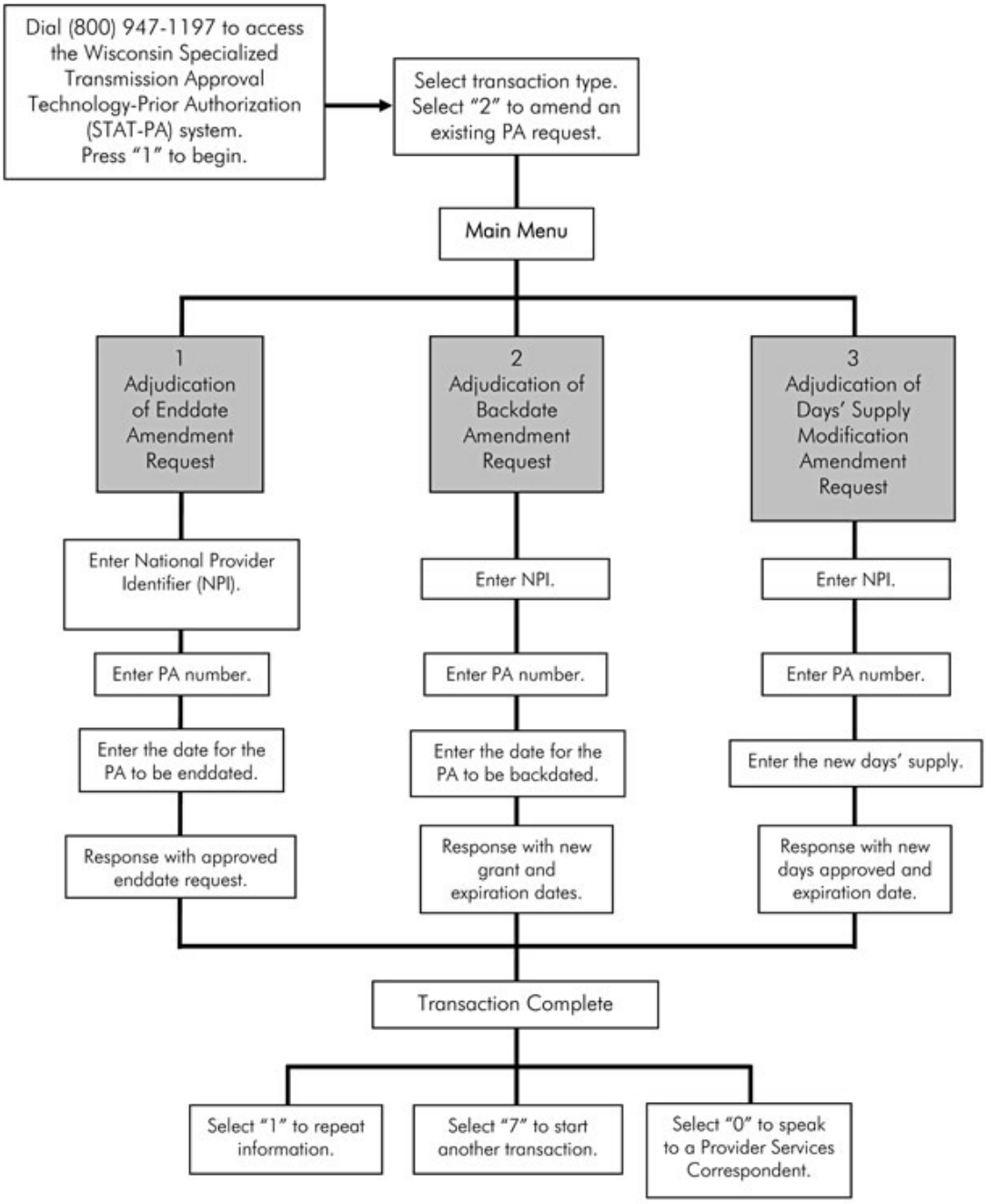
1. Obtain the member's ForwardHealth identification card, beige paper or white paper EE (Express Enrollment) card, or SeniorCare identification card, and verify enrollment. Enrollment verification may be done by submitting a real-time claim for the drug or by using one of the other enrollment verification methods such as Wisconsin's EVS (Enrollment Verification System).
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 (Drug Utilization Review) 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.



STAT-PA Drug Amendment Quick Reference Guide



Provider Enrollment and Ongoing Responsibilities

7

Archive Date:04/01/2013

Provider Enrollment and Ongoing Responsibilities:Documentation

Topic #6277

1099 Miscellaneous Forms

ForwardHealth generates the 1099 Miscellaneous form in January of each year for earnings greater than $600.00, per IRS (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 (National Provider Identifier) share the same tax identification number. For example, a provider who conducts business with both Medicaid and WCDP (Wisconsin Chronic Disease Program) will receive separate 1099 Miscellaneous forms for each program.

The 1099 Miscellaneous forms are sent to the address designated as the "1099 mailing address."

Topic #1640

Availability of Records to Authorized Personnel

The DHCAA (Division of Health Care Access and Accountability) 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 (prior authorization) 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 (managed care organizations), including HMOs (health maintenance organizations) and SSI (Supplemental Security Income) HMOs, are not reimbursed for the reproduction costs covered in their contract with the DHS (Department of Health Services).

The reproduction of records requested by the PRO (Peer Review Organization) under contract with the DHCAA is reimbursed at a rate established by the PRO.

Topic #200

Confidentiality and Proper Disposal of Records

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. Use or disclosure of any information concerning an applicant or member (including an applicant or member's billing information or medical claim records) for any purpose not connected with

program administration is prohibited unless authorized by the applicant or member (program administration includes contacts with third-party payers that are necessary for pursuing third-party payment and the release of information as ordered by the court).

Federal HIPAA (Health Insurance Portability and Accountability Act of 1996) Privacy and Security regulations establish requirements regarding the confidentiality and proper disposal of health care and related records containing PHI (protected health information). These requirements apply to all providers (who are considered "covered entities") and their business associates who create, retain, and dispose of such records.

For providers and their business partners who are not subject to HIPAA, Wisconsin confidentiality laws have similar requirements pertaining to proper disposal of health care and related records.

HIPAA Privacy and Security Regulations

Definition of Protected Health Information

As defined in the HIPAA privacy and security regulations, PHI is protected health information (including demographic information) that:

- Is created, received, maintained, or transmitted in any form or media.
- Relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the payment for the provision of health care to an individual.
- Identifies the individual or provides a reasonable basis to believe that it can be used to identify the individual.

A member's name combined with his or her member identification number or Social Security number is an example of PHI.

Requirements Regarding "Unsecured" Protected Health Information

Title XIII of the American Recovery and Reinvestment Act of 2009 (also known as the HITECH (Health Information Technology for Economic and Clinical Health) Act) included a provision that significantly expanded the scope, penalties, and compliance challenges of HIPAA. This provision imposes new requirements on covered entities and their business associates to notify patients, the federal government, and the media of breaches of "unsecured" PHI (refer to 45 CFR Parts 160 and 164 and s. 13402 of the HITECH Act).

Unsecured PHI is PHI that has not been rendered unusable, unreadable, or indecipherable to unauthorized individuals through the use of physical destruction approved by the HHS (U.S. Department of Health and Human Services). According to the HHS, destruction is the only acceptable method for rendering PHI unusable, unreadable, or indecipherable.

As defined by federal law, unsecured PHI includes information in *any* medium, not just electronic data.

Actions Required for Proper Disposal of Records

Under the HIPAA privacy and security regulations, health care and related records containing PHI must be disposed of in such a manner that they cannot be reconstructed. This includes ensuring that the PHI is secured (i.e., rendered unusable, unreadable, or indecipherable) prior to disposal of the records.

To secure PHI, providers and their business associates are required to use one of the following destruction methods approved by the HHS:

- Paper, film, labels, or other hard copy media should be shredded or destroyed such that the PHI cannot be read or otherwise reconstructed.
- Electronic media should be cleared, purged, or destroyed such that the PHI cannot be retrieved according to National Institute of Standards and Technology Special Publication 800-88, Guidelines for Media Sanitization, which can be found

on the NIST (National Institute of Standards and Technology) Web site.

For more information regarding securing PHI, providers may refer to Health Information Privacy on the HHS Web site.

Wisconsin Confidentiality Laws

Section 134.97, Wis. Stats., requires providers and their business partners who are not subject to HIPAA regulations to comply with Wisconsin confidentiality laws pertaining to the disposal of health care and related records containing PHI.

Section 146.836, Wis. Stats., specifies that the requirements apply to "all patient health care records, including those on which written, drawn, printed, spoken, visual, electromagnetic or digital information is recorded or preserved, regardless of physical form or characteristics." Paper *and* electronic records are subject to Wisconsin confidentiality laws.

"Personally Identifiable Data" Protected

According to s.134.97(1)(e), Wis. Stats., the types of records protected are those containing "personally identifiable data."

As defined by the law, personally identifiable data is information about an individual's medical condition that is not considered to be public knowledge. This may include account numbers, customer numbers, and account balances.

Actions Required for Proper Disposal of Records

Health care and related records containing personally identifiable data must be disposed of in such a manner that no unauthorized person can access the personal information. For the period of time between a record's disposal and its destruction, providers and their business partners are required to take actions that they reasonably believe will ensure that no unauthorized person will have access to the personally identifiable data contained in the record.

Businesses Affected

Sections 134.97 and 134.98, Wis. Stats., governing the proper disposal of health care and related records, apply to medical businesses as well as financial institutions and tax preparation businesses. For the purposes of these requirements, a medical business is any for-profit or nonprofit organization or enterprise that possesses information — other than personnel records — relating to a person's physical or mental health, medical history, or medical treatment. Medical businesses include sole proprietorships, partnerships, firms, business trusts, joint ventures, syndicates, corporations, limited liability companies, or associates.

Continuing Responsibilities for All Providers After Ending Participation

Ending participation in a ForwardHealth program does not end a provider's responsibility to protect the confidentiality of health care and related records containing PHI.

Providers who no longer participate in a ForwardHealth program are responsible for ensuring that they and their business associates/partners continue to comply with all federal and state laws regarding protecting the confidentiality of members' PHI. Once record retention requirements expire, records must be disposed of in such a manner that they cannot be reconstructed — according to federal and state regulations — in order to avoid penalties.

All ForwardHealth providers and their business associates/partners who cease practice or go out of business should ensure that they have policies and procedures in place to protect all health care and related records from any unauthorized disclosure and use.

Penalties for Violations

Any covered entity provider or provider's business associate who violates federal HIPAA regulations regarding the confidentiality

and proper disposal of health care and related records may be subject to criminal and/or civil penalties, including any or all of the following:

- Fines up to $1.5 million per calendar year.
- Jail time.
- Federal HHS Office of Civil Rights enforcement actions.

For entities not subject to HIPAA, s.134.97(4), Wis. Stats., imposes penalties for violations of confidentiality laws. Any provider or provider's business partner who violates Wisconsin confidentiality laws may be subject to fines up to $1,000 per incident or occurrence.

For more specific information on the penalties for violations related to members' health care records, providers should refer to s. 13410(d) of the HITECH Act, which amends 42 USC s. 1320d-5, and s. 134.97(3), (4) and 146.84, Wis. Stats.

Topic #201

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.

Topic #202

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.

Topic #199

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 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. This applies regardless of the member's enrollment status on the DOS (dates of service) 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.

Providers are limited to charging members enrolled in state-funded health care programs 25 percent of the applicable fees for providing one set of copies of the member's health care records.

Note: A provider may charge members 100 percent of the applicable fees for providing a second or additional set of copies of the member's health care records.

For information regarding fees that may be charged to members for copies of health care records, refer to s. 146.83(3f), Wis. Stats.

Topic #203

Preparation and Maintenance of Records

All providers who receive payment from Wisconsin Medicaid, including state-contracted MCOs (managed care organizations), 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.

Topic #204

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 (rural health clinics), which 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.

Maintaining Confidentiality of Records

Ending participation in a ForwardHealth program does not end a provider's responsibility to protect the confidentiality of health care and related records containing PHI (protected health information).

Providers who no longer participate in a ForwardHealth program are responsible for ensuring that they and their business associates/partners continue to comply with all federal and state laws regarding protecting the confidentiality of members' PHI. Once record retention requirements expire, records must be disposed of in such a manner that they cannot be reconstructed — according to federal and state regulations — in order to avoid penalties. For more information on the proper disposal of records, refer to Confidentiality and Proper Disposal of Records.

All ForwardHealth providers and their business associates/partners who cease practice or go out of business should ensure that they have policies and procedures in place to protect all health care and related records from any unauthorized disclosure and use.

Reviews and Audits

The DHS (Department of Health Services) 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.

Topic #205

Records Requests

Requests for billing or medical claim information regarding services reimbursed by ForwardHealth 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 ForwardHealth.

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 (managed care organization), 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-enrolled 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.

Topic #1646

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 (Department of Health Services) or the federal HHS (Department of Health and Human Services) to perform any function related to program administration, such as auditing, program monitoring, and evaluation.

Providers are authorized under Wisconsin Medicaid 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

Topic #220

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).

Topic #215

Change in Ownership

New provider enrollment 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 (Division of Quality Assurance) certification for Wisconsin Medicaid enrollment change in ownerships:

- Ambulatory surgery centers.
- ESRD (end-stage renal disease) services providers.
- FQHCs (federally qualified health centers).
- Home health agencies.
- Hospice providers.
- Hospitals (inpatient and outpatient).
- Nursing homes.
- Outpatient rehabilitation facilities.
- Rehabilitation agencies.
- RHCs (rural health clinics).

All changes in ownership must be reported in writing to ForwardHealth and new provider enrollment 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 enrollment effective date in the mail.

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

Repayment Following Change in Ownership

Medicaid-enrolled 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 (Department of Health Services) 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.

Topic #219

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 (Americans with Disabilities Act) 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 (limited English proficient) at no cost to the LEP individual in order to provide meaningful 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 (Department of Health Services) 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 (Americans with Disabilities Act) 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.

Topic #198

Contracted Staff

Under a few circumstances (e.g., personal care, case management services), providers may contract with non-Medicaid enrolled 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.

Topic #216

Examples of Ongoing Responsibilities

Responsibilities for which providers are held accountable are described throughout the Online Handbook. Medicaid-enrolled 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 (prior authorization) 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 revalidation notifications.
- Safeguarding member confidentiality.
- Verifying member enrollment.
- Keeping up-to-date with changes in program requirements as announced in ForwardHealth publications.

Topic #217

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 (prior authorization), and/or financial.
- Business name.
- Contact name.
- Federal Tax ID number (IRS (Internal Revenue Service) number).
- Group affiliation.
- Licensure.
- NPI (National Provider Identifier).
- Ownership.
- Professional certification.
- Provider specialty.
- Supervisor of nonbilling providers.
- Taxonomy code.
- Telephone number, including area code.

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 enrolled, 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 (F-01181 (07/12)) 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 (Division of Quality Assurance) 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.

Topic #577

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 (Department of Health Services). Within the DHS, the DHCAA (Division of Health Care Access and Accountability) is directly responsible for managing these programs.

Topic #13557

SeniorCare Legal Framework

In addition to all of the above, the following laws and regulations provide the legal framework for SeniorCare:

- 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 and 49.665.
  - Regulation — Wisconsin Administrative Code, Chapters DHS 101, 102, 103, 104, 105, 106, 107, and 108.
- SeniorCare Law and Regulation:
  - Law — Wisconsin Statutes: 49.688.
  - Regulation — Wisconsin Administrative Code, Chapter 109.

Topic #15157

Recovery Audit Contractor Audits

The ACA (Affordable Care Act) requires states to establish an RAC (Recovery Audit Contractor) program to enable the auditing of Medicaid claim payments to providers. In Wisconsin, the RAC will audit claim payments from Wisconsin Medicaid and BadgerCare Plus. The Wisconsin DHS (Department of Health Services) has awarded the contract to HMS (Health Management Systems, Inc.) as the RAC for the state of Wisconsin.

Note: The RAC will not audit claims submitted for Family Planning Only Services, SeniorCare, WCDP (Wisconsin Chronic Disease Program), the WWWP (Wisconsin Well Woman Program), and ADAP (Wisconsin AIDS/HIV Drug Assistance Program).

The overall goal of the RAC program is to identify and decrease improper payments. The audits will ensure that payments are for

services covered under the programs in which the member was enrolled and that the services were actually provided and properly billed and documented. The audits are being conducted under Generally Accepted Government Auditing Standards.

Providers will be selected for audits based on data analysis by the RAC and referrals by state agencies. The RAC will ensure that its audits neither duplicate state audits of the same providers nor interfere with potential law enforcement investigations.

Providers who receive a notification regarding an audit should follow the instructions as outlined in the notification within the requested time frames.

Affected Providers

Any provider may be audited, including, but not limited to, fee-for-service providers, institutional and non-institutional providers, as well as managed care entities.

Additional Information

Any questions regarding the RAC program should be directed to HMS at (800) 310-0865. Refer to the RAC Web site for additional information regarding HMS RAC activities.

Topic #13277

Reporting Suspected Waste, Fraud, and Abuse

The DHS (Department of Health Services) OIG (Office of Inspector General) investigates fraud and abuses including, but not limited to, the following:

- Billing Medicaid for services or equipment that were not provided.
- Submitting false applications for a DHS-funded assistance program such as Medicaid, BadgerCare Plus, WIC (Special Supplemental Nutrition Program for Women, Infants, and Children), or FoodShare.
- Trafficking FoodShare benefits.
- Crime, misconduct, and/or mismanagement by a DHS employee, official, or contractor.

Those who suspect fraudulent activity in Medicaid programs are required to notify the OIG if they have reason to believe that a person is misusing or abusing any DHS health care program 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 misusing or abusing their benefits. A provider may not confiscate a ForwardHealth card from a member in question.

Reporting Suspected Fraud and Abuse

Those who suspect any form of fraud, waste, or abuse of a program by providers, trading partners, billing services, agencies, or recipients of any government assistance program are required to report it. Those reporting allegations of fraud and abuse may remain anonymous. However, not providing contact information may prevent OIG from fully investigating the complaint if questions arise during the review process.

If a provider suspects that someone is committing fraudulent activities or is misusing his or her ForwardHealth card, the provider is required to notify ForwardHealth by one of the following methods:

- Going to the OIG fraud and abuse reporting Web site.
- Calling the DHS fraud and abuse hotline at (877) 865-3432.

The following information is helpful when reporting fraud and abuse:

- A description of the fraud, waste, and/or abuse, including the nature, scope, and timeframe of the activity in question. The description should include sufficient detail for the complaint to be evaluated.
- The names and dates of birth (or approximate ages) of the people involved, as well as the number of occurrences and length of the suspected activity.
- The names and date(s) of other people or agencies to which the activity may have been reported.

After the allegation is received, the DHS OIG will evaluate it and take appropriate action. If the name and contact information of the person reporting the allegation was provided, the OIG may be in contact to verify details or ask for additional information.

Prescription

Topic #1966

Advanced Practice Nurse Prescriber Requirements

Chapter N8, Wis. Admin. Code, authorizes the enrollment 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 (Drug Enforcement Agency) number on all prescriptions for BadgerCare Plus and SeniorCare members.

Topic #1963

Federal Registration Numbers

Section 146.87, Wis. Stats., mandates that providers may not disclose a practitioner's federal registration number without consent. Under this statute, prescribing providers may decline to authorize the use of their federal registration number for claims and PA (prior authorization) requests for prescription orders for drugs or devices, except when indicated on a prescription for a controlled substance. Violators of the provisions of s. 146.87, Wis. Stats, are subject to financial penalties.

DEA (Drug Enforcement Agency) numbers, including "default" DEA numbers, are not accepted for the Prescriber ID on compound and noncompound claims. An NPI (National Provider Identifier) is the only identifier accepted in the Prescriber ID field on compound and noncompound 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.

Optometrists may refer to Therapeutic Pharmaceutical Agents-Certified Optometrists Requirements for information about DEA numbers and NPIs for information about prescriptions written by optometrists with a TPA certificate.

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.

Topic #523

Prescriber Information for Drug Prescriptions

Most legend and certain OTC (over-the-counter) 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 (Preferred Drug List).
- PA (prior authorization).
- 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.

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 (Centers for Medicare and Medicaid Services). 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-enrolled 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 (Food and Drug Administration)-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 (Prior Authorization/Drug Attachment, F-11049 (07/12)) to the pharmacy where the drug will be dispensed. Pharmacies should complete the PA/RF (Prior Authorization Request Form, F-11018 (07/12)) 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 (F-13072 (07/12)) indicating the actual NDC of the drug with the Pharmacy Special Handling Request (F-13074 (07/12)) form.

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

Members Enrolled in 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.

Members Enrolled in 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 Plan Product List, BadgerCare Plus Core Plan Product List, BadgerCare Plus Core Plan Brand Name Drugs Quick Reference, and the BadgerCare Plus Basic Plan Product List. 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 (Omnibus Budget Reconciliation Act of 1990) (42 CFR Parts 456.703 and 456.705) called for a DUR (Drug Utilization Review) 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-enrolled retail pharmacies to deliver prescriptions to members via the mail. Wisconsin Medicaid-enrolled 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 (less-than-effective) 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 (Erectile Dysfunction). 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.

Topic #1964

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. 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 (date of service). 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.

Topic #4346

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

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.

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.

Topic #1965

Therapeutic Pharmaceutical Agents-Certified Optometrists Requirements

In accordance with ch. SPS 10.01(10), Wis. Admin. Code, BadgerCare Plus, Medicaid, and SeniorCare allow prescriptions written by optometrists with a TPA (Therapeutic Pharmaceutical Agent) certificate. Prescriptions for schedule III, IV, or V narcotic analgesics prescribed by optometrists with a TPA certificate must include the optometrist's DEA (Drug Enforcement Agency) number.

DEA numbers are not accepted for the Prescriber ID on compound and noncompound claims. An NPI (National Provider Identifier) is the only identifier accepted in the Prescriber ID field on compound and noncompound claims. Pharmacy providers should contact the prescribing optometrist for his or her NPI if it is not known. Pharmacy providers are required to make every effort possible to obtain the prescribing optometrist'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.

Providers may refer to the Federal Registration Numbers topic for more information about DEA numbers and NPIs.

Provider Enrollment

Topic #3969

Categories of Enrollment

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

- Billing/rendering provider.
- Rendering-only provider.
- Billing-only provider (including group billing).

Providers should refer to the service-specific information in the Online Handbook or the Information for Specific Provider Types page on the Provider Enrollment Information home page to identify which category of enrollment is applicable.

Billing/Rendering Provider

Enrollment as a 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-Only Provider

Enrollment as a rendering-only provider is given to those providers who practice under the professional supervision of another provider (e.g., physician assistants). Providers with a rendering provider enrollment cannot submit claims to Wisconsin Medicaid directly, but they 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.

Billing-Only Provider (Including Group Billing)

Enrollment as a billing-only provider is given to certain provider types when a separate rendering provider is required on claims.

Group Billing

Groups of individual practitioners are enrolled as billing-only providers as an accounting convenience. This allows the group to receive one reimbursement, one RA (Remittance Advice), and the 835 (835 Health Care Claim Payment/Advice) transaction for covered services rendered by individual practitioners within the group.

Providers may not have more than one group practice enrolled in Wisconsin Medicaid with the same ZIP+4 code address, NPI (National Provider Identifier), and taxonomy code combination. Provider group practices located at the same ZIP+4 code address are required to differentiate their enrollment using an NPI or taxonomy code that uniquely identifies each group practice.

Individual practitioners within group practices are required to be Medicaid-enrolled 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.

Topic #14137

Enrollment Requirements Due to the Affordable Care Act

In 2010, the federal government signed into law the ACA (Affordable Care Act), also known as federal health care reform, which affects several aspects of Wisconsin health care. ForwardHealth has begun working toward ACA compliance by implementing some new requirements for providers and provider screening processes. To meet federally mandated requirements, ForwardHealth will implement changes in phases, the first of which began in 2012. A high-level list of the changes included under ACA is as follows:

- Providers will be assigned a risk level of limited, moderate, or high. Most of the risk levels have been established by the CMS (Centers for Medicare and Medicaid Services) based on an assessment of potential fraud, waste, and abuse for each provider type.
- Providers will be screened according to their assigned risk level. Screenings will be conducted during initial enrollment and revalidation.
- Certain provider types will be subject to an enrollment application fee of $523. This fee has been federally mandated and may be adjusted annually. The fee is used to offset the cost of conducting screening activities.
- The enrollment process will require additional information. During the enrollment process, providers are required to provide additional information for persons with an ownership or control interest, managing employees, and agents. "Persons" in this instance may mean a person or a corporation.
- Revalidation will occur at least every three to five years.
- Ordering and referring physicians or other professionals will be required to be enrolled as a participating Medicaid provider.
- Payment suspensions will be imposed on providers based on a credible allegation of fraud.

ForwardHealth Implementation of Affordable Care Act Requirements to Date

Provider Screenings

Wisconsin Medicaid screens all enrolling providers to accommodate the ACA limited risk level screening requirements. Limited risk level screening activities include:

- Checking federal databases, which include:
  - The SSA (Social Security Administration's) Death Master File.
  - The NPPES (National Plan and Provider Enumeration System).
  - OIG (Office of the Inspector General) LEIE (List of Excluded Individuals/Entities).
  - EPLS (The Excluded Parties List System).
  - MED (Medicare Exclusion Database).
- Verifying licenses are appropriate in accordance with state laws and that there are no current limitations on the license.

These screening activities are conducted on applicants, providers, and any person with an ownership or control interest or who is an agent or managing employee of the provider at the time of enrollment, on a monthly basis for enrolled providers, and at revalidation.

ForwardHealth will deny enrollment or terminate the enrollment of any provider where any person with a five percent or greater direct or indirect ownership interest in the provider has been convicted of a criminal offense related to that person's involvement with the Medicare, Medicaid, or title XXI program in the last 10 years, or if invalid licensure information is found.

Additional Information Needed During Provider Enrollment

ForwardHealth collects some personal data information from persons with an ownership or control interest, agents, and managing employees. ForwardHealth will only use the provided information for provider enrollment. All information provided will be protected under the HIPAA (Health Insurance Portability and Accountability Act of 1996) privacy rule.

Providers are required to submit the following information at the time of enrollment and revalidation for their individual owners with control interest:

- First and last name.
- Provider's SSNs (Social Security numbers).
- Dates of birth.
- Street address, city, state, and ZIP+4 code.

Providers are required to submit the following information at the time of enrollment and revalidation for their organizational owners with control interest:

- Legal business name.
- Tax identification number.
- Business street address, city, state, ZIP+4 code.

Providers are required to submit the following information at the time of enrollment and revalidation for their managing employees and agents:

- First and last name.
- Employees' and agents' SSNs.
- Dates of birth.
- Street address, city, state, and ZIP+4 code.

Topic #193

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 *ForwardHealth Updates*. *Updates* are available for viewing and downloading on the ForwardHealth Publications page.

Topic #194

Non-enrolled In-State Emergency Providers

ForwardHealth reimburses non-enrolled 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 Medicaid-enrolled providers rendering the same service.

Claims from non-enrolled in-state providers must be submitted with an In-State Emergency Provider Data Sheet (F-11002 (07/12)). The In-State Emergency Provider Data Sheet provides ForwardHealth with minimal tax and licensure information.

Non-enrolled in-state providers may call Provider Services with questions.

Topic #4457

Provider Addresses

ForwardHealth has the capability to store the following types of addresses and contact information:

- *Practice location address and related information.* 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 the telephone number for members' use. With limited exceptions, the practice location and telephone number for members' 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 accurate address information to aid in proper mail delivery.
- *PA (prior authorization) address.* This address is where ForwardHealth will mail PA information.
- *Financial addresses.* Two separate financial addresses are stored for ForwardHealth. The checks address is where ForwardHealth will mail paper checks. The 1099 mailing address is where ForwardHealth 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 (F-01181 (07/12)) form.

Note: Providers are cautioned that any changes to their practice location on file with Wisconsin Medicaid 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.

Topic #14157

Provider Enrollment Information Home Page

ForwardHealth has consolidated all information providers will need for the enrollment process in one location on the ForwardHealth Portal. For information related to enrollment criteria and to complete online provider enrollment applications, providers should refer to the Provider Enrollment Information home page.

The Provider Enrollment Information home page includes enrollment applications for each provider type and specialty eligible for enrollment with Wisconsin Medicaid. Prior to enrolling, providers may consult a provider enrollment criteria menu, which is a reference for each individual provider type detailing the information the provider may need to gather before beginning the enrollment process, including:

- Links to enrollment criteria for each provider type.
- Provider terms of reimbursement.
- Disclosure information.
- Category of enrollment.
- Additional documents needed (when applicable).

Providers will also have access to a list of links related to the enrollment process, including:

- General enrollment information.
- Regulations and forms.
- Provider type-specific enrollment information.
- In-state and out-of-state emergency enrollment information.
- Contact information.

Information regarding enrollment policy and billing instructions may still be found in the Online Handbook.

Topic #1931

Provider Type and Specialty Changes

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

Topic #12857

Providing Services to SeniorCare Members

Wisconsin Medicaid-enrolled pharmacies, dispensing physicians, blood banks, and FQHCs (federally qualified health centers) do not need to be separately enrolled to provide services to SeniorCare members. These providers are required by law to participate in SeniorCare and to submit SeniorCare claims during all levels of participation when a SeniorCare member presents his or her card and a prescription is filled.

Topic #1967

Requirements

For Wisconsin Medicaid and SeniorCare certification for dispensing pharmaceuticals, the provider is required to be licensed by the Wisconsin DSPS (Department of Safety and Professional Services) 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 s. 448.05 and s. 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-enrolled 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 does not enroll 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 enrollment.

In addition to drugs, pharmacies may dispense DME (durable medical equipment), DMS (disposable medical supplies), and enteral nutrition products without separate enrollment. The DME service area, the DMS service area, and the Enteral Nutrition Products service area contain information about covered services, PA (prior authorization) guidelines, and billing instructions.

Medicare

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

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.

Topic #14317

Terminology to Know for Provider Enrollment

Due to the ACA (Affordable Care Act), ForwardHealth has adopted new terminology. The following table includes new terminology that will be useful to providers during the provider enrollment and revalidation processes. Providers may refer to the Medicaid rule 42 CFR s. 455.101 for more information.

New Terminology	Definition
Agent	Any person who has been delegated the authority to obligate or act on behalf of a provider.
Disclosing entity	A Medicaid provider (other than an individual practitioner or group of practitioners) or a fiscal agent.
Federal health care programs	Federal health care programs include Medicare, Medicaid, Title XX, and Title XXI.
Other disclosing agent	Any other Medicaid disclosing entity and any entity that does not participate in Medicaid but is required to disclose certain ownership and control information because of participation in any of the programs established under Title V, XVII, or XX of the Act. This includes: • Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or HMO that participates in Medicare (Title XVIII). • Any Medicare intermediary or carrier. • Any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under Title V or XX of the Act.
Indirect ownership	An ownership interest in an entity that has an ownership interest in the disclosing entity. This term includes an ownership interest in any entity that has an indirect ownership in the disclosing entity.
Managing employee	A general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization, or agency.
Ownership interest	The possession of equity in the capital, the stock, or the profits of the disclosing entity.
Person with an ownership or control interest	A person or corporation for which one or more of the following applies: • Has an ownership interest totaling five percent or more in a disclosing entity. • Has an indirect ownership interest equal to five percent or more in a disclosing entity. • Has a combination of direct and indirect ownership interest equal to five percent or more in a disclosing entity. • Owns an interest of five percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least five percent of the value of the property or asset of the disclosing entity. • Is an officer or director of a disclosing entity that is organized as a corporation. • Is a person in a disclosing entity that is organized as a partnership.
Subcontractor	• An individual, agency, or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or,

	• An individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or leases of real property) to obtain space, supplies, equipment, or services provided under the Medicaid agreement.
Re-enrollment	Re-enrollment of a provider whose Medicaid enrollment has ended for any reason other than sanctions or failure to revalidate may be re-enrolled as long as all licensure and enrollment requirements are met. If a provider's enrollment with Wisconsin Medicaid lapses for longer than one year, they will have to re-enroll as a "new" provider. Providers should note that when they re-enroll, application fees and screening activities may apply. Re-enrollment was formerly known as re-instate.
Revalidation	All enrolled providers are required to revalidate their enrollment information every three years to continue their participation with Wisconsin Medicaid. Revalidation was formerly known as recertification.

Note: Providers should note that the CMS (Centers for Medicare and Medicaid Services) requires revalidation at least every five years. However, Wisconsin Medicaid will continue to revalidate providers every three years.

Provider Numbers

Topic #3421

Provider Identification

Health Care Providers

Health care providers are required to indicate an NPI (National Provider Identifier) on enrollment applications and electronic and paper transactions submitted to ForwardHealth.

The NPI is a 10-digit number obtained through the NPPES (National Plan and Provider Enumeration System).

Providers should ensure that they have obtained an appropriate NPI prior to beginning their enrollment application. 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 enrollments — one enrollment as an individual physical therapist and the other enrollment as the physical therapy group. A Type 1 NPI for the individual enrollment and a Type 2 NPI for the group enrollment are required.

NPIs and classifications may be viewed on the NPPES Web site. The CMS (Centers for Medicare and Medicaid Services) Web site includes more information on Type 1 and Type 2 NPIs.

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

Non-healthcare Providers

Non-healthcare providers, such as SMV (specialized medical vehicle) providers, personal care agencies, and blood banks, are exempt from federal NPI requirements. Providers exempt from federal NPI requirements are assigned a Medicaid provider number once their enrollment application is accepted; they are required to indicate this Medicaid provider number on electronic and paper transactions submitted to ForwardHealth.

Topic #5096

Taxonomy Codes

Taxonomy codes are standard code sets used to provide information about provider type and specialty for the provider's enrollment. ForwardHealth uses taxonomy codes as additional data for correctly matching the NPI (National Provider Identifier) to the provider file.

Providers are required to use a taxonomy code when the NPI reported to ForwardHealth corresponds to multiple enrollments and the provider's practice location ZIP+4 code does not uniquely identify the provider.

Providers are allowed to report multiple taxonomy codes to ForwardHealth as long as the codes accurately describe the provider type and specialty for the provider's enrollment. When doing business with ForwardHealth, providers may use any one of the reported codes. Providers who report multiple taxonomy codes will be required to designate one of the codes as the primary taxonomy code; ForwardHealth will use this primary code for identification purposes.

Providers who wish to change their taxonomy code or add additional taxonomy codes may do so using the demographic maintenance tool found in the secure Provider area of the ForwardHealth Portal. Refer to the Demographic Maintenance Tool User Guide on the Portal User Guides page of the Portal for more detailed instructions. Most taxonomy code changes entered through the demographic maintenance tool will take effect in real time; providers may use the new codes immediately on transactions.

Alternatively, providers may use the Provider Change of Address or Status (F-01181 (07/12)) form to report new taxonomy codes. Providers who submit new taxonomy codes using the Provider Change of Address or Status form will need to check the demographic maintenance tool to verify ForwardHealth has received and added the new taxonomy codes prior to using them on transactions.

Omission of a taxonomy code when it is required as additional data to identify the provider will cause claims and other transactions to be denied or delayed in processing.

Note: Taxonomy codes do not change provider enrollment or affect reimbursement terms.

Topic #5097

ZIP Code

The ZIP code of a provider's practice location address on file with ForwardHealth must be a ZIP+4 code. The ZIP+4 code helps to identify a provider when the NPI (National Provider Identifier) reported to ForwardHealth corresponds to multiple enrollments and the reported taxonomy code does not uniquely identify the provider.

When a ZIP+4 code is required to identify a provider, omission of it 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

Topic #208

A Comprehensive Overview of Provider Rights

Medicaid-enrolled 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 (Enrollment Verification System) methods, including calling Provider Services.

Topic #207

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
313 Blettner Blvd
Madison WI 53784

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.

Topic #209

Hearing Requests

A provider who wishes to contest a DHS (Department of Health Services) action or inaction for which due process is required

under s. 227, Wis. Stats., may request a hearing by writing to the DHA (Division of Hearings and Appeals).

A provider who wishes to contest the DHCAA's (Division of Health Care Access and Accountability) 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.

Topic #210

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.

Topic #206

Requesting Discretionary Waivers and Variances

In rare instances, a provider or member may apply for, and the DHCAA (Division of Health Care Access and Accountability) 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 DHS 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 (Centers for Medicare and Medicaid Services), 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

Revalidation

Topic #8517

An Overview

Each year approximately one-third of all Medicaid-enrolled providers undergo a revalidation process, during which they update their enrollment information and sign the Wisconsin Medicaid Provider Agreement and Acknowledgement of Terms of Participation. Providers are required to complete the revalidation process to continue their participation with Wisconsin Medicaid. Wisconsin Medicaid will notify providers when they need to revalidate their enrollment information and provide instructions on how to complete the revalidation process. Most providers will conduct their revalidation process on the ForwardHealth Portal.

Topic #8521

Checking the Status of a Revalidation Application

Providers may check the status of their revalidation on the ForwardHealth Portal by entering the ATN (application tracking number) from the Provider Revalidation Notice and pressing "Search."

Providers will receive one of the following status responses:

- "Approved." ForwardHealth has reviewed the revalidation materials and all requirements have been met. ForwardHealth is completing updates to provider files.
- "Awaiting Additional Info." ForwardHealth has reviewed the revalidation 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 revalidation materials.
- "Awaiting Follow-On Documents." ForwardHealth requires additional paper documents to process the revalidation. After the provider has submitted revalidation 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 (specialized medical vehicle) provider revalidation.
- "Denied." The provider's revalidation has been denied.
- "Failure to Revalidate." The provider has not revalidated by the established revalidation deadline.
- "In Process." The revalidation materials are in the process of being reviewed by ForwardHealth.
- "Paper Requested." The provider requested a paper revalidation application and ForwardHealth has not received the paper application yet.
- "Revalidation Initiated." The Provider Revalidation Notice and PIN (personal identification number) letter have been sent to the provider. The provider has not started the revalidation process yet.
- "Revalidated." The provider has successfully completed revalidation. There are no actions necessary by the provider.
- "Referred To DHS." ForwardHealth has referred the provider revalidation materials to the State Enrollment Specialist for revalidation determination.

Note: Status responses may not yet reflect changes in certification terminology which are being made in compliance with the ACA (Affordable Care Act).

Topic #8519

Notification Letters

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

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

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 Revalidation area of the Portal to complete the revalidation process. If a provider needs to replace one of the letters, the revalidation process will be delayed.

Topic #8522

Revalidation Completed by an Authorized Representative

A provider has several options for submitting information to the DHS (Department of Health Services), 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 an 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.

Sanctions

Topic #211

Intermediate Sanctions

According to DHS 106.08(3), Wis. Admin. Code, the DHS (Department of Health Services) 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 (Division of Hearings and Appeals).

Topic #212

Involuntary Termination

The DHS (Department of Health Services) may suspend or terminate the Medicaid enrollment 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 enrollment 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 enrollment with Wisconsin Medicaid, termination from Medicare results in automatic termination from Wisconsin Medicaid.

Topic #213

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 enrollment. 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 s. 49.49(3m), Wis. Stats.

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

Topic #214

Withholding Payments

The DHS (Department of Health Services) 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.

Reimbursement

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Topic #258

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 or Medicaid) may not exceed the 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 allowed amount for a service (i.e., balance billing).

Other health insurance payments may exceed the allowed amount if no additional payment is received from the member or BadgerCare Plus or Medicaid.

Topic #694

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.

Topic #1349

Dispensing Fees

BadgerCare Plus, Medicaid, 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 (Drug Utilization Review), and counseling.)
- A traditional dispensing fee with a repackaging allowance.
- Compound drug dispensing fee.
- PC (Pharmaceutical Care) 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 obtain a repackaging allowance for drugs that are repackaged by the pharmacy by entering the appropriate value in the Special Packaging Indicator field. 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 EOB (Explanation of Benefits) 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.

Compound Drug Dispensing Fee

BadgerCare Plus, Medicaid, 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, Medicaid, or SeniorCare. Examples of these services include increasing patient compliance or preventing potential adverse drug reactions.

Topic #1351

Drug Reimbursement

The DHS (Department of Health Services) uses one of the following pricing methods on claims submitted with an NDC (National Drug Code), including diabetic supplies:

- WAC (Wholesale Acquisition Cost).
- Expanded MAC (Maximum Allowed Cost).
- State MAC.

The DHS determines maximum reimbursement rates for all covered pharmaceutical drugs and OTC (over-the-counter) 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 447.512).

Some covered legend drugs are reimbursed at either the drug's WAC rate 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 State Maximum Allowed Cost List pharmacy data table plus a dispensing fee or the provider's usual and customary charge, whichever is less. If a federal, legend OTC drug does not have a WAC rate, an expanded MAC rate will be assigned.

Multiple Rates or No Rates on File

If an NDC has multiple rates (e.g., WAC, state MAC, and expanded MAC) on file and is a non-innovator, the NDC will be reimbursed at the lesser of the rates on file. A generic copayment and generic dispensing fee will be applied in this situation.

If an NDC does not have a WAC, state MAC, or expanded MAC rate on file, the claim will be denied.

State 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 (Wisconsin Chronic Disease Program) may assign state 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. State MAC rates are set by using best estimates of prices currently in the marketplace in comparison to WAC as stated in the approved Wisconsin State Plan.

Providers will receive informational EOB (Explanation of Benefits) code on pharmacy noncompound and compound claims that are reimbursed at the state MAC rate.

Topic #8117

Electronic Funds Transfer

EFT (electronic funds transfer) 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. EFT 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 (managed care organizations) 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 (specialized medical vehicle) providers during their provisional enrollment 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 "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 Electronic Funds Transfer User Guide on the Portal User Guides page of the Portal 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.

Topic #12317

Expanded Maximum Allowed Cost

If a federal legend or OTC (over-the-counter) drug does not have a WAC () rate assigned to it by First DataBank, an expanded MAC (Maximum Allowed Cost) rate will be assigned. NDCs (National Drug Codes) use the expanded MAC reimbursement rate, brand dispensing fee, and brand copayment for either of the situations below:

- Situation 1
  - The drug does not have a WAC rate on file.
  - The drug does not have a state MAC rate on file.
  - The NDC is defined by First DataBank as a brand name drug.
- Situation 2
  - The drug does not have a WAC rate on file.
  - The drug has a state MAC rate on file.
  - The NDC is defined by First DataBank as a brand name drug.
  - The NDC is defined as an innovator and is billed with a DAW (Dispense As Written) code of 1 or 8.

NDCs use the expanded MAC reimbursement rate, generic dispensing fee, and generic copayment if the following apply:

- The drug does not have a WAC rate on file.
- The NDC is defined by First DataBank as a generic drug.

Providers may refer to the Expanded Maximum Allowed Cost data table for a list of drugs that are subject to the expanded MAC rate.

Topic #897

Fee Schedules

Maximum allowable fee information is available on the ForwardHealth Portal in the following forms:

- Interactive fee schedule.
- Downloadable fee schedule in TXT (text) 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.

Topic #10297

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.

Wisconsin Medicaid-enrolled pharmacies and other health care providers can use the drug search tool to help identify and calculate ingredient rates of drugs. Information provided through the drug search tool does not guarantee coverage or payment.

ForwardHealth will periodically update the information on the drug search tool.

Information Included in the Drug Search Tool

For each NDC (National Drug Code) and label name listed in the search tool, the following information is available:

- Age restrictions associated with the NDC.
- Copayment amount (brand, generic, compound, or not applicable).
- Diagnosis code restrictions.
- Effective date of the listed ingredient rate.
- Indicator for whether the NDC can only be billed as a compound drug ingredient.
- Maximum days' supply permitted in one dispensing (34 or 100 days).
- Medicare coverage of the prescription.
- The package size used to derive a unit price. It is the usual labeled quantity from which the pharmacist dispenses, such as 100 tablets, 1,000 capsules, or 20 ml vials.
- The reimbursement methodology applicable to the prescription.
- Unit of measurement, or drug form that indicates the basic drug measurement unit for performing price calculations. This includes valid values are for each (tablets, kits, etc.), milliliters (liquids), or grams (solids).
- PA (prior authorization) requirements.

Instructions for Using the Drug Search Tool

Use the following instructions for the drug search tool:

1. Identify the drug for which the provider wants to search by entering the 11-digit NDC or the drug label name into the appropriate box. For a list of NDCs by labeler code, enter a minimum of five digits for the NDC followed by an asterisk (*). For a list of NDCs with similar names, enter a minimum of five characters in the label name.
2. Select the criteria by which the provider wishes to sort the results: NDC, brand/generic, or label name.
3. After entering all applicable information, click on the "Search" button.
4. For details about a particular drug, click on the applicable NDC of the drugs listed on the search results.

Topic #260

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.

Topic #4385

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 (managed care organization), for members enrolled in BadgerCare Plus HMOs, Medicaid SSI (Supplemental Security Income) 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 (Current Procedural Terminology) 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 (Program of All-Inclusive Care for the Elderly) 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 (Healthcare Common Procedure Coding System) procedure code indicated.

Topic #2013

Reimbursement for Brand Name and Generic Drugs

BadgerCare Plus, Wisconsin Medicaid, and SeniorCare reimburse providers for innovator drugs (i.e., the patented brand name product of the generic drug on the State 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 (prior authorization) 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, Wisconsin Medicaid, and SeniorCare will reimburse pharmacy providers at the lesser of component pricing; 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.

Topic #7437

State Maximum Allowed Cost Drug Pricing Review

To request a review of state MAC (maximum allowed cost) pricing, pharmacy providers are required to submit the State Maximum Allowed Cost Drug Pricing Review Request (F-00030 (07/12)) along with supporting documentation.

Pharmacy providers are required to submit the following supporting documentation along with the State 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 (National Drug Code). If the NDC is not indicated on the invoice, the provider is required to handwrite the NDC on the invoice.
- Invoice price.

The State Maximum Allowed Cost Drug Pricing Review Request form and the supporting documentation must be submitted to the DAPO (Drug Authorization and Policy Override) Center via fax at (608) 250-0246 or by mail to the following address:

ForwardHealth
Drug Authorization and Policy Override Center
313 Blettner Blvd
Madison WI 53784

Any action taken by ForwardHealth will be reflected in the state MAC data table.

Topic #12297

Wholesale Acquisition Cost

The DHS (Department of Health Services) has established different EACs (estimated acquisition costs) for brand name drugs, generic drugs, specialty drugs, including diabetic supplies, using WAC (Wholesale Acquisition Cost) reimbursement.

Brand Wholesale Acquisition Cost

The brand WAC reimbursement rate for brand name drugs for BadgerCare Plus, Medicaid, SeniorCare, and WCDP (Wisconsin Chronic Disease Program) prescriptions will be WAC plus 2 percent.

NDCs (National Drug Codes) use the brand WAC reimbursement rate, brand dispensing fee, and brand copayment for either of the situations below:

- Situation 1:
  - The drug does not have a state MAC (Maximum Allowed Cost) rate on file.
  - The NDC is defined by First DataBank as a brand name drug.
- Situation 2:
  - The drug has a state MAC rate on file.
  - The NDC is defined by First DataBank as a brand name drug.
  - The NDC is defined as an innovator and is billed with a DAW (Dispense As Written) code of 1 or 8.

NDCs for diabetic supplies will use the brand WAC reimbursement rate, generic dispensing fee, and $0.50 copayment, if the following apply:

- The NDC does not have a state MAC rate on file.
- The NDC is defined by First DataBank as a non-drug item.

Generic Wholesale Acquisition Cost

The generic WAC reimbursement rate for generic drugs for BadgerCare Plus, Medicaid, SeniorCare, and WCDP prescriptions will be WAC minus 3.8 percent.

NDCs use the generic WAC reimbursement rate, generic dispensing fee, and generic copayment if the following apply:

- The drug does not have a state MAC rate on file.
- The NDC is defined by First DataBank as a generic drug or non-drug item (excluding diabetic supplies).
- The NDC is not defined as an innovator.

Specialty Wholesale Acquisition Cost

An EAC is established for specialty pharmacy drugs by therapeutic class. The EAC will be based on the WAC 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

Topic #227

Conditions That Must Be Met

A member may request a noncovered service, a covered service for which PA (prior authorization) 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.

Topic #224

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 (prior authorization) 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 enrollment.

Copayment

Topic #1927

Amounts

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 (over-the-counter) drugs (excluding iron supplements for pregnant or lactating women) is $0.50 for each new or refilled prescription.

For OTC drugs, DMS (disposable medical supplies), and DME (durable medical equipment), 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 (date of service). 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.

SeniorCare

SeniorCare members pay a $5.00 copayment for covered generic drugs and a $15.00 copayment for covered brand name drugs.

Topic #9139

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.

Topic #231

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:

- Children in a mandatory coverage category. In Wisconsin, this includes:
  - Children in foster care, regardless of age.
  - Children in subsidized adoption, regardless of age.
  - Children in the Katie Beckett program, regardless of age.
  - Children under age one with income up to 150 percent of the FPL (Federal Poverty Level).
  - Children ages 1 through 5 with income up to 185 percent FPL.
  - Children ages 6 through 18 years of age with incomes at or below 100 percent of the FPL.
- Children who are American Indian or Alaska Natives who are enrolled in the state's CHIP (Child Health Insurance Program).
- American Indians or Alaskan Natives, regardless of age or income level, when they receive items and services either directly from an Indian health care provider or through referral under contract health services.
- Terminally-ill individuals receiving hospice care.
- Nursing home residents.

The following services do not require copayment:

- Case management services.
- Crisis intervention services.
- CSP (Community Support Program) services.
- Emergency services.
- Family planning services, including sterilizations.
- Home care services.
- Hospice care services.
- Immunizations.
- Independent laboratory services.
- Injections.
- PDN (private duty nursing) and PDN services for ventilator-dependent members.
- SBS (school-based services).
- 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:

- Children in a mandatory coverage category. In Wisconsin, this includes:
  - Children in foster care, regardless of age.
  - Children in subsidized adoption, regardless of age.
  - Children in the Katie Beckett program, regardless of age.
  - Children under age one with income up to 150 percent of the FPL (Federal Poverty Level).
  - Children ages 1 through 5 with income up to 185 percent FPL.
  - Children ages 6 through 18 years of age with incomes at or below 100 percent of the FPL.
- Children who are American Indian or Alaska Natives who are enrolled in the state's CHIP (Child Health Insurance Program).
- American Indians or Alaskan Natives, regardless of age or income level, when they receive items and services either directly from an Indian health care provider or through referral under contract health services.
- Terminally-ill individuals receiving hospice care.
- Nursing home residents.

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 (Wisconsin Well Woman Medicaid) from the BadgerCare Plus Benchmark Plan or the BadgerCare Plus Core Plan for any Medicaid covered service.

Topic #4273

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 (Enrollment Verification System) 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.

Topic #233

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 (health maintenance organization).
- 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.

Topic #237

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.

Topic #239

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.

Section 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

Topic #242

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:

- Birth to 3.
- Crime Victim Compensation Fund.
- GA (General Assistance).
- HCBS (Home and Community-Based Services) waiver programs.
- IDEA (Individuals with Disabilities Education Act).
- Indian Health Service.
- Maternal and Child Health Services.
- WCDP (Wisconsin Chronic Disease Program).
    - 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.

Topic #251

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 (Civilian Health and Medical Plan of the Veterans Administration).
- Other governmental benefits.

Topic #253

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 (managed care organization).

Topic #12797

SeniorCare as Payer of Last Resort

SeniorCare is payer of last resort, except when the member is also eligible for the WCDP (Wisconsin Chronic Disease Program).

For members with other health insurance sources, SeniorCare requires pharmacies to bill other health insurance sources before submitting a claim to SeniorCare. After obtaining a response from a member's other health insurance sources, the pharmacy may submit a claim to SeniorCare, including reporting any out-of-pocket expenses (coinsurance, deductible, copayment) determined by the other health insurance sources. Using this information, SeniorCare will coordinate with the other health insurance sources to determine the SeniorCare out-of-pocket expense.

Pharmacies should submit claims for drugs reimbursed by other health insurance sources separately from those not covered by other health insurance sources for the same SeniorCare member.

Topic #255

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

Topic #2319

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 (premenstrual syndrome)
Legend Multivitamins (nonprenatal) — excludes HealthCheck
*SeniorCare does not cover prescription drugs, even with a PA (prior authorization) request, that do not have a signed rebate agreement between the DHS (Department of Health Services) 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

Topic #1928

Reimbursement Not Available

BadgerCare Plus and Medicaid

BadgerCare Plus and Wisconsin Medicaid may deny or recoup payment for covered services that fail to meet program requirements. 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 (prior authorization) 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 (disposable medical supplies), and DME (durable medical equipment) included in the nursing facility daily rate for nursing facility residents.
- Items that are in the inventory of a nursing facility.
- Brand name OTC (over-the-counter) 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.
- Sales tax.
- 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.

SeniorCare

SeniorCare may deny or recoup payment for covered services that fail to meet program requirements. Reimbursement is also not available for noncovered services.

The following are not reimbursable as SeniorCare services:

- Drugs produced by manufacturers who have not 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 for Schedule II, III, IV, or V drugs beyond the policy described in DHS 107.10(3), Wis. Admin. Code.
- Claims from pharmacy providers for reimbursement for drugs, DMS, and DME included in the nursing facility daily rate for nursing facility residents.
- Cosmetics.
- Common medicine chest items (e.g., antiseptics and Band-Aids™.)
- Drugs included in the Wisconsin Negative Formulary.
- OTC drugs other than insulin.
- Personal hygiene items.
- Patent medicines.
- Prescriptions administered in a physician's office.
- Sales tax.

- Uneconomically small package sizes.
- 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.
- Brand-name innovator drugs without "brand medically necessary" handwritten by the prescriber on the prescription.
- For members in levels 2b and 3, SeniorCare does not cover drugs that do not have a signed rebate agreement between the manufacturer and SeniorCare.

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.

Topic #695

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.

Topic #51

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 (durable medical equipment) delivery charges are included in the reimbursement for DME items.

Resources

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Resources:Contact Information

Topic #476

Member Services

Providers should refer ForwardHealth members with questions to Member Services. The telephone number for Member Services is for member use only.

Topic #473

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 enrolled 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 (prior authorization) 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 (Provider Electronic Solutions) 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.

If contacting a field representative by e-mail, providers should ensure that no individually identifiable health information, known as PHI (protected health information), is included in the message. PHI can include things such as the member's name combined with his/her identification number or SSN (Social Security number).

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 (National Provider Identifier) 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 (date of service).

Topic #474

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 (Wisconsin Chronic Disease Program), and WWWP (Wisconsin Well Woman Program) 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.
- Provider enrollment.
- COB (coordination of benefits) (e.g., verifying a member's other health insurance coverage).
- Assistance with completing forms.
- Assistance with remittance information and claim denials.
- Policy clarification.

- PA (prior authorization) 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 (National Provider Identifier) 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 (dates of service).
- Amount billed.
- RA (Remittance Advice).
- 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 (Specialized Transmission Approval Technology-Prior Authorization) for STAT-PA inquiries, including inquiries from pharmacies, DME (durable medical equipment) 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 (end-stage renal disease), and hospice services or NIP (nurses in independent practice)).
- 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 (F-01170 (07/12)) 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
313 Blettner Blvd
Madison WI 53784

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.

Topic #475

Provider Suggestions

The DHCAA (Division of Health Care Access and Accountability) 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 (F-1016 (02/09)) form.

Topic #4456

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.

Provider Services and Resources

Services and resources, contact information, and hours of availability are effective after ForwardHealth implementation, unless otherwise noted.

ForwardHealth Portal	***www.forwardhealth.wi.gov/***	**24 hours a day, seven days a week**
Public and secure access to ForwardHealth information with direct link to contact Provider Services for up-to-date access to ForwardHealth programs information, including publications, fee schedules, and forms.		
WiCall Automated Voice Response System	**(800) 947-3544**	**24 hours a day, seven days a week**
WiCall, the ForwardHealth Automated Voice Response system, provides responses to the following inquiries: • Checkwrite. • Claim status. • Prior authorization. • Member enrollment.		
ForwardHealth Provider Services Call Center	**(800) 947-9627**	**Monday through Friday, 7:00 a.m. to 6:00 p.m. (Central Time)***
To assist providers in the following programs: • BadgerCare Plus. • Medicaid. • SeniorCare. • Wisconsin Well Woman Medicaid. • Wisconsin Chronic Disease Program (WCDP). • Wisconsin Well Woman Program (WWWP). • Wisconsin Medicaid and BadgerCare Plus Managed Care Programs.		
ForwardHealth Portal Helpdesk	**(866) 908-1363**	**Monday through Friday, 8:30 a.m. to 4:30 p.m. (Central Time)***
To assist providers and trading partners with technical questions regarding Portal functions and capabilities, including Portal accounts, registrations, passwords, and submissions through the Portal.		
Electronic Data Interchange Helpdesk	**(866) 416-4979**	**Monday through Friday, 8:30 a.m. to 4:30 p.m. (Central Time)***
For providers, trading partners, billing services, and clearing houses with technical questions about the following: • Electronic transactions. • Companion documents. • Provider Electronic Solutions (PES) software.		
Managed Care Ombudsman Program	**(800) 760-0001**	**Monday through Friday, 7:00 a.m. to 6:00 p.m. (Central Time)***
To assist managed care enrollees with questions about enrollment, rights, responsibilities, and general managed care information.		
Member Services	**(800) 362-3002**	**Monday through Friday, 7:00 a.m. to 6:00 p.m. (Central Time)***
To assist ForwardHealth members or persons calling on behalf of members with program information and requirements, enrollment, finding certified providers, and resolving concerns.		

* With the exception of state-observed holidays.

Electronic Data Interchange

Topic #459

Companion Guides and NCPDP Version D.0 Payer Sheet

Companion guides and the NCPDP (National Council for Prescription Drug Programs) version D.0 payer sheet are available for download on the ForwardHealth Portal.

Purpose of Companion Guides

ForwardHealth companion guides and payer sheet provide trading partners with useful technical information on ForwardHealth's standards for nationally recognized electronic transactions.

The information in companion guides and payer sheet applies to BadgerCare Plus, Medicaid, SeniorCare, WCDP (Wisconsin Chronic Disease Program), and WWWP (Wisconsin Well Woman Program). Companion guides and payer sheet are intended for information technology and systems staff who code billing systems or software.

The companion guides and payer sheet complement the federal HIPAA (Health Insurance Portability and Accountability Act of 1996) 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 (Remittance Advice), and enrollment inquiries).

Companion guides and payer sheet do *not* include program requirements, but help those who create the electronic formats for electronic data exchange.

Companion guides and payer sheet 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 (Electronic Data Interchange) Helpdesk.
- Transaction formats.

Revisions to Companion Guides and Payer Sheet

Companion guides and payer sheet may be updated as a result of changes to federal requirements. When this occurs, ForwardHealth will do the following:

- Post the revised companion guides and payer sheet 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 revised companion guides and payer sheet on the Portal. If trading partners do not follow the revisions identified in the companion guides or payer sheet, transactions may not process successfully (e.g., claims may deny or process incorrectly).

A change summary located at the end of the revised companion guide lists the changes that have been made. The date on the

companion guide reflects the date the revised companion guide was posted to the Portal. In addition, the version number located in the footer of the first page is changed with each revision.

Revisions to the payer sheet are listed in Appendix A. The date on the payer sheet reflects the date the revised payer sheet was posted to the Portal.

Topic #460

Data Exchange Methods

The following data exchange methods are supported by the EDI (Electronic Data Interchange) 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 (National Council for Prescription Drug Programs) D.0, 270/271 (270/271 Health Care Eligibility/Benefit Inquiry and Information Response), 276/277 (276/277 Health Care Claim Status Request and Response), or 278 (278 Health Care Services Review — Request for Review and Response) transactions via an approved clearinghouse.

The EDI Helpdesk supports the exchange of the transactions for BadgerCare Plus, Medicaid, SeniorCare, WCDP (Wisconsin Chronic Disease Program), and WWWP (Wisconsin Well Woman Program).

Topic #461

Electronic Data Interchange Helpdesk

The EDI (Electronic Data Interchange) 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.

Topic #462

Electronic Transactions

HIPAA (Health Insurance Portability and Accountability Act of 1996) ASC (Accredited Standards Committee) X12 version 5010 companion guides and the NCPDP (National Council for Prescription Drug Programs) version D.0 payer sheet are available for download on the HIPAA Version 5010 Companion Guides and NCPDP Version D.0 Payer Sheet page of the ForwardHealth Portal.

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 (Electronic Data Interchange) Helpdesk, trading partners may exchange the following electronic transactions:

- 270/271 (270/271 Health Care Eligibility/Benefit Inquiry and Information Response). The 270 is the electronic transaction for inquiring about a member's enrollment. The 271 is received in response to the inquiry.
- 276/277 (276/277 Health Care Claim Status Request and Response). The 276 is the electronic transaction for checking

claim status. The 277 is received in response.
- 278 (278 Health Care Services Review - Request for Review and Response). The electronic transaction for health care service PA (prior authorization) requests.
- 835 (835 Health Care Claim Payment/Advice). The electronic transaction for receiving remittance information.
- 837 (837 Health Care Claim). The electronic transaction for submitting claims and adjustment requests.
- 999 (999 Functional Acknowledgment). 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 D.0 Telecommunication Standard for Retail Pharmacy Claims. The real-time POS (Point-of-Sale) electronic transaction for submitting pharmacy claims.

Topic #9177

Provider Electronic Solutions Software

ForwardHealth offers electronic billing software at no cost to providers. The PES (Provider Electronic Solutions) software allows providers to submit NCPDP (National Council for Prescription Drug Programs) 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 (Electronic Data Interchange) Helpdesk.

Topic #464

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 (Provider Electronic Solutions) 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 (Electronic Data Interchange) Helpdesk.

Topic #465

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

Topic #256

270/271 Transactions

The 270/271 (270/271 Health Care Eligibility/Benefit Inquiry and Information Response) 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 (National Provider Identifier), 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 enrollment 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 enrollment on file with ForwardHealth. The 271 response will report the provider ID that was indicated on the 270.

Topic #469

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 (managed care organization) enrollment.
- Medicare enrollment.
- Limited benefits categories.
- Any other commercial health insurance coverage.
- Exemption from copayments for BadgerCare Plus members.

Topic #259

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 (Enrollment Verification System) 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 (date of service) 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.

Topic #4903

Copayment Information

If a member is enrolled in BadgerCare Plus or Wisconsin Medicaid and is exempt 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, Medicaid, or SeniorCare and is required to pay a copayment, the provider 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.

Topic #264

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 (Enrollment Verification System) to receive the most current enrollment information through the following methods:

- ForwardHealth Portal.
- WiCall, Wisconsin's AVR (Automated Voice Response) system.
- Commercial enrollment verification vendors.
- 270/271 (270/271 Health Care Eligibility/Benefit Inquiry and Response) 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.

Topic #4901

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.

Topic #4900

Entering Dates of Service

Enrollment information is provided based on a "From" DOS (date of service) 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 (Wisconsin Chronic Disease Program) 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.

Topic #265

Member Forgets ForwardHealth Identification Card

Even if a member does not present a ForwardHealth identification card, a provider can use Wisconsin's EVS (Enrollment Verification System) 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 (Social Security number) 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.

Topic #4899

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 (date of service) 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.

Topic #4898

Responses Are Based on Financial Payer

When making an enrollment inquiry through Wisconsin's EVS (Enrollment Verification System), 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 (Wisconsin Chronic Disease Program).
- WWWP (Wisconsin Well Woman Program).

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 (Tuberculosis-Related Services Only) Benefit and Family Planning Only Services at the same time, both of which are administered by Medicaid.)

Forms

Topic #767

An Overview

ForwardHealth requires providers to use a variety of forms for PA (prior authorization), claims processing, and documenting special circumstances.

Topic #470

Fillable Forms

Most forms may be obtained from the Forms page of the ForwardHealth Portal.

Forms on the Portal are available as fillable PDF (Portable Document Format) 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.

Topic #766

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
    313 Blettner Blvd
    Madison WI 53784

Portal

Topic #4904

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 (Direct Data Entry) through the secure Portal.

Topic #8524

Conducting Revalidation Via the ForwardHealth Portal

Providers can conduct revalidation online via a secure revalidation area of the ForwardHealth Portal.

Topic #5157

Cost Share Reports for Long-Term Managed Care Organizations

Individual cost share reports for long-term care MCOs (managed care organizations) that provide Family Care, Family Care Partnership, and PACE (Program of All-Inclusive Care for the Elderly) services are available via the secure area of the ForwardHealth Portal and can be downloaded as an Excel file.

Topic #4345

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 (personal identification number) 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 ForwardHealth 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.

Refer to the Account User Guide on the Portal User Guides page of the Portal for more detailed instructions on performing these functions.

Topic #4340

Designating a Trading Partner to Receive 835 Health Care Claim Payment/Advice Transactions

Providers must designate a trading partner to receive their 835 (835 Health Care Claim Payment/Advice) 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 (Electronic Data Interchange) Helpdesk or submit a paper (Trading Partner 835 Designation, F-13393 (07/12)) form.

Topic #5087

Electronic Communications

The secure ForwardHealth 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.

Topic #5088

Enrollment Verification

The secure ForwardHealth 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 (managed care organization).
- 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 (Enrollment Verification System) (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.

Topic #4338

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 (managed care organization).
- 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.

Topic #4441

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.

Topic #4451

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.

Topic #4400

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 (Provider Electronic Solutions) 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.

Topic #4351

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 ForwardHealth 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.

Topic #4743

Managed Care Organization Portal

Information and Functions Through the Portal

The MCO (managed care organization) 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:

- Listing of all Medicaid-enrolled 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 (Social Security number) with date of birth and a "from DOS (date of service)" 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, taxonomy code (if applicable), and provider type and specialty.
- HealthCheck information.
- MCO contact information.
- Technical contact information. Entries may be added via the Portal.

Topic #5158

Managed Care Organization Portal Reports

The following reports are generated to MCOs (managed care organizations) 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 (file transfer protocol).

Topic #4744

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.

Topic #4344

Obtaining a Personal Identification Number

To establish an account on the ForwardHealth Portal, providers are required to obtain a PIN (personal identification number). 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 revalidation. Providers will receive a

separate PIN for revalidation.

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 enrollment. A separate PIN will be needed for each provider enrollment. Health care providers will need to supply their NPI (National Provider Identifier) 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 enrollments. Select the correct enrollment for the account. The taxonomy code, ZIP+4 code, and financial payer for that enrollment will be automatically populated. Enter the SSN (Social Security number) or TIN (Tax Identification Number).
    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 (Supplemental Security Income).
        - WCDP (Wisconsin Chronic Disease Program).
        - The WWWP (Wisconsin Well Woman Program).

    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.

Topic #4459

Online Handbook

The Online Handbook allows providers access to all policy and billing information for Wisconsin Medicaid, BadgerCare Plus, and WCDP (Wisconsin Chronic Disease Program) 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:

- Claims.
- Coordination of Benefits.
- Managed Care.
- Member Information.
- Prior Authorization.
- Provider Enrollment and Ongoing Responsibilities.

- 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.)

Topic #5089

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 (Remittance Advice).
- Designate which trading partner is eligible to receive the provider's 835 (835 Health Care Claim Payment/Advice).
- 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 (electronic funds transfer).
- Track provider-submitted PA (prior authorization) requests.

Topic #4911

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 (managed care organization).
- 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 (Health Insurance Portability Accountability Act of 1996). 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 (protected health information) 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.

Topic #4912

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 ForwardHealth 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.

Topic #4913

Portal Clerks

The administrator (or the clerk administrator if the administrator has granted them authorization) may set up clerks within their ForwardHealth Portal account. Clerks may be assigned one or many roles (i.e., claims, PA (prior authorization), member 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 enrollments). 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 member enrollment verification for one Portal account, and HealthCheck inquires for another).

Topic #4740

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 maximum allowable fee schedules for Medicaid, BadgerCare Plus, and WCDP (Wisconsin Chronic Disease Program) are interactive and searchable. Providers can enter the DOS (date of service), 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 policy information are incorporated into the Online Handbook in conjunction with published *Updates*. The Online Handbook also links to the ForwardHealth Publications page, an archive section where providers can research previously published *Updates*.

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 Enrollment

Providers can speed up the enrollment process for Medicaid by completing a provider enrollment application via the Portal. Providers can then track their application by entering their ATN (application tracking number) 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 (prior authorization).
- E-mail subscription service for *Updates*. Providers can register for e-mail subscription 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.

Topic #4741

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 (prior authorization) 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 (Direct Data Entry) through the secure Portal.

Submitting Prior Authorization and Amendment Requests Via the Portal

Nearly all service areas can submit PA requests via the Portal. Providers can do the following:

- Correct errors on PA or amendment requests via the Portal, regardless of how the PA request was originally submitted.
- View all recently submitted and finalized PA and amendment requests.
- Save a partially completed PA request and finish completing it at a later time. (*Note:* Providers are required to submit or re-save a PA request within 30 calendar days of the date the PA request was last saved.)
- View all saved PA requests and select any to continue completing or delete.
- 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 (managed care organization).
- 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 (Automated Voice Response) system or the EVS (Enrollment Verification System) (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 (Remittance Advices).
- Designate which trading partner is eligible to receive the provider's 835 (835 Health Care Claim Payment/Advice) transaction.
- 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 (electronic funds transfer).
- Track provider-submitted PA requests.

Topic #4401

System and Browser Requirements

The following table lists the recommended system and browser requirements for using the ForwardHealth Portal. PES (Provider Electronic Solutions) users should note that the Windows-based requirements noted in the table apply; PES cannot be run on Apple-based systems.

Recommended System Requirements	Recommended Browser Requirements
Windows-Based Systems	
Computer with at least a 500Mhz processor, 256 MB of RAM, and 100MB of free disk space	Microsoft Internet Explorer v. 6.0 or higher, or Firefox v. 1.5 or higher
Windows XP or higher operating system	
Apple-Based Systems	
Computer running a PowerPC G4 or Intel processor, 512 MB of RAM, and 150MB of free disk space	Safari, or Firefox v. 1.5 or higher
Mac OS X 10.2.x or higher operating system	

Topic #4742

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 (Provider Electronic Solutions) software and upgrade information.
- EDI (Electronic Data Interchange) companion guides.

In the secure Trading Partner area of the Portal, trading partners can exchange electronic transactions with ForwardHealth.

Trading partners using PES should be sure to enter the Web logon and Web password associated with the ForwardHealth trading partner ID that will be used on PES transactions. Prior to submitting transactions through PES, trading partners must also make sure their trading partner account is entered as the "Default Provider ID" on the Switch Organization page of the secure Trading Partner account on the Portal.

Training Opportunities

Topic #12757

Training Opportunities

The Provider Relations representatives conduct training sessions in a variety of formats on both program-specific and topic-specific subjects. There is no fee for attending/accessing these training sessions.

On-Site Sessions

On-site training sessions are offered at various locations (e.g., hotel conference rooms, provider facilities) throughout the state. These training sessions include general all-provider sessions, service-specific and/or topic-specific sessions, and program-specific (such as WCDP (Wisconsin Chronic Disease Program) or the WWWP (Wisconsin Well Woman Program)) sessions.

Registration is required to attend on-site sessions. Online registration is available on the Trainings page of the Providers area of the Portal.

Online (Real-Time, Web-Based) Sessions

Online (real-time, Web-based) training sessions are available and are facilitated through HP® Virtual Room. Virtual Room sessions are offered on many of the same topics as on-site sessions, but online sessions offer the following advantages:

- Participants can attend training at their own computers without leaving the office.
- Sessions are interactive as participants can ask questions during the session.
- If requested or needed, a session can be quickly organized to cover a specific topic for a small group or office.

For some larger training topics (such as ForwardHealth Portal Fundamentals), the training may be divided into individual modules, with each module focused on a particular subject. This allows participants to customize their training experience.

Registration, including an e-mail address, is required to attend Virtual Room sessions, so important session information can be sent to participants prior to the start of the session. Online registration is available on the Trainings page of the Portal.

Recorded Webcasts

Recorded Webcasts are available on a variety of topics, including some of the same topics as on-site and online sessions. Like Virtual Room sessions, some recorded Webcasts on larger training topics may be divided into individual Webcast modules, allowing participants to customize their training experience. Recorded Webcasts allow providers to view the training at their convenience on their own computers.

Registration is not required to view a recorded Webcast. Related training materials are available to download and print from the specific Webcast training session page on the Portal.

Notification of Training Opportunities

In addition to information on the Trainings page of the Portal, upcoming training session information is distributed directly through messages to providers who have secure Portal accounts and to providers who have registered for the ForwardHealth e-mail subscription service.

To sign up for a secure Portal account, click the "Request Portal Access" link in the Quick Links box on the Provider page of the Portal. To sign up for e-mail subscription, click "Register for E-mail Subscription" in the Quick Links box on the Provider page of the Portal.

Updates

Topic #4460

Full Text Publications Available

Providers may request full-text versions of *ForwardHealth Updates* to be mailed to them by calling Provider Services.

Topic #478

General Information

ForwardHealth Updates are the first source of provider information. *Updates* announce the latest information on policy and coverage changes, PA (prior authorization) submission requirements, claims submission requirements, and training announcements.

The *ForwardHealth Update Summary* is posted to the ForwardHealth Portal on a monthly basis and contains an overview of *Updates* published that month. Providers with a ForwardHealth Portal account are notified through their Portal message box when the *Update Summary* is available on the Portal.

Updates included in the *Update Summary* are posted in their entirety on the Provider area of the Portal. Providers may access Updates from direct links in the electronic *Update Summary* as well as navigate to other Medicaid iinformation 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 in conjunction with published *Updates*. The Online Handbook also includes a link to the ForwardHealth Publications page, an archive section where providers can research previously published *Updates*.

Topic #4458

Multiple Ways to Access ForwardHealth Publications

Users may register for 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.

E-mail Subscription Service

Providers and other interested parties may register for e-mail subscription 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 (Wisconsin Chronic Disease Program)) and provider type (e.g., physician, hospital, DME (durable medical equipment) 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.

Users may sign up for an e-mail subscription by following these steps:

1. Click the Providers link on the ForwardHealth Portal.
2. In the Quick Links section on the right side of the screen, click Register for E-mail Subscription.
3. The Subscriptions page will be displayed. In the E-Mail field in the New Subscriber section, enter the e-mail address to which messages should be sent.
4. Enter the e-mail address again in the Confirm E-Mail field.
5. Click Register. A message will be displayed at the top of the Subscriptions page indicating the registration was successful. If there are any problems with the registration, an error message will be displayed instead.
6. Once registration is complete, click the program for which you want to receive messages in the Available Subscriptions section of the Subscriptions page. The selected program will expand and a list of service areas will be displayed.
7. Select the service area(s) for which you want to receive messages. Click Select All if you want to receive messages for all service areas.
8. When service area selection is complete, click Save at the bottom of the page.
9. The selected subscriptions will load and a confirmation message will appear at the top of the page.

WiCall

Topic #257

Enrollment Inquiries

WiCall is an AVR (Automated Voice Response) system that allows providers with touch-tone telephones direct access to enrollment information.

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 (date of service) 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 (Health Personnel Shortage Area) on the DOS or within the DOS range selected, HPSA information will be given.
- MCO (managed care organization): 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.

Topic #6257

Entering Letters into WiCall

For some WiCall inquries, health care providers are required to enter their taxonomy code with their NPI (National Provider Identifier). 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.

Topic #466

Information Available Via WiCall

WiCall, ForwardHealth's AVR (Automated Voice Response) 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 (prior authorization) 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 (National Provider Identifier) 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 (Wisconsin Chronic Disease Program), or WWWP (Wisconsin Well Woman Program) by entering their provider ID, member identification number, DOS (date of service), 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 (Social Security number). 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 (National Drug Code), procedure code, revenue code, or ICD-9-CM (International Classification of Diseases, Ninth Revision, Clinical Modification) 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.

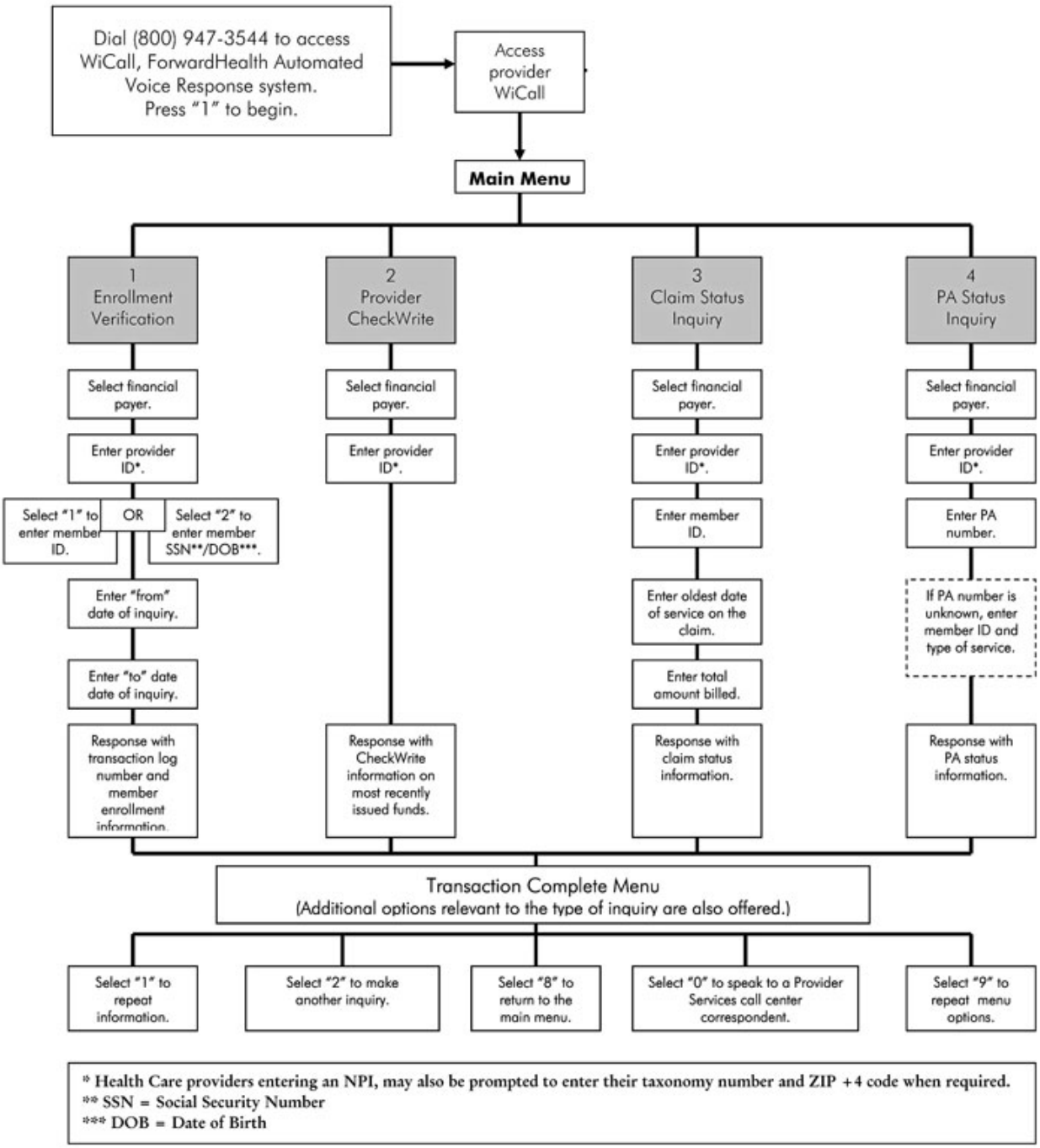
Note: PA information for BadgerCare Plus and SeniorCare is available by selecting the Medicaid option.

Topic #765

Quick Reference Guide

The WiCall AVR (Automated Voice Response) Quick Reference Guide displays the information available for WiCall inquiries.

Automated Voice Response Quick Reference Guide



* Health Care providers entering an NPI, may also be prompted to enter their taxonomy number and ZIP +4 code when required.
** SSN = Social Security Number
*** DOB = Date of Birth