Claims

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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 Wisconsin 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 the claim is found, the provider can alter it to reflect the desired change and resubmit it to ForwardHealth. Any claim ForwardHealth has paid within 365 days of the DOS (date of service) can be adjusted and resubmitted on the Portal, regardless of how the claim was originally submitted.

Claim adjustments with DOS beyond the 365-day submission deadline should *not* be submitted electronically. Providers who attempt to submit a claim adjustment electronically for DOS beyond 365 days will have the entire amount of the claim recouped.

Requests for adjustments to claims with DOS beyond the 365-day submission deadline may be submitted using the timely filing process (a paper process) if the claim adjustment meets one of the exceptions to the claim submission deadline.

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 (08/15)) 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 #21577

Drug Utilization Review

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 the 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, Wisconsin 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 physicians, pharmacists, and a nurse practitioner with prescribing authority. The DUR Board and the Wisconsin 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 Wis. Admin. Code §§ Phar. 7.01(1)(e) and 7.08, and Wis. Stat. § 450.01(16)(i), for additional information about DUR program requirements.

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. Prospective DUR alerts inform providers of potential drug therapy problems.

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 #21597

Prospective Drug Utilization Review

Prospective Drug Utilization Review System

To help individual pharmacies comply with their prospective DUR (Drug Utilization Review) responsibility, BadgerCare Plus, Wisconsin 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) noncompound claims submitted to ForwardHealth. Prospective DUR alerts are returned to pharmacy providers as a conflict code. Providers may refer to the ForwardHealth Payer Sheet: 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 noncompound drug 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 independently perform prospective DUR.

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

Noncompound drug claims submitted through the real-time pharmacy POS system for assisted living facility, group home, and

nursing facility members are reviewed through the prospective DUR system. Providers are required to respond to all prospective DUR alerts for members in an assisted living facility, group home, or nursing facility, with the exception of insufficient quantity (NS or three-month supply), high cumulative dose (HC or high MME (morphine milligram equivalent)), and underuse precaution (LR or Late Refill). The assisted living facility, group home, or nursing facility pharmacist consultant is responsible for prospective DUR.

Overriding Prospective Drug Utilization Review Alerts

When a noncompound drug claim is processed for a drug that has the potential to cause problems for a member, BadgerCare Plus, Wisconsin Medicaid, or SeniorCare will return a prospective DUR alert to inform the pharmacy provider about the potential problem. The provider is then required to respond to the prospective DUR alert to obtain reimbursement. Providers are required to resubmit the claim and include information about the action taken and the resulting outcome.

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)

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

When multiple prospective DUR alerts are returned on a claim, and one of the prospective DUR alerts is an informational alert, providers cannot override the prospective DUR alerts by responding solely to the informational prospective DUR alert. To override a prospective DUR alert, providers are required to respond to at least one prospective DUR alert other than an informational prospective DUR alert to obtain reimbursement.

Providers may override non-informational prospective DUR alerts. For certain drugs, pharmacy providers are required to call the DAPO (Drug Authorization and Policy Override) Center to obtain an override.

If providers receive a prospective DUR alert and subsequently receive an override through the DAPO Center, the prospective DUR alert override is not required on the resubmitted claim. If multiple prospective DUR alerts are received for a claim and an override from the DAPO Center is obtained for one prospective DUR alert, providers may be required to 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 ForwardHealth Payer Sheet: NCPDP Version D.0, for information about NCPDP transactions.

Alerts and Alert Hierarchy

The DUR Board has established a hierarchy for the order in which multiple prospective DUR alerts appear if more than one prospective DUR 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 prospective DUR alerts used by other state Medicaid programs for prospective DUR. The clinical drug tables used to establish the prospective DUR alerts are provided to BadgerCare Plus, Wisconsin Medicaid, and SeniorCare by First DataBank, Inc.

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

- PA (Drug-age precaution)

- DD (Drug-drug interaction)
- MC (Reported disease)
- TD (Therapeutic duplication)
- PG (Pregnancy alert)
- ER (Overuse precaution)
- LR (Underuse precaution)

Informational Prospective Drug Utilization Review Alerts

Some prospective DUR alerts are informational. Informational prospective DUR alerts will be posted on the NCPDP real-time response but will not cause the claim to deny. These prospective DUR alerts are intended to provide the dispensing pharmacy with the DUR information without causing a claim denial. Insufficient quantity (NS or three-month supply) and the high cumulative dose (HC or high MME) are current informational prospective DUR alerts. Of note, certain drugs monitored by the NS prospective DUR alert are not informational and require the provider to contact the DAPO Center to obtain an override.

Drug-Age Precaution

The drug-age precaution (PA or patient age) prospective DUR alert is activated when claims include any products containing codeine or tramadol or prescription cough and cold products containing codeine or hydrocodone if the member is less than 18 years of age.

Pharmacy providers should assess whether or not it is clinically appropriate to dispense the product for the child prior to entering an override to proceed. Pharmacy providers are required to respond to the prospective DUR alert to obtain reimbursement. ForwardHealth recommends that the pharmacy provider document the reason for overriding the PA prospective DUR alert.

Drug-Drug Interaction

The drug-drug interaction (DD) prospective DUR alert is activated when another drug in ForwardHealth 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, Wisconsin Medicaid, and SeniorCare.

DD is defined as a pharmacological response in a patient taking two drugs that differs from the expected pharmacological response when each drug is taken separately.

Note: The history claim and current claim must be from a different pharmacy and prescriber.

High Cumulative Dose

The high cumulative dose (HC or high MME) prospective DUR alert is an informational alert and is activated when a drug being dispensed has a dose that is equal to or greater than 90 MME on the current claim.

MMEs will be calculated based on the drug ingredient, strength, and the days' supply indicated on the noncompound drug claim. This is an approximation of the daily MME for the claim. This prospective DUR alert does not calculate a cumulative daily MME and does not consider other opioids the member may be taking. Buprenorphine products and all liquids, including methadone for medication-assisted therapy will be excluded from the prospective DUR alert. However, methadone for pain will be included in the prospective DUR alert.

Pharmacy providers are to perform an appropriate review and counseling of the member considering their overall medication use.

Pharmacy providers will not be required to respond to the HC prospective DUR alert. This prospective DUR alert will be informational only.

Insufficient Quantity—Three-Month Supply

The insufficient quantity (NS or three-month supply) prospective DUR alert is an informational prospective DUR alert that informs pharmacy providers that there is an opportunity to dispense a drug in a three-month supply. Certain drugs are required to be dispensed in a three-month supply, while other drugs are allowed to be dispensed in a three-month supply. Pharmacy providers are not required to respond to the NS informational prospective DUR alert.

For drugs that are required to be dispensed in a three-month supply, pharmacy providers are required to call the DAPO Center to obtain an override to dispense less than a three-month supply.

Overuse Precaution

The overuse precaution (ER or Early Refill) prospective DUR alert for a claim is activated when the drug, drug strength, and dosage form on that claim matches the drug, drug strength, and dosage form on another claim in ForwardHealth claims history for which the threshold percentage of the days' supply remains on the prescription fill/refill. The prospective DUR alert will indicate the date that the drug can be refilled without activating the prospective DUR alert.

Days' Supply	Threshold
6-9 days' supply	65% threshold
10-34 days' supply	80% threshold
35-100 days' supply	85% threshold

All drugs will be subject to this prospective DUR alert, with the exception of:

- Drugs listed on the Quantity Limit Drugs and Diabetic Supplies data table.
- Drugs with a five days' supply or less.

Pharmacy providers are required to respond to the prospective DUR alert to obtain reimbursement. ForwardHealth recommends that pharmacy providers document the reason for manual overrides of the ER prospective DUR alert.

For certain drugs monitored by the ER prospective DUR alert, pharmacy providers are required to call the DAPO Center to obtain an override. A comprehensive list of drugs monitored by the DAPO Center for the ER prospective DUR alert is available to providers on the Pharmacy provider-specific resources page of the ForwardHealth Portal. The thresholds described above also apply to ER prospective DUR alerts that must be overridden by the DAPO Center.

Early Refill—Drug Authorization and Policy Override

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

- The member has an appropriate medical need (for example, the member's medications were lost or stolen, the member has requested a vacation supply, or the member was involved in a natural disaster).
- The member has been taking too much of a medication because they misunderstood the directions for administration from the prescriber.
- The 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 DAPO Center 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 the proper threshold percentage of the 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)

Pregnancy Alert

The pregnancy (PG) prospective DUR alert is activated when a drug being dispensed has a potentially dangerous effect on a pregnant member.

This prospective DUR 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 noncompound drug claim for the member that indicates pregnancy using a diagnosis code.
- A noncompound claim for a drug that possesses a clinical significance code of D, X, or 1 (as assigned by the FDA (Food and Drug Administration) or First DataBank, Inc.) is submitted for the 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 the 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 value is assigned by the FDA.
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 value is assigned by the FDA.
1	There is no FDA rating, but the drug is contraindicated or not recommended; it may have animal and/or human studies or pre- or post-marketing information. This value is assigned by First DataBank, Inc.

The pregnancy diagnosis will be deactivated from a member's disease profile after 260 days or if an intervening diagnosis indicating delivery or other pregnancy termination is received on a claim.

Reported Disease

The reported disease (MC or drug-disease contraindication) prospective DUR alert is activated when a drug being dispensed has a potentially dangerous interaction with a reported disease. Disease profiles are created for members using diagnosis information from medical, institutional, and noncompound drug claims. Diseases are assigned a duration of acute, chronic, or lifetime. Acute diseases remain in the member's disease profile for 120 days, chronic diseases remain for 200 days, and lifetime diseases remain permanently.

Therapeutic Duplication

The therapeutic duplication (TD) prospective DUR alert is activated when a drug being dispensed has the same therapeutic benefit as a previously dispensed drug.

This prospective DUR alert is activated when all the following apply:

- A drug is present in claims history in the same therapeutic category as the drug being dispensed.
- The drugs have the same therapeutic category but have a different active ingredient.
- The DOS (dates of service) of the two interacting drugs overlap.
- The history claim and the current claim must be from a different pharmacy and prescriber.

The message sent to the provider includes the drug name in claims history that is causing the prospective DUR alert. Refer to the table below for the therapeutic categories monitored for the therapeutic duplication prospective DUR alert.

Therapeutic Categories for Duplication Alert	
Anti-anxiety agents	Histamine H2 receptor inhibitors
Antidepressants	Hypoglycemics
Antihistamines	Narcotic analgesics
Antihypertensives	NSAIDs (Nonsteroidal anti-inflammatory drugs) (including COX-2 (cyclooxygenase-2) selective agents)
Antipsychotics	Oral contraceptives
Antithrombotics	Platelet aggregation inhibitors
Barbiturates	Proton pump inhibitor drugs
Cardiovascular agents	Sedatives and hypnotics
Diuretics	Skeletal muscle relaxants

Underuse Precaution

The underuse precaution (LR or Late Refill) prospective DUR alert is activated when a drug being dispensed is being refilled less than what is recommended. The prospective DUR alert is returned on a claim when the drug being refilled exceeds 120 percent of the days' supply on the same drug in ForwardHealth claims history.

The number of days late is calculated as the days after the prescription should have been refilled. Claims in history must be for greater than or equal to 28 days' supply to be included in this prospective DUR alert.

Refer to the table below for the therapeutic categories monitored for the underuse precaution prospective DUR alert.

Therapeutic Categories for Late Refill Alert	
Alzheimer's agents	Bipolar agents
Antiarrhythmics (including digitalis)	COPD (Chronic obstructive pulmonary disease) agents
Anticoagulants (except warfarin)	Diuretics (except loops)
Anticonvulsants	Glaucoma agents

Antidepressants	Hepatitis C agents
Antihyperglycemics (except insulin)	HIV antivirals
Antihyperlipidemics	Immunosuppressants
Antihypertensives	Platelet aggregation inhibitors
Antipsychotics	Thyroid hormones
Asthma controllers (except the beta adrenergic agents)	

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.

Good Faith Claims

Topic #1961

Definition

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.

Topic #518

Definition of Good Faith Claims

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 identification card for BadgerCare Plus or Family Planning Only Services, the provider should check the member's enrollment via Wisconsin's EVS (Enrollment Verification System) and, if the enrollment is not on file yet, make a photocopy of the member's temporary identification card.

When a member presents a temporary ID card for EE (Express Enrollment) in BadgerCare Plus or Family Planning Only Services but the member's enrollment is not on file yet in the EVS, the provider should check enrollment again in two days or wait one week to submit a claim to ForwardHealth. If, after two days, the EVS indicates that the member still is not enrolled or the claim is denied with an enrollment-related EOB (Explanation of Benefits) code, the provider should contact Provider Services for assistance.

When a member who received a real-time eligibility determination presents a temporary ID card but the member's enrollment is not on file yet in the EVS, the provider should wait up to one week to submit a claim to ForwardHealth. If the claim is denied with an enrollment-related EOB code, the provider should contact Provider Services for assistance.

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 Wis. Admin. Code DHS 106.08.
- 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

Wisconsin Medicaid 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 (08/15)) 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, Wisconsin Medicaid 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 Wis. Admin. Code DHS 106.04(5), 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."

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

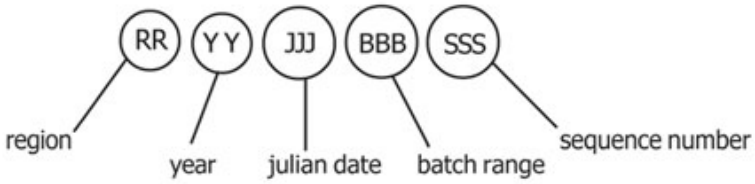
control number)). However, denied real-time compound and noncompound claims are not assigned an ICN, but receive an authorization number. Authorization numbers are not reported to the RA (Remittance Advice) or 835 (835 Health Care Claim Payment/Advice).

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 121 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 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

ForwardHealth offers electronic billing software at no cost to providers. The PES (Provider Electronic Solutions) software allows providers to submit electronic claims and claim reversals, and 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 PPACA (Patient Protection and Affordable Care Act) of 2010, the federal 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 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 and outpatient hospital claims submitted with CPT (Current Procedural Terminology) or HCPCS (Healthcare Common Procedure Coding System) procedure codes for Wisconsin Medicaid, BadgerCare Plus, WCDP (Wisconsin Chronic Disease Program), and Family Planning Only Services for compliance with the following NCCI edits:

- MUE (Medically Unlikely Edits), or units-of-service detail edits
- Procedure-to-procedure detail edits

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 the maximum units of service that a provider would report under most circumstances for a single member on a single DOS (date of service) for each CPT or HCPCS procedure code. 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 if procedure code 11102 (tangential biopsy of skin [eg, shave, scoop, saucerize, curette]; single lesion) was billed by a provider on a professional claim with a quantity of two or more. 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 or 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 if procedure codes 11451 (excision of skin and subcutaneous tissue for hidradenitis, axillary; with complex repair) and 93000 (electrocardiogram, routine ECG with at least 12 leads; with interpretation and report) were billed on the same claim for the same DOS. Procedure code 11451 describes a more complex service than procedure code 93000, and therefore, the secondary procedure would be denied.

Quarterly Code List Updates

CMS will issue quarterly revisions to the table of codes subject to NCCI edits that ForwardHealth will adopt and implement. Refer to the CMS Medicaid website 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 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 (08/15)) 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 121 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) include 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
- Noncompound 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	Provider Types
Dental claims	Dentists, dental hygienists, HealthCheck agencies that provide dental services
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 ((02/12))
Noncompound and compound drug claims	Pharmacies and dispensing physicians

Outpatient claims	Outpatient hosptial 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, physicial 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	V—Capitation adjustment

transaction that created the accounts receivable.	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 (that is, 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, ADAP (Wisconsin AIDS Drug Assistance Program), 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

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

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

MEMBER NAME: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     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 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

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                  PAYEE ID      999999999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                         NPI                9999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                         CHECK/EFT NUMBER    999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX, 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: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX    MEMBER NO.: XXXXXXXXXXX
RRYYJJJBBBSSS  XXXXXXXXXXX  XXXXXXXXXXX  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, ADAP (Wisconsin AIDS Drug Assistance Program), 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)
- ADAP (Wisconsin AIDS Drug Assistance Program)
- WCDP (Wisconsin Chronic Disease Program)
- WWWP (Wisconsin Well Woman Program)

A separate Portal account is required for each financial payer.

Note: Each of the four 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
- Noncompound 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, ADAP (Wisconsin AIDS Drug Assistance Program), 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 #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).

Exceptions to the Submission Deadline

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

- Change in a nursing home resident's LOC (level of care) or liability amount
- Decision made by a court order, fair hearing, or the Wisconsin 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 #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, plus a professional dispensing fee, if applicable, or the maximum allowable fee established.

Submission

Topic #17797

1500 Health Insurance Claim Form Completion Instructions

These instructions are for the completion of the 1500 Health Insurance Claim Form ((02/12)) for ForwardHealth. Refer to the 1500 Health Insurance Claim Form Reference Instruction Manual for Form Version 02/12, prepared by the NUCC (National Uniform Claim Committee) and available on their website, to view instructions for all item numbers not listed below.

Use the following claim form completion instructions, in conjunction with the 1500 Health Insurance Claim Form Reference Instruction Manual for Form Version 02/12, prepared by the NUCC, to avoid denial or inaccurate claim payment. Be advised that every code used is required to be a valid code, even if it is entered in a non-required field. Do not include attachments unless instructed to do so.

Members enrolled in BadgerCare Plus or Medicaid receive a ForwardHealth member identification card. Always verify a member's enrollment before providing nonemergency services to determine if there are any limitations to 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.

Other health insurance (for example, commercial health insurance, Medicare, Medicare Advantage Plans) sources must be billed prior to submitting claims to ForwardHealth, unless the service does not require commercial health insurance billing as determined by ForwardHealth. When submitting paper claims, if the member has any other health insurance sources, providers are required to complete and submit an Explanation of Medical Benefits form, along with the completed paper claim.

Submit completed paper claims and the completed Explanation of Medical Benefits form, as applicable, to the following address:

ForwardHealth
Claims and Adjustments
313 Blettner Blvd
Madison WI 53784

Item Number 6 — Patient Relationship to Insured
Enter "X" in the "Self" box to indicate the member's relationship to insured when Item Number 4 is completed. Only one box can be marked.

Item Number 9 — Other Insured's Name (not required)
This field is not required on the claim.

Note: When submitting paper claims to ForwardHealth, if the member has any other health insurance sources (for example, commercial health insurance, Medicare, Medicare Advantage Plans), providers are required to complete and submit a separate Explanation of Medical Benefits form for each other payer as an attachment(s) to their completed paper claim.

Item Number 9a — Other Insured's Policy or Group Number (not required)
This field is not required on the claim.

Note: When submitting paper claims to ForwardHealth, if the member has any other health insurance sources (for example, commercial health insurance, Medicare, Medicare Advantage Plans), providers are required to complete and submit a separate Explanation of Medical Benefits form for each other payer as an attachment(s) to their completed paper claim.

Item Number 9d — Insurance Plan Name or Program Name (not required)
This field is not required on the claim.

Note: When submitting paper claims to ForwardHealth, if the member has any other health insurance sources (for example, commercial health insurance, Medicare, Medicare Advantage Plans), providers are required to complete and submit a separate Explanation of Medical Benefits form for each other payer as an attachment(s) to their completed paper claim.

Item Number 10d — Claim Codes (Designated by NUCC)
When applicable, enter the Condition Code. The Condition Codes approved for use on the 1500 Health Insurance Claim Form are available on the NUCC website under Code Sets.

Item Number 11 — Insured's Policy Group or FECA Number (not required)
This field is not required on the claim.

Note: When submitting paper claims to ForwardHealth, if the member has any other health insurance sources (for example, commercial health insurance, Medicare, Medicare Advantage Plans), providers are required to complete and submit a separate Explanation of Medical Benefits form for each other payer as an attachment(s) to their completed paper claim.

Item Number 11d — Is There Another Health Benefit Plan?
This field is not used for processing by ForwardHealth.

Item Number 19 — Additional Claim Information (Designated by NUCC)
When applicable, enter provider identifiers or taxonomy codes. A list of applicable qualifiers are defined by the NUCC and can be found in the NUCC 1500 Health Insurance Claim Form Reference Instruction Manual for Form Version 02/12, prepared by the NUCC.

If a provider bills an unlisted (or not otherwise classified) procedure code, a description of the procedure must be indicated in this field. If a more specific code is not 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.

Item Number 22 — Resubmission Code and/or Original Reference Number
This field is not used for processing by ForwardHealth.

Section 24
The six service lines in section 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.

For provider-administered drugs: NDCs (National Drug Codes) must be indicated in the shaded area of Item Numbers 24A-24G. Each 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, with no space in between.
- Indicate one space between the NDC and the unit qualifier.
- Indicate one unit qualifier (F2 [International unit], GR [Gram], ME [Milligram], ML [Milliliter], or UN [Unit]), followed by the NDC units, with no space in between.

For additional information about submitting a 1500 Health Insurance Claim Form with supplemental NDC information, refer to the completion instructions located under "Section 24" in the Field Specific Instructions section of the NUCC's 1500 Health Insurance

Claim Form Reference Instruction Manual for Form Version 02/12.

Item Number 24C — EMG
Enter a "Y" in the unshaded area for each procedure performed as an emergency. If the procedure was not an emergency, leave this field blank.

Item Number 29 — Amount Paid (not required)
This field is not required on the claim.

Note: When submitting paper claims to ForwardHealth, if the member has any other health insurance sources (for example, commercial health insurance, Medicare, Medicare Advantage Plans), providers are required to complete and submit a separate Explanation of Medical Benefits form for each other payer as an attachment(s) to their completed paper claim.

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 ((02/12)). 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
19	Off Campus — Outpatient Hospital
22	On Campus — 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 DMS (Division of Medicaid Services) auditors.

All diagnosis codes indicated on claims (and PA (prior authorization) requests when applicable) must be the most specific 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. A code completed to its fullest character must be used. 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 #20082

Claims for Drugs Purchased Through the 340B Drug Pricing Program

Providers are required to submit accurate claim-level identifiers to identify claims for drugs purchased through the 340B Program (340B Drug Pricing Program). ForwardHealth uses submission clarification codes on compound and noncompound drug claims and a modifier on professional claims to identify claims for drugs purchased through the 340B Program. ForwardHealth monitors claims for the appropriate submission clarification code or modifier based on whether or not providers have designated themselves on the HRSA (Health Resources & Services Administration) 340B MEF (Medicaid Exclusion File).

ForwardHealth uses claim-level identifiers to identify claims for drugs purchased through the 340B Program in order to exclude these claims from the drug rebate invoicing process. It is the responsibility of the 340B covered entity to indicate the AAC (Actual Acquisition Cost) and to correctly report claims filled with 340B inventory for 340B-eligible members to ensure rebates are not collected for these drugs. If a rebate is received by ForwardHealth for a drug purchased through the 340B Program due to incorrect claim-level identifiers, the 340B covered entity will be responsible to reimburse the manufacturer the 340B discount.

A 340B contract pharmacy must carve-out ForwardHealth from its 340B operation and purchase all drugs billed to ForwardHealth outside of the 340B Program.

Pharmacy Compound and Noncompound Claim Submission Clarification Codes for Drugs Purchased Through the 340B Drug Pricing Program

The compound and noncompound drug claim formats require submission clarification codes in order to identify claims for drugs

purchased through the 340B Program. ForwardHealth uses the submission clarification code value to ensure appropriate rebate processes and avoid duplicate discounts. Providers should only submit claims for drugs purchased through the 340B Program if the provider is present on the HRSA 340B MEF.

ForwardHealth relies solely on these claim level identifiers to identify claims for drugs purchased through the 340B Program. If a 340B claim level identifier is present, then the claim will be excluded from the drug rebate invoicing process.

The following submission clarification codes are applicable to compound and noncompound drug claims submitted by 340B providers:

- "20" (340B) — Providers who submit a compound or noncompound drug claim for a drug purchased through the 340B Program are required to enter submission clarification code "20" to indicate that the provider determined the drug being billed on the claim was purchased pursuant to rights available under Section 340B of the Public Health Act of 1992. ForwardHealth uses the submission clarification code value of "20" to apply 340B reimbursement and to ensure that only eligible claims are being used to obtain drug manufacturer rebates. The claim will be reimbursed at the lesser of the calculated 340B ceiling price or the provider-submitted 340B AAC plus a professional dispensing fee. If a calculated 340B ceiling price is not available for a drug, ForwardHealth will reimburse 340B ingredient cost at the lesser of WAC (Wholesale Acquisition Cost) minus 50 percent or the provider-submitted 340B AAC plus a professional dispensing fee.
- "99" (Other) — If a provider who is listed on the HRSA 340B MEF submits a compound or noncompound drug claim without submission clarification code "20," the claim will be denied with an EOB (Explanation of Benefits) code stating they are a 340B provider submitting a claim for a drug not purchased through the 340B Program. Once a provider has verified that the claim is not for a drug purchased through the 340B Program, they should resubmit the claim with submission clarification code "99" to verify that the claim was submitted as intended and is not a claim for a drug purchased through the 340B Program. A claim with a submission clarification code of "99" will be reimbursed at the lesser of the current ForwardHealth reimbursement rate or the billed amount plus a professional dispensing fee. 340B reimbursement will not be applied.
- "2" (Other Override) — If a submitting provider is not listed on the HRSA 340B MEF but submits a compound or noncompound drug claim for a drug purchased through the 340B Program (by indicating a submission clarification code of "20"), the claim will be denied with an EOB code stating they are not on the HRSA 340B MEF. If the provider believes they are or should be on the HRSA 340B MEF as a 340B-covered entity choosing to carve-in for Wisconsin Medicaid, the provider should resubmit the claim with submission clarification code "2" to indicate that the claim is for a drug purchased through the 340B Program. The provider should also contact HRSA to update the HRSA 340B MEF with the provider's information. Covered entities are responsible for the accuracy of the information in the HRSA 340B MEF. A claim with a submission clarification code of "2" will be reimbursed at the lesser of the calculated 340B ceiling price or the provider-submitted 340B AAC plus a professional dispensing fee. If a calculated 340B ceiling price is not available for a drug, ForwardHealth will reimburse 340B ingredient cost at the lesser of WAC minus 50 percent or the provider-submitted 340B AAC plus a professional dispensing fee.

Note: The compound drug claim format only accepts one submission clarification code value. If a compound drug includes an ingredient that was purchased through the 340B Program, the provider should use the appropriate submission clarification code to identify the claim is for a drug purchased through the 340B Program, and ForwardHealth will assume the submission clarification code "8" (Process Compound for Approved Ingredients) applies to all ingredients of the compound drug claim.

Basis of Cost Determination and Submission Clarification Code

The Basis of Cost Determination is a required field in which the provider is required to submit the appropriate code indicating the method by which "ingredient cost submitted" was calculated. Providers are responsible for submitting a valid Basis of Cost Determination value, per the ForwardHealth Payer Sheet: NCPDP Version D.0 (ForwardHealth Payer Sheet: National Council for Prescription Drug Programs Version D.0, P-00272 (10/17)). When a claim is for a drug purchased through the 340B Program, the Basis of Cost Determination field must contain a value of "8" (340B/Disproportionate Share Pricing/Public Health Service); in addition, there must be an appropriate corresponding Submission Clarification Code of "2" (Other Override) or "20" (340B). ForwardHealth will deny claims with Basis of Cost Determination and Submission Clarification Code values that do **not** correspond.

Professional Claim Modifier for Drugs Purchased Through the 340B Program

Professional claim formats require a "UD" modifier in order to identify claims for drugs purchased through the 340B Program. Providers who submit professional claims for provider-administered drugs purchased through the 340B Program to ForwardHealth are required to indicate modifier UD for each HCPCS (Healthcare Common Procedure Coding System) procedure code to indicate that the provider determined that the product being billed on the claim detail was purchased pursuant to rights available under Section 340B of the Public Health Act of 1992. ForwardHealth uses modifier UD to identify that a claim is for a provider-administered drug purchased through the 340B Program and to ensure that only eligible claims are being used to obtain drug manufacturer rebates. Providers should only submit claims for drugs purchased through the 340B Program if the provider is present on the HRSA 340B MEF.

ForwardHealth relies solely on modifier UD to identify professional claims for drugs purchased through the 340B Program. If modifier UD is present, then the claim will be excluded from the drug rebate invoicing process.

In addition, providers are required to submit their AAC when they submit claims for provider-administered drugs purchased through the 340B Program. Provider-administered drugs purchased through the 340B Program will be reimbursed at the lesser of the maximum allowable fee or the provider-submitted AAC.

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 #15737

Claims for Services Prescribed, Referred, or Ordered

Claims for services that are prescribed, referred, or ordered must include the NPI (National Provider Identifier) of the Medicaid-enrolled provider who prescribed, referred, or ordered the service. Claims that do not include the NPI of a Medicaid-enrolled

provider will be denied. (However, providers should **not** include the NPI of a provider who prescribes, refers, or orders services on claims for services that are not prescribed, referred, or ordered, as those claims will also deny if the provider is not Medicaid-enrolled.)

Note: Claims submitted for ESRD (end-stage renal disease) services do not require **referring** provider information; however, **prescribing** and **ordering** provider information will still be required on claims.

Contacting Prescribing/Referring/Ordering Provider After a Claim Denial

If a claim for services prescribed, referred, or ordered is denied because the prescribing/referring/ordering provider was not Medicaid-enrolled, the rendering provider should contact the prescribing/referring/ordering provider and do the following:

- Communicate that the prescribing/referring/ordering provider is required to be Medicaid-enrolled.
- Inform the prescribing/referring/ordering provider of the limited enrollment available for prescribing/referring/ordering providers.
- Resubmit the claim once the prescribing/referring/ordering provider has enrolled in Wisconsin Medicaid.

Exception for Services Prescribed, Referred, or Ordered Prior to a Member's Medicaid Enrollment

Providers may submit claims for services prescribed, referred, or ordered by a non-Medicaid-enrolled provider if the member was not yet enrolled in Wisconsin Medicaid at the time the prescription, referral, or order was written (and the member has since enrolled in Wisconsin Medicaid). However, once the prescription, referral, or order expires, the prescribing/referring/ordering provider is required to enroll in Wisconsin Medicaid if they continue to prescribe, refer, or order services for the member.

The procedures for submitting claims for this exception depend on the type of claim submitted:

- Institutional, professional, and dental claims for this exception must be sent to the following address:

  ForwardHealth
  P.R.O. Exception Requests
  Ste 50
  313 Blettner Blvd
  Madison WI 53784

  A copy of the prescription, referral, or order must be included with the claim.

- Pharmacy and compound claims for this exception do **not** require any special handling. These claims include a prescription date, so they can be processed to bypass the prescriber Medicaid enrollment requirement in situations where the provider prescribed services before the member was Medicaid-enrolled.

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 (04/17)) 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.

ForwardHealth covers certain APIs (active pharmaceutical ingredients) and excipients on compound drug claims. Providers should refer to the Covered Active Pharmaceutical Ingredients (APIs) and Excipients list for covered APIs and excipients.

An API is a bulk drug substance, which is defined by the FDA (Food and Drug Administration) as any substance that is represented for use in a drug and that, when used in the manufacturing, processing, or packaging of a drug, becomes an active ingredient of the drug product. Excipients are inactive substances used in compounds.

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 "8" in the compound drug field. This alerts the POS system that the NDCs indicated comprise a single compound drug.

Providers who submit compound drug claims to ForwardHealth for drugs purchased through the 340B Program (340B Drug Pricing Program) are required to use the appropriate submission clarification code.

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.

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

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 Wis. Admin. Code § DHS 107.10(3)(e), 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 #15957

Documenting and Billing the Appropriate National Drug Code

Providers are required to use the NDC (National Drug Code) of the administered drug and not the NDC of another manufacturer's product, even if the chemical name is the same. Providers should not preprogram their billing systems to automatically default to NDCs that do not accurately reflect the product that was administered to the member.

Per Wis. Admin. Code §§ DHS (Department of Health Services) 106.03(3) and 107.10, submitting a claim with an NDC other than the NDC on the package from which the drug was dispensed is considered an unacceptable practice.

Upon retrospective review, ForwardHealth can seek recoupment for the payment of a claim from the provider if the NDC(s) submitted does not accurately reflect the product that was administered to the member.

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

Wisconsin Medicaid 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 their 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

ForwardHealth 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 #16937

Electronic Claims and Claim Adjustments With Other Commercial Health Insurance Information

Effective for claims and claim adjustments submitted electronically via the Portal or PES software on and after June 16, 2014, other insurance information must be submitted at the detail level on professional, institutional, and dental claims and adjustments if it was processed at the detail level by the primary insurance. Except for a few instances, Wisconsin Medicaid or BadgerCare Plus is the payer of last resort for any covered services; therefore, providers are 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).

Other insurance information that is submitted at the detail level via the Portal or PES software will be processed at the detail level by ForwardHealth.

Under HIPAA (Health Insurance Portability and Accountability Act of 1996), claims and adjustments submitted using an 837 transaction must include detail-level information for other insurance if they were processed at the detail level by the primary insurance.

Adjustments to Claims Submitted Prior to June 16, 2014

Providers who submit professional, institutional, or dental claim adjustments electronically on and after June 16, 2014, for claims originally submitted prior to June 16, 2014, are required to submit other insurance information at the detail level on the adjustment

if it was processed at the detail level by the primary insurance.

Topic #365

Extraordinary Claims

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

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 #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 an 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 health insurance (for example, commercial health insurance, Medicare, Medicare Advantage Plans) 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 health insurance sources that are primary to BadgerCare Plus, Medicaid, or SeniorCare. A claim must be submitted to each other health 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 health 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 health 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 (04/17)) form or a Compound Drug Claim (F-13073 (04/17)) 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)(C) of the Social Security Act requires NDCs to be indicated on all claims submitted to ForwardHealth for covered outpatient drugs, 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.

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 ForwardHealth members for LTE (less-than-effective) drugs as identified by the federal CMS (Centers for Medicare & Medicaid Services) or identical, related, or similar drugs.

Claim Submission

Institutional Claims

Providers that submit claims for services on an institutional claim also are required to submit claims for provider-administered drugs on an institutional claim.

Institutional claims that include provider-administered drugs must be submitted to ForwardHealth fee-for-service for fee-for-service members and to the HMO for managed care members.

Professional Claims

Providers that submit claims for services on a professional claim also are required to submit claims for provider-administered drugs on a professional claim.

Professional claims that include provider-administered drugs must be submitted to ForwardHealth fee-for-service for fee-for-service members.

Professional claims for provider-administered drugs must be submitted to ForwardHealth fee-for-service for managed care members. Other services submitted on a professional claim must be submitted to the HMO for managed care members.

The following POS (place of service) codes will not be accepted by Medicaid fee-for-service when submitted by a provider on a professional claim:

POS Code	Description
06	Indian Health Services Provider-Based Facility
08	Tribal 638 Provider-Based Facility
21	Inpatient Hospital
22	On Campus—Outpatient Hospital
23	Emergency Room—Hospital
51	Inpatient Psychiatric Facility
61	Comprehensive Inpatient Rehabilitation Facility
65	ESRD Treatment Facility

Medicare Crossover Claims

To be considered for reimbursement, NDCs and a HCPCS procedure code must be indicated on Medicare crossover claims.

ForwardHealth will deny crossover claims if an NDC was not submitted to Medicare with a provider-administered drug HCPCS code.

340B Providers

The 340B Program (340B Drug Pricing Program) enables covered entities to fully utilize federal resources, reaching more eligible patients and providing more comprehensive services. Providers who participate in the 340B Program are required to indicate an NDC on claims for provider-administered drugs. When submitting the 340B billed amount, they are also required to indicate the AAC (Actual Acquisition Cost) and appropriate claim level identifier(s).

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 (date of service) within seven days of the clinic's DOS, then the pharmacy's claim will be denied as a duplicate claim.

Reconsideration of the denied drug claim may occur if the claim was denied with 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 (F-13072 (04/17)) form along with the Pharmacy Special Handling Request (F-13074 (04/14)) form indicating the EOB code and requesting an override.

Provider-Administered Drugs Carve-Out Code Sets

Provider-administered drugs carve-out policy is defined to include the following procedure codes:

- Drug-related "J" codes
- Drug-related "Q" codes
- Certain drug-related "S" codes

The Provider-Administered Drugs Carve-Out Procedure Codes table indicates the status of procedure codes considered under the provider-administered drugs carve-out policy. This table provides information on Medicaid and BadgerCare Plus coverage status as well as carve-out status based on POS.

Note: The table will be revised in accordance with national annual and quarterly HCPCS code updates.

Provider-administered drugs carve-out policy applies to certain procedure code sets, services, POS, and claim types. A service is carved-out based on the procedure code, POS, and claim type on which the service is submitted. It is important to note that provider-administered drugs may be given in many different practice settings and submitted on different claim types. Whether the service is carved in or out depends on the combination of these factors, not simply on the procedure code.

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 (managed care organization).

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

Note: For Family Care Partnership members who are not enrolled in Medicare (Medicaid-only members), outpatient drugs (excluding diabetic supplies), provider-administered drugs, compound drugs (including parenteral nutrition), and any other drugs requiring drug utilization review are covered by fee-for-service Medicaid. All fee-for-service policies, procedures, and requirements apply for pharmacy services provided to Medicaid-only Family Care Partnership members. Dual eligibles (enrolled in Medicare and Medicaid) receive their outpatient drugs through their Medicare Part D plans. However, if the member's Part D plan does not cover the outpatient drug, these dually eligible members may access certain Medicaid outpatient drugs that are excluded or otherwise restricted from Medicare coverage through fee-for-service Medicaid. For these drugs, fee-for-service policies would apply.

Exemptions

Claims for drugs included in the cost of the procedure (for example, 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 (for example, hydration, catheter maintenance, TPN (total parenteral nutrition)) should continue to be reimbursed by the member's MCO. Providers 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 websites:

- CMS DRA information page
- NUBC (National Uniform Billing Committee)
- NUCC (National Uniform Claim Committee)

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

- The FDA (Food and Drug Administration) website
- The Drug Search Tool (Providers may verify if an NDC and its segments are valid using this website.)

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 ((02/12))
- 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

These instructions apply to claims submitted for provider-administered drugs. NDCs for provider-administered drugs must be indicated in the shaded area of Item Numbers 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], ME [Milligram], ML [Milliliter], or UN [Unit]), followed by the NDC units, with no space in between (For further instruction on submitting a 1500 Health Insurance Claim Form with supplemental NDC information, providers may refer to the 1500 Health Insurance Claim Form Reference Instruction Manual for Form Version 02/12 on the NUCC (National Uniform Claim Committee) website.)

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

837 Health Care Claim: Professional Transactions

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

Direct Data Entry on the ForwardHealth Portal

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

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

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

Provider Electronic Solutions Software

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

The Quantity Limit Drugs and Diabetic Supplies data table contains the most current quantity limits.

When a claim is submitted with a quantity that exceeds the limit, the claim will be denied.

Prior to requesting a quantity limit policy override, the pharmacy provider should contact the prescriber to determine whether or not it is medically appropriate for a member to exceed the quantity limit. 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.

Note: Pharmacy providers may dispense up to the allowed quantity limit without contacting the DAPO Center.

Pharmacy providers may request a quantity limit policy override for members enrolled in BadgerCare Plus, Medicaid, or SeniorCare.

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

- If the member has an appropriate medical need (for example, 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 they 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

A quantity limit override request for drugs in the stimulants drug class and the stimulants, related agents - wake promoting drug class is limited to a one-month override and may be approved for the following situations:

- Lost or stolen medication
- Vacation supply
- Medication and/or dosage change by the prescriber

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 (04/14)) form.

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 form.

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) 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 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) 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) 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 health insurance (for example, commercial health insurance, Medicare, Medicare Advantage Plans) 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.

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		

Coordination of Benefits Examples for Wisconsin AIDS Drug Assistance Program (ADAP)					
		ADAP and Medicare Part D		ADAP 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 ((02/12))
- UB-04 (CMS 1450) Claim Form
- Compound Drug Claim (F-13073 (04/17)) form
- Noncompound Drug Claim (F-13072 (04/17)) 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, such as:
  - Hysterectomy claims must be submitted along with an Acknowledgment of Receipt of Hysterectomy Information (F-01160 (06/13)) form
  - Sterilization claims must be submitted along with a paper Consent for Sterilization (F-01164 (10/08)) form.
  - Claims submitted to Timely Filing appeals must be submitted on paper with a Timely Filing Appeals Request (F-13047 (08/15)) form.
  - In certain circumstances, drug claims must be submitted on paper with a Pharmacy Special Handling Request (F-13074 (07/12)) form.
  - Claims submitted with four or more NDCs (National Drug Codes) for compound and noncompound drugs with specific and non-specific HCPCS (Healthcare Common Procedure Coding System) procedure codes.

Topic #1954

Repackaging

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

To indicate that repackaging has occurred for non-unit dose oral drugs in a solid form, 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 an oral drug in a solid form that is not packaged by the manufacturer in individual unit doses, ForwardHealth will add $0.015 per unit billed to the professional dispensing fee for repackaging.

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

Topic #21197

Select High Cost, Orphan, and Accelerated Approval Drugs

For the interim, select high cost, orphan, and accelerated approval drugs will be covered and reimbursed under the pharmacy benefit. When a noncompound drug is covered under the pharmacy benefit, providers may submit claims for the cost of the drug to ForwardHealth through one of the following methods:

- Real-time POS (point-of-sale) system using the NCPDP (National Council for Prescription Drug Programs) Telecommunication Standard
- ForwardHealth Portal
- PES (Provider Electronic Solutions) software
- Noncompound Drug Claim (F-13072 (04/17)) form

Related physician and clinical services associated with the administration of the drug will be reimbursed separately based on existing coverage and reimbursement policy.

The Services Requiring Prior Authorization chapter of the Prior Authorization section of the Pharmacy service area of the Online Handbook contains clinical criteria for select high cost, orphan, and accelerated approval drugs that are identified in the Select High Cost, Orphan, and Accelerated Approval Drugs data table.

Pharmacy Direct Billing for Select High Cost, Orphan, and Accelerated Approval Drugs

To clarify, if a provider or facility obtains a drug that is specifically addressed in the Select High Cost, Orphan, and Accelerated Approval Drugs data table from a pharmacy provider, then the administering provider or facility may not bill for the cost of that drug because the pharmacy provider will bill for the cost of the drug.

It is the responsibility of the pharmacy provider to use appropriate management and packaging practices to ensure drug stability and integrity are maintained during drug shipment and delivery. Once the drug is in possession of the administering provider or facility, it is the responsibility of the administering provider or facility to use appropriate management and storage practices to ensure drug stability and integrity are maintained. If a drug is damaged prior to administration or is delivered but not administered to a member, ForwardHealth will not reimburse for the cost of the drug; it is the responsibility of the administering provider or facility to alert the pharmacy provider and the responsibility of the pharmacy provider to reverse their claim to ForwardHealth and work with the pharmaceutical company or administering provider or facility regarding payment for the damaged or wasted drug.

For the interim, select high cost, orphan, and accelerated approval drugs will be covered under the pharmacy benefit, but it is the responsibility of the health care provider to determine the medically appropriate setting for administration. Providers are required to comply with all relevant safety protocols when administering these drugs to ForwardHealth members.

For specific questions about institutional billing or coverage of high cost, orphan, and accelerated approval drugs listed in the Select High Cost, Orphan, and Accelerated Approval Drugs data table, providers may contact Provider Services or email DHSOrphanDrugs@dhs.wisconsin.gov.

Note: Select high cost, orphan, and accelerated approval drugs covered under the pharmacy benefit will not be covered as provider-administered drugs. When a high cost, orphan, or accelerated approval drug is covered under the pharmacy benefit, it will be reimbursed fee-for-service and MCOs (managed care organizations) will not be responsible for the cost of the drug, but MCOs are still responsible for the physician and clinical services associated with the high cost, orphan, or accelerated approval drug.

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 Wis. Admin. Code § DHS 109.51(5) 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 ((02/12))
- 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) should be provided and reimbursed by the special managed care program.

Note: For Family Care Partnership members who are not enrolled in Medicare (Medicaid-only members), outpatient drugs (excluding diabetic supplies), provider-administered drugs, compound drugs (including parenteral nutrition), and any other drugs requiring drug utilization review are covered by fee-for-service Medicaid. All fee-for-service policies, procedures, and requirements apply for pharmacy services provided to Medicaid-only Family Care Partnership members. Dual eligibles (enrolled in Medicare and Medicaid) receive their outpatient drugs through their Medicare Part D plans. However, if the member's Part D plan does not cover the outpatient drug, these dually eligible members may access certain Medicaid outpatient drugs that are excluded or otherwise restricted from Medicare coverage through fee-for-service Medicaid. For these drugs, fee-for-service policies would apply.

Topic #15977

Submitting Multiple National Drug Codes per Procedure Code

If two or more NDCs (National Drug Codes) are submitted for a single procedure code, the procedure code is required to be repeated on separate details for each unique NDC. Whether billing a compound or noncompound drug, the procedures for billing multiple components (NDCs) with a single HCPCS (Healthcare Common Procedure Coding System) code are the same.

Claim Submission Instructions for Claims With Two or Three National Drug Codes

When two NDCs are submitted on a claim, a KP modifier (first drug of a multiple drug unit dose formulation) is required on the first detail and a KQ modifier (second or subsequent drug of a multiple drug unit dose formulation) is required on the second detail.

For example, if a provider administers 150 mg of Synagis, and a 100 mg vial and a 50 mg vial were used, then the NDC from each vial must be submitted on the claim. Although the vials have different NDCs, the drug has one procedure code, 90378 (Respiratory syncytial virus, monoclonal antibody, recombinant, for intramuscular use, 50 mg, each). In this example, the same procedure code would be reported on two details of the claim and paired with different NDCs.

Procedure Code	NDC	NDC Description
90378	60574-4111-01	Synagis®— 100 mg
90378	60574-4112-01	Synagis®— 50 mg

Example 1500 Health Insurance Claim Form
for Submitting Two National Drug Codes per Procedure Code

	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	N460574411101 ME100											
	11 13 14	11 13 14	11		90378	KP	AC	500 00	2	N	NPI	0123456789
2	N460574411201 ME50											
	11 13 14	11 13 14	11		90378	KQ	AC	500 00	1	N	NPI	0123456789

When three NDCs are submitted on a claim, a KP modifier is required on the first detail, a KQ modifier on the second detail, and the modifier should be left blank on the third detail.

For example, if a provider administers a mixture of 1 mg of hydromorphone HCl powder, 125 mg of bupivacaine HCl powder, and 50 ml of sodium chloride 0.9 percent solution, each NDC is required on a separate detail. However, this compound drug formulation is required to be billed under one procedure code, J3490 (Unclassified drugs), and the same procedure code must be reported on three separate details on the claim and paired with different NDCs.

Procedure Code	NDC	NDC Description
J3490	00406-3245-57	Hydromorphone HCl Powder — 1 mg
J3490	38779-0524-03	Bupivacaine HCl Powder — 125 mg
J3490	00409-7984-13	Sodium Chloride 0.9% Solution — 50 ml

Example 1500 Health Insurance Claim Form
for Submitting Three National Drug Codes per Procedure Code

	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	N400406324557 ME1											
	11 13 14	11 13 14	11		J3490	KP	AC	500 00	1	N	NPI	0123456789
2	N438779052403 ME125											
	11 13 14	11 13 14	11		J3490	KQ	AC	500 00	1	N	NPI	0123456789
3	N400409798413 ML50											
	11 13 14	11 13 14	11		J3490		AC	500 00	1	N	NPI	0123456789

Claims for provider-administered drugs with two or three NDCs may be submitted to ForwardHealth via the following methods:

- The 837P (837 Health Care Claim: Professional) transaction
- PES (Provider Electronic Solutions) software
- DDE (Direct Data Entry) on the ForwardHealth Portal
- A 1500 Health Insurance Claim Form ((02/12))

Claim Submission Instructions for Claims with Four or More National Drug Codes

When four or more components are reported, each component is required to be listed separately in a statement of ingredients on an attachment that must be appended to a paper 1500 Health Insurance Claim Form.

Note: The reimbursement reduction for paper claims will not affect claims submitted on paper with four or more NDCs, as described above.

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 as a prophylaxis to reduce lower respiratory tract diseases caused by RSV (respiratory syncytial virus) in premature, high-risk children.

PA (prior authorization) is required for Synagis.

Synagis is part of the provider-administered drugs carve-out policy; all fee-for-service policies apply.

Professional Claim Submission

Claims for Synagis must be submitted on a professional claim. 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. 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 are required to indicate modifier "U1" on claims for Synagis to obtain reimbursement for the dispensing fee.

For example, if a provider administers 150 mg of Synagis, and a 100 mg vial and a 50 mg vial were used, then the NDC from each vial must be submitted on the claim. Although the vials have different NDCs, the drug has one procedure code, 90378 (Respiratory syncytial virus, monoclonal antibody, recombinant, for intramuscular use, 50 mg, each). In this example, the same procedure code would be reported on two details of the claim and paired with different NDCs.

Procedure Code	NDC	NDC Description
90378	60574-4111-01	Synagis—100 mg
90378	60574-4112-01	Synagis—50 mg

Example 1500 Health Insurance Claim Form
for Submitting Two National Drug Codes per Procedure Code

	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	N460574411101 ME100											
	11 13 14	11 13 14	11		90378	KP	AC	500 00	2	N	NPI	0123456789
2	N460574411201 ME50											
	11 13 14	11 13 14	11		90378	KQ	AC	500 00	1	N	NPI	0123456789

Topic #1950

Total Parenteral Nutrition and Lipids

For members enrolled in BadgerCare Plus, 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 (04/17)) 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 ((02/12)) or the 837P (837 Health Care Claim: Professional)

transaction.

Topic #1949

Unacceptable Practices

Based on the claims submission requirements in Wis. Admin. Code § DHS 106.03(3), and the definition of covered services in Wis. Admin. Code § DHS 107.10, 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 Wis. Admin. Code §§ DHS 106.06 and DHS 106.08, 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 mail ForwardHealth a Timely Filing Appeals Request form (F-13047 (08/15)) with a paper claim or an Adjustment/Reconsideration Request form (F-13046 (08/15)) to override the submission deadline. If claims or adjustment requests are submitted electronically, the entire amount of the claim will be recouped.

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 (08/15)) 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 (08/15)) form for each claim and each adjustment to allow for documentation of individual claims and adjustments submitted to ForwardHealth
- A legible claim or Adjustment/Reconsideration Request (F-13046 (08/15)) form
- All required documentation as specified for the exception to the submission deadline
- A properly completed Explanation of Medical Benefits form for paper claims and paper claim adjustments where other health insurance sources are indicated

Note: Providers are reminded to complete and submit the most current versions of these forms supported by ForwardHealth.

To receive consideration for an exception, a Timely Filing Appeals Request form must be received by ForwardHealth before the applicable submission deadlines specified for the exception.

When completing the claim or adjustment request, providers are required to indicate the procedure code, diagnosis code, POS (place of service) code, and all other required claims data elements 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 additional 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 LOC (level of care) or liability amount.	To receive consideration, the request must be submitted within 455 days from the DOS. Include the following documentation as part of the request: - The correct liability amount or LOC must be indicated on the Adjustment/Reconsideration Request (F-13046 (08/15)) 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. - A copy of the Explanation of Medical Benefits form, if applicable.	ForwardHealth Timely Filing Ste 50 313 Blettner Blvd Madison WI 53784
Decision Made by a Court, Fair Hearing, or the Wisconsin 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 Wisconsin 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. Include the following documentation as part of the request: - A complete copy of the decision notice received from the court, fair hearing, or DHS	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 request must be submitted within 455 days from the DOS. Include the following documentation as part of the request: - 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	ForwardHealth Good Faith/Timely Filing Ste 50 313 Blettner Blvd Madison WI

	the DOS: ¡ Temporary Identification Card for Express Enrollment in BadgerCare Plus ¡ Temporary Identification Card for Express Enrollment in Family Planning Only Services ¡ The response received through Wisconsin's EVS (Enrollment Verification System) from a commercial eligibility vendor ¡ The transaction log number received through WiCall ¡ The enrollment tracking number received through the ForwardHealth Portal	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. Include the following documentation as part of the request: ı A copy of the RA message that shows the ForwardHealth-initiated adjustment ı A copy of the Explanation of Medical Benefits form, if applicable	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 income maintenance 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. Include the following documentation as part of the request: ı A copy of the Explanation of Medical Benefits form, if applicable **And** ı "GR retroactive enrollment" indicated on the claim **Or** ı A copy of the letter received from the income maintenance 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 request must be submitted within 90 days of the Medicare processing date. Include the following documentation as part of the request: - A copy of the Medicare remittance information - A copy of the Explanation of Medical Benefits form, if applicable	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 request must be submitted within 90 days from the date of recoupment notification. Include the following documentation as part of the request: - A copy of the recoupment notice - An updated Explanation of Medical Benefits form, if applicable *Note:* When the reason for resubmitting is due to Medicare recoupment, ensure that the associated Medicare disclaimer code (i.e., M-7 or M-8) is included on the updated Explanation of Medical Benefits form.	ForwardHealth Timely Filing Ste 50 313 Blettner Blvd Madison WI 53784
Retroactive Member Enrollment into Medicaid		
Description of the Exception	**Documentation Requirements**	**Submission Address**
This exception occurs when a claim cannot be submitted within the	To receive consideration, the request must be submitted within 180 days from the date the backdated enrollment was added to the	ForwardHealth Timely Filing

submission deadline due to a delay in the determination of a member's retroactive enrollment.	member's enrollment information. In addition, retroactive enrollment must be indicated by selecting "Retroactive member enrollment for ForwardHealth (attach appropriate documentation for retroactive period, if available)" box on the Timely Filing Appeals Request (F-13047 (08/15)) form.	Ste 50 313 Blettner Blvd Madison WI 53784

Coordination of Benefits

2

Archive Date:12/01/2020

Coordination of Benefits:Commercial Health Insurance

Topic #595

Assignment of Insurance Benefits

Assignment of insurance benefits is the process by which a specified party (for example, provider or policyholder) becomes entitled to receive payment for claims in accordance with the insurance company policies.

Other health insurance (for example, commercial health insurance, Medicare, Medicare Advantage Plans) companies may permit reimbursement to the provider or member. Providers should verify whether other health insurance benefits may be assigned to the provider. As indicated by the other 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 other health insurance.

If the member is assigned insurance benefits, it is appropriate to submit a claim to ForwardHealth without billing the other health insurance. In this instance providers should indicate the appropriate other insurance indicator or complete the Explanation of Medical Benefits form, as applicable. ForwardHealth will bill the other 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 by BadgerCare Plus and Wisconsin Medicaid, 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).

Note: The provider is required to demonstrate that a correct and complete claim was denied by the commercial health insurance company for a reason other than that the provider was out of network.

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.

When commercial health insurance plans give the member the option of getting care within or outside a provider network, non-network providers **may** be reimbursed by the commercial health insurance company for covered services if they follow the commercial health insurance plan's billing rules.

Topic #601

Definition of Commercial Health Insurance

Commercial 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.

Common types of commercial health insurance include HMOs, PPOs (preferred provider organizations), POS (point-of-service) plans, Medicare Advantage plans, Medicare supplemental plans, dental plans, vision plans, HRAs (health reimbursement accounts), and LTC (long term care) plans. Some commercial health insurance providers restrict coverage to a specified group of providers in a particular service area.

When commercial health insurance plans require members to use a designated network of providers, non-network (i.e., providers who do not have a contract with the member's commercial health insurance plan) will be reimbursed by the commercial health insurance 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 health insurance plan, members enrolled in both a commercial health insurance 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 health insurance plan. In this situation, providers are required to refer the members to the commercial health insurance plan's network 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 health insurance plan denied or would deny payment because a service otherwise covered under the commercial health insurance plan was performed by a provider outside the plan. In addition, if a member receives a covered service outside their commercial health insurance plan, the provider cannot collect payment from the member.

Topic #602

Discounted Rates

Providers of services that are discounted by other health insurance (for example, commercial health insurance, Medicare, Medicare Advantage Plans) should include the following information on claims or on the Explanation of Medical Benefits form, as applicable:

- Their usual and customary charge
- The appropriate claim adjustment reason code, NCPDP (National Council for Prescription Drug Programs) reject code, or other insurance indicator
- The amount, if any, actually received from other health insurance as the amount paid by other 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 real-time Other Coverage Discrepancy Report via the ForwardHealth Portal or submit a completed Commercial Other Coverage Discrepancy Report (F-01159 (04/17)) 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 they believe 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 or on the Explanation of Medical Benefits form, as applicable.

The provider may not bill Wisconsin Medicaid and commercial health insurance simultaneously. Simultaneous billing may constitute fraud and interferes with Wisconsin Medicaid'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 or complete the Explanation of Medical Benefits form, as applicable.

If the commercial health insurance reimburses the member, the provider may collect the payment from the member. If the provider receives reimbursement from Wisconsin Medicaid and the member, the provider is required to return the lesser amount to Wisconsin Medicaid.

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 or complete the Explanation of Medical Benefits form, as applicable. Commercial remittance information should not be attached to the claim.

Topic #2326

Pharmacy Providers

Pharmacy providers are required to bill all other health insurance (for example, commercial health insurance, Medicare, Medicare Advantage Plans) sources prior to ForwardHealth when a member has verified drug coverage.

Topic #18497

Explanation of Medical Benefits Form Requirement

An Explanation of Medical Benefits (F-01234 (04/2018)) form must be included for each other payer when other health insurance (for example, commercial health insurance, Medicare, Medicare Advantage Plans) sources are indicated on a paper claim or paper adjustment.

Note: ADA (American Dental Association) claims and claim adjustments and compound and noncompound drug claims and claim adjustments are **not** subject to the requirements regarding use of the Explanation of Medical Benefits form.

Paper claims or adjustment requests that have other health insurance indicated may be returned to the provider unprocessed or denied if they are submitted without the Explanation of Medical Benefits form for each other payer. Paper claims or adjustments submitted with incorrect or incomplete Explanation of Medical Benefits forms will also be returned or denied.

Use of the ForwardHealth Explanation of Medical Benefits form is mandatory; providers are required to use an exact copy. ForwardHealth will not accept alternate versions (i.e., retyped or otherwise reformatted) of the Explanation of Medical Benefits form.

The Explanation of Medical Benefits form requirement for paper claims and adjustments is intended to help ensure consistency with electronic claims and adjustments submitted via the ForwardHealth Portal or using an 837 (837 Health Care Claim) transaction (including those submitted using PES (Provider Electronic Solutions) software or through a clearinghouse or software vendor).

The Explanation of Medical Benefits form requirement applies to paper claims and paper adjustments submitted to Wisconsin Medicaid, BadgerCare Plus, SeniorCare, and the WCDP (Wisconsin Chronic Disease Program). Providers are reminded that, except for a few instances, Wisconsin Medicaid, BadgerCare Plus, SeniorCare, and WCDP are payers of last resort for any covered service. Therefore, providers are required to make a reasonable effort to exhaust all other existing health insurance sources before submitting claims to ForwardHealth or to a state-contracted MCO (managed care organization).

Wisconsin Medicaid and BadgerCare Plus are not payers of last resort for members who receive coverage from certain governmental programs. Providers should ask members if they have coverage from these other government programs.

If a member becomes retroactively enrolled in Wisconsin Medicaid or BadgerCare Plus after the provider has already been reimbursed by one of these government programs, the provider may be required to submit the claims to ForwardHealth and refund the payment from the government program.

Ink, Data Alignment, and Quality Standards for Paper Claim Submission

In order for OCR (Optical Character Recognition) software to read paper claim forms accurately, the claim forms must comply with certain ink standards, as well as other data alignment and quality standards. The Explanation of Medical Benefits form will

also need to comply with these standards.

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, Wisconsin Medicaid will reimburse 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 the other insurance information on the Explanation of Medical Benefits Form for 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 Health Insurance Services

Providers are not reimbursed for the following:

- Services covered by a commercial health insurance plan, except for coinsurance, copayment, or deductible
- Services for which providers contract with a commercial health insurance 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 according to Wisconsin Medicaid expectations. Providers are required to use these indicators as applicable on professional, institutional, or dental claims or on the Explanation of Medical Benefits form, as applicable, 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.

Code	Description
OI-P	PAID in part or in full by commercial health insurance, and/or was applied toward the deductible, coinsurance, copayment, blood deductible, or psychiatric reduction. Indicate the amount paid by commercial health insurance to the provider or to the insured.
OI-D	DENIED by commercial health insurance following submission of a correct and complete claim. 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 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.

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 Wis. Admin. Code § DHS 106.02(9)(a).

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 other health insurance (for example, commercial health insurance, Medicare, Medicare Advantage Plans) has a different policy. Therefore, pharmacy providers and dispensing physicians are required to obtain PA for non-preferred drugs, regardless of other 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
- In-home mental health/substance abuse treatment services for children (HealthCheck "Other Services") rendered by providers at the less than bachelor degree level, bachelor's degree level, QTT (qualified treatment trainee) level, or certified psychotherapist level
- Personal care 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)
- Behavioral treatment
- 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
- In-home mental health/substance abuse treatment services for children (HealthCheck "Other Services") rendered by providers at the master's degree level, doctoral level, and psychiatrist level
- Outpatient mental health/substance abuse services
- Mental health/substance abuse day treatment services, including child and adolescent day treatment
- Narcotic treatment services
- 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 120 days of the date of admission; if benefits greater than 120 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 Advantage 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 Health 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 or Explanation of Medical Benefits form, as applicable.

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 ForwardHealth and/or the MCO's (managed care organization) RA after 30 days of the Medicare processing date, providers are required to resubmit the claim directly to ForwardHealth or the MCO 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 or Medicare Cost 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.

Providers are advised to wait 30 days before billing for claims submitted to Medicare to allow time for the automatic crossover process to complete. If automatic crossover claims do not appear on the ForwardHealth and/or the MCO (managed care organization)'s RA (Remittance Advice) after 30 days of the Medicare processing date, providers are required to resubmit the claim directly to ForwardHealth or the MCO using the NPI (National Provider Identifier) that was reported to ForwardHealth as the primary NPI.

If the service is covered by the MCO, the ForwardHealth RA will indicate EOB (Explanation of Benefits) code 0287 (Member is enrolled in a State-contracted managed care program). If the service is covered on a fee-for-service basis, the MCO RA will indicate that the service is not covered. If the crossover claim is submitted without error, the responsible entity (either ForwardHealth or the MCO) will process the claim to a payable status.

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 or MCO RA within 30 days of the Medicare processing date.
- The automatic crossover claim is denied, and additional information may allow payment.
- The claim is for a member who 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 or Medicare Cost Plan.
- The claim is for a member who is enrolled in Medicare and commercial health insurance that is secondary to Medicare (e.g., Medicare Supplemental).

When submitting crossover claims directly, the following additional data may be required on the claim to identify the billing and rendering provider:

- The NPI that ForwardHealth has on file for the provider
- 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 Solutions) software
- Paper claim form

Topic #9077

Crossover Claims for Diabetic Supplies

Medicare Part B

Claims for dual eligibles enrolled in BadgerCare Plus 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 ((02/12)) 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 BadgerCare Plus 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 (04/17)) form, or a Noncompound Drug Claim (F-13072 (04/17)) 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). A commercial health plan that acts for Medicare Parts A and B, and sometimes Medicare Part D, for all Medicare covered services except hospice. Medicare Part A continues to provide coverage for hospice services. There are limitations on coverage outside of the carrier's provider network.
- 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 (08/15)) form, the provider should complete and submit the Explanation of Medical Benefits form, as applicable.

Provider-Submitted Crossover Claim

The provider may submit a provider-submitted crossover claim in the following situations:

- 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 a Medicare Advantage Plan.
- The claim is for a member who is enrolled in Medicare and commercial health insurance that is secondary to Medicare (**for example**, 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, complete the Explanation of Medical Benefits form.

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 on the claim or the Explanation of Medical Benefits form, as applicable.

* 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 (08/15)) form and Explanation of Medical Benefits form, as applicable. 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 on the claim or the Explanation of Medical Benefits form, as applicable. 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 occurred:

- 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 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.

ForwardHealth has identified services requiring Medicare Advantage billing.

Paper Crossover Claims

Providers are required to complete and submit an Explanation of Medical Benefits form, along with provider-submitted paper crossover claims for services provided to members enrolled in a Medicare Advantage Plan.

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 BadgerCare Plus, Medicaid, or SeniorCare with a Medicare Advantage Plan will be returned due to the Medicare Advantage Plan being on the member's file or if EOMB (Explanation of Medicare Benefits) information is incomplete or not included. To be reimbursed, providers are required to submit a Pharmacy Special Handling Request (F-13074 (04/14)) and a Noncompound Drug Claim (F-13072 (04/17)). 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.

Providers are required to complete and submit the Explanation of Medical Benefits form when submitting paper Medicare Advantage crossover claims for diabetic supplies for members dually enrolled in a Medicare Advantage Plan and BadgerCare Plus or Wisconsin Medicaid.

Topic #20677

Medicare Cost

Providers are required to bill the following services to the Medicare Cost Plan before submitting claims to ForwardHealth if the member was enrolled in the Medicare Cost Plan at the time the service was provided:

- Ambulance services
- ASC (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

Providers who are not within the member's Medicare Cost network and are not providing an emergency service or Medicare-allowed service with a referral may submit a claim to traditional Medicare Part A or Medicare Part B for the Medicare-allowed service prior to billing ForwardHealth.

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 on the claim or the Explanation of Medical Benefits form, as applicable.

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, SOI (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).

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 Wis. Admin. Code § DHS 106.02(9)(a).

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 they are 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 Medicare. 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. Claims for barbiturates for dual eligibles should be submitted to Medicare Part D.

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 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-Contracted Managed Care Organizations or HMOs

Drug claims for dual eligibles enrolled in state-contracted MCOs (managed care organizations) or HMOs 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:

- 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

Pharmacy 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.

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.

Pharmacy 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 Medicare. 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 #689

Medicare Provider 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 Wis. Admin. Code § DHS 106.03(7), a provider is required to be enrolled in Medicare if both of the following are true:

- They provide a Medicare Part A service to a dual eligible.
- They 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 #690

Medicare Retroactive Eligibility — Member

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) website 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)	$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.

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

Nursing Home Crossover Claims

Medicare deductibles, coinsurance, and copayments are paid in full.

Topic #770

Services Requiring Medicare Advantage Billing

Providers are required to bill the following services to the Medicare Advantage Plan before submitting claims to ForwardHealth:

- Ambulance services
- ASC (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

Providers who are not within the member's Medicare Advantage network and are not providing an emergency service or Medicare-allowed service with a referral are required to refer the member to a provider within their network.

ForwardHealth has identified services requiring commercial health insurance billing.

Other Coverage Information

Topic #4940

After Reporting Discrepancies

After receiving a Commercial Other Coverage Discrepancy Report (F-01159 (04/17)) form or Medicare Other Coverage Discrepancy Report (F-02074 (04/2018)) form, 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 Commercial Other Coverage Discrepancy Report (F-01159 (04/17)) form or Medicare Other Coverage Discrepancy Report (F-02074 (04/18)) 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

Other health insurance (for example, commercial health insurance, Medicare, Medicare Advantage Plans) sources also have MTM (Medication Therapy Management) programs. If a member is eligible for an other health insurance MTM program, the pharmacy provider is required to submit the claim to the member's other health insurance before submitting the claim to ForwardHealth.

The 1500 Health Insurance Claim Form Completion Instructions contain information regarding documenting other insurance information.

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

Topic #4942

Reporting Discrepancies

Providers are encouraged to report discrepancies to ForwardHealth by submitting the Commercial Other Coverage Discrepancy Report (F-01159 (04/17)) form or Medicare Other Coverage Discrepancy Report (F-02074 (04/2018)) 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 Commercial Other Coverage Discrepancy Report form or Medicare 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 Wis. Admin. Code § DHS 106.03(7).

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 608-243-0676. 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 and necessary information for providers to review and handle each claim.

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 (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 provider-based billing summary).	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.	- A Commercial Other Coverage Discrepancy Report (F-01159 (04/17)) form or Medicare Other Coverage Discrepancy Report (F-02074 (04/18)) 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 provider-based billing summary).	Send the Commercial Other Coverage Discrepancy Report form or Medicare 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 provider-based billing summary). - The appropriate other insurance indicator on the claim or complete and submit the Explanation of Medical Benefits form, as applicable. - The amount received from the other health insurance source on the claim or complete and submit the Explanation of Medical Benefits form, as applicable.	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 provider-based billing summary). - The appropriate other insurance indicator or Medicare disclaimer code on the claim or complete and submit the Explanation of Medical Benefits form, as applicable.	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.	ı A claim according to normal claims submission procedures (do **not** use the provider-based billing summary). ı The appropriate other insurance indicator on the claim or complete and submit the Explanation of Medical Benefits form, as applicable.	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.	ı A claim (do **not** use the provider-based billing summary). ı A Timely Filing Appeals Request (F-13047 (08/15)) form according to normal timely filing appeals procedures.	ForwardHealth Timely Filing Ste 50 313 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.	ı A Commercial Other Coverage Discrepancy Report form or Medicare Other Coverage Discrepancy Report form. ı **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 provider-based billing summary.) ¡ A Timely Filing Appeals Request form according to normal timely filing appeals procedures.	Send the Commercial Other Coverage Discrepancy Report form or Medicare Other Coverage Discrepancy Report form to the address indicated on the form. Send the timely filing appeals request to the following address: ForwardHealth Timely Filing Ste 50 313 Blettner Blvd Madison WI 53784
The commercial health insurance carrier reimburses or partially reimburses the provider-based billing claim.	ı A claim (do **not** use the provider-based billing summary). ı Indicate the amount received from the commercial health insurance on the claim or complete and submit the Explanation of Medical Benefits form, as applicable. ı 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	ı A claim.	ForwardHealth

denies the provider-based billing claim.	• The appropriate other insurance indicator or Medicare disclaimer code on the claim or complete and submit the Explanation of Medical Benefits form, as applicable.
	• 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.
		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 billing claim.	• A claim (do **not** use the provider-based billing summary). • The appropriate other insurance indicator on the claim or complete and submit the Explanation of Medical Benefits form, as applicable. • A Timely Filing Appeals Request form according to normal timely filing appeals procedures.	ForwardHealth Timely Filing Ste 50 313 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 website 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. - A copy of the Explanation of Medical	ForwardHealth Provider-Based Billing PO Box 6220 Madison WI 53716-0220 Fax 608-221-4567

	Benefits form, as applicable. *Note:* In this situation, ForwardHealth will initiate an adjustment if the amount of the other health insurance payment does not exceed the allowed amount (even though an adjustment request should not be submitted). However, providers (except nursing home and hospital providers) may issue a cash refund. Providers who choose this option should include a refund check but should not use the Claim Refund form.	

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.
	  ◦ A copy of the Explanation of Medical Benefits form, as applicable.
	• 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	• The Provider-Based Billing Summary. • Indication that no response was received by	ForwardHealth Provider-Based Billing

provider-based billing claim.	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.	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 should add all information required by the other health insurance source 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 Wis. Admin. Code § DHS 106.03(8), 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, they 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 an accident-related diagnosis code on claims when services are provided to an accident victim. 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:12/01/2020

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, Medicaid SSI HMOs, and most special MCOs (managed care organizations), all CPT (Current Procedural Terminology) administration procedure codes should be indicated on claims submitted for reimbursement to the member's MCO.

Topic #1941

Contraceptive Supply Procedure Codes

Providers are required to submit claims for condoms using the paper 1500 Health Insurance Claim Form ((02/12)) 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 #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.
- 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.

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) codebook, 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:

- If submitting on paper using the 1500 Health Insurance Claim Form ((02/12)), the provider may do either of the following:

- Include supporting information/description in Item Number 19 of the claim form.
- Include supporting documentation on a separate paper attachment. This option should be used if Item Number 19 on the 1500 Health Insurance Claim Form does not allow enough space for the description or when billing multiple unlisted procedure codes. Providers should indicate "See Attachment" in Item Number 19 of the claim form and send the supporting documentation along with the claim form.

- If submitting electronically using DDE (Direct Data Entry) on the Portal, PES (Provider Electronic Solutions) software, or 837 (837 Health Care Claim) electronic transactions, the provider may do one of the following:
  - Include supporting documentation in the Notes field. The Notes field is limited to 80 characters.
  - Indicate 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.

Topic #830

Valid Codes Required on Claims

ForwardHealth requires that all codes indicated on claims and PA (prior authorization) requests, including diagnosis codes, revenue codes, HCPCS (Healthcare Common Procedure Coding System) codes, and CPT (Current Procedural Terminology) codes be valid codes. Claims received without valid diagnosis codes, revenue codes, and HCPCS or CPT codes will be denied; PA requests received without valid codes will be returned to the provider. Providers should refer to current national coding and billing manuals for information on valid code sets.

Code Validity

In order for a code to be valid, it must reflect the highest number of required characters as indicated by its national coding and billing manual. If a stakeholder uses a code that is not valid, ForwardHealth will deny the claim or return the PA request, and it will need to be resubmitted with a valid code.

Code Specificity for Diagnosis

All codes allow a high level of detail for a condition. The level of detail for ICD (International Classification of Diseases) diagnosis codes is expressed as the level of specificity. In order for a code to be valid, it must reflect the highest level of specificity (i.e., contain the highest number of characters) required by the code set. For some codes, this could be as few as three characters. If a stakeholder uses an ICD diagnosis code that is not valid (i.e., not to the specific number of characters required), ForwardHealth will deny the claim or return the PA request, and it will need to be resubmitted with a valid ICD diagnosis code.

Covered Services and Requirements

Topic #2331

Age-Restricted Drugs

The drugs in the table below are age-restricted by BadgerCare Plus, Medicaid, and SeniorCare.

The table includes the most current information and may be updated periodically.

Age-Restricted Drugs	
Product	**Allowable Ages**
Certain OTC (over-the-counter) medications for HealthCheck "Other Services" (e.g., iron supplements, multivitamins)	Under 21 years of age
Oral Contraceptives	10 to 65 years of age
Prenatal Vitamins	12 to 60 years of age

Topic #16617

Alpha Hydroxyprogesterone Caproate and Makena Injections

Both alpha hydroxyprogesterone caproate and Makena injections are covered services and are reimbursed fee-for-service for members enrolled in BadgerCare Plus and Wisconsin Medicaid, including members enrolled in state-contracted HMOs.

The alpha hydroxyprogesterone caproate and Makena injections are provider-administered drugs and must be administered by a medical professional. Members may not self-administer either alpha hydroxyprogesterone caproate or Makena injections.

Claim Submission

To be reimbursed for alpha hydroxyprogesterone caproate or Makena injections, providers may submit a claim to ForwardHealth using the 1500 Health Insurance Claim Form ((02/12)), the 837P (837 Health Care Claim: Professional) transaction, PES (Provider Electronic Solutions) software, or DDE (Direct Data Entry). Providers may refer to the Provider-Administered Drug Injection, Hydroxyprogesterone Caproate HCPCS (Healthcare Common Procedure Coding System)-NDC (National Drug Codes) Crosswalk table for allowable NDCs and their associated modifiers.

Note: **Pharmacy** providers may not submit claims for alpha hydroxyprogesterone caproate or Makena injections.

The alpha hydroxyprogesterone caproate and Makena injections are age-restricted and are only reimbursed for members between the ages of 12 and 60 years old.

Reimbursement

For reimbursement rates for alpha hydroxyprogesterone caproate or Makena injections, providers should refer to the interactive maximum allowable fee schedules on the Portal for the following HCPCS procedure codes:

- J1726 (Injection, hydroxyprogesterone caproate, [makena], 10 mg)
- J1729 (Injection, hydroxyprogesterone caproate, not otherwise specified, 10 mg)

These rates do not include reimbursement for the administration of the drugs.

Providers may be reimbursed for the administration of alpha hydroxyprogesterone caproate or Makena injections by indicating CPT (Current Procedural Terminology) procedure code 96372 (Therapeutic, prophylactic, or diagnostic injection [specify substance or drug]; subcutaneous or intramuscular) on the claim.

Topic #1940

Compound Drugs

BadgerCare Plus, 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 BadgerCare Plus, Medicaid, or SeniorCare
- Does not contain any LTE (less-than-effective) drugs as identified by CMS (Centers for Medicare and Medicaid Services), or any equivalent or similar drug. LTE/identical, related, or similar drugs are drugs that are considered noncovered because the drugs are determined by the FDA (Food and Drug Administration) 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.

BadgerCare Plus, 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.

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 (04/17)) form

Providers who participate in the 340B Program (340B Drug Pricing Program) and submit claims for drugs purchased through the 340B Program are also required to indicate the AAC (Actual Acquisition Cost).

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 #17897

Continuous Glucose Monitoring

Professional Continuous Glucose Monitoring (Provider-Owned Equipment)

Professional continuous glucose monitoring utilizing provider-owned equipment is covered for BadgerCare Plus and Medicaid members as a supplement to standard care for diabetes when the primary care provider or attending provider determines such monitoring is medically necessary to establish an optimal insulin regimen. Results must be monitored and interpreted under physician supervision.

Professional continuous glucose monitoring is a diagnostic measurement of glucose levels received throughout the day and night. This type of glucose monitoring is done as a 3-5 day test to evaluate diabetes control.

The following CPT (Current Procedural Terminology) procedure codes are covered for members receiving professional continuous glucose monitoring:

- 95250 (Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; physician or other qualified health care professional [office] provided equipment, sensor placement, hook-up, calibration of monitor, patient training, removal of sensor, and printout of recording).
- 95251 (Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; analysis, interpretation and report).

Procedure codes 95250 and 95251 require a minimum of 72 hours of data and may be reimbursed up to four times per year but may not be reimbursed more than once per month. PA (prior authorization) is not required.

Supplies and equipment are not separately reimbursable as they are included in the reimbursement for procedure code 95250.

Allowable provider types and POS (places of service) are listed in the interactive maximum allowable fee schedules.

Note: Procedure code 99091 (Collection and interpretation of physiologic data [eg, ECG, blood pressure, glucose monitoring] digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified health care professional, qualified by education, training, licensure/regulation [when applicable] requiring a minimum of 30 minutes of time, each 30 days) should not be used with professional continuous glucose monitoring and cannot be reported in conjunction with procedure code 95250 or 95251. Procedure code 95251 does not require a face-to-face visit.

Documentation Requirements

The member's medical record must include documentation supporting the medical necessity of professional continuous glucose monitoring to establish an optimal insulin regimen for a member with insulin-requiring diabetes and documented inadequate glycemic control. The documentation must also include monitor calibration, member training, sensor removal, and recording

printout, as well as the physician report with interpretation and findings based on information obtained during monitoring.

Personal Continuous Glucose Monitoring (Purchased for Individual Member)

Personal continuous glucose monitoring devices, transmitters, and sensors are covered in certain circumstances. PA is required for coverage of monitoring devices and transmitters, but it is not required for sensors.

Allowable Procedure Codes

The following HCPCS (Healthcare Common Procedure Coding System) procedure codes are allowable for personal continuous glucose monitoring devices and accessories:

- A9276 (Sensor; invasive [e.g., subcutaneous], disposable, for use with interstitial continuous glucose monitoring system, one unit = 1 day supply)
- A9277 (Transmitter; external, for use with interstitial continuous glucose monitoring system)
- A9278 (Receiver [monitor]; external, for use with interstitial continuous glucose monitoring system)

Topic #12357

Contraceptives

Contraceptives are covered for members who are 10 through 65 years of age. Quantity limits and age 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 #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. Wis. Admin. Code § DHS 101.03(35) and ch. DHS 107 contain more information about covered services.

Topic #17817

Dispensing Clotting Factor Concentrates

ForwardHealth requires pharmacy providers to follow program requirements for dispensing clotting factor concentrates. Pharmacy providers are required to retain documentation supporting adherence to the new program requirements and produce it for and/or submit it to ForwardHealth upon request. ForwardHealth may deny or recoup payment for services that fail to meet program requirements.

Entities Affected by Program Requirements

Program requirements for dispensing clotting factor concentrates apply to any outpatient pharmacy providing clotting factor concentrates and dispensing services to the member. The pharmacy provider includes the entity's employees and representatives.

The program requirements affect the following programs:

- Wisconsin Medicaid
- BadgerCare Plus
- SeniorCare
- WCDP (Wisconsin Chronic Disease Program)

Required Documentation for New Patients

Upon initial acceptance of a ForwardHealth member as a patient receiving treatment with clotting factor concentrates, pharmacy providers are required to collect and maintain the following information:

- Name
- ForwardHealth identification number
- Address and telephone number
- Birth date
- Gender
- Primary language spoken in the home
- Weight
- Inhibitor status
- Date the current prescription was issued by the prescriber
- Current clotting factor concentrate prescribed
- Current dose of clotting factor concentrate
- Prophylactic and as needed dosing instructions
- Minimum number of as needed doses the prescriber has determined the member should maintain in the home
- Estimated quantity of clotting factor concentrate the member has at home
- Usual pattern of clotting factor concentrate utilization (e.g., for a month)
- Prescribing provider
- HTC (Hemophilia Treatment Center), if applicable

Reporting Incidents to the Hemophilia Treatment Center or Prescriber

Within one business day of learning about an incident such as a bleed, trauma, planned elective surgery, or any other situation that may indicate that a member needs to follow up with the prescriber, the pharmacy provider is required to report the incident(s) to the prescriber and/or HTC.

Clotting Factor Concentrate Dispensing Requirements

Delivery of Clotting Factor Concentrate and Supplies

Shipments from the pharmacy and deliveries to the member of clotting factor concentrate, including overnight deliveries, must use appropriate cold chain management and packaging practices to ensure proper temperature, drug stability, integrity, and efficacy are maintained during shipment. A signature by the member or caregiver is required upon delivery. A caregiver is defined as any family member or nonfamily person who is responsible for providing the member's health care needs. The words "signature on file" are not acceptable to allow delivery to a location that does not have an individual present to physically receive the delivery. The pharmacy provider may not instruct a delivery service to leave a package at a location where an individual is not present to receive the delivery.

Emergency Situations

Pharmacy providers are required to establish and document processes that ensure patient access to clotting factor concentrates in

an emergency situation and to communicate these processes to the member. Emergency processes should be coordinated with the prescriber and/or HTC.

Assay Management

Prescriptions for clotting factor concentrate must be filled within plus or minus five percent of prescribed assays, unless extenuating circumstances exist and are documented by the pharmacy. Variance in the prescription or target dosage for clotting factor concentrate must not exceed five percent, as measured in aggregate per quarter.

Maintenance of Stock

Pharmacy providers are required to stock clotting factor concentrate products in assay range levels sufficient to dispense treatment regimens as prescribed for a member and to ensure dispensing within the variance parameters described under "Assay Management" above.

Auto Fill

Pharmacy providers may not auto fill prescriptions for clotting factor concentrate.

Initiation of Dispensing

Requests for the dispensing of clotting factor concentrate must be initiated by the member or caregiver. Pharmacy providers are required to contact the HTC or prescriber if a refill is due and has not been requested by the member or caregiver. Pharmacy providers may not dispense multiple refills of a clotting factor concentrate at one time.

Filling or Refilling Prescriptions

Upon contact by a member or caregiver to request an initial fill or refill of clotting factor concentrate, pharmacy providers are required to request the following information from the member or caregiver and maintain the information:

- The amount of clotting factor concentrate that the member currently has on hand
- Assessment of any unexpected variation from usual patterns of clotting factor concentrate utilization
- The member's current address and telephone number for delivery of clotting factor concentrate

In addition, the pharmacy provider is required to confirm the delivery date with the member.

Days' Supply

Pharmacy providers are required to dispense clotting factor concentrate based on the prescription and the member's current clinical situation such that the member maintains a supply sufficient to meet the member's needs for prophylactic dosing, if applicable, and additional as needed doses for treatment of bleeds necessary based on the prescriber's order(s) and/or the emergency plan for the member.

Prohibition of Billing for Drugs Used During Inpatient Hospital Stays

Pharmacy providers may not bill ForwardHealth for drugs, including clotting factor concentrate, dispensed to a member or to a hospital for use by the member during an inpatient hospital stay.

Clotting Factor Concentrate Purchasing Records and Reporting Requirements

When requested by ForwardHealth, pharmacy providers are required to provide detailed copies of purchase invoices that document clotting factor concentrate inventory acquired and dispensed.

Product Recalls

Product in Stock

Pharmacy providers are required to immediately remove and quarantine any stock of recalled clotting factor concentrate, equipment, or supplies on the pharmacy premises.

Items Previously Dispensed

Pharmacy providers are required to notify members of a recall of clotting factor concentrate, equipment, or supplies within 24 hours of receiving notice of the recall. Pharmacy providers are required to retrieve and quarantine any recalled clotting factor concentrates, equipment, or supplies dispensed to the member within seven calendar days of notifying the member.

Prescriber Notification

Pharmacy providers are required to inform the prescriber of a clotting factor concentrate recall within 24 hours of receiving notice of the recall. In addition, pharmacy providers are required to inform the prescriber of the member's available supply of usable clotting factor concentrate and may obtain a prescription for an alternative product, as appropriate.

National Patient Notification System

Pharmacy providers are required to participate in the National Patient Notification System for clotting factor concentrate recalls. Current and accurate contact information must be maintained with the National Patient Notification System.

Adverse Effects

Member Education Related to Adverse Effects

Pharmacy providers are required to counsel the member, family, and/or caregiver in accordance with the OBRA '90 (Omnibus Budget Reconciliation Act of 1990) to encourage appropriate medication use, promote realistic therapy expectations, help members manage or minimize adverse effects (including those that can be related to inhibitors), and encourage adherence.

Contact and Communication with Members

Communication Related to Clotting Factor Concentrate Brands

Pharmacy providers and their representatives may not suggest to a member or caregiver that the member needs a specific brand of clotting factor concentrate other than that which was prescribed by the member's prescriber. The prescriber is required to determine the brand of clotting factor concentrate that is appropriate for the member.

Communication Related to Elective Procedures

Pharmacy providers may not suggest that a member needs a specific number of doses of clotting factor concentrate for elective procedures. Pharmacy providers are required to refer the member to the prescribing provider and/or HTC to discuss dosing of clotting factor concentrates for elective procedures.

Gift Ban

Pharmacy providers are prohibited from providing gifts or facilitating gift giving from another entity to a member, member's family, and/or caregiver. Gifts are any gratuity, discount, entertainment, travel, transportation, hospitality, loan, forbearance, use of pharmacy provider-owned vehicle, or other tangible or intangible item having more than a nominal monetary value.

Services Must Meet Program Requirements

Pharmacy providers who receive Medicaid or WCDP reimbursement for clotting factor concentrate products may be subject to audit at any time. Pharmacy providers are required to retain relevant documentation supporting adherence to the new program requirements and produce it for and/or submit it to ForwardHealth upon request. ForwardHealth may deny or recoup payment for services that fail to meet program requirements.

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 are allowed to be dispensed in a three-month 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 BadgerCare Plus, 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 (for example, 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 policy.

Drugs Allowed to Be Dispensed in a Three-Month Supply

For drugs that are allowed to 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 not be denied regarding the informational prospective DUR (Drug Utilization Review) alert for insufficient quantity (NS or three-month supply). Providers will receive the informational claim message "Three Month Supply Opportunity" on claims for these drugs.

Unbreakable Pre-Packaged Items

If a claim is submitted for an unbreakable pre-packaged 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 (for example, 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.

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 Wis. Admin. Code § DHS 107.10(3)(e), 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.

If a prescription is written for a drug that is required to be dispensed in a three-month supply, the pharmacy provider 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 a sufficient quantity on prescription orders to allow pharmacy providers to dispense a three-month supply of drugs that are required to be dispensed in a three-month supply.

Pharmacy providers must work with prescribers to make certain the total quantity of a drug dispensed per a prescription order does not exceed the total quantity of the drug authorized by the prescriber on the prescription order.

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 copays
- Requiring fewer trips to the pharmacy
- Allowing the member to obtain a larger quantity of generic, maintenance drugs for chronic conditions (for example, hypertension)

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 BadgerCare Plus, Medicaid, and SeniorCare may collect payment from members in the previously listed circumstances.

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 Wis. Admin. Code § DHS 101.03(52), 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-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 BadgerCare Plus, Wisconsin Medicaid, and SeniorCare.

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

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 (04/17)) form with a Pharmacy Special Handling Request (F-13074 (04/14)) 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 (Preferred Drug List) and BMN (brand medically necessary) policies. However, other policies, such as the member enrollment, diagnosis restriction, quantity limit, and noncovered service 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.

Policy for Expedited Emergency Supply of Drugs

The expedited emergency supply policy is an emergency dispensing option available for certain drugs on the PDL. A list of the drugs available by expedited supply may be found on the Expedited Emergency Supply Request Drugs data table.

ForwardHealth allows pharmacy providers to submit PA 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 14-day expedited emergency supply PA approvals of the same drug from one pharmacy provider within a six-month time period. A maximum of six expedited emergency supply PAs per member regardless of drug or pharmacy provider may be approved in a six-month time period.

Expedited emergency supply PA requests will generally be approved for up to a 14-day supply; however, for certain drugs, expedited emergency supply PA requests may be approved for up to a 34-day supply or up to a 100-day supply.

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

An approved expedited emergency supply PA 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.

An approved expedited emergency supply PA request overrides PDL PA policies for certain drugs available through STAT-PA. Providers should refer to the Expedited Emergency Supply Request Drugs data table for a list of the drug names or drug names allowed.

An approved expedited emergency supply PA request does **not** override PA polices, such as BMN, BBG (brand before generic), or PDL drugs not available through STAT-PA. The expedited emergency supply PA request does **not** override other policies, such as the member enrollment, diagnosis restriction, quantity limit, early refill, and noncovered service policies.

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 PA request is submitted.

If a second expedited emergency supply is necessary for a member, there must be a non-expedited emergency supply PA request submitted to ForwardHealth, and it must be in the process of being adjudicated. The second expedited emergency supply PA request may be approved if a non-expedited emergency supply PA request is in process for the same drug and strength and the PA is submitted by the pharmacy that submitted the first expedited emergency supply PA request.

Once a non-expedited emergency supply PA request has been approved, the second expedited emergency supply PA request will not be approved.

Requests for a second expedited emergency supply PA request may be submitted seven to 21 days after the initial request was submitted. Second expedited emergency supply PA requests will not be approved if they are submitted before day seven or after day 21.

For example, if an initial expedited emergency supply PA request was submitted on March 4 and a non-expedited emergency supply PA request was submitted on March 7 and a second expedited emergency supply is necessary for the member because the non-expedited emergency supply PA request had not yet been adjudicated, the second expedited emergency request may be submitted on March 10, or as late as March 24.

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

For drugs that can be dispensed in up to a 34-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 PA request has been approved; however, only one expedited emergency supply every six months will be allowed for those drugs.

Drugs That Can Be Dispensed in up to a 100-Day Supply

For drugs that can be dispensed in up to a 100-day expedited emergency supply, pharmacy providers may dispense the quantity indicated on the prescription, up to a 100-day supply, after an expedited emergency supply PA request has been approved; however, only one expedited emergency supply every six months will be allowed for those drugs.

Submitting PA Requests for an Expedited Emergency Supply

Pharmacy providers are required to complete, date, and sign the PA/PDL for Expedited Emergency Supply Request (Prior Authorization/Preferred Drug List, F-00401 (01/20)) form before a PA request for an expedited emergency supply is submitted.

Expedited emergency supply PA requests may only be submitted using the STAT-PA system. Expedited emergency supply PA 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 PA request has been approved. After an expedited emergency supply PA request has been approved, the pharmacy provider may submit a claim for the drug.

Expedited emergency supply PA requests cannot be amended.

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 Wis. Admin. Code § DHS 101.03(75m), 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 #1934

Legend Drugs

Most legend drugs and many OTC (over-the-counter) drugs are covered.

As defined under Wis. Admin. Code § DHS 101.03(94), 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 #17937

Low-Dose Computed Tomography Scans

ForwardHealth covers low-dose CT (computed tomography) scans (identified by HCPCS (Healthcare Common Procedure Coding System) procedure code G0297) for lung cancer screening without PA (prior authorization) for Wisconsin Medicaid and BadgerCare Plus-enrolled members who are at high risk for lung cancer and meet all of the following criteria:

- Are aged 55 to 80
- Have a 30-pack-a-year smoking history, as indicated by the appropriate ICD (International Classification of Diseases) diagnosis code
- Are either current smokers or have quit smoking within the past 15 years, as indicated by the appropriate ICD diagnosis code
- Have no signs or symptoms suggestive of underlying cancer

ForwardHealth requires PA for coverage of all other CT scans, including those that would be performed as a follow up to the initial low-dose CT screening, unless the provider has an exemption under ForwardHealth's advanced imaging PA exemption program.

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 #1938

Manufacturer Rebate Agreements

In accordance with the OBRA (Omnibus Budget 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, 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.

Prescribers are required to complete the appropriate section(s) of the PA/DGA (Prior Authorization/Drug Attachment, F-11049 (07/16)) form as it pertains to the drug being requested.

Included with the PA request, 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 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 (04/17)) indicating the actual NDC of the drug with the Pharmacy Special Handling Request (F-13074 (04/14)) 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, Wis. Stat. § 49.688(6) requires SeniorCare to cover drugs from only those manufacturers who have signed a separate SeniorCare rebate agreement with DHS (Wisconsin 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.

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.

Topic #84

Medical Necessity

Wisconsin Medicaid reimburses only for services that are medically necessary as defined under Wis. Admin. Code § DHS 101.03(96m). 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)(C) of the Social Security Act requires NDCs to be indicated on all claims submitted to ForwardHealth for covered outpatient drugs, 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, 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 BadgerCare Plus, 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.

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 BadgerCare Plus, 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 BadgerCare Plus, Medicaid, and SeniorCare members.

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 BadgerCare Plus, 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 BadgerCare Plus, 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 BadgerCare Plus, 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 BadgerCare Plus, 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 (04/17)) 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

As required by the OBRA (Omnibus Budget Reconciliation Act) of 1990, BadgerCare Plus 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.

Providers will be reimbursed at the lesser of the OTC drug's NADAC (National Average Drug Acquisition Cost) rate, plus a professional dispensing fee, or the billed amount. If an OTC drug does not have a NADAC rate available, then the provider will be reimbursed at the lesser of the drug's WAC (Wholesale Acquisition Cost) or SMAC (State Maximum Allowed Cost), if available, plus a professional dispensing fee, or the billed amount.

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

With the exception of OTC insulin, SeniorCare does not cover OTC drugs.

HealthCheck "Other Services"

Additional OTCs may be covered for members under 21 years of age through HealthCheck "Other Services."

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 Wis. Admin. Code § DHS 107.10(1). 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, injectable, intravenous, or inhaled drug administered by a physician or a designee of the physician (e.g., nurse, nurse practitioner, physician assistant).

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.

Provider-administered drugs carve-out policy is defined to include the following procedure codes:

- Drug-related "J" codes
- Drug-related "Q" codes
- Certain drug-related "S" codes

The Provider-Administered Drugs Carve-Out Procedure Codes table indicates the status of procedure codes considered under the provider-administered drugs carve-out policy. This table provides information on Medicaid and BadgerCare Plus coverage status as well as carve-out status based on POS (place of service).

Note: The table will be revised in accordance with national annual and quarterly HCPCS code updates.

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 (managed care organization).

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

Note: For Family Care Partnership members who are not enrolled in Medicare (Medicaid-only members), outpatient drugs (excluding diabetic supplies), provider-administered drugs, compound drugs (including parenteral nutrition), and any other drugs requiring drug utilization review are covered by fee-for-service Medicaid. All fee-for-service policies, procedures, and requirements apply for pharmacy services provided to Medicaid-only Family Care Partnership members. Dual eligibles (enrolled in Medicare and Medicaid) receive their outpatient drugs through their Medicare Part D plans. However, if the member's Part D plan does not cover the outpatient drug, these dually eligible members may access certain Medicaid outpatient drugs that are excluded or otherwise restricted from Medicare coverage through fee-for-service Medicaid. For these drugs, fee-for-service policies would apply.

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. Prescribers may obtain a provider-administered drug from a pharmacy provider if the drug is delivered 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 or direct purchase. 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 BadgerCare Plus, Medicaid, and SeniorCare, providers may request a policy override.

Topic #1317

Refills

According to Wis. Admin. Code § DHS 107.10(3), 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 #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 identified 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 Wis. Admin. Code § DHS 107.02(2), 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 Wis. Admin. Code § DHS 106.03, 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 Wisconsin 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 Wis. Admin. Code ch. DHS 105
- 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 DHS

Topic #5657

Tobacco Cessation Drugs

BadgerCare Plus, Medicaid, and SeniorCare cover legend drugs for tobacco cessation.

BadgerCare Plus and Medicaid also cover OTC (over-the-counter) nicotine gum, patches, and lozenges.

A written prescription from a Medicaid-enrolled prescriber is required for 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 diagnoses indicated on the Diagnosis Restricted Drugs data table.

Tobacco cessation services, as preventive services with an A or B rating from the USPSTF (U.S. Preventive Services Task Force), do not require copayments from any member enrolled in BadgerCare Plus or Medicaid. SeniorCare members are not exempt from copayment for tobacco cessation services.

Topic #12457

Vaccines

Influenza Vaccines

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

Influenza Vaccines Provided to Children

Pharmacy providers may obtain influenza vaccines at no cost to provide to members between 6–18 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 6–18 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 VFC Program website.

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 website.

Immunizations Covered for Children

Per 2015 Wisconsin Act 55, trained pharmacy providers who enroll in the federal VFC Program are authorized to receive reimbursement. Wisconsin Medicaid reimburses pharmacy providers for all vaccines recommended by the ACIP (Advisory Committee for Immunization Practices) and approved by the CDC (Centers for Disease Control and Prevention) for children 6–18 years of age. In general, all ACIP/CDC recommended vaccines for children are available through the VFC Program.

ForwardHealth does not publish best practice standards for immunizations provided to children. Pharmacy providers are responsible for keeping up-to-date on immunization best practice standards, including immunization schedules, dosages, and contraindications that are recommended by ACIP/CDC.

Provider Participation Requirements

Medicaid-enrolled pharmacies are required to meet the following requirements to be reimbursed for administering vaccines to children:

- The pharmacy is required to enroll in the VFC Program and comply with the requirements of the program. For enrollment information, refer to the VFC Program website.
- The pharmacist administering the vaccine is required to have the authority and training to administer immunizations to children per the requirements of the Pharmacy Examining Board under Wis. Stat. ch. 450.
- The pharmacy is required to enter immunizations given in the WIR within **seven** days of administering the immunization, per Wis. Stat. § 252.04(9m). For more information about the WIR, refer to the WIR website.

Claim Submission

Wisconsin Medicaid and BadgerCare Plus fee-for-service will reimburse pharmacy providers for influenza immunization services for both children and adult members and for allowable vaccines for children 6–18 years of age, even if the member is enrolled in a state-contracted MCO (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 and claims for allowable vaccines for members 6–18 years of age via the following:

- The 1500 Health Insurance Claim Form ((02/12))
- The 837P (837 Health Care Claim: Professional) electronic transaction
- DDE (Direct Data Entry) on the ForwardHealth Portal
- PES (Provider Electronic Solutions) claims submission software

Claims submitted using the POS (Point-of-Sale) system for vaccination services will be denied.

If a member is enrolled in a BadgerCare Plus HMO, pharmacy providers are required to submit claims to Wisconsin fee-for-service Medicaid. BadgerCare Plus HMOs are not able to accept claims from pharmacy providers.

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 vaccination services. Pharmacy providers should not separately bill the administration code.

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

Pharmacy providers may not submit claims for vaccination services using NDCs (National Drug Codes). Claims submitted with NDCs for vaccination services will be denied.

Diabetic Supplies

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 BadgerCare Plus and Wisconsin Medicaid. The following preferred and non-preferred diabetic supplies also have quantity limits:

- Blood glucose meters
- Blood glucose test strips

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.

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

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 the term used for EPSDT (Early and Periodic Screening, Diagnosis, and Treatment) in Wisconsin. The HealthCheck benefit provides periodic, comprehensive health screening exams (also known as "well child checks"), as well as interperiodic screens, outreach and case management, and additional medically necessary services (referred to as HealthCheck "Other Services") for members under 21 years of age.

Wisconsin Medicaid covers most diagnostic and intervention services a member may need. However, federal law requires that states provide any additional health care services that are coverable under the federal Medicaid program and found to be medically necessary to treat, correct, or reduce illnesses and conditions discovered regardless of whether or not the service is covered in a state's Medicaid program. HealthCheck "Other Services" is Wisconsin's term for this federal requirement.

The requested service must be allowable under federal Medicaid law, per § 1905(a) of the Social Security Act, and must be medically necessary and reasonable for the member to be covered by Wisconsin Medicaid, per Wis. Admin. Code § DHS 107.02(3)(e). Most HealthCheck "Other Services" require PA (prior authorization) per Wis. Admin. Code § DHS 107.02.

Topic #1401

Covered Over-the-Counter Drugs

All requests for HealthCheck "Other Services" require PA, except for OTC (over-the-counter) drugs listed in the Over-the-Counter Drugs Covered by HealthCheck "Other Services" table, which are covered for members under 21 years of age.

All other OTC drug requests require PA. In that case, prescribers are required to complete the appropriate section(s) of the PA/DGA (Prior Authorization/Drug Attachment, F-11049 (07/16)) as it pertains to the drug being requested.

Topic #1

Prior Authorization for HealthCheck "Other Services"

Providers submitting PA (prior authorization) requests for HealthCheck "Other Services" should review the two types of PA requests. The following types of PA requests have their own submission requirements:

- Requests for exceptions to coverage limitations
- Requests for federally allowable Medicaid services not routinely covered by Wisconsin Medicaid

PA Submission Requirements for Exceptions to Coverage Limitations

HealthCheck "Other Services" may additionally cover established Medicaid health care services that are limited in coverage for members under 21 years of age.

If a PA request is submitted requesting additional coverage for a benefit where there is established policy, the request is automatically processed under the HealthCheck "Other Services" benefit to evaluate whether the requested service is likely to

correct or ameliorate the member's condition, including maintaining current status or preventing regression.

Examples of coverage limitations include service amounts that are prohibited by policy, or the requested service is not expected to result in a favorable improvement in the member's condition or diagnosis.

Every PA request for a member under age 21 is first processed according to standard Medicaid guidelines and then reviewed under HealthCheck "Other Services" guidelines. For these reasons, providers do **not** need to take additional action to identify the PA request as a HealthCheck "Other Services" request.

If an established benefit will be requested at a level that exceeds Wisconsin Medicaid coverage limits, in addition to the required PA documentation detailed in the appropriate service area of the Online Handbook, the request should provide:

- The rationale detailing why standard coverage is not considered acceptable to address the identified condition.
- The rationale detailing why the requested service is needed to correct or ameliorate the member's condition.

PA Submission Requirements for Services Not Routinely Covered by Wisconsin Medicaid

HealthCheck "Other Services" allows coverage of health care services that are not routinely covered by Wisconsin Medicaid, but are federally allowable and medically necessary to maintain, improve, or correct the member's physical and mental health, per § 1905(a) of the Social Security Act. These HealthCheck "Other Services" require PA since the determination of medical necessity is made on a case-by-case basis depending on the needs of the member.

If a PA request is submitted requesting coverage for a service that does not have established policy and is not an exception to coverage limitations, the provider is required to identify the PA as a HealthCheck "Other Services" request by **checking the HealthCheck "Other Services" box** and submit the following information:

- A current, valid order or prescription for the service being requested:
  - Prescriptions are valid for 12 or fewer months from the date of the signature (depending on the service area).
  - Updated prescriptions may be required more frequently for some benefits.
- A completed PA/RF (Prior Authorization Request Form, F-11018 (05/13)), for most service areas, including the following:
  - For Element 1, **check the HealthCheck "Other Services" box.**
  - For Element 19, enter the procedure code that most accurately describes the service, even if the code is not ordinarily covered by Wisconsin Medicaid. Unlisted procedure codes can be requested if the service is not accurately described by existing procedure codes.
  - For Element 20, enter informational procedure code modifier EP (Service provided as part of Medicaid early periodic screening diagnosis and treatment [EPSDT] program) to indicate that the service is requested as a HealthCheck "Other Services" benefit.
  - For Element 22, include the description of the service.
- A completed PA/DRF (Prior Authorization/Dental Request Form, F-11035 (07/12)), or PA/HIAS1 (Prior Authorization Request for Hearing Instrument and Audiological Services, F-11020 (05/13)) when the PA/RF is not applicable
- A PA attachment form(s) for the related service area, if known, or clinical documentation substantiating the medical necessity of the requested procedure code and:
  - The rationale detailing why services typically covered by Wisconsin Medicaid are not considered acceptable to address the identified condition or why services were discontinued.
  - The rationale detailing why the requested service is needed to correct or ameliorate the member's condition.

  Note: Providers may call Provider Services to determine the appropriate PA attachment.

- Evidence the requested service is clinically effective and not harmful (If the requested service is new to Wisconsin Medicaid, additional documentation regarding current research and/or safety of the intervention may be submitted.)
- The MSRP (manufacturer's suggested retail price) for requested equipment or supplies

- The 11-digit NDC (National Drug Code) for any dispensed OTC (over-the-counter) drugs on pharmacy PA requests

Providers may call Provider Services for more information about HealthCheck "Other Services."

If the PA request is incomplete or additional information is needed to substantiate the necessity of the requested service, the PA request will be returned to the provider. **A return for more information is not a denial.**

Topic #2245

Pharmacy providers should submit a completed PA/DGA (Prior Authorization Drug Attachment, F- 11049 (07/16)) form to ForwardHealth to request PA for HealthCheck "Other Services."

Prescribers are required to complete the appropriate section(s) of the PA/DGA as it pertains to the drug being requested.

Topic #41

Requirements

For a service to be reimbursed through HealthCheck "Other Services," the following requirements must be met:

- The service is provided to a member who is under 21 years of age.
- The service is coverable under federal Medicaid law.
- The service is medically necessary and reasonable.
- The service is prior authorized before it is provided.
- Services currently available 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 the authorized amount is reasonable and maintains the preventive intent of the HealthCheck benefit.

HealthCheck "Other Services" does not include reimbursement in excess of ForwardHealth published maximum allowable fees.

All PA (prior authorization) requests must follow NCCI (National Correct Coding Initiative) guidelines.

Medication Therapy Management

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 CMR/A (Comprehensive Medication Review and Assessment) services, which 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 their 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.

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 Wis. Stat. § 49.688(5)(a). 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 Medicaid 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 Medicaid 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 Wisconsin Medicaid 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 Medicaid 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 Wisconsin Medicaid 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 their 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, they must then meet the $850 deductible. Once the deductible is met, the pharmacy may be reimbursed by Wisconsin Medicaid for covered MTM services.

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 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.

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 for Members

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

- The member 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.
- The member has diabetes.
- The member requires coordination of care due to multiple prescribers.
- The member has been discharged from a hospital or long term care setting within the past 14 days; these services are referred to as transition of care CMR/A services.
- The member has health literacy issues as determined by the pharmacist.
- The member 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.

Conducting Transition of Care Comprehensive Medication Review and Assessment Services

ForwardHealth expects the pharmacist to complete the following steps when rendering transition of care CMR/A services:

1. Obtain a complete list of the prescription and over-the-counter medications, vitamins, and supplements the member was taking prior to admission to the hospital or long term care setting. (If the pharmacist performing the service does not have a complete pre-admission medication list, the pharmacist should contact the member's pharmacy/pharmacies to obtain this information. An admission history obtained from an Electronic Medical Record does not fulfill this step requirement.)
2. Obtain the discharge medication orders and compare to the pre-admission medication list.
3. Upon conclusion of the CMR/A service, provide an updated medication list to the member that calls attention to changes made to the member's pre-admission medication regimen.
4. Provide a MAP (Medication Action Plan) to the member that reminds the member of action items they should take until following up with their primary care provider. The final MAP should be provided to the member within 14 days of consultation.
5. Maintain documentation in the member's file of the transition of care CMR/A services provided and submit required documentation electronically to ForwardHealth.
6. Attempt to contact the member after the visit to ensure and reinforce understanding of the post-discharge medication regimen.

Note: Providers are reminded that PA from the DAPO Center is required in order to be reimbursed for providing transition of care CMR/A services.

Coordination of Benefits

Other health insurance (for example, commercial health insurance, Medicare, Medicare Advantage Plans) sources also have MTM programs. If a member is eligible for an other health insurance MTM program, the pharmacy provider is required to submit the claim to the member's other health insurance before submitting the claim to ForwardHealth.

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

The 1500 Health Insurance Claim Form Completion Instructions contain information regarding documenting other insurance information.

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 ((02/12))

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).

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:

- 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.

ForwardHealth also requires providers to submit MTM documentation electronically using one of the following options:

- ForwardHealth-approved MTM case management software
- The ForwardHealth Portal

This electronic submission requirement is in addition to the requirement for providers to maintain on-site MTM documentation (either on paper or electronically) in the member's file. The information required to be submitted to ForwardHealth electronically is the same information required to be maintained in the member's file. Documentation for MTM services that is submitted to ForwardHealth may be used by ForwardHealth to evaluate the MTM benefit.

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., 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., their 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 their 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	Is the member currently residing in a nursing home?
0123456789	❑ 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	Date Signed
Im A. Member	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.

Topic #14737

Comprehensive Medication Review and Assessments — Procedure Codes and Modifiers

Claims submitted for CMR/As (Comprehensive Medication Review and Assessments) must be submitted with at least one of the following CPT (Current Procedural Terminology) procedure 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	$85.00	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	$40.00	No	3/member/ rolling year

Topic #14777

Comprehensive Medication Review and Assessments — Reimbursement

Pharmacies will be reimbursed at $85.00 for the initial CMR/A (Comprehensive Medication Review and Assessment) and $40.00 for a 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 #17297

Electronic Submission of Documentation Requirement and Submission Options

ForwardHealth requires providers to submit MTM (Medication Therapy Management) documentation electronically using one of the following options:

- ForwardHealth-approved MTM case management software
- The ForwardHealth Portal

This electronic submission requirement is in addition to the requirement for providers to maintain on-site MTM documentation (either on paper or electronically) in the member's file. The information required to be submitted to ForwardHealth electronically is the same information required to be maintained in the member's file. Documentation for MTM services that is submitted to ForwardHealth may be used by ForwardHealth to evaluate the MTM benefit.

Providers are required to submit the associated MTM documentation electronically within 365 days of submitting the claim for MTM services. Providers are encouraged to submit associated MTM documentation electronically within 30 days of submitting the claim for MTM services provided.

A separate record is required for each MTM service provided. Providers are reminded to only submit one record for each service provided. Documentation that is stored in ForwardHealth-approved MTM case management software is automatically sent to ForwardHealth; documentation stored on the Portal is also automatically sent to ForwardHealth. In order to avoid duplication, providers should not record documentation for the same services on both the Portal and in ForwardHealth-approved MTM case management software.

ForwardHealth-Approved Case Management Software

ForwardHealth will approve MTM case management software that meets certain criteria to access ForwardHealth's claim information. Approved software will be able to do the following:

- Identify BadgerCare Plus, SeniorCare, and Wisconsin Medicaid members who are eligible for MTM services.
- Submit claims for MTM services on a pharmacy provider's behalf.
- Capture, store, and maintain clinical information, including the required documentation for CMR/A (Comprehensive Medication Review and Assessment) services, in a member's file.
- Exchange clinical information with ForwardHealth. ForwardHealth will use this clinical information to evaluate the MTM benefit.

A list of ForwardHealth-approved vendors and their contact information is available.

Contracting Options

Pharmacy providers may choose to do one of the following:

- Contract with a ForwardHealth-approved MTM case management software vendor. Pharmacy providers who contract

with a ForwardHealth-approved MTM case management software vendor are still required to receive approval from the DAPO (Drug Authorization and Policy Override) Center to provide CMR/A services.
- Contract with another MTM case management software vendor. Pharmacy providers who contract with an MTM case management software vendor not approved by ForwardHealth should note that the unapproved vendor will not be able to receive claim information from or exchange documentation with ForwardHealth.
- Not contract with any MTM case management software vendor. Pharmacy providers who do not contract with any MTM case management software vendor can still submit claims for MTM services and are still required to capture, store, and maintain required documentation in a member's file and to submit required documentation electronically.

Documentation on the ForwardHealth Portal

Pharmacy providers have the option to capture, retrieve, and submit required MTM documentation on the secure Provider area of the ForwardHealth Portal. This is an optional service for providers; however, it will fulfill ForwardHealth's electronic documentation submission requirement for MTM services.

For assistance regarding the submission of MTM documentation on the Portal, call the ForwardHealth Portal Helpdesk or refer to the Medication Therapy Management Documentation Storage User Guide.

Topic #14537

Medication Therapy Management Coordination

Pharmacies are responsible for COB (coordination of benefits) for 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 their 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:

- BadgerCare Plus
- 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 CMR/A (Comprehensive Medication Review and Assessment) services:

Code	Description
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
19	Off Campus—Outpatient Hospital
22	On Campus—Outpatient Hospital*
31	Skilled Nursing Facility**
32	Nursing Facility**
49	Independent Clinic
50	Federally Qualified Health Center
54	Intermediate Care Facility/Individuals with Intellectual Disabilities**
56	Psychiatric Residential Treatment Center
57	Non-residential Substance Abuse Treatment Facility
71	Public Health Clinic
72	Rural Health Clinic

* When a pharmacist performs a CMR/A service in an on-campus outpatient hospital setting, ForwardHealth does not reimburse the facility charge.

** These POS codes are only allowed for cost effectiveness, dose/dosage form/duration change, medication addition, and medication deletion.

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 #68

Definition of Noncovered Services

A noncovered service is a service, item, or supply for which reimbursement is not available. Wis. Admin. Code § DHS 101.03 (103) and ch. 107 contain more information about noncovered services. In addition, Wis. Admin. Code § DHS 107.03 contains a general list of noncovered 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.
- If a member needs assistance in obtaining transportation to a medical appointment, encourage the member to call MTM, Inc. (Medical Transportation Management, Inc.) for NEMT (non-emergency medical transportation). Most Medicaid and BadgerCare Plus members may receive NEMT services through MTM, Inc. if they have no other way to receive a ride. 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

Nursing Facility Members

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 Wis. Stat. § 49.45(10), 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 Wis. Stat. § 49.45(10), 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

Wis. Admin. Code § Phar 7.04, 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. Wis. Admin. Code § DHS 132.65(6)(c), defines the procedural and record keeping requirements that nursing facilities must follow for members' unused medications.

Managed Care

4

Archive Date:12/01/2020

Managed Care:Claims

Topic #384

Appeals to BadgerCare Plus and Medicaid SSI HMOs

BadgerCare Plus and Medicaid SSI managed care contracted and non-contracted providers are required to first file an appeal directly with the BadgerCare Plus or Medicaid SSI HMO after the initial payment denial or reduction. Providers should refer to their signed contract with the HMO or the HMO's website for specific filing timelines and responsibilities (for example, PA (prior authorization), claim filing timelines, and coordination of benefits requirements) pertaining to filing a claim reconsideration and/or filing a formal appeal. The provider's signed contract with the HMO may dictate the final decision. Filing a claim reconsideration is not the same as filing a formal appeal.

Appeal documents must reach the HMO within the time frame established by the HMO. Special care should be taken to ensure the documents reach the HMO by the timely filing deadline by allowing enough time for U.S. Postal Service mail handling or by using a verifiable delivery method (for example, fax, certified mail, or secure email).

The BadgerCare Plus or Medicaid SSI HMO has 45 calendar days to respond in writing to an appeal. The BadgerCare Plus or Medicaid SSI HMO decides whether or not to pay the claim and sends a letter stating this decision. If the BadgerCare Plus or Medicaid SSI HMO does not respond in writing within 45 calendar days or the provider is dissatisfied with the BadgerCare Plus or Medicaid SSI HMO's response, the provider may send a written appeal to ForwardHealth within 60 calendar days from the end of the 45 calendar day timeline or the date of the HMO response.

Topic #385

Appeals to ForwardHealth

BadgerCare Plus or Wisconsin Medicaid **will not review** appeals that were not first made to the BadgerCare Plus or Medicaid SSI HMO. If a provider sends an appeal directly to BadgerCare Plus or Wisconsin Medicaid without first filing it with the BadgerCare Plus or Medicaid SSI HMO, the appeal will be returned to the provider.

The provider has 60 calendar days to file an appeal with BadgerCare Plus or Wisconsin Medicaid after the BadgerCare Plus or Medicaid SSI HMO either does not respond in writing within 45 calendar days or if the provider is dissatisfied with the BadgerCare Plus or Medicaid SSI HMO response.

Appeals will only be reviewed for enrollees who were eligible for and who were enrolled in a BadgerCare Plus or Medicaid SSI HMO on the DOS (date of service) in question.

Once all pertinent information is received, ForwardHealth has 45 calendar days to make a final decision. The provider and the BadgerCare Plus or Medicaid SSI HMO will be notified by ForwardHealth in writing of the final decision. If the decision is in the provider's favor, the BadgerCare Plus or Medicaid SSI HMO is required to pay the provider within 45 calendar days of the final decision. The decision is final, and all parties are required to abide by the decision.

Providers are required to submit an appeal with legible copies of all of the following documentation using either the Managed Care Program Provider Appeal (F-12022 (02/2020)) form or their own appeal letter:

- The original claim submitted to the HMO and all corrected claims submitted to the HMO
- All of the HMO's payment denial remittances showing the dates of denial and reason codes with descriptions of the exact reasons for the claim denial

- The provider's written appeal to the HMO
- The HMO's response to the appeal
- Relevant medical documentation for appeals regarding coding issues or emergency determination that supports the appeal
- Any contract language that supports the provider's appeal with the exact language that supports overturning the payment denial indicated
- Any other documentation that supports the appeal (for example, commercial insurance Explanation of Benefits/Explanation of Payment to support Wisconsin Medicaid as the payer of last resort)

Only relevant documentation should be included. Large documents should be submitted on a CD.

Appeals may be faxed to ForwardHealth at 608-224-6318 or mailed to the following address:

BadgerCare Plus and Medicaid SSI
Managed Care Unit—Provider Appeal
PO Box 6470
Madison WI 53716-0470

A decision to uphold the HMO's original payment denial or to overturn the denial will be made based on the documentation submitted for review. Failure to submit the required documentation or submitting incomplete or insufficient documentation may lead to an upholding of the original denial. The decision to overturn an HMO's denial must be clearly supported by the documentation.

Providers must notify ForwardHealth if the HMO subsequently overturns their original denial and reprocesses and pays the claim for which they have submitted an appeal. Notifications should be faxed to ForwardHealth at 608-224-6318. This documentation will be added to the original appeal documentation to complete the record.

Contact ForwardHealth Provider Services (Managed Care Unit) at 800-760-0001, option 1, to check the status of an appeal submitted to ForwardHealth.

Topic #386

Claims Submission

BadgerCare Plus and Medicaid SSI HMOs have requirements for timely filing of claims, and providers are required to follow the BadgerCare Plus and Medicaid SSI HMO claims submission guidelines for each organization. Providers should contact the enrollee's BadgerCare Plus or Medicaid SSI HMO for organization-specific submission deadlines.

Topic #387

Extraordinary Claims

Extraordinary claims are BadgerCare Plus or Medicaid claims for a BadgerCare Plus or Medicaid SSI HMO enrollee that have been denied by a BadgerCare Plus or Medicaid 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 a BadgerCare Plus or Medicaid SSI HMO at the time they were admitted to an inpatient hospital, but then they enrolled in a BadgerCare Plus or Medicaid 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 Item Number 18 of the paper 1500 Health Insurance Claim Form ((02/12)).

- The claims are for orthodontia/prosthodontia services that began before BadgerCare Plus or Medicaid SSI HMO coverage. The provider must include a record with the claim indicating when the bands were placed.

Submitting Extraordinary Claims

When submitting an extraordinary claim, providers must 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
- A copy of the Explanation of Medical Benefits form as applicable

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 or Medicaid SSI HMO. Before submitting claims to BadgerCare Plus and Medicaid SSI HMOs, providers are required to submit claims to other health insurance sources. Providers should contact the enrollee's BadgerCare Plus or Medicaid SSI HMO for more information about billing other health insurance sources.

Topic #389

Provider Appeals

When a BadgerCare Plus or Medicaid SSI HMO denies a provider's claim, the BadgerCare Plus or Medicaid SSI HMO is required to send the provider a notice informing them of the right to file an appeal.

A BadgerCare Plus or Medicaid SSI HMO network or non-network provider may file an appeal to the BadgerCare Plus or Medicaid SSI HMO when:

- A claim submitted to the BadgerCare Plus or Medicaid SSI HMO is denied payment.
- The full amount of a submitted claim is not paid.

Providers are required to file an appeal with the BadgerCare Plus or Medicaid SSI HMO **before** filing an appeal with ForwardHealth.

Covered and Noncovered Services

Topic #16197

Care4Kids Program Benefit Package

Covered Services

Members enrolled in the Care4Kids program are eligible to receive all medically necessary services covered under Wisconsin Medicaid; however, Care4Kids will have the flexibility to provide services in a manner that best meets the unique needs of children in out-of-home care, including streamlining PA (prior authorization) requirements and offering select services in home settings. Members will also be allowed to go to any Medicaid-enrolled provider for emergency medical services or family planning services.

Noncovered Services

The following services are not provided as covered benefits through the Care4Kids program, but can be reimbursed for eligible Medicaid members on a fee-for-service basis:

- Behavioral treatment
- Chiropractic services
- CRS (Community Recovery Services)
- CSP (Community Support Programs)
- CCS (Comprehensive Community Services)
- Crisis intervention services
- Directly observed therapy for individuals with tuberculosis
- MTM (Medication therapy management)
- NEMT (Non-emergency medical transportation) services
- Prescription and over-the-counter drugs and diabetic supplies dispensed by the pharmacy
- Provider-administered drugs and their administration, and the administration of Synagis
- SBS (School-based services)
- Targeted case management

Children's Hospital of Wisconsin will establish working relationships, defined in writing through a memorandum of understanding, with providers of the following services:

- CSP
- CCS
- Crisis intervention services
- SBS
- Targeted case management services

Providers of these services must coordinate with Care4Kids to help assure continuity of care, eliminate duplication, and reduce fragmentation of services.

Topic #390

Covered Services

HMOs

HMOs 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 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 or Medicaid SSI HMOs but are provided to enrollees on a fee-for-service basis provided the service is covered for the member and is medically necessary:

- Behavioral treatment
- County-based mental health programs, including CRS (Community Recovery Services), CSP (Community Support Program) benefits, and crisis intervention services
- Environmental lead investigation services provided through local health departments
- CCC (child care coordination) services provided through county-based programs
- Pharmacy services and diabetic supplies
- PNCC (prenatal care coordination) services
- Provider-administered drugs

  *Note:*The Provider-Administered Drugs Carve-Out Procedure Codes table indicates the status of procedure codes considered under the provider-administered drugs carve-out policy.

- SBS (school-based services)
- Targeted case management services
- NEMT (non-emergency medical transportation) services
- DOT (directly observed therapy) and monitoring for TB (tuberculosis)-Only Services

Providers that render these services to an SSI HMO member are required to submit claims directly to ForwardHealth on a fee-for-service basis.

Note: Members enrolled in an SSI HMO are not eligible for targeted case management services.

Enrollment

Topic #392

Disenrollment and Exemptions

In some situations, a member may be exempt from enrolling in a BadgerCare Plus HMO or Medicaid SSI HMO. Exempted members receive health care under fee-for-service. Exemptions allow members to complete a course of treatment with a provider who is not contracted with BadgerCare Plus HMO or SSI HMOs. For example, in certain circumstances, members seeing a specialist when they are enrolled in an HMO **may** qualify for an exemption if their specialty provider is not in the HMO networks.

The contracts between the Wisconsin DHS (Department of Health Services) and the HMOs 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 or Medicaid SSI HMO. Enrollees also have the right to file a grievance when the HMO or SSI HMO refuses to provide a service. All HMOs and SSI HMOs are required to have written policies and procedures in place to handle enrollee grievances. Enrollees should be encouraged to work with their HMO's or SSI HMO's customer service department to resolve problems first.

If enrollees are unable to resolve problems by talking to their HMO or SSI HMO, or if they would prefer to speak with someone outside their HMO or SSI HMO, they should contact the Enrollment Specialist or the Ombudsman Program.

The contracts between the Wisconsin 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 BadgerCare Plus are eligible for enrollment in a BadgerCare Plus HMO.

An individual who receives Tuberculosis-Related Medicaid, SeniorCare, or Wisconsin Well Woman Medicaid cannot be enrolled in a BadgerCare Plus HMO.

Information about a member's HMO enrollment status and other health insurance (for example, commercial health insurance, Medicare, Medicare Advantage Plans) 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 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.

Topic #394

Enrollment Periods

BadgerCare Plus HMOs

Eligible enrollees are sent enrollment packets that explain the BadgerCare Plus HMOs and the enrollment process and provide contact information. Once enrolled in a BadgerCare Plus HMO, members 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, they will be disenrolled from the HMO.

SSI HMOs

Eligible enrollees are sent enrollment packets that explain the Medicaid SSI HMO enrollment process and provide contact information. Once enrolled in an SSI HMO, members may change their HMO assignment within the first 90 days of enrollment in an HMO (whether they chose the HMO or were auto-assigned).

Topic #395

Enrollment Specialist

The Enrollment Specialist provides objective enrollment, education, outreach, and advocacy services to BadgerCare Plus HMO and Medicaid SSI HMO enrollees. The Enrollment Specialist is a knowledgeable single point of contact for enrollees, solely dedicated to managed care issues. The Enrollment Specialist is not affiliated with any health care agency.

The Enrollment Specialist provides the following services to HMO and SSI HMO enrollees:

- Education regarding the correct use of HMO and SSI HMO benefits
- Telephone and face-to-face support
- Assistance with enrollment, disenrollment, and exemption procedures

Topic #398

Member Enrollment

HMOs

BadgerCare Plus HMO enrollment is either mandatory or voluntary based on ZIP code-defined enrollment areas as follows:

- Mandatory enrollment — Enrollment is mandatory for eligible members who reside in ZIP code areas served by two or more BadgerCare Plus HMOs. Some members may meet criteria for exemption from BadgerCare Plus HMO enrollment.
- Voluntary enrollment — Enrollment is voluntary for members who reside in ZIP code areas served by only one

BadgerCare Plus HMO.

Members living in areas where enrollment is mandatory are encouraged to choose their BadgerCare Plus HMO. Automatic assignment to a BadgerCare Plus HMO occurs if the member does not choose a BadgerCare Plus HMO. In general, all members of a member's immediate family eligible for enrollment must choose the same HMO.

Members in voluntary enrollment areas can choose whether or not to enroll in a BadgerCare Plus HMO. There is no automatic assignment for members who live within ZIP codes where enrollment is voluntary.

SSI HMOs

Medicaid SSI HMO enrollment is either mandatory or voluntary as follows:

- Mandatory enrollment — Most SSI and SSI-related members are required to enroll in an SSI HMO. A member may choose the SSI HMO in which he or she wishes to enroll.
- Voluntary enrollment — Some SSI and SSI-related members may choose to enroll in an SSI HMO on a voluntary basis.

Topic #396

Ombudsman Program

The Ombudsmen, or Ombuds, are resources for enrollees who have questions or concerns about their BadgerCare Plus HMO or Medicaid SSI HMO. Ombuds provide advocacy and assistance to help enrollees understand their rights and responsibilities in the grievance and appeal process.

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 and Medicaid SSI 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 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 #16177

Care4Kids Program Overview

Care4Kids is a health care program for children and youth in out-of-home care in Wisconsin. The Care4Kids program will offer comprehensive, coordinated services that are intended to improve the quality and timeliness of and access to health services for these children.

The Care4Kids program will serve children in out-of-home care placements (other than residential care centers) in Kenosha, Milwaukee, Ozaukee, Racine, Washington, and Waukesha counties. Member participation will be voluntary and enrollment will be allowed to continue for up to 12 months after the child leaves the out-of-home care system, as long as the child remains Medicaid-eligible and resides within one of the six counties.

Care4Kids is required to provide at least the same benefits as those provided under fee-for-service arrangements.

Program Administration

Children's Hospital of Wisconsin is currently the only integrated health system certified by ForwardHealth to administer the Care4Kids program. Children's Hospital of Wisconsin will be responsible for providing or arranging for the provision of all services covered under Medicaid, with a small number of exceptions. The services not included in the Care4Kids program will be reimbursed as fee-for-service benefits. Children's Hospital of Wisconsin's integrated network of health care providers, which includes specialty and primary care physicians and clinics within the Children's Hospital System as well as providers who are participating in CCHP (Children's Community Health Plan), is intended to provide coordinated care and services to meet the individualized needs of each of the children enrolled across multiple disciplines, including physical, behavioral health, and dental care.

Care4Kids will be responsible for providing or arranging for the provision of all medically necessary services covered by Wisconsin Medicaid to enrollees. Providers are required to be part of the CCHP network to get reimbursed by Care4Kids. Providers interested in being a part of the network should contact CCHP. Out-of-network providers are required to call Care4Kids prior to providing services to a Care4Kids enrollee. In situations where emergency medical services are needed, out-of-network providers are required to contact Care4Kids within 24 hours of providing services.

Member Enrollment Verification

Providers should verify a member's enrollment before providing services to determine if the member is enrolled in Care4Kids. Members enrolled in Care4Kids will present a ForwardHealth member identification card.

Providers verifying enrollment on the ForwardHealth Portal will see Care4Kids under the MC Program heading in the Managed Care Enrollment panel.

For 271 response transactions, Care4Kids enrollment will be identified in the EB segment of the 2110C loop. Identified by "MC" in the EB01, "HM" in the EB04, and "Care4Kids" in the EB05. The MC provider contact information will be reported in the NM1 (name info), N3 (address info), and PER (telephone numbers) segments within the 2120C loop.

The WiCall AVR (automated voice response) system will identify Care4Kids as the state-contracted managed care program in which the member is enrolled.

Contact Information

Providers can contact CCHP at 800-482-8010 for the following:

- To become part of the CCHP network
- For coverage policy and procedure information, including PA (prior authorization) and claim submission guidelines, if they are already a Care4Kids network provider

Topic #405

Managed Care

Managed Care refers to the BadgerCare Plus HMO program, the Medicaid SSI HMO program, and the following MLTC (managed long-term care) programs available: Family Care, Family Care Partnership, and PACE (Program of All-Inclusive Care for the Elderly).

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 Wisconsin DHS (Department of Health Services) and the BadgerCare Plus HMO or Medicaid SSI HMO takes precedence over other ForwardHealth provider publications. Information contained in ForwardHealth publications is used by 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 #403

Managed Long-Term Care Programs

Wisconsin Medicaid has several MLTC (managed long-term 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, PACE (Program of All-Inclusive Care for the Elderly), and the Family Care Partnership Program. Additional information about these MLTC programs may be obtained from the Managed Care Organization area of the ForwardHealth Portal.

Topic #404

SSI HMO Program

Medicaid SSI HMOs provide the same benefits as Medicaid fee-for-service (e.g., medical, dental [in certain counties only], mental health/substance abuse, and vision) at no cost to their members through a care management model. Medicaid SSI members and SSI-related Medicaid members 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

Certain eligible SSI members and SSI-related Medicaid adult members are required to enroll in an SSI HMO. The following groups are excluded from the requirement to enroll in an SSI HMO:

- Members under 19 years of age
- Members of a federally recognized tribe
- Dual eligible members
- MAPP (Medicaid Purchase Plan) eligible members
- Members enrolled in a LTC (long-term care) MCO (managed care organization) or waiver program

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 90 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 ForwardHealth. The PA must be honored for 90 days or until the month following the HMO's completion of the assessment and care plan, whichever comes later.

To assure payment, non-contracted providers should contact the SSI HMO to confirm claim submission and reimbursement processes. If an SSI HMO is not honoring a PA that is currently approved by ForwardHealth, the provider should first contact the HMO. If the provider is not able to resolve their issue with the HMO, the provider should contact ForwardHealth Provider Services.

For new authorizations during the member's first 90 days of enrollment, the provider is required to follow the SSI HMO's PA process. SSI HMOs may use PA guidelines that differ from fee-for-service guidelines; however, these guidelines may not result in less coverage than fee-for-service.

Care Management

SSI HMO health plans employ a care management model to ensure high-quality care to members. The care management model provides each enrollee with the following:

- An initial health assessment
- A comprehensive care plan
- Assistance in choosing providers and identifying a primary care provider
- Assistance in accessing social and community services
- Information about health education programs, treatment options, and follow-up procedures
- Advocates on staff to assist members in choosing providers and accessing needed care

ForwardHealth requires all SSI HMO health plans to have dedicated care managers to assist providers in meeting the medical care needs of members. SSI HMOs, through their care management teams, will serve as single points of contact for providers who need assistance addressing the health care needs of members, especially those who have multiple points of contact within the health care system.

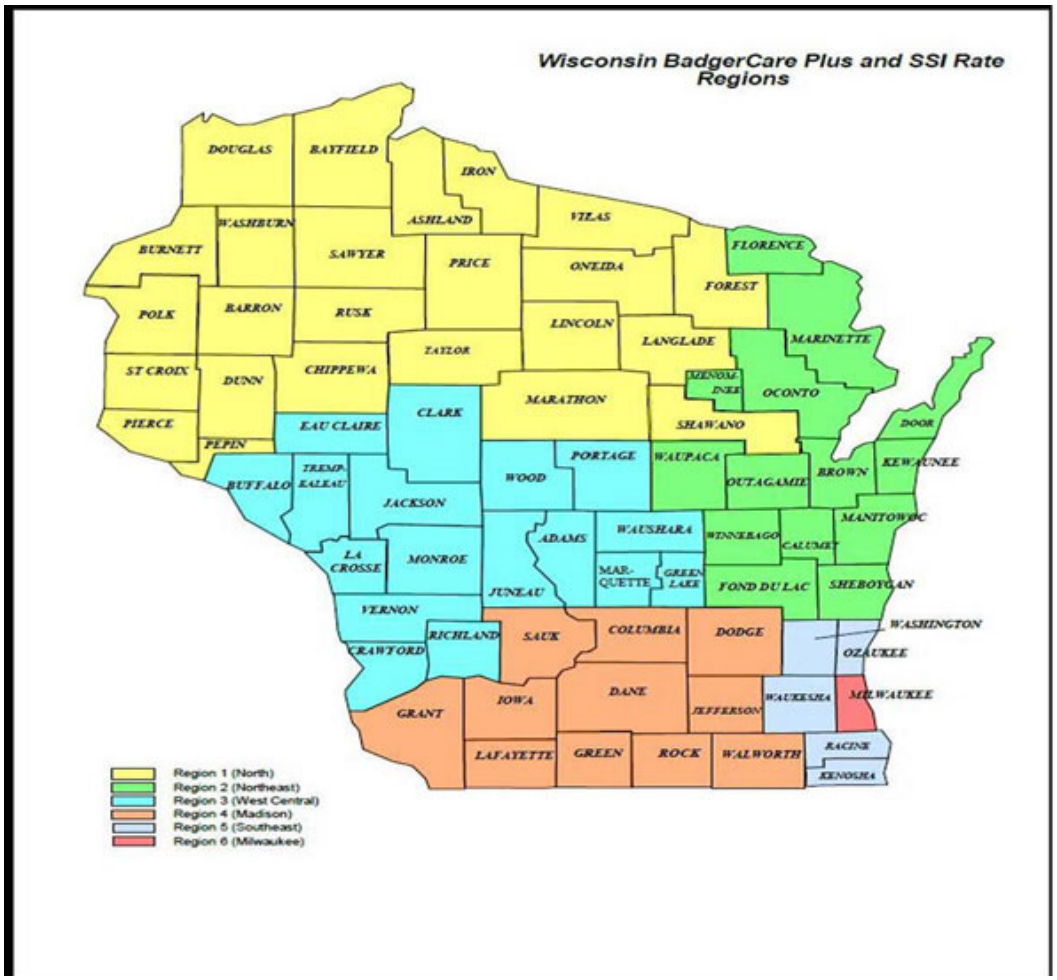
The SSI HMO care management teams will be responsible, when it is deemed appropriate, for notifying primary care providers of members' emergency room visits, hospital discharges, and other major medical events, as well as sharing patient-specific care management plans with appropriate providers to reduce hospital admissions and readmission, to reduce appointment no-shows, and to improve compliance with health care recommendations such as medication regimens.

Topic #20697

SSI Rate Regions

The map below shows the Wisconsin BadgerCare Plus and SSI (Supplemental Security Income) Rate Regions for the SSI HMO Program.

SSI Rate Regions


Wisconsin BadgerCare Plus and SSI Rate Regions
DOUGLAS
BAYFIELD
IRON
ASHLAND
VILAS
WASHBURN
BURNETT
SAWYER
PRICE
ONEIDA
FLORENCE
FOREST
POLK
BARRON
RUSK
LINCOLN
LANGLADE
MARINETTE
ST CROIX
DUNN
CHIPPEWA
TAYLOR
MENOM-INEE
OCONTO
PIERCE
EAU CLAIRE
CLARK
MARATHON
SHAWANO
DOOR
PEPIN
TREMP-EALEAU
WOOD
PORTAGE
WAUPACA
OUTAGAMIE
BROWN
KEWAUNEE
BUFFALO
JACKSON
WAUSHARA
WINNEBAGO
CALUMET
MANITOWOC
LA CROSSE
MONROE
ADAMS
MAR-QUETTE
GREEN LAKE
FOND DU LAC
SHEBOYGAN
JUNEAU
VERNON
RICHLAND
SAUK
COLUMBIA
DODGE
WASHINGTON
CRAWFORD
OZAUKEE
IOWA
DANE
WAUKESHA
MILWAUKEE
GRANT
JEFFERSON
LAFAYETTE
GREEN
ROCK
WALWORTH
RACINE
KENOSHA
Region 1 (North)
Region 2 (Northeast)
Region 3 (West Central)
Region 4 (Madison)
Region 5 (Southeast)
Region 6 (Milwaukee)

Prior Authorization

Topic #400

Prior Authorization Procedures

BadgerCare Plus HMOs and Medicaid SSI 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 HMO enrollees copayments for covered services except in cases where the Medicaid SSI HMO does not cover services such as dental, chiropractic, and pharmacy. However, even in these cases, providers are prohibited from collecting copayment from members who are exempt from the copayment requirement.

When services are provided through fee-for-service or to members enrolled in a BadgerCare Plus HMO, copayments will apply, except when the member or the service is exempt from the copayment requirement.

Topic #407

Emergencies

Non-network providers may provide services to BadgerCare Plus HMO and Medicaid SSI HMO enrollees in an emergency without authorization or in urgent situations when authorized by the HMO or SSI HMO. The contract between the Wisconsin 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 C.F.R. § 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 or Medicaid SSI HMO are referred to as non-network providers. (HMO and SSI HMO network providers agree to payment amounts and billing procedures in a contract with the HMO or SSI HMO.) Non-network providers are required to direct enrollees to HMO or SSI HMO network providers except in the following situations:

- When a non-network provider is treating an HMO or SSI HMO enrollee for an emergency medical condition as defined in the contract between the Wisconsin 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 and Medicaid SSI HMOs may cover medically necessary care provided to enrollees when they travel outside the HMO's or SSI HMO's service area. The HMO or SSI HMO is required to authorize the services before the services are provided, except in cases of emergency. If the HMO or SSI HMO does not authorize the services, the enrollee may be held responsible for the cost of those services.

Topic #410

Provider Participation

Providers interested in participating in a BadgerCare Plus HMO or Medicaid SSI HMO or changing HMO or SSI HMO network affiliations should contact the HMO or SSI HMO for more information. Conditions and terms of participation in an HMO or SSI HMO are pursuant to specific contract agreements between HMOs or SSI HMOs and providers. An HMO or SSI HMO has the right to choose whether or not to contract with any provider but must provide access to Medicaid-covered, medically-necessary services under the scope of their contract for enrolled members. Each HMO may have policies and procedures specific to their provider credentialing and contracting process that providers are required to meet prior to becoming an in-network provider for that HMO.

Topic #411

Referrals

Non-network providers may at times provide services to BadgerCare Plus HMO and Medicaid SSI HMO enrollees on a referral basis. Non-network providers are always required to contact the enrollee's HMO or SSI HMO. Before services are provided, the non-network provider and the HMO or SSI HMO should discuss and agree upon billing procedures and fees for all referrals. Non-network providers and HMOs or SSI HMOs should document the details of any referral in writing before services are provided.

Billing procedures for out-of-plan referrals may vary depending on the HMO or SSI HMO. For specific billing instructions, non-network providers should always contact the enrollee's HMO or SSI HMO.

Topic #412

Services Not Provided by HMOs or SSI HMOs

If an enrollee's BadgerCare Plus HMO or Medicaid SSI 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

5

Archive Date:12/01/2020

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 Wisconsin 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 Wis. Stats. § 51.44, and the regulations are found in Wis. Admin. Code ch. DHS 90.

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 their 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 #225

BadgerCare Plus

Populations Eligible for BadgerCare Plus

The following populations are eligible for BadgerCare Plus:

- Parents and caretakers with incomes at or below 100 percent of the FPL (Federal Poverty Level)
- Pregnant women with incomes at or below 300 percent of the FPL
- Children (ages 18 and younger) with household incomes at or below 300 percent of the FPL
- Childless adults with incomes at or below 100 percent of the FPL
- Transitional medical assistance individuals, also known as members on extensions, with incomes over 100 percent of the FPL

Where available, BadgerCare Plus members are enrolled in BadgerCare Plus HMOs. In those areas of Wisconsin where HMOs are not available, services will be reimbursed on a fee-for-service basis.

Premiums

The following members are required to pay premiums to be enrolled in BadgerCare Plus:

- Transitional medical assistance individuals with incomes over 133 percent of the FPL. Transitional medical assistance individuals with incomes between 100 and 133 percent FPL are exempt from premiums for the first six months of their eligibility period.
- Children (ages 18 and younger) with household incomes greater than 200 percent with the following exceptions:
  - Children under age 1 year.
  - Children who are tribal members or otherwise eligible to receive Indian Health Services.

Topic #16677

BadgerCare Plus Benefit Plan Changes

Effective April 1, 2014, all members eligible for BadgerCare Plus were enrolled in the BadgerCare Plus Standard Plan. As a result of this change, the following benefit plans were discontinued:

- BadgerCare Plus Benchmark Plan
- BadgerCare Plus Core Plan
- BadgerCare Plus Basic Plan

Members who are enrolled in the Benchmark Plan or the Core Plan who met new income limits for BadgerCare Plus eligibility were automatically transitioned into the BadgerCare Plus Standard Plan on April 1, 2014. In addition, the last day of BadgerRx Gold program coverage for all existing members was March 31, 2014.

Providers should refer to the March 2014 Online Handbook archive of the appropriate service area for policy information pertaining to these discontinued benefit plans.

Topic #785

BadgerCare Plus Prenatal Program

As a result of 2005 Wisconsin Act 25, 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 Plus Prenatal Program 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 income maintenance or tribal 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., claim 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 #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 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 income maintenance or tribal agency.

Topic #226

Family Planning Only Services

Family Planning Only Services is a limited benefit program that provides routine contraceptive management or related services to low-income individuals who are of childbearing/reproductive age (typically 15 years of age or older) and who are otherwise not eligible for Wisconsin Medicaid or BadgerCare Plus. Members receiving Family Planning Only Services must be receiving routine contraceptive management or related services.

Note: Members who meet the enrollment criteria may receive routine contraceptive management or related services **immediately** by temporarily enrolling in Family Planning Only Services through EE (Express Enrollment).

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 Wisconsin Medicaid and BadgerCare Plus (e.g., mammograms and hysterectomies). If a medical condition, other than an STD (sexually transmitted disease), is discovered during routine contraceptive management or 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 management or 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 management or 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 coverage options and provide referrals for care not covered by Family Planning Only Services.

Topic #4757

ForwardHealth and ForwardHealth interChange

ForwardHealth brings together many Wisconsin 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

- ADAP (Wisconsin AIDS Drug Assistance Program)
- 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, Gainwell Technologies.

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 Prenatal Program
- EE (Express Enrollment) for Children
- EE for Pregnant Women
- Family Planning Only Services, including EE for individuals applying 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)
- Tuberculosis-Related Medicaid

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 the BadgerCare Plus Prenatal Program, Family Planning Only Services, EE for Children, EE for Pregnant Women, or Tuberculosis-Related Medicaid 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 Tuberculosis-Related Medicaid.

Providers are strongly encouraged to verify dates of enrollment and other coverage information using Wisconsin's EVS (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 Wis. Stat. ch. 49.

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 they are 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:

- Income maintenance 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 #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 income maintenance 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 Beneficiary)

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 income maintenance 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 income maintenance 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 #18777

Real-Time Eligibility Determinations

ForwardHealth may complete real-time eligibility determinations for BadgerCare Plus and/or Family Planning Only Services applicants who meet pre-screening criteria and whose reported information can be verified in real time while applying in ACCESS Apply for Benefits. Once an applicant is determined eligible through the real-time eligibility process, they are considered eligible for BadgerCare Plus and/or Family Planning Only Services and will be enrolled for 12 months, unless changes affecting eligibility occur before the 12-month period ends.

A member determined eligible through the real-time eligibility process will receive a temporary ID (identification) card for BadgerCare Plus and/or Family Planning Only Services. Each member will get their own card, and each card will include the member's ForwardHealth ID number. The temporary ID card will be valid for the dates listed on the card and will allow the member to get immediate health care or pharmacy services.

Eligibility Verification

When a member is determined eligible for BadgerCare Plus and/or Family Planning Only Services through the real-time eligibility process, providers are able to see the member's eligibility information in Wisconsin's EVS (Enrollment Verification System) in real time. Providers should always verify eligibility through EVS prior to providing services.

On rare occasions, it may take up to 48 hours for eligibility information to be available through interChange. In such instances, if a

member presents a valid temporary ID card, **the provider is still required to provide services**, even if eligibility cannot be verified through EVS.

Sample Temporary Identification Card for Badger Care Plus

To the Provider

The individual listed on this card has been enrolled in BadgerCare Plus. This card entitles the listed individual to receive health care services, including pharmacy services, through BadgerCare Plus from any Medicaid-enrolled provider. For additional information, call Provider Services at 800-947-9627 or refer to the ForwardHealth Online Handbook at *www.forwardhealth.wi.gov*.

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 for this individual, including the prohibition against billing members. If "Pending Assignment" is indicated after the name on this card, the member identification (ID) number will be assigned within one business day; the card is still valid. Refer to the ForwardHealth Online Handbook for further information regarding this temporary ID card. Providers are encouraged to keep a photocopy of this card.

WISCONSIN DEPARTMENT OF HEALTH SERVICES

TEMPORARY IDENTIFICATION CARD FOR BADGERCARE PLUS

Name:	Program	ID Number
IM A MEMBER DOB: 09/01/1984	BadgerCare Plus	0987654321

This card is valid from **October 01, 2016 to November 30, 2016.**

This individual's eligibility should be available through the ForwardHealth Portal. Eligibility should always be verified through the ForwardHealth Portal prior to services being provided.

SAMPLE

Sample Temporary Identification Card for Family Planning Only Services

To the Provider

The individual listed on this card has been enrolled in Family Planning Only Services. This card entitles the listed individual to receive health care services, including pharmacy services, through Family Planning Only Services from any Medicaid-enrolled provider. For additional information, call Provider Services at 800-947-9627 or refer to the ForwardHealth Online Handbook at *www.forwardhealth.wi.gov*.

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 for this individual, including the prohibition against billing members. If "Pending Assignment" is indicated after the name on this card, the member identification (ID) number will be assigned within one business day; the card is still valid. Refer to the ForwardHealth Online Handbook for further information regarding this temporary ID card. Providers are encouraged to keep a photocopy of this card.

WISCONSIN DEPARTMENT OF HEALTH SERVICES

TEMPORARY IDENTIFICATION CARD FOR FAMILY PLANNING ONLY SERVICES

Name:	Program	ID Number
IM A MEMBER DOB: 09/01/1984	Family Planning Only Services	0987654321

This card is valid from **October 01, 2016 to November 30, 2016.**

This individual's eligibility should be available through the ForwardHealth Portal. Eligibility should always be verified through the ForwardHealth Portal prior to services being provided.

SAMPLE

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 Wisconsin DHS (Department of Health Services). Within DHS, the DMS (Division of Medicaid Services) 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 Wis. Stats § s. 49.688(5)(a). 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.

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 $15 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 their 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.

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

Dollars applied toward the deductible are not carried over into the next benefit period. After the member meets the deductible amount, they 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 their 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 $850 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 $850 deductible. Once the deductible is met, they 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 Tuberculosis-Related Medicaid 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 income maintenance 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 #262

Tuberculosis-Related Medicaid

Tuberculosis-Related Medicaid is a limited benefit category that allows individuals with TB (tuberculosis) infection or disease to receive covered TB-related outpatient services.

Topic #15780

Wisconsin AIDS Drug Assistance Program

Authorized by Wis. Stats. § 49.686, ADAP (Wisconsin AIDS Drug Assistance Program) is designed to maintain the health and independence of persons living with human immunodeficiency virus (HIV) infection in Wisconsin by providing access to antiretroviral drugs, prophylactic medications, and vaccines for hepatitis A and B.

Wisconsin ADAP provides eligible low-income Wisconsin residents living with AIDS (Acquired Immune Deficiency Syndrome) or HIV infection access to antiretroviral medications and certain other medications used in the treatment of AIDS or HIV infection. To be eligible for ADAP, an individual must meet the following requirements:

- Live in Wisconsin.
- Have an AIDS or HIV infection documented by a health care provider.
- Have gross household income that is at or below 300 percent of the FPL (Federal Poverty Level).
- Not be covered under BadgerCare Plus or Wisconsin Medicaid.
- Have no health insurance or insurance that is insufficient to cover the cost of ADAP medications.

For more information about ADAP, refer to the Wisconsin AIDS/HIV Program website.

To apply for ADAP, an individual must complete and submit the AIDS/HIV Health Insurance Premium Subsidy Program and Drug Assistance Program Application/Recertification (F-44614A (01/14)) form and the AIDS/HIV Drug Insurance Premium Subsidy Program and Drug Assistance Program Application/Recertification Part B-Physician Portion (F-44614B (01/14)) form. The applicant should complete and submit Part A of the form and the applicant's health care provider is required to complete and submit Part B.

Applications are also available from AIDS service organizations and community-based organizations that provide HIV case management services. Case managers at these agencies are available to assist individuals in applying for ADAP. A list of the agencies with contact information is included in the application instructions. Applicants with questions may contact ADAP by telephone at 800-991-5532 or 608-267-6875.

Catagory	Detail
Members without insurance	Covered medications are paid at 100 percent of ADAP allowable cost
Insurance with deductible and copayment or coinsurance without an out-of-pocket maximum	Covered medications are paid at 100 percent of ADAP allowable cost until deductible is met, then ADAP pays the copayment or coinsurance

Insurance with deductible and copayment or coinsurance with an out-of-pocket maximum	Covered medications paid at 100 percent of ADAP allowable cost until deductible is met, then ADAP pays the copayment or coinsurance until the out-of-pocket maximum is met
Insurance with copayment or coinsurance without an out-of-pocket maximum	ADAP pays the copayment or coinsurance for covered medications
Insurance with copayment or coinsurance with an out-of-pocket maximum	ADAP pays the copayment or coinsurance for covered medications until the out-of-pocket maximum is met
Wisconsin Medicaid with deductible (spenddown)	ADAP pays 100 percent of the ADAP allowable cost until the deductible (spenddown) is met, and then ADAP eligibility ends because Wisconsin Medicaid will pay for medications
Medicare Part D Prescription Drug Plan	Medicare Part D pays first. ADAP provides wrap-around coverage and pays for the portion not covered by Medicare Part D up to 100 percent of the ADAP allowable cost
Medicare Supplemental and Part D Prescription Drug Plan	Medicare Part D pays first then Medicare Supplemental. ADAP pays any remaining cost or copayment after other payers have paid
Dual eligible	If the member owes a copayment on a medication covered by ADAP, ADAP pays the copayment on behalf of the member

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.

Enrollment Responsibilities

Topic #241

General Information

Members have certain responsibilities per Wis. Admin. Code § DHS 104.02 and the ForwardHealth Enrollment and Benefits (P-00079 (07/14)) 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 Wis. Admin. Code § DHS 104.02(2), a member should inform providers that they are 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 their 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, Medicaid, or ADAP (Wisconsin AIDS Drug Assistance Program) 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 Wis. Admin. Code § HA 3.03, 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, ADAP, or Wisconsin Medicaid was denied.
- Application for BadgerCare Plus, ADAP, 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

Claim Denial Due to Termination of BadgerCare Plus or Wisconsin Medicaid Enrollment

If a claim is denied due to termination of BadgerCare Plus or Wisconsin Medicaid 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.

Claim Denial Due to Termination of ADAP Enrollment

If a claim is denied due to termination of ADAP 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
ADAP Claims and Adjustments
PO Box 8758
Madison WI 53708

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 ADAP Claims and Adjustments.

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 Wis. Admin. Code ch. DHS 103.

Topic #250

Notification of Discontinued Benefits

When 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, 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 #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 their 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 they do 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, they may call Member Services to request a new one.

If a member lost their 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 #1435

Types of Identification Cards

ForwardHealth members receive an identification card upon initial eligibility determination. Identification cards may be presented in different formats (e.g., white plastic cards, paper cards, or paper printouts), depending on the program and the method used to enroll (i.e., paper application or online application). Members who are temporarily enrolled in BadgerCare Plus or Family Planning Only Services receive temporary identification cards.

Topic #15796

Wisconsin AIDS Drug Assistance Program Member Identification

Members enrolled in ADAP (Wisconsin AIDS Drug Assistance Program) are not issued identification cards. Providers may verify member enrollment using one of the options listed in the Member Enrollment Verification.

Providers may obtain a member's identification number by calling ADAP or Provider Services.

Misuse and Abuse of Benefits

Topic #271

Examples of Member Abuse or Misuse

Examples of member abuse or misuse are included in Wis. Admin. Code § DHS 104.02(5).

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 Wis. Admin. Code § DHS 104.02.

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 Wis. Admin. Code § DHS 104.02. 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 HMOs and BadgerCare Plus HMOs. Members remain enrolled in the Pharmacy Services Lock-In Program for two years and are continuously monitored for their prescription drug usage. At the end of the two-year enrollment period, an assessment is made to determine if the member should continue enrollment in the Pharmacy Services Lock-In Program.

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.

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 their 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 them to the income maintenance 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-01162 (02/09)) form for clients to take to the income maintenance 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.

Note: "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.

Pregnant women detained by legal process who qualify for the BadgerCare Plus Prenatal Program and state prison inmates who qualify for Wisconsin Medicaid or BadgerCare Plus during inpatient hospital stays may receive certain benefits. Additionally, inmates of county jails admitted to a hospital for inpatient services who are expected to remain in the hospital for 24 hours or more will be eligible for PE (presumptive eligibility) determinations for BadgerCare Plus by qualified hospitals. Refer to the Presumptive Eligibility chapter of either the Inpatient or Outpatient Hospital service area for more information on the PE determination process.

The DOC (Department of Corrections) oversees health care-related needs for individuals detained by legal process who do not qualify for the BadgerCare Plus Prenatal Program or for state prison inmates who do not qualify for Wisconsin Medicaid or BadgerCare Plus during an inpatient hospital stay.

Topic #16657

State Prison Inmates May Qualify for BadgerCare Plus or Wisconsin Medicaid During Inpatient Hospital Stays

As a result of 2013 Wisconsin Act 20, state prison inmates may qualify for BadgerCare Plus or Wisconsin Medicaid during inpatient hospital stays.

Eligibility

Only inmates of a state prison, not a county jail, are eligible to receive benefits. To qualify for BadgerCare Plus or Wisconsin Medicaid, state prison inmates must meet all applicable eligibility criteria. The DOC coordinates and reimburses inpatient hospital services for inmates who do not qualify for BadgerCare Plus or Wisconsin Medicaid.

Inmates are eligible for BadgerCare Plus or Wisconsin Medicaid for the duration of their hospital stay. Eligibility begins on their date of admission and ends on their date of discharge.

Inmates are not eligible for outpatient hospital services, including observations, under BadgerCare Plus and Wisconsin Medicaid. Inmates may only be eligible for ER (emergency room) services if they are admitted to the hospital directly from the ER and are

counted in the midnight census; otherwise, ER services are considered outpatient services. Outpatient hospital services approved by the DOC are reimbursed by the DOC.

Inmates are not presumptively eligible. Retroactive eligibility will only apply to dates of admission on and after April 1, 2014.

Enrollment

The DOC coordinates the submission of enrollment applications on behalf of inmates.

Covered Services

The only services allowable by BadgerCare Plus or Wisconsin Medicaid for inmates are inpatient hospital services and professional services provided during the inpatient hospital stay that are covered under BadgerCare Plus and Wisconsin Medicaid. Providers with questions regarding services covered by BadgerCare Plus and Wisconsin Medicaid may refer to the applicable service area or contact Provider Services.

Fee-for-Service

Inmates receive services on a fee-for-service basis; they are not enrolled in HMOs.

Prior Authorization

The DOC will assist inpatient hospital providers with their submission of PA (prior authorization) requests for any services requiring PA. If PA is denied, the DOC is responsible for reimbursement of the services.

Enrollment Verification

Inmates are only enrolled for the duration of their hospital stay. Providers should always verify an inmate's enrollment in BadgerCare Plus or Wisconsin Medicaid before submitting a claim.

Claim Submission

When submitting a claim for an inmate's inpatient hospital stay, providers should follow the current claim submission procedures for each applicable service area.

Reimbursement

Acute care hospitals that provide services to inmates are reimbursed at a percentage of their usual and customary charge.

Critical access hospitals that provide services to inmates are reimbursed according to their existing Wisconsin Medicaid reimbursement methodology.

Wisconsin Medicaid reimburses professional services related to an inmate's inpatient hospital stay (e.g., laboratory services, physician services, radiology services, or DME (durable medical equipment)) at the current maximum allowable fee.

Contact Information

Providers may contact the DOC at 608-240-5139 or 608-240-5190 with questions regarding enrollment or PA for inmate inpatient hospital stays.

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 Wis. Admin. Code § DHS 104.01(11). A Medicaid-enrolled provider is required to submit claims to ForwardHealth 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 ForwardHealth **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 (02/14)) 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:12/01/2020

Prior Authorization:Brand Medically Necessary Drugs and Brand Before Generic Drugs

Topic #20078

An Introduction to Brand Medically Necessary Drugs and Brand Before Generic Drugs

Per Wis. Admin. Code § DHS 107.10(2), ForwardHealth requires PA (prior authorization) for the coverage of certain drugs.

Providers should refer to the Brand Medically Necessary Drugs and Brand Before Generic Drugs data table for a list of drugs that have specific PA or policy requirements for BMN (brand medically necessary) drugs or BBG (brand before generic) drugs. The table is updated monthly. It is the prescriber's responsibility to regularly review the table for the most current information on which drugs require PA.

If a drug is listed on the Brand Medically Necessary Drugs and Brand Before Generic Drugs data table as requiring PA, the prescriber is required to complete the appropriate PA request form for that drug. The form must include accurate and complete answers to clinical information about the member's medical history.

Topic #20077

Brand Before Generic Drugs

The Brand Medically Necessary Drugs and Brand Before Generic Drugs data table provides the most current list of BBG (brand before generic) drugs that require PA (prior authorization).

Clinical Criteria for Brand Before Generic Drugs

Clinical criteria for approval of a BBG drug that requires PA are **all** of the following:

- The drug has been defined by ForwardHealth as a generic drug that requires BBG PA.
- The member satisfies established coverage and PA policy for the brand equivalent drug.
- The prescriber submits detailed documentation of the member's relevant medication treatment history.
- The member has taken the requested generic drug for at least 30 consecutive days and had a measurable therapeutic response. (*Note:* Documentation of approximate dates taken may come from the pharmacy or the prescriber.)
- The member has experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction to the brand equivalent drug. (*Note:* Documentation of approximate dates taken may come from the pharmacy or the prescriber.)
- The prescriber includes a description of the unsatisfactory therapeutic response or clinically significant adverse drug reaction that can be directly attributed to the brand equivalent drug.
- The prescriber has indicated how the generic drug will prevent recurrence of an unsatisfactory therapeutic response or clinically significant adverse drug reaction.

Note: Member or prescriber preference for the use of a BBG drug will not be considered as criteria to support the need for a BBG drug.

Submitting Prior Authorization Requests for Brand Before Generic Drugs

PA requests for BBG drugs must be completed and signed by the prescriber and must be submitted using **both** of the following forms:

- Section VI (Clinical Information for Drugs with Specific Criteria Addressed in the ForwardHealth Online Handbook) of the PA/DGA (Prior Authorization/Drug Attachment, F-11049 (07/16)) form
- The PA/RF (Prior Authorization Request Form, F-11018 (05/13))

Pharmacy providers may submit PA requests for BBG drugs on the Portal, by fax, or by mail (but **not** using the STAT-PA (Specialized Transmission Approval Technology-Prior Authorization) system).

Brand Before Generic Drugs on the Preferred Drug List

In addition to meeting the clinical criteria for BBG drugs, all existing PDL (Preferred Drug List) policies apply to BBG drugs on the PDL. This includes, but is not limited to, policy pertaining to drug classes that require step therapy, drugs that require clinical PA, and drugs that have non-preferred brand equivalents.

In addition to completing the PA/DGA form for BBG drugs, the prescriber is required to complete any other required drug- or drug-class-specific PA form and provide any medical records and/or documentation required for the brand drug or applicable drug class. Examples include, but are not limited to, the following:

- A BBG drug, where the non-preferred brand requires a specific PA form
- A drug or drug class that requires specific medical records and/or documentation to be submitted with the PA request

For example, if a prescriber requests BBG PA for a generic drug and the non-preferred brand drug's PDL PA criteria requires the use of at least two PDL preferred drugs in the same drug class with an unsatisfactory therapeutic response or clinically significant adverse drug reaction, this requirement must also be met before a PA request can be approved for the generic drug.

Submitting Prior Authorization Requests for Brand Before Generic Drugs on the Preferred Drug List

PA requests for BBG drugs on the PDL must be completed and signed by the prescriber and must be submitted using **all** of the following forms:

- Section VI (Clinical Information for Drugs with Specific Criteria Addressed in the ForwardHealth Online Handbook) of the PA/DGA form
- The PA/RF
- Any other drug- or drug class-specific PA request form that would be required for the brand equivalent drug or applicable drug class

Pharmacy providers may submit PA requests for BBG drugs on the PDL on the Portal, by fax, or by mail (but **not** using the STAT-PA system).

Topic #2017

Brand Medically Necessary Drugs: A Pharmacy Provider's Responsibilities

Pharmacy providers are required to submit the completed PA/BMNA (Prior Authorization/Brand Medically Necessary

Attachment, F-11083 (04/17)) form received from the prescriber for BMN (brand medically necessary) drugs requiring PA (prior authorization) and a completed PA/RF (Prior Authorization Request Form, F-11018 (05/13)) to ForwardHealth. Pharmacy providers may submit PA requests for BMN drugs requiring PA on the Portal, by fax, or by mail (but **not** using the STAT-PA (Specialized Transmission Approval Technology-Prior Authorization) system.)

To obtain BMN PA, pharmacies are required to do the following:

- Obtain a prescription with "brand medically necessary" written in the prescriber's own handwriting either directly on the prescription or on a separate order attached to the original prescription.
- Receive the completed, signed, and dated PA/BMNA form from the prescriber.
- Complete a PA/RF to be submitted with the PA/BMNA form.

Documentation on the PA/BMNA form regarding the following may come from the pharmacy or the prescriber:

- The names of the manufacturers of the generic drugs that were taken
- The NDCs (National Drug Codes) for the generic drugs that were taken
- The approximate dates the generic and brand drugs were taken

Note: For appropriate reimbursement, pharmacy providers are required to submit claims with a "1" in the DAW (Dispense As Written)/Product Selection Code, as appropriate.

ForwardHealth does not require pharmacy providers to submit a copy of the BMN prescription or order attachment with the PA request. Pharmacy providers should retain the prescription, and if applicable, the order attachment, for all BMN drugs with the prescriber's handwritten certification of "brand medically necessary" in their pharmacy records. Pharmacy providers are required to ensure all necessary documentation is obtained before submission of the PA request. Pharmacy providers who receive BMN PA for brand name drugs requiring PA or for drugs subject to BMN policy may be subject to audits at any time. Pharmacy providers are also required to retain a completed, signed, and dated copy of the PA forms and any additional supporting documentation received from the prescriber and produce it for and/or submit it to ForwardHealth upon request. ForwardHealth may deny or recoup payment for claims submitted that do not meet BMN PA or policy requirements.

Pharmacy providers may submit an amendment request to ForwardHealth to amend an approved or modified BMN PA request.

Topic #2016

Brand Medically Necessary Drugs: A Prescriber's Responsibilities

As required in Wis. Admin. Code § DHS 107.10(3)(c) when a prescription is for a BMN (brand medically necessary) drug, the prescriber is required to handwrite "brand medically necessary" directly on the prescription. ForwardHealth also allows the required statement to be handwritten 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. Blanket authorization for an individual member, drug, or prescriber is not acceptable documentation.

Prescribers are also required to complete a PA/BMNA (Prior Authorization/Brand Medically Necessary Attachment, F-11083 (04/17)) form for BMN drugs that require PA (prior authorization). The PA/BMNA form must include accurate and complete answers and clinical information about the member's medical history and must include the prescriber's handwritten signature and date.

The PA/BMNA form may be faxed or mailed to the pharmacy, or the member may carry the form with the prescription to the pharmacy. The pharmacy provider will use the completed PA/BMNA form to submit a PA request to ForwardHealth. Prescribers should **not** submit the PA/BMNA form to ForwardHealth.

Prescribers are required to retain a completed, signed, and dated copy of the PA form and any supporting documentation.

The following drugs are subject to BMN policy but do not require PA:

- Anticonvulsants — included on the PDL (Preferred Drug List) Quick Reference in the anticonvulsants drug class
- Cellcept
- Certain thyroid hormones
- Contraceptives
- Coumadin
- Lanoxin
- Neoral
- Prograf

Prescribers are still required to handwrite "brand medically necessary" on the prescription for the above drugs either directly on the prescription or on a separate order attached to the original prescription, and pharmacy providers are required to submit a DAW (Dispense as Written)/Product Selection Code 1 (Substitution not allowed by prescriber) for the above drugs. The completion of the PA/BMNA form for the drugs listed above is not required.

The Brand Medically Necessary Drugs and Brand Before Generic Drugs data table provides the most current list of the BMN drugs that require PA.

Clinical Criteria for Brand Medically Necessary Drugs That Require Prior Authorization

Clinical criteria for approval of a BMN drug that requires PA are **all** of the following:

- The drug has been defined by ForwardHealth as a brand drug that requires BMN PA.
- The member satisfies established coverage and PA policy for the generic equivalent drug.
- The prescriber submits detailed documentation of the member's relevant medication treatment history.
- The member has taken the requested BMN drug for at least 30 consecutive days and had a measurable therapeutic response. (*Note:* Documentation of approximate dates taken may come from the pharmacy or the prescriber.)
- The prescriber has indicated how the BMN drug will prevent recurrence of an unsatisfactory therapeutic response or clinically significant adverse drug reaction.
- The member has experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction to the generic equivalent drug from at least two different manufacturers.

  For each generic trial, the following must be documented:

  - Generic drug manufacturer or NDC (National Drug Code) (*Note:* Documentation may come from the pharmacy or the prescriber.)
  - Approximate dates taken (*Note:* Documentation may come from the pharmacy or the prescriber.)
  - A description of the unsatisfactory therapeutic response or clinically significant adverse drug reaction that can be directly attributed to the generic equivalent drug

Note: Member or prescriber preference for the use of a BMN drug will not be considered as criteria to support the need for a BMN drug.

Brand Medically Necessary Drugs with Generic Equivalents on the Preferred Drug List

In addition to meeting the clinical criteria for BMN drugs that require PA, existing PDL policies will apply to BMN drugs with

generic equivalents on the PDL. This includes, but is not limited to, policy pertaining to drug classes that require step therapy, drugs that require clinical PA, and drugs that have non-preferred generic equivalents.

In addition to completing the PA/BMNA form for BMN drugs requiring PA, the prescriber is required to complete any other required drug- or drug-class-specific PA form and provide any medical records and/or documentation required for the generic equivalent drug or applicable drug class. Examples include, but are not limited to, the following:

- A BMN drug, where its non-preferred generic equivalent requires a specific PA form
- A drug or drug class that requires specific medical records and/or documentation to be submitted with the PA request

For example, if a prescriber requests BMN PA for a brand drug and the non-preferred generic equivalent drug's PDL PA criteria requires the use of at least two PDL preferred drugs in the same drug class with an unsatisfactory therapeutic response or clinically significant adverse drug reaction, this requirement must also be met before a PA request can be approved for the brand name drug.

The Preferred Drug List Quick Reference provides the most current list of preferred and non-preferred drugs.

Topic #2012

Titration

A prescriber who titrates a BMN (brand medically necessary) drug requiring PA (prior authorization) for a member may request more than one strength of the drug on a PA/BMNA (Prior Authorization/Brand Medically Necessary Attachment, F-11083 (04/17)) form. The prescriber should handwrite "brand medically necessary" on each prescription for each strength of the titrated BMN drug requiring PA directly on the prescription or on a separate order attached to the original prescription sent to the pharmacy 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 (05/13)).

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 #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 their 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, they 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. When correcting errors, providers only need to address the items identified in the returned provider review letter or the amendment provider review letter. Providers are not required to resubmit PA information already submitted to ForwardHealth.

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 their 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 (05/13)), 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 (05/13)).
- 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 their 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	XXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX.XX	XXXXX.XX
XXXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXX	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	XXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX.XX	XXXXX.XX
XXXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXX	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 responds 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.

Diabetic Supplies

Topic #16457

Requesting Prior Authorization for Non-preferred Diabetic Supplies

Providers may submit PA (prior authorization) requests for non-preferred blood glucose meters and test strips. To receive PA for non-preferred blood glucose meters and test strips, members are required to meet **one** of the following clinical criteria:

- The member uses an insulin pump that requires the use of a non-preferred meter.
- The member has a medical condition, such as visual impairment, that requires the use of a specialized (talking) non-preferred meter.
- The member is unable to use a product from each of the preferred manufacturers, and there is clinical rationale to support the use of a non-preferred product.

If clinical criteria for non-preferred blood glucose meters and/or test strips are met, initial PA requests may be approved for up to one year.

Providers may refer to the Diabetic Supply List Quick Reference on the Pharmacy Resources page of the Providers area of the Portal for the most current list of covered preferred diabetic supplies.

Providers must submit a PA request using the Prior Authorization Drug Attachment for Blood Glucose Meters and Test Strips (F-00239 (12/13)). PA requests may be submitted using the Portal, by fax, or by mail.

Members do not have appeal rights for noncovered diabetic supplies.

Diagnosis-Restricted Drugs

Topic #15537

Diagnosis-Restricted Drugs

Prescribers are required to indicate a diagnosis on prescriptions for all drugs that are identified by ForwardHealth as diagnosis-restricted. If a diagnosis is not indicated on the prescription, pharmacy providers should contact the prescriber to obtain the diagnosis and document the diagnosis on the prescription or pharmacy health care record. It is not acceptable for pharmacy providers to obtain the diagnosis from the member.

The diagnosis submitted on a claim must also be verifiable within the member's prescription record or pharmacy health care record. Upon retrospective review, ForwardHealth may seek recoupment for the payment of the prescription from the pharmacy if the prescription record or pharmacy health care record does not document that the diagnosis submitted on the claim was provided by the prescriber.

Refer to the Diagnosis Restricted Drugs data table for a list of diagnosis-restricted drugs.

Prescribers are required to complete the appropriate section(s) of the PA/DGA (Prior Authorization/Drug Attachment, F-11049 (07/16)) as it pertains to the drug being requested.

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 Wis. Admin. Code DHS 101.03(52) 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 DMS (Division of Medicaid Services) 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 DMS. All telephone consultations for urgent services should be directed to Provider Services at 800-947-9627. Providers should have the following information ready when calling:

- Member's name
- Member ID 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 necessary information. 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 their 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 their 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 their 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 to submit a claim for the service, the provider should submit the following to ForwardHealth after the service 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	XXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX.XX	XXXXX.XX
XXXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXX	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, they can enter the number to retrieve the PA information. If the provider does not know the PA number, they 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 (05/13)), PA/DRF (Prior Authorization/Dental Request Form, F-11035 (07/12)), or PA/HIAS1 (Prior Authorization Request for Hearing Instrument and Audiological Services, F-11020 (05/13))
- A service-specific PA attachment(s)
- Additional supporting clinical documentation (Typical PA requirements regarding attachments may not apply for some HealthCheck "Other Services" PA requests.)

Topic #446

Attachments

In addition to the PA/RF (Prior Authorization Request Form, F-11018 (05/13)), PA/HIAS1 (Prior Authorization for Hearing Instrument and Audiological Services 1, F-11020 (05/13)), 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 PA Via the Portal

Certain providers may complete the PA/RF (Prior Authorization Request Form, F-11018 (05/13)) 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 (07/16)) form 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 (05/13)) 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 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 (Wis. Admin. Code § DHS 104.02[4]).

Under Wis. Stat. § 49.45(4), 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 (05/13)) 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.

Element 6a — Name — Prescribing / Referring / Ordering Provider
Enter the prescribing provider's name.

Element 6b — National Provider Identifier — Prescribing / Referring / Ordering Provider
Enter the prescribing provider's 10-digit NPI.

SECTION II — MEMBER INFORMATION

Element 7 — 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 8 — Date of Birth — Member
Enter the member's date of birth in MM/DD/CCYY format.

Element 9 — 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 10 — Name — Member
Enter the member's last name, followed by their 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 11 — Gender — Member
Enter an "X" in the appropriate box to specify male or female.

SECTION III — DIAGNOSIS / TREATMENT INFORMATION

Element 12 — Diagnosis — Primary Code and Description
Enter the appropriate ICD (International Classification of Diseases) diagnosis code and description with the highest level of specificity most relevant to the service/procedure requested. The ICD diagnosis code must correspond with the ICD description.

Element 13 — Start Date — SOI (spell of illness) (not required)

Element 14 — First Date of Treatment — SOI (not required)

Element 15 — Diagnosis — Secondary Code and Description
Enter the appropriate secondary ICD diagnosis code and description with the highest level of specificity most relevant to the service/procedure requested, if applicable. The ICD diagnosis code must correspond with the ICD description.

Element 16 — 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 17 — Rendering Provider Number
Enter the provider ID of the provider who will be performing the service, only if this number is different from the billing provider ID listed in Element 5a.

Element 18 — 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 19 — Service Code
Enter the appropriate NDC (National Drug Code) for each service/procedure/item requested.

Element 20 — Modifiers
Enter the modifier(s) corresponding to the service code listed if a modifier is required.

Element 21 — POS
Enter the appropriate place of service code designating where the requested item would be provided/performed/dispensed.

Element 22 — Description of Service
Enter a written description corresponding to the appropriate NDC for each item requested.

Element 23 — QR

Enter the appropriate quantity (e.g., days' supply) requested for the procedure code listed.

Element 24 — 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 Wisconsin DHS (Department of Health Services).

Element 25 — Total Charges
Enter the anticipated total charges for this request.

Element 26 — Signature — Requesting Provider
The original signature of the provider requesting/performing/dispensing this service/procedure/item must appear in this element.

Element 27 — Date Signed
Enter the month, day, and year the PA/RF was signed (in MM/DD/CCYY format).

Sample PA/RF for Pharmacy Services

DEPARTMENT OF HEALTH SERVICES
ForwardHealth
F-11018 (05/13)

STATE OF WISCONSIN
DHS 106.03(4), Wis. Admin. Code
DHS 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, 313 Blettner Boulevard, Madison, WI 53784. **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	(555) 555-5555

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

6a. Name — Prescribing / Referring / Ordering Provider	6b. National Provider Identifier — Prescribing / Referring / Ordering Provider
I.M. PRESCRIBING PROVIDER	0111111110

SECTION II — MEMBER INFORMATION

7. Member Identification Number	8. Date of Birth — Member	9. Address — Member (Street, City, State, ZIP Code)
1234567890	MM/DD/CCYY	322 RIDGE ST ANYTOWN WI 55555

10. Name — Member (Last, First, Middle Initial)	11. Gender — Member
MEMBER, IM A	❑ Male ☒ Female

SECTION III — DIAGNOSIS / TREATMENT INFORMATION

12. Diagnosis — Primary Code and Description	13. Start Date — SOI	14. First Date of Treatment — SOI
I48.91 — Unspecified atrial fibrillation		

15. Diagnosis — Secondary Code and Description	16. Requested PA Start Date
	MM/DD/CCYY

17. Rendering Provider Number	18. Rendering Provider Taxonomy Code	19. Service Code	20. Modifiers 1	2	3	4	21. POS	22. Description of Service	23. QR	24. Charge
		00056-0172-70					01	Coumadin 5mg tablet	365	XXX.XX

An approved authorization does not guarantee payment. Reimbursement is contingent upon enrollment of the member and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after the authorization expiration date. Reimbursement will be in accordance with ForwardHealth payment methodology and policy. If the member is enrolled in a BadgerCare Plus Managed Care Program at the time a prior authorized service is provided, ForwardHealth reimbursement will be allowed only if the service is not covered by the Managed Care Program.

25. Total Charges	XXX.XX

26. **SIGNATURE** — Requesting Provider	27. Date Signed
I.M. Requesting Provider	MM/DD/CCYY

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 (Wis. Admin. Code § DHS 104.02[4]).

Under Wis. Stat. § 49.45(4), 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 (05/13)) 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.

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.

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.

Element 6a — Name — Prescribing / Referring / Ordering Provider

Enter the prescribing/referring/ordering provider's name.

Element 6b — National Provider Identifier — Prescribing / Referring / Ordering Provider
Enter the prescribing/referring/ordering provider's 10-digit NPI.

SECTION II — MEMBER INFORMATION

Element 7 — 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 8 — Date of Birth — Member
Enter the member's date of birth in MM/DD/CCYY format.

Element 9 — 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 10 — Name — Member
Enter the member's last name, followed by their 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 11 — Gender — Member
Enter an "X" in the appropriate box to specify male or female.

SECTION III — DIAGNOSIS / TREATMENT INFORMATION

Element 12 — Diagnosis — Primary Code and Description
Enter the appropriate ICD (International Classification of Diseases) diagnosis code and description with the highest level of specificity most relevant to the service/procedure requested. The ICD diagnosis code must correspond with the ICD description.

Element 13 — Start Date — SOI (not required)

Element 14 — First Date of Treatment — SOI (not required)

Element 15 — Diagnosis — Secondary Code and Description
Enter the appropriate secondary ICD diagnosis code and description with the highest level of specificity most relevant to the service/procedure requested, if applicable. The ICD diagnosis code must correspond with the ICD description.

Element 16 — Requested PA Start Date
Enter the requested start DOS (date of service) in MM/DD/CCYY format.

Element 17 — 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 18 — 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 19 — Service Code (not required)

Element 20 — Modifiers (not required)

Element 21 — POS
Enter the appropriate place of service code designating where the requested item would be provided/performed/dispensed.

Element 22 — Description of Service
Enter the drug name and dose for each item requested (e.g., drug name, milligrams, capsules).

Element 23 — QR
Enter the appropriate quantity (e.g., days' supply) requested for each item requested.

Element 24 — Charge (not required)

Element 25 — Total Charges (not required)

Element 26 — Signature — Requesting Provider
The original signature of the provider requesting this item must appear in this element.

Element 27 — Date Signed
Enter the month, day, and year the PA/RF was signed (in MM/DD/CCYY format).

Topic #15937

Prior Authorization/Drug Attachment

When completing the PA/DGA (Prior Authorization/Drug Attachment, F-11049 (07/16)) form, prescribers should complete the most appropriate section as it pertains to the drug being requested. The specific sections are as follows:

- HealthCheck "Other Services" drug requests
- Diagnosis-restricted drug requests
- Drugs with specific PA (prior authorization) criteria addressed in the Online Handbook
- Other drug requests

Prescribers are required to fill out the appropriate section(s), then provide a handwritten signature and date on the PA/DGA form. Once completed, the prescriber should send the PA/DGA form to the pharmacy. The pharmacy should complete a PA/RF (Prior Authorization Request Form, F-11018 (05/13)) and submit it to ForwardHealth, along with the PA/DGA form from the prescriber.

Clinical Information for HealthCheck "Other Services" Drug Requests

If the prescriber writes a prescription for a drug that is not covered under the member's ForwardHealth benefit plan, the prescriber is required to document the clinical rationale to support the medical necessity of the drug being requested through a HealthCheck "Other Services" PA request. Documentation of previous treatments and detailed reasons why other covered drug treatments were discontinued or not used are required. Medical records and peer-reviewed medical literature should be provided as necessary to support the PA request. This information should be documented in Section IV (Clinical Information for HealthCheck "Other Services" Drug Requests) of the PA/DGA form.

When completing the PA/DGA form, prescribers should provide the diagnosis code and description, complete Section IV, and use Section VIII (Additional Information), if needed. Prescribers are reminded to provide a handwritten signature and date on the form before submitting it to the pharmacy provider where the prescription will be filled. The pharmacy provider is required to complete a PA/RF before submitting the forms and supporting documentation to ForwardHealth. Prescribers should **not** submit PA/DGA forms to ForwardHealth.

Note: All HealthCheck "Other Services" drug PA requests must also include the date of the member's most recent HealthCheck screen, along with the name of the HealthCheck screener (who is required to be Medicaid-enrolled). HealthCheck "Other Services" is limited to members under 21 years of age.

Clinical Information for Diagnosis-Restricted Drug Requests

If the prescriber writes a prescription with a diagnosis outside the ForwardHealth-allowed diagnoses for a drug, the prescriber is required to include peer-reviewed medical literature to support the proven efficacy and safety of the requested use of the drug. Documentation of previous treatments and detailed reasons why other covered drug treatments were discontinued or not used are required. Medical records should be provided as necessary to support the PA request. This information should be documented in Section V (Clinical Information for Diagnosis-Restricted Drug Requests) of the PA/DGA form.

When completing the PA/DGA form, prescribers should provide the diagnosis code and description, complete Section V, and use Section VIII (Additional Information), if needed. Prescribers are reminded to provide a handwritten signature and date on the form before submitting it to the pharmacy provider where the prescription will be filled. The pharmacy provider is required to complete a PA/RF before submitting the forms and supporting documentation to ForwardHealth. Prescribers should **not** submit PA/DGA forms to ForwardHealth.

Clinical Information for Drugs With Specific Criteria Addressed in the ForwardHealth Online Handbook

If a prescriber writes a prescription for one of the following drugs, a PA request must be submitted on the PA/DGA form:

- Abilify MyCite
- Ampyra
- BBG drugs (brand before generic)
- Cayston
- Crinone
- Cystic fibrosis drugs containing ivacaftor
- Diacomit
- Dupixent
- Emflaza
- Emgality 100 mg
- Endari
- Hetlioz
- Hypoglycemics, GLP-1 (glucagon-like peptide) agents—combinations
- Jublia and Kerydin
- Jynarque
- Lipotropics, ACL (Adenosine Triphosphate-Citrate Lyase) inhibitors
- Lipotropics, apo-B (apolipoprotein B) inhibitors
- Luxturna
- Methamphetamine
- Misoprostol
- Palynziq
- Spinraza
- Strensiq
- Takhzyro
- TOBI inhalation solution
- TOBI Podhaler
- Tobramycin solution
- Vigadrone
- Zolgensma

This information should be documented using Section VI (Clinical Information for Drugs With Specific Criteria Addressed in the ForwardHealth Online Handbook) of the PA/DGA form.

When completing the PA/DGA form, prescribers should provide the diagnosis code and description, complete Section VI, and use Section VIII (Additional Information), if needed. Prescribers are reminded to provide a handwritten signature and date on the form before submitting it to the pharmacy provider where the prescription will be filled. The pharmacy provider is required to complete a PA/RF before submitting the forms and supporting documentation to ForwardHealth. Prescribers should **not** submit PA/DGA forms to ForwardHealth.

Clinical Information for Other Drug Requests

If the prescriber writes a prescription for a drug that requires the use of the PA/DGA form and has not been previously referenced in the above PA/DGA sections, the prescriber is required to document the clinical rationale to support the medical necessity of the drug being requested. Documentation of previous treatments and detailed reasons why other covered drug treatments were discontinued or not used are required. In addition, if the drug requested is a non-preferred PDL (Preferred Drug List) drug, prescribers are required to specifically address why other preferred PDL drugs cannot be used. Medical records and peer-reviewed medical literature should be provided as necessary to support the PA request. This information should be documented in Section VII (Clinical Information for Other Drug Requests) of the PA/DGA form.

If the pharmacy submitting the PA request is an out-of-state pharmacy providing a non-emergency service and the drug being requested does not have specific PA criteria established, additional documentation is required to be submitted. PA request documentation must demonstrate that the member has a medical condition for which the requested drug has FDA (Food and Drug Administration) approval (medical records must be provided to verify the member's medical condition). Additionally, the drug must be prescribed in a dose and manner consistent with the FDA-approved product labeling.

When completing the PA/DGA form, prescribers should provide the diagnosis code and description, complete Section VII, and use Section VIII (Additional Information), if needed. Prescribers are reminded to provide a handwritten signature and date on the form before submitting it to the pharmacy provider where the prescription will be filled. The pharmacy provider is required to complete a PA/RF before submitting the forms and supporting documentation to ForwardHealth. Prescribers should **not** submit PA/DGA forms to ForwardHealth.

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

Note: For assistance in identifying PDL drugs that require completion of Section VI and Section VII of the PA/DGA form, providers may refer to the Preferred Drug List Quick Reference.

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 may designate a separate address for PA correspondence using the demographic maintenance tool.

Topic #2334

Drugs

Wisconsin Medicaid has the authority to require PA (prior authorization) for certain drug products under Wis. Admin. Code § DHS 107.10(2) 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.

Most drug PAs are not pharmacy provider-specific. For most approved drug PA requests, the member may go to any Medicaid-enrolled pharmacy provider to obtain the prior authorized drug. For these drug PAs, the PA does not need to be enddated when the member changes pharmacies.

Hepatitis C agents included in the hepatitis C agents drug class on the PDL are approved as pharmacy provider-specific.

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 (05/13)), 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 (for example, 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 = eviCore healthcare
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 4 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 Wis. Admin. Code ch. DHS 107 for information regarding services that require PA. According to Wis. Admin. Code § DHS 107.02(3)(b), 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 Wisconsin 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 out-of-state providers when nonemergency services are necessary to help a member attain or regain their 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 ForwardHealth'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 provider, the referring provider should instruct the out-of-state provider to go to the Provider Enrollment Information home page on the ForwardHealth Portal to complete a Medicaid Out-of-State Provider Enrollment Application.

All out-of-state nursing homes, regardless of location, are required to obtain PA for all services. All other out-of-state nonborder-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 Websites

The ForwardHealth Portal allows providers access to all policy and billing information for BadgerCare Plus, Medicaid, SeniorCare, ADAP (Wisconsin AIDS Drug Assistance Program), 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 websites 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 Brief Overview of the Preferred Drug List

ForwardHealth makes recommendations to the Wisconsin Medicaid Pharmacy PA (Prior Authorization) Advisory Committee on whether certain PDL (Preferred Drug List) drugs should be preferred or non-preferred. These recommendations are based primarily on objective evaluations of a drug's relative safety, effectiveness, clinical outcomes, and relative cost (to Wisconsin Medicaid) in comparison with other therapeutically interchangeable alternative agents in the same drug class.

New drugs are usually added to existing drug classes on the PDL as non-preferred drugs until their next scheduled class review by the Wisconsin Medicaid Pharmacy PA Advisory Committee.

The PDL is not a drug formulary and is not a comprehensive list of covered drugs.

Most drugs and drug classes included on the PDL are covered by BadgerCare Plus, Wisconsin Medicaid, and SeniorCare, but certain drugs may have restrictions (for example, diagnosis restrictions, quantity limits, age limits). Prescribers are encouraged to write prescriptions for preferred drugs if medically appropriate. Non-preferred drugs may be covered with an approved PA request. Most preferred drugs do not require PA except in designated classes identified on the Preferred Drug List Quick Reference. Noncovered drugs (for example, drugs used for hair loss or cosmetic purposes) are not reimbursed, even with PA.

Topic #10937

A Pharmacy Provider's 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 do the following:

- Submit the PA request using the PA form received from the prescriber and the PA request submission option most appropriate for the drug. Pharmacy providers may submit PA requests using the STAT-PA (Specialized Transmission Approval Technology-Prior Authorization) system (when applicable), on the Portal, by fax, or by mail.
- Retain a completed, signed, and dated copy of the PA form and any supporting documentation received from the prescriber.

Pharmacy providers may **not** reuse PA forms from previously approved PA requests for subsequent PA request submissions.

Note: If additional information needs to be addressed and can be provided by the pharmacy provider (for example, medication refill history and compliance), the pharmacy provider should add the information to the Prior Authorization Fax Cover Sheet (F-01176 (12/11)) or to the Additional Information section available on most PA forms. The representative for the pharmacy

provider should sign and date the entry to clearly identify the information source.

Topic #1987

A Prescriber's Responsibilities for Prior Authorization for Preferred Drug List Drugs

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.

Prescribers are required to provide clinical information so that pharmacy providers can request and obtain PA (prior authorization). Prescribers are required to complete the PA/PDL Exemption Request (Prior Authorization/Preferred Drug List Exemption Request, F-11075 (09/13)) form for non-preferred drugs that do not require a drug- or drug class-specific PA form.

Clinical Criteria for Non-Preferred Drugs

Clinical criteria for approval of a PA request for a non-preferred drug are **at least one** of the following, unless drug class-specific clinical criteria have been established and published by ForwardHealth:

- The member has experienced an unsatisfactory therapeutic response or a clinically significant adverse drug reaction with **at least one** of the preferred drugs from the same PDL (Preferred Drug List) drug class as the drug being requested.
- There is a clinically significant drug interaction between another drug the member is taking and **at least one** of the preferred drugs from the same PDL drug class as the drug being requested.
- The member has a medical condition(s) that prevents the use of **at least one** of the preferred drugs from the same PDL drug class as the drug being requested.

Alternate Clinical Criteria for Non-Preferred Drugs in Eligible Drug Classes Only

The following drug classes have alternate clinical criteria that may be considered if the member does not meet the previously listed clinical criteria for non-preferred drugs:

- Alzheimer's agents drug class
- Anticonvulsants drug class
- Antidepressants, other drug class
- Antidepressants, SSRI (selective serotonin reuptake inhibitor) class
- Antiparkinson's agents drug class
- Antipsychotics drug class
- Pulmonary arterial hypertension drug class

Alternate clinical criteria may be considered if a member does not meet the previously listed clinical criteria for non-preferred drugs. Alternate clinical criteria are **one** of the following:

- The member is new to ForwardHealth (that is, the member has been granted eligibility for ForwardHealth within the past month) and has taken the requested non-preferred drug continuously for the last 30 days or longer and had a measurable therapeutic response.
- The member had an approved PA request issued by ForwardHealth that recently expired for the non-preferred drug, and the member has taken the requested non-preferred drug continuously for the last 30 days or longer and had a measurable therapeutic response.

- The member was recently discharged from an inpatient stay in which the member was stabilized on the non-preferred drug being requested.

Note: Starting a member on a medication by using manufacturer-provided samples or manufacturer patient assistance programs will not be considered as previous medication history for PA review.

Completing a PA Form

If a non-preferred drug or a preferred drug that requires clinical PA is medically necessary for a member, the prescriber is required to do the following:

- Complete the appropriate PA form for the drug
- Include accurate and complete answers and clinical information about the member's medical history on the PA form
- Provide the prescriber's handwritten signature and the date on the form

The PA form must be sent to the pharmacy where the prescription will be filled. The prescriber may send the PA form to the pharmacy, or the member may carry the PA form with the prescription to the pharmacy. 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. Pharmacy providers may **not** reuse PA forms from previously approved PA requests for subsequent PA request submissions.

Note: If additional information needs to be addressed and can be provided by the pharmacy provider (for example, medication refill history and compliance), the pharmacy provider should add the information to the Prior Authorization Fax Cover Sheet (F-01176 (12/11)) or to the Additional Information section available on most PA forms. The representative for the pharmacy provider should sign and date the entry to clearly identify the information source.

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, Medicaid, and SeniorCare members
- Noncovered for BadgerCare Plus, Medicaid, and SeniorCare (e.g., OTC (over-the-counter) drugs, drugs without signed manufacturer rebate agreements, convenience or combination packaged drugs, drugs terminated by 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.

Convenience and combination packaged drugs are not covered by ForwardHealth.

Topic #15037

Alzheimer's Agents

Note: The Preferred Drug List Quick Reference provides the most current list of preferred and non-preferred drugs in this drug

class.

Memantine Products and Namenda Products

Because the safety and effectiveness of all memantine products and Namenda products for pediatric patients has not been established, coverage will be restricted to adult members who are 18 years of age or older.

ForwardHealth will not cover memantine products and Namenda products for members 17 years of age or younger. PA (prior authorization) requests submitted for memantine products and Namenda products for members 17 years of age or younger will be returned as a noncovered service. Members do not have appeal rights for noncovered services.

Memantine Products and Namenda Products Policy Exceptions

Effective for DOS (dates of service) from July 1, 2014, to December 31, 2016, BadgerCare Plus, Medicaid, and SeniorCare members who were 44 years of age or younger and were taking Namenda (as identified from claims history) prior to February 15, 2013, were allowed to continue receiving memantine, Namenda, or Namenda XR products without PA. Those members who remained eligible in 2017 and 2018 to receive these products without PA will no longer be eligible to continue receiving memantine, memantine ER, Namenda, or Namenda XR without PA for DOS on and after January 1, 2019, if **one** of the following is true:

- They do not have other primary insurance on file with ForwardHealth and have no claim activity for any memantine, memantine ER, Namenda, or Namenda XR products for DOS in the last six months of 2018.
- They have other primary insurance on file with ForwardHealth and have no claim activity for any memantine, memantine ER, Namenda, or Namenda XR products for any DOS in 2018.

The remaining previously identified BadgerCare Plus, Medicaid, and SeniorCare members with active claim activity will be allowed to continue receiving memantine, memantine ER, Namenda, or Namenda XR products without PA until further notice.

Topic #17084

Angiotensin Modulators, ACE Inhibitors

Note: The Preferred Drug List Quick Reference provides the most current list of preferred and non-preferred drugs in this drug class.

Epaned

PA (prior authorization) is not required for Epaned for members who are 12 years of age or younger. However, for members who are 13 years of age or older, PA is required for Epaned.

Topic #9837

Antibiotics, Inhaled

Note: The Preferred Drug List Quick Reference provides the most current list of preferred and non-preferred drugs in this drug class.

Preferred drugs in the antibiotics, inhaled drugs class do not require PA (prior authorization).

Tobramycin Solution, TOBI Inhalation Solution, TOBI Podhaler, and Cayston

Tobramycin solution, TOBI Inhalation Solution, TOBI Podhaler, and Cayston are non-preferred drugs in the antibiotics, inhaled drug class.

PA requests for tobramycin solution, TOBI Inhalation Solution, TOBI Podhaler, and Cayston must be completed and signed by the prescriber. PA requests for tobramycin solution, TOBI Inhalation Solution, TOBI Podhaler, and Cayston should be submitted using Section VI (Clinical Information for Drugs With Specific Criteria Addressed in the ForwardHealth Online Handbook) of the PA/DGA (Prior Authorization/Drug Attachment, F-11049 (07/16)) form and the PA/RF (Prior Authorization Request Form, F-11018 (05/13)).

PA requests for tobramycin solution, TOBI Inhalation Solution, TOBI Podhaler, and Cayston may be submitted on the Portal, by fax, or by mail. PA requests for tobramycin solution, TOBI Inhalation Solution, TOBI Podhaler, and Cayston may **not** be submitted using the STAT-PA (Specialized Transmission Approval Technology-Prior Authorization) system.

The following indicate how PA requests for tobramycin solution, TOBI Inhalation Solution, TOBI Podhaler, and Cayston will be approved when clinical criteria have been met:

- PA requests will be approved for up to a maximum 28-day supply per dispensing.
- PA requests will be approved with an alternating 28-day treatment schedule of 28 days of tobramycin solution, TOBI Inhalation Solution, TOBI Podhaler, or Cayston treatment with 28 days of no inhaled antibiotics/anti-infective agents.

Clinical Criteria for Tobramycin Solution, TOBI Inhalation, and TOBI Podhaler

Clinical criteria that must be documented for approval of a PA request for tobramycin solution, TOBI Inhalation Solution, or TOBI Podhaler are **all** of the following:

- The member has cystic fibrosis.
- The member is 6 years of age or older.
- The prescriber has confirmed that the member has a positive sputum culture for Pseudomonas aeruginosa. Prescribers are required to include a copy of the sputum culture report with all PA requests.
- The prescriber has confirmed that the member is not colonized with Burkholderia cepacia.
- The member's sputum culture shows susceptibility to tobramycin.
- The member's FEV1 (forced expiratory volume in one second) is less than 90 percent predicted. Prescribers are required to include the member's most recent, complete pulmonary function test report.
- The member is not receiving treatment with other inhaled antibiotics/anti-infective agents, including alternating treatment schedules. Prescribers are required to provide a history of all inhaled antibiotics/anti-infective agents within the most recent 90-day period.
- The prescriber has submitted detailed clinical justification for prescribing tobramycin solution, TOBI Inhalation Solution, or TOBI Podhaler instead of Bethkis or Kitabis Pak, including clinical information describing why the member cannot use Bethkis or Kitabis Pak and why it is medically necessary that the member receive tobramycin solution, TOBI Inhalation Solution, or TOBI Podhaler instead of Bethkis or Kitabis Pak.
- The member has been adherent with their prescribed treatment plan for inhaled medications.

Initial and renewal PA requests for tobramycin solution, TOBI Inhalation Solution, and TOBI Podhaler may be approved for up to 168 days.

Renewal PA requests for tobramycin solution, TOBI Inhalation Solution, and TOBI Podhaler require that the member be adherent with their inhaled antibiotic treatment.

Clinical Criteria for Cayston

Clinical criteria that must be documented for approval of a PA request for Cayston are **all** of the following:

- The member has cystic fibrosis.
- The member is 6 years of age or older.
- The prescriber has confirmed that the member has a positive sputum culture for Pseudomonas aeruginosa. Prescribers are required to include a copy of the sputum culture report with all PA requests.
- The prescriber has confirmed that the member is not colonized with Burkholderia cepacia.
- The member's sputum culture shows susceptibility to Cayston.
- The member's FEV1 is less than 90 percent predicted. Prescribers are required to include the member's most recent, complete pulmonary function test report.
- The member is not receiving treatment with other inhaled antibiotics/anti-infective agents, including alternating treatment schedules. Prescribers are required to provide a history of all inhaled antibiotics/anti-infective agents within the most recent 90-day period.
- At least **one** of the following is true:
  - The member has previously used inhaled tobramycin and experienced a clinically significant adverse drug reaction or an unsatisfactory therapeutic response.
  - The member has a medical condition(s) that prevents the use of inhaled tobramycin.
  - The member's sputum culture shows resistance to tobramycin.
- The member has been adherent with their prescribed treatment plan for inhaled medications.

Note: Prescribers should indicate the specific details about the clinically significant adverse drug reaction(s), the unsatisfactory therapeutic response(s), the medical condition(s) preventing the member from using a preferred antibiotics, inhaled drug, or the member's sputum culture results showing resistance to tobramycin.

Initial and renewal PA requests for Cayston may be approved for up to 168 days.

Renewal PA requests for Cayston require that the member be adherent with their Cayston treatment.

Clinical Criteria for Cayston for Continuous Alternating Therapy

Clinical criteria that must be documented for approval of a PA request for Cayston for CAT (continuous alternating therapy) are **all** of the following:

- The member has cystic fibrosis.
- The member is 6 years of age or older.
- The prescriber has confirmed that the member has a positive sputum culture for Pseudomonas aeruginosa. Prescribers are required to include a copy of the sputum culture report with all PA requests.
- The prescriber has confirmed that the member is not colonized with Burkholderia cepacia.
- The member's sputum culture shows susceptibility to tobramycin and Cayston.
- The member's FEV1 is less than 90 percent predicted. Prescribers are required to include the member's most recent, complete pulmonary function test report.
- The member is experiencing persistent exacerbations or FEV1 decline with no significant improvement while using a single inhaled antibiotic drug or significant worsening of other markers that are being regularly tracked to monitor pulmonary disease progression.
- The prescriber has provided specific treatment goals for the member's CAT.
- The prescriber has provided a history of all inhaled antibiotics/anti-infective agents within the most recent 90-day period.
- The member has been adherent with their prescribed treatment plan for inhaled medications.

Note: ForwardHealth will not consider CAT as an initial choice for inhaled antibiotic therapy.

Initial and renewal PA requests for Cayston for CAT may be approved for up to 168 days.

Renewal PA requests for Cayston for CAT require that the member has been adherent with their CAT treatment. Prescribers are required to include documentation with renewal PA requests that clearly demonstrates the member has made progress toward their CAT treatment goals.

Topic #13617

Anticoagulants

Note: The Preferred Drug List Quick Reference provides the most current list of preferred and non-preferred drugs in this drug class.

Xarelto

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.

Topic #21237

Anticonvulsants

Note: The Preferred Drug List Quick Reference provides the most current list of preferred and non-preferred drugs in this drug class.

Expedited Emergency Supply for Anticonvulsants

ForwardHealth strongly encourages pharmacy providers to utilize the expedited emergency supply process for anticonvulsant drugs when it is determined that the member should begin taking the medication immediately, but the PA (prior authorization) request submission and adjudication process would delay dispensing the medication to the member. This may occur if the member receives a prescription for a covered anticonvulsant drug and the prescriber has not completed the necessary PA form or the PA request is still in process.

Expedited emergency supply PA requests for anticonvulsant drugs will be approved for up to a 14-day supply. Members will be limited to receiving two 14-day expedited emergency supply PA approvals of the same drug from one pharmacy provider within a six-month time period. A PA is not required to be in process when the first expedited emergency supply PA request is submitted.

If a second expedited emergency supply is necessary for a member, there must be a non-expedited emergency supply PA request submitted to ForwardHealth, and it must be in the process of being adjudicated. The second expedited emergency supply PA request may be approved if a non-expedited emergency supply PA request is in process for the same drug and strength and the PA is submitted by the pharmacy that submitted the first expedited emergency supply PA request.

Once a non-expedited emergency supply PA request has been approved, the second expedited emergency supply PA request will not be approved.

Requests for a second expedited emergency supply PA request may be submitted seven to 21 days after the initial request was submitted. Second expedited emergency supply PA requests will not be approved if they are submitted before day seven or after day 21.

Diacomit

PA requests for Diacomit must be completed, signed, and dated by the prescriber. PA requests for Diacomit must be submitted using Section VI (Clinical Information for Drugs With Specific Criteria Addressed in the ForwardHealth Online Handbook) of the PA/DGA (Prior Authorization/Drug Attachment, F-11049 (07/16)) form and the PA/RF (Prior Authorization Request Form, F-11018 (05/13)).

The PA form must be sent to the pharmacy where the prescription will be filled. The prescriber may send the PA form to the pharmacy, or the member may carry the PA form with the prescription to the pharmacy. 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.

PA requests for Diacomit may be submitted on the Portal, by fax, or by mail (but **not** using the STAT-PA (Specialized Transmission Approval Technology-Prior Authorization) system).

Clinical Criteria for Diacomit

Clinical criteria that must be documented for approval of a PA request for Diacomit are **both** of the following:

- The member has Dravet syndrome.
- The member must take Diacomit in combination with clobazam.

Clinical documentation and medical records must be submitted with the PA request to support the member's condition of Dravet syndrome and concurrent use of clobazam. Initial PA requests for Diacomit may be approved for up to 183 days.

Renewal PA requests may be approved for up to 365 days. Medical records must be submitted demonstrating clinical improvement and must reflect member compliance with Diacomit and clobazam.

Note: Diacomit will not be available through expedited emergency supply. Diacomit is available through emergency medication dispensing.

Epidiolex

PA requests for Epidiolex must be completed, signed, and dated by the prescriber. PA requests for Epidiolex should be submitted using the PA/PDL for Epidiolex (Prior Authorization/Preferred Drug List for Epidiolex, F-02433 (01/19)) form and the PA/RF.

The PA form must be sent to the pharmacy where the prescription will be filled. The prescriber may send the PA form to the pharmacy, or the member may carry the PA form with the prescription to the pharmacy. 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.

PA requests for Epidiolex may be submitted using the STAT-PA system, on the Portal, by fax, or by mail.

Clinical Criterion for Epidiolex

ForwardHealth has established a clinical criterion for Epidiolex.

The clinical criterion for approval of a PA request for Epidiolex is **one** of the following:

- The member has Dravet syndrome.
- The member has Lennox-Gastaut syndrome.

If the clinical criterion for Epidiolex is met, PA requests may be approved for up to 365 days.

Vigadrone

PA requests for Vigadrone must be completed, signed, and dated by the prescriber. PA requests for Vigadrone must be submitted using Section VI (Clinical Information for Drugs With Specific Criteria Addressed in the ForwardHealth Online Handbook) of the PA/DGA form and the PA/RF.

The PA form must be sent to the pharmacy where the prescription will be filled. The prescriber may send the PA form to the pharmacy, or the member may carry the PA form with the prescription to the pharmacy. 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.

PA requests for Vigadrone may be submitted on the Portal, by fax, or by mail (but **not** using the STAT-PA system).

Clinical Criteria for Vigadrone

The clinical criteria that must be documented for approval of a PA request for Vigadrone includes **both** of the following:

- The prescriber has submitted detailed clinical justification for prescribing Vigadrone instead of Sabril.
- The clinical information must document why the member cannot use Sabril, including why it is medically necessary that the member receive Vigadrone instead of Sabril.

Clinical documentation and medical records must be submitted with the PA request to support the need for Vigadrone. Initial PA requests for Vigadrone may be approved for up to 183 days.

Renewal PA requests may be approved for up to 365 days. Medical records must be submitted demonstrating clinical improvement and must reflect member compliance with Vigadrone.

Note: Vigadrone will not be available through expedited emergency supply.

Topic #8377

Antiemetics, Cannabinoids

Note: The Preferred Drug List Quick Reference provides the most current list of preferred and non-preferred drugs in this drug class.

PA (prior authorization) is required for all antiemetic, cannabinoid drugs. PA requests for antiemetics, cannabinoids drugs must be completed, signed, and dated by the prescriber. PA requests for antiemetics, cannabinoids drugs should be submitted using the Prior Authorization Drug Attachment for Antiemetics, Cannabinoids (F-00194 (07/20)) form. Clinical documentation supporting the use of antiemetics, cannabinoids drugs must be submitted with the PA request.

The PA form must be sent to the pharmacy where the prescription will be filled. The prescriber may send the PA form to the pharmacy, or the member may carry the PA form with the prescription to the pharmacy. 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.

Pharmacy providers are required to submit the completed Prior Authorization Drug Attachment for Antiemetics, Cannabinoids form and a completed PA/RF (Prior Authorization Request Form, F-11018 (05/13)) to ForwardHealth.

PA requests for antiemetics, cannabinoids drugs may be submitted on the Portal, fax, or by mail (but **not** using the STAT-PA (Specialized Transmission Approval Technology-Prior Authorization) system).

A copy of the member's current medical records must be submitted with all PA requests for antiemetics, cannabinoids drugs.

Medical records must document the member's medical work-up for the condition being treated including complete problem and medication lists.

If the clinical criteria for antiemetics, cannabinoids drugs are met, PA requests may be approved for up to 183 days.

Clinical Criteria for Dronabinol for Anorexia Associated With Weight Loss With AIDS

The clinical criteria for approval of a PA request for dronabinol for the treatment of anorexia associated with weight loss with AIDS for members who are **not** currently receiving dronabinol are **all** of the following:

- The member has AIDS.
- The member is experiencing anorexia associated with weight loss.
- **One** of the following is true:
  - The member's current BMI (body mass index) is 18.5 or greater, and the member had a 10 percent or greater decrease in weight from baseline in the past six months.
  - The member's current BMI is less than 18.5.
- The member's daily caloric intake has been optimized.

The clinical criteria for approval of a PA request for dronabinol for the treatment of anorexia associated with weight loss with AIDS for members who are currently receiving dronabinol are **one** of the following:

- The member's current BMI is less than 18.5.
- The member's current BMI is in the normal range (18.5–24.9) and has been stabilized in this range for less than six months.

Note: Members whose BMI has been stabilized in the normal range or above (18.5 or greater) for at least six months will **not** be granted a dronabinol PA renewal.

Clinical Criteria for Dronabinol and Cesamet for Chemotherapy-Related Nausea and Vomiting

The clinical criteria for approval of a PA request for dronabinol or Cesamet for the treatment of chemotherapy-related nausea and vomiting are **all** of the following:

- The member is currently receiving chemotherapy.
- The member is experiencing chemotherapy-related nausea and vomiting.
- **At least one** of the following is true:
  - The member has experienced an unsatisfactory therapeutic response or a clinically significant adverse drug reaction with ondansetron or granisetron.
  - The member is unable to take **both** ondansetron and granisetron due to one of the following:
    - There is a clinically significant drug interaction between another drug(s) the member is taking and **both** ondansetron and granisetron.
    - The member has a medical condition(s) that prevents the use of **both** ondansetron and granisetron.
- The member has experienced an unsatisfactory therapeutic response or a clinically significant adverse drug reaction with at least one of the following chemotherapy-related nausea and vomiting treatments: dexamethasone, haloperidol, lorazepam, metoclopramide, olanzapine, prochlorperazine, or promethazine.

Topic #18357

Antifungals, Topical

Note: The Preferred Drug List Quick Reference provides the most current list of preferred and non-preferred drugs in this drug class.

Jublia and Kerydin

PA (prior authorization) requests for Jublia and Kerydin must be completed and signed by the prescriber. PA requests for Jublia and Kerydin should be submitted using Section VI (Clinical Information for Drugs with Specific Criteria Addressed in the ForwardHealth Online Handbook) of the PA/DGA (Prior Authorization/Drug Attachment, F-11049 (07/16)) and the PA/RF (Prior Authorization Request Form, F-11018 (05/13)).

PA requests for Jublia and Kerydin may be submitted on the Portal, by fax, or by mail. PA requests for Jublia and Kerydin may **not** be submitted using the STAT-PA (Specialized Transmission Approval Technology-Prior Authorization) system.

Clinical Criteria for Jublia and Kerydin

Clinical criteria that must be documented for approval of a PA request for Jublia or Kerydin are **both** of the following:

- The member has onychomycosis of the toenails.
- The member has been treated with ciclopirox topical solution for 48 weeks and experienced an unsatisfactory therapeutic response.

In addition to meeting **both** of the above clinical criteria, **one** of the following must be true:

- The member has been treated with oral terbinafine and experienced an unsatisfactory therapeutic response or a clinically significant adverse drug reaction.
- There is a clinically significant drug interaction between another drug the member is taking and terbinafine.
- The member has a medical condition(s) that prevents the use of oral terbinafine.

Prescribers should indicate the specific details about the unsatisfactory therapeutic response, clinically significant adverse drug reaction, clinically significant drug interaction or the medical condition(s) preventing the member from using oral terbinafine.

PA requests for Jublia and Kerydin may be approved for up to a maximum of one year.

Topic #18457

Antipsychotics

Note: The Preferred Drug List Quick Reference provides the most current list of preferred and non-preferred drugs in this drug class.

Abilify MyCite

Abilify MyCite requires clinical PA (prior authorization).

PA requests for Abilify MyCite must be completed, signed, and dated by the prescriber. PA requests for Abilify MyCite must be submitted using Section VI (Clinical Information for Drugs With Specific Criteria Addressed in the ForwardHealth Online Handbook) of the PA/DGA (Prior Authorization/Drug Attachment, F-11049 (07/16)) form and the PA/RF (Prior Authorization Request Form, F-11018 (05/13)).

The PA form must be sent to the pharmacy where the prescription will be filled. The prescriber may send the PA form to the pharmacy, or the member may carry the PA form with the prescription to the pharmacy. 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.

PA requests for Abilify MyCite may be submitted on the Portal, by fax, or by mail (but **not** using the STAT-PA (Specialized Transmission Approval Technology-Prior Authorization) system).

Clinical Criteria for Abilify MyCite

Clinical criteria that must be documented for approval of a PA request for Abilify MyCite are **all** of the following:

- The member has a mobile device with a data plan that is compatible with the MyCite monitoring application.
- The member has attempted standard measures to improve medication adherence. The prescriber must identify what adherence measures the member has previously attempted.
- The member has previously taken oral aripiprazole and had a measurable therapeutic response. The aripiprazole dose and approximate dates taken must be documented.
- The prescriber has agreed to track and document the member's adherence with Abilify MyCite using the MyCite software program.

Clinical documentation and medical records must be submitted with the PA request to support the need for Abilify MyCite. PA requests for Abilify MyCite may be approved for up to 90 days.

PA for Antipsychotic Drugs for Children 8 Years of Age and Younger

All antipsychotic drugs prescribed for oral use for all children 8 years of age and younger require PA.

PA requests must meet the criteria for children 8 years of age and younger to allow coverage of an antipsychotic drug.

PA requests for antipsychotic drugs for children 8 years of age and younger must be submitted on the Prior Authorization Drug Attachment for Antipsychotic Drugs for Children 8 Years of Age and Younger (F-00556 (01/18)) form.

Claims submitted for an antipsychotic drug for children 8 years of age and younger without an approved Prior Authorization Drug Attachment for Antipsychotic Drugs for Children 8 Years of Age and Younger form on file will be denied.

Prescribers are encouraged to write prescriptions for preferred antipsychotic drugs.

Background

ForwardHealth monitors the use of antipsychotic drugs in young children. The PA process is intended to scrutinize the prescribing of antipsychotic drugs for mood disorders and the monitoring of metabolic effects of this class of drugs. ForwardHealth strongly encourages prescribers to earnestly engage in clarifying the differentiation between DMDD (disruptive mood dysregulation disorder) and bipolar disorder, NOS (not otherwise specified).

The increased use of antipsychotic drugs in young children over the past decade has been associated with the frequent use of the diagnosis of bipolar disorder, NOS (F31.9) per the DSM-5 (Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition) in many of these children. A discussion and review of the issues in differentiating bipolar disorder, NOS from DMDD can be found in the Journal of the American Academy of Child and Adolescent Psychiatry, Volume 52, Issue 5, May 5, 2013, pp. 466-481 (Towbin, K. MD, Axelson, D. MD, Leibenluft, E. MD, Birmaher, B. MD, "Differentiating Bipolar Disorder-Not Otherwise Specified and Severe Mood Dysregulation").

In recent years, there has been some progress in the research of these clinical issues. Specifically, the DSM-5 addresses the inclusion of DMDD (F34.8). This evolved out of the observation that many children with a diagnosis of bipolar disorder do not progress to having bipolar disorder, NOS as adults, thus bringing into question the use of antipsychotic drugs for these children. Many of the children with DMDD (or severe mood dysregulation as referenced in several research studies) respond to stimulants

and/or SSRI (selective serotonin reuptake inhibitor) antidepressants. Although SSRIs may cause mild activation when first administered, this is not necessarily mania. These antidepressants can be very effective for irritability associated with anxiety and depression in young children, and they have far fewer side effects than antipsychotic drugs. Clinicians need to be vigilant about target symptoms and strive to clarify persistent irritability as seen in DMDD versus the more classic episodic irritability typical of bipolar spectrum disorders. Clinicians who prescribe antipsychotic drugs to children with bipolar disorder, NOS diagnoses will need to become familiar with the details of the current research on differentiating DMDD from bipolar disorder, NOS.

Prescriber Responsibilities for Antipsychotic Drugs for Children 8 Years of Age and Younger

If a child is 8 years of age or younger and requires an oral antipsychotic drug, the prescriber is required to complete the Prior Authorization Drug Attachment for Antipsychotic Drugs for Children 8 Years of Age and Younger form. PA request forms 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 8 Years of Age and Younger form directly to ForwardHealth. Prescribers are required to retain a completed and signed copy of the PA form.

PA requests for covered antipsychotic drugs for children 8 years of age and younger are approved at the active ingredient level. Therefore, an approved PA request allows any covered NDC (National Drug Code) 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 tablets and the prescriber orders a new prescription for risperidone 2 mg tablets, an amended PA request or new PA request is not required.

Clinical Documentation

If the PA request for antipsychotic drugs for children 8 years of age and younger is for a member who is being treated for autism or tics, the only documentation required is the diagnosis information described in the following list. Pharmacy providers are encouraged to submit all PA requests for autism and tics using the STAT-PA system. The following clinical documentation is required on PA requests for members who are being treated for a condition other than autism or tics and must be submitted on the Portal, by fax, or by mail:

- Information about the child's diagnoses—There are appropriate indications for the use of antipsychotic drugs in young children with certain diagnoses, including autism spectrum disorders, psychotic disorders, and tic disorders. Antipsychotic drugs may also be helpful for severe symptoms of irritability, aggression, anger, or defiance that may accompany severe mood disorders, developmental disorders, or ADHD (attention-deficit hyperactivity disorder).
- BMI (body mass index) measurements—Antipsychotic drugs 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 8 Years of Age and Younger form requires the submission of a BMI percentile measurement with each PA request. The BMI percentile measurement is required because it is the standard for stratifying individuals as obese or at-risk for obesity and, therefore, requiring closer monitoring and active intervention. Children who have a BMI percentile measurement greater than or equal to 85 percent are at risk for diabetes and the metabolic syndrome associated with many antipsychotic drugs. If the child's BMI percentile is 85 percent or greater, the PA request must include a triglyceride level and a fasting glucose or HBA1c (hemoglobin A1c) drawn within the past six months for the PA request to be approved.
- Target symptoms—The prescriber is required to be very familiar with the criteria for DMDD and to clarify persistent versus episodic irritability/anxiety/anger/temper outbursts as well as to identify the presence, or absence, of comorbid conditions.
- Polypharmacy information—The Prior Authorization Drug Attachment for Antipsychotic Drugs for Children 8 Years of Age and Younger form requires documentation of the child's experience with any psychoactive drugs, concurrent drugs, as well as previous drug trials in the preceding 12 months.
- Specialty information—ForwardHealth is interested in tracking the prescriber's practice specialty information.
- Documentation for non-preferred antipsychotic drug requests—If the prescriber is requesting a non-preferred antipsychotic drug, clinical documentation must be provided to support the request and must include detailed reasons why preferred

drugs were discontinued or not utilized.

Pharmacy Responsibilities for Antipsychotic Drugs for Children 8 Years of Age and Younger

Pharmacy providers should ensure that they have received the completed Prior Authorization Drug Attachment for Antipsychotic Drugs for Children 8 Years of Age and Younger form from the prescriber.

For BadgerCare Plus and Medicaid members, pharmacy providers should review the Preferred Drug List Quick Reference for the most current list of preferred and non-preferred drugs.

If a BadgerCare Plus 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.

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 8 Years of Age and Younger form to ForwardHealth. Pharmacy providers are required to retain a completed and signed copy of the PA form.

Brand name antipsychotic drugs prescribed to children 8 years of age and younger that are BMN (brand medically necessary) require that a Prior Authorization Drug Attachment for Antipsychotic Drugs for Children 8 Years of Age and Younger form be submitted on the Portal, by fax, or by mail with the PA/BMNA (Prior Authorization/Brand Medically Necessary Attachment, F-11083 (04/17)) form and the PA/RF.

Two unique PA numbers will be assigned for a BMN antipsychotic drug. One PA number will be assigned to the Prior Authorization Drug Attachment for Antipsychotic Drugs for Children 8 Years of Age and Younger form, and the other will be assigned to the PA/BMNA form.

PA Request Submission Methods

Pharmacy providers are encouraged to use the STAT-PA system to submit PA requests for antipsychotic drugs for children who have one of the following conditions:

- Autism
- Tics

If the prescriber indicates on the Prior Authorization Drug Attachment for Antipsychotic Drugs for Children 8 Years of Age and Younger form that the child has autism or tics, no additional clinical information is required on the form, and the pharmacy may submit the request using the STAT-PA system.

PA requests cannot be submitted using the STAT-PA system if **any** of the following are true:

- The child has a condition other than autism or tics.
- The drug being requested is a non-preferred antipsychotic drug.
- The child is 2 years of age or younger.
- The PA request is for a BMN antipsychotic drug.

If the PA request is not approved through the STAT-PA system, pharmacy providers are required to submit the Prior Authorization Drug Attachment for Antipsychotic Drugs for Children 8 Years of Age and Younger form, a PA/RF, and any supporting documentation from the prescriber on the Portal, by fax, or by mail.

Approved PA Requests for Antipsychotic Drugs for Children 8 Years of Age and Younger

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 notice letters for antipsychotic drugs for children 8 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."

Expedited Emergency Supply for Antipsychotic Drugs for Children 8 Years of Age and Younger

ForwardHealth strongly encourages pharmacy providers to utilize the expedited emergency supply process for antipsychotic drugs for children 8 years of age and younger when it is determined that the member should begin taking the medication immediately, but the PA request submission and adjudication process would delay dispensing the medication to the member. This may occur if a child 8 years of age or younger receives a prescription for an antipsychotic covered drug and the prescriber has not completed the necessary PA form or the PA request is still in process.

Expedited emergency supply PA requests for antipsychotic drugs will be approved for up to a 14-day supply. Members will be limited to receiving two 14-day expedited emergency supply PA approvals of the same drug from one pharmacy provider within a six-month time period. A PA is not required to be in process when the first expedited emergency supply PA request is submitted.

If a second expedited emergency supply is necessary for a member, there must be a non-expedited emergency supply PA request submitted to ForwardHealth, and it must be in the process of being adjudicated. The second expedited emergency supply PA request may be approved if a non-expedited emergency supply PA request is in process for the same drug and strength and the PA is submitted by the pharmacy that submitted the first expedited emergency supply PA request.

Once a non-expedited emergency supply PA request has been approved, the second expedited emergency supply PA request will not be approved.

Requests for a second expedited emergency supply PA request may be submitted seven to 21 days after the initial request was submitted. Second expedited emergency supply PA requests will not be approved if they are submitted before day seven or after day 21.

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, Medicaid, and SeniorCare members
- Noncovered by BadgerCare Plus, Medicaid, and SeniorCare (e.g., certain OTC drugs, drugs without signed manufacturer rebate agreements, drugs terminated by the federal 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.

Topic #16217

Cytokine and Cell Adhesion Molecule Antagonist Drugs

Clinical PA (prior authorization) is required for non-preferred cytokine and CAM (cell adhesion molecule) antagonist drugs.

Initial PA requests for non-preferred cytokine and CAM antagonist drugs may be approved for up to 183 days. Renewal PA requests for non-preferred cytokine and CAM antagonist drugs may be approved for up to 365 days.

PA requests for non-preferred cytokine and CAM antagonist drugs will only be approved for use to treat the following identified clinical conditions:

- Ankylosing spondylitis
- Crohn's disease
- Giant cell arteritis
- JIA (juvenile idiopathic arthritis) and systemic JIA
- NOMID (Neonatal Onset Multisystem Inflammatory Disease)
- nr-axSpA (non-radiographic axial spondyloarthritis)
- Psoriasis
- Psoriatic arthritis
- RA (rheumatoid arthritis)
- Ulcerative colitis

Humira is a preferred cytokine and CAM antagonist drug and the only cytokine and CAM antagonist drug that is indicated for the clinical conditions of hidradenitis suppurativa and uveitis. Otezla is a preferred cytokine and CAM antagonist drug and the only cytokine and CAM antagonist drug that is indicated for the clinical condition of oral ulcers associated with Behcet's disease. Preferred cytokine and CAM antagonist drugs do not require PA.

PA requests for cytokine and CAM antagonist drugs will only be approved for **one cytokine and CAM antagonist drug per member.** ForwardHealth does not cover treatment with more than one cytokine and CAM antagonist drug.

Note: Starting a member on a medication by using manufacturer-provided samples or manufacturer patient assistance programs will not be considered as previous medication history for PA review.

PA requests for cytokine and CAM antagonist drugs must be completed, signed, and dated by the prescriber. The PA form must be sent to the pharmacy where the prescription will be filled. The prescriber may send the PA form to the pharmacy, or the member may carry the PA form with the prescription to the pharmacy. 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.

PA requests will not be considered for cytokine and CAM antagonist drugs that will be administered in a medical office or medical facility.

Non-Preferred Oral Agents

The following will **not** be considered as criteria to support the need for a non-preferred oral cytokine and CAM antagonist drug agent:

- Nonadherence to previous cytokine and CAM antagonist drug treatment
- Member fear of needles
- Member or prescriber preference for the use of an oral agent

Clinical Criteria for Cytokine and CAM Antagonist Drugs for Ankylosing Spondylitis

Enbrel and Humira are preferred drugs used to treat ankylosing spondylitis. Preferred drugs do not require PA.

Cimzia, Cosentyx, Simponi, and Taltz are non-preferred drugs used to treat ankylosing spondylitis.

Clinical criteria for approval of a PA request for non-preferred cytokine and CAM antagonist drugs used to treat ankylosing spondylitis are **all** of the following:

- The member has ankylosing spondylitis.
- The prescription is written by a rheumatologist or through a rheumatology consultation.
- The prescriber has indicated if the member has axial symptoms of ankylosing spondylitis.
- The prescriber has indicated if the member has attempted any of the following drugs for ankylosing spondylitis: leflunomide, methotrexate, NSAIDs (non-steroidal anti-inflammatory drugs), or sulfasalazine.
- The prescriber has indicated what other drugs the member has attempted for ankylosing spondylitis (for example, glucocorticoids or IV immunomodulators such as infliximab).
- 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.
- The prescriber has indicated the clinical reason(s) why a non-preferred cytokine and CAM antagonist drug is being requested.

A copy of the member's medical records must be submitted with all PA requests for non-preferred drugs. Medical records should document the following:

- The member's medical condition being treated
- Details regarding previous medication use
- The member's current treatment plan

Submitting PA Requests for Cytokine and CAM Antagonist Drugs for Ankylosing Spondylitis

PA requests for non-preferred cytokine and CAM antagonist drugs must be completed, signed, and dated by the prescriber. PA requests for non-preferred cytokine and CAM antagonist drugs used to treat ankylosing spondylitis must be submitted using the Prior Authorization Drug Attachment for Cytokine and CAM Antagonist Drugs for Ankylosing Spondylitis (Prior Authorization Drug Attachment for Cytokine and Cell Adhesion Molecule Antagonist Drugs for Ankylosing Spondylitis, F-11304 (01/19)) form and the PA/RF (Prior Authorization Request Form, F-11018 (05/13)).

The PA form must be sent to the pharmacy where the prescription will be filled. The prescriber may send the PA form to the pharmacy, or the member may carry the PA form with the prescription to the pharmacy. 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.

PA requests for non-preferred cytokine and CAM antagonist drugs used to treat ankylosing spondylitis may be submitted on the Portal, by fax, or by mail (but **not** using the STAT-PA (Specialized Transmission Approval Technology-Prior Authorization) system).

Clinical Criteria for Cytokine and CAM Antagonist Drugs for Crohn's Disease

Humira is a preferred drug used to treat Crohn's disease. Preferred drugs do not require PA.

Cimzia and Stelara are non-preferred drugs used to treat Crohn's disease.

Clinical criteria for approval of a PA request for non-preferred cytokine and CAM antagonist drugs used to treat Crohn's disease are **all** of the following:

- The member has Crohn's disease.
- The prescription is written by a gastroenterologist or through a gastroenterology consultation.
- The prescriber has indicated if the member has attempted any of the following drugs for Crohn's disease: 6MP (6-mercaptopurine), azathioprine, oral aminosalicylates (balsalazide, mesalamine, olsalazine, or sulfasalazine), or methotrexate.
- The prescriber has indicated what other drugs the member has attempted for Crohn's disease (for example, antibiotics, glucocorticoids, or IV immunomodulators such as infliximab).
- The member has taken **one** preferred cytokine and CAM antagonist drug for **at least three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction.
- The prescriber has indicated the clinical reason(s) why a non-preferred cytokine and CAM antagonist drug is being requested.

A copy of the member's medical records must be submitted with all PA requests for non-preferred drugs. Medical records should document the following:

- The member's medical condition being treated
- Details regarding previous medication use
- The member's current treatment plan

Submitting PA Requests for Cytokine and CAM Antagonist Drugs for Crohn's Disease

PA requests for non-preferred cytokine and CAM antagonist drugs must be completed, signed, and dated by the prescriber. PA requests for non-preferred cytokine and CAM antagonist drugs used to treat Crohn's disease must be submitted using the Prior Authorization Drug Attachment for Cytokine and CAM Antagonist Drugs for Crohn's Disease and Ulcerative Colitis (Prior Authorization Drug Attachment for Cytokine and Cell Adhesion Molecule Antagonist Drugs for Crohn's Disease and Ulcerative Colitis, F-01950 (01/19)) form and the PA/RF.

The PA form must be sent to the pharmacy where the prescription will be filled. The prescriber may send the PA form to the pharmacy, or the member may carry the PA form with the prescription to the pharmacy. 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.

PA requests for non-preferred cytokine and CAM antagonist drugs used to treat Crohn's disease may be submitted on the Portal, by fax, or by mail (but **not** using the STAT-PA system).

Clinical Criteria for Cytokine and CAM Antagonist Drugs for Giant Cell Arteritis

Actemra is a non-preferred drug used to treat giant cell arteritis.

Clinical criteria for approval of a PA request for Actemra used to treat giant cell arteritis are **both** of the following:

- The member has giant cell arteritis.
- The prescription is written by a rheumatologist or through a rheumatology consultation.

Clinical documentation and medical records must be submitted with the PA request to support the member's condition of giant cell arteritis and outline the member's current treatment plan for giant cell arteritis.

Submitting PA Requests for Cytokine and CAM Antagonist Drugs for Giant Cell Arteritis

PA requests for non-preferred cytokine and CAM antagonist drugs must be completed, signed, and dated by the prescriber. PA requests for non-preferred cytokine and CAM antagonist drugs used to treat giant cell arteritis must be submitted using the Prior Authorization Drug Attachment for Cytokine and CAM Antagonist Drugs for Giant Cell Arteritis, NOMID, and nr-axSpA (Prior Authorization Drug Attachment for Cytokine and Cell Adhesion Molecule Antagonist Drugs for Giant Cell Arteritis, Neonatal Onset Multisystem Inflammatory Disease and Non-Radiographic Axial Spondyloarthritis, F-01952 (07/19)) form and the PA/RF.

The PA form must be sent to the pharmacy where the prescription will be filled. The prescriber may send the PA form to the pharmacy, or the member may carry the PA form with the prescription to the pharmacy. 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.

PA requests for Actemra used to treat giant cell arteritis may be submitted on the Portal, by fax, or by mail (but **not** using the STAT-PA system).

Cytokine and CAM Antagonist Drug for Hidradenitis Suppurativa

Humira is a preferred drug used to treat hidradenitis suppurativa. Preferred drugs do not require PA.

Clinical Criteria for Cytokine and CAM Antagonist Drugs for NOMID

Kineret is a non-preferred drug used to treat NOMID.

Clinical criteria for approval of a PA request for Kineret used to treat NOMID are **both** of the following:

- The member has NOMID.
- The prescription is written by a rheumatologist or through a rheumatology consultation.

Clinical documentation and medical records must be submitted with the PA request to support the member's condition of NOMID and outline the member's current treatment plan for NOMID.

Submitting PA Requests for Cytokine and CAM Antagonist Drugs for NOMID

PA requests for non-preferred cytokine and CAM antagonist drugs must be completed, signed, and dated by the prescriber. PA requests for non-preferred cytokine and CAM antagonist drugs used to treat NOMID must be submitted using the Prior Authorization Drug Attachment for Cytokine and CAM Antagonist Drugs for Giant Cell Arteritis, NOMID, and nr-axSpA form and the PA/RF.

The PA form must be sent to the pharmacy where the prescription will be filled. The prescriber may send the PA form to the pharmacy, or the member may carry the PA form with the prescription to the pharmacy. 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.

PA requests for Kineret used to treat NOMID may be submitted on the Portal, by fax, or by mail (but **not** using the STAT-PA system).

Clinical Criteria for Cytokine and CAM Antagonist Drugs for nr-axSpA

Cimzia, Cosentyx, and Taltz are non-preferred drugs used to treat nr-axSpA.

Clinical criteria for approval of a PA request for non-preferred cytokine and CAM antagonist drugs used to treat nr-axSpA are **both** of the following:

- The member has nr-axSpA.

- The prescription is written by a rheumatologist or through a rheumatology consultation.

Clinical documentation and medical records must be submitted with the PA request to support the member's condition of nr-axSpA and outline the member's current treatment plan for nr-axSpA.

Submitting PA Requests for Cytokine and CAM Antagonist Drugs for nr-axSpA

PA requests for non-preferred cytokine and CAM antagonist drugs must be completed, signed, and dated by the prescriber. PA requests for non-preferred cytokine and CAM antagonist drugs used to treat nr-axSpA must be submitted using the Prior Authorization Drug Attachment for Cytokine and CAM Antagonist Drugs for Giant Cell Arteritis, NOMID, and nr-axSpA form and the PA/RF.

The PA form must be sent to the pharmacy where the prescription will be filled. The prescriber may send the PA form to the pharmacy, or the member may carry the PA form with the prescription to the pharmacy. 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.

PA requests for non-preferred cytokine and CAM antagonist drugs used to treat nr-axSpA may be submitted on the Portal, by fax, or by mail (but **not** using the STAT-PA system).

Clinical Criteria for Cytokine and CAM Antagonist Drugs for Psoriasis

Enbrel, Humira, and Otezla are preferred drugs used to treat psoriasis. Preferred drugs do not require PA.

Cimzia, Cosentyx, Siliq, Skyrizi, Stelara, Taltz, and Tremfya are non-preferred drugs used to treat psoriasis.

Clinical criteria for approval of a PA request for non-preferred cytokine and CAM antagonist drugs used to treat psoriasis are **all** of the following:

- The member has psoriasis.
- The provider has indicated the areas affected and the approximate percent of BSA (body surface area) involved.
- The prescription is written by a dermatologist or through a dermatology consultation.
- The prescriber has indicated if the member has attempted any of the following drugs or therapies for psoriasis: cyclosporine, methotrexate, phototherapy, or acitretin.
- The prescriber has indicated what other drugs the member has attempted for psoriasis (for example, topicals, glucocorticoids, or IV immunomodulators such as infliximab).
- 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.
- The prescriber has indicated the clinical reason(s) why a non-preferred cytokine and CAM antagonist drug is being requested.

A copy of the member's medical records must be submitted with all PA requests for non-preferred drugs. Medical records should document the following:

- The member's medical condition being treated
- Details regarding previous medication use
- The member's current treatment plan

Submitting PA Requests for Cytokine and CAM Antagonist Drugs for Psoriasis

PA requests for non-preferred cytokine and CAM antagonist drugs must be completed, signed, and dated by the prescriber. PA requests for non-preferred cytokine and CAM antagonist drugs used to treat psoriasis must be submitted using the Prior Authorization Drug Attachment for Cytokine and CAM Antagonist Drugs for Psoriasis (Prior Authorization Drug Attachment for

Cytokine and Cell Adhesion Molecule Antagonist Drugs for Psoriasis, F-11306 (01/19)) form and the PA/RF.

The PA form must be sent to the pharmacy where the prescription will be filled. The prescriber may send the PA form to the pharmacy, or the member may carry the PA form with the prescription to the pharmacy. 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.

PA requests for non-preferred cytokine and CAM antagonist drugs used to treat psoriasis may be submitted on the Portal, by fax, or by mail (but **not** using the STAT-PA system).

Clinical Criteria for Cytokine and CAM Antagonist Drugs for Psoriatic Arthritis

Enbrel, Humira, and Otezla are preferred drugs used to treat psoriatic arthritis. Preferred drugs do not require PA.

Cimzia, Cosentyx, Orencia subQ solution, Simponi, Stelara, Taltz, Xeljanz, and Xeljanz XR are non-preferred drugs used to treat psoriatic arthritis.

Clinical criteria for approval of a PA request for non-preferred cytokine and CAM antagonist drugs used to treat psoriatic arthritis are **all** of the following:

- The member has psoriatic arthritis.
- The prescription is written by a dermatologist or rheumatologist or through a dermatology or rheumatology consultation.
- The prescriber has indicated if the member has axial symptoms of psoriatic arthritis.
- The prescriber has indicated if the member has attempted any of the following drugs for psoriatic arthritis: azathioprine, hydroxychloroquine, leflunomide, or methotrexate.
- The prescriber has indicated what other drugs the member has attempted for psoriatic arthritis (for example, NSAIDs, glucocorticoids, or IV immunomodulators such as infliximab).
- 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.
- The prescriber has indicated the clinical reason(s) why a non-preferred cytokine and CAM antagonist drug is being requested.

  Note: The prescriber is required to submit detailed clinical justification for prescribing Xeljanz XR instead of Xeljanz. The clinical information must document why the member cannot use Xeljanz, including why it is medically necessary that the member receive Xeljanz XR instead of Xeljanz. Members currently taking Xeljanz XR who had previous claims for Xeljanz XR paid by ForwardHealth will be allowed to receive PA request approval as long as the PA request demonstrates that the member is currently stable on Xeljanz XR and has been adherent with treatment.

A copy of the member's medical records must be submitted with all PA requests for non-preferred drugs. Medical records should document the following:

- The member's medical condition being treated
- Details regarding previous medication use
- The member's current treatment plan

Submitting PA Requests for Cytokine and CAM Antagonist Drugs for Psoriatic Arthritis

PA requests for non-preferred cytokine and CAM antagonist drugs must be completed, signed, and dated by the prescriber. PA requests for non-preferred cytokine and CAM antagonist drugs used to treat psoriatic arthritis must be submitted using the Prior Authorization Drug Attachment for Cytokine and CAM Antagonist Drugs for RA, JIA, and Psoriatic Arthritis (Prior Authorization Drug Attachment for Cytokine and Cell Adhesion Molecule Antagonist Drugs for Rheumatoid Arthritis, Juvenile Idiopathic Arthritis, and Psoriatic Arthritis, F-01951 (01/20)) form and the PA/RF.

The PA form must be sent to the pharmacy where the prescription will be filled. The prescriber may send the PA form to the pharmacy, or the member may carry the PA form with the prescription to the pharmacy. 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.

PA requests for non-preferred cytokine and CAM antagonist drugs used to treat psoriatic arthritis may be submitted on the Portal, by fax, or by mail (but **not** using the STAT-PA system).

Clinical Criteria for Cytokine and CAM Antagonist Drugs for RA

Enbrel and Humira are preferred drugs used to treat RA. Preferred drugs do not require PA.

Actemra subQ solution, Cimzia, Kevzara, Kineret, Olumiant, Orencia subQ solution, Rinvoq, Simponi, Xeljanz, and Xeljanz XR are non-preferred drugs used to treat RA.

Clinical criteria for approval of a PA request for non-preferred cytokine and CAM antagonist drugs used to treat RA are **all** of the following:

- The member has RA.
- The prescription is written by a rheumatologist or through a rheumatology consultation.
- The prescriber has indicated if the member has attempted any of the following drugs for RA: azathioprine, hydroxychloroquine, leflunomide, methotrexate, or sulfasalazine.
- The prescriber has indicated what other drug therapies the member has attempted for RA (for example, NSAIDs, glucocorticoids, or IV immunomodulators such as infliximab).
- At least **one** of the following is true:
  - The member has taken **two** preferred cytokine and CAM antagonist drugs for **at least three** consecutive months each and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction. Additionally, for PA requests for Simponi, members must also continue to take methotrexate in combination with Simponi.
  - The member has taken Enbrel or Humira along with one or more disease-modifying antirheumatic drugs for **at least three** consecutive months, and the member continues to have moderate to severe disease activity. Additionally, for PA requests for Simponi, members must also continue to take methotrexate in combination with Simponi.
- The prescriber has indicated the clinical reason(s) why a non-preferred cytokine and CAM antagonist drug is being requested.

  Note: The prescriber is required to submit detailed clinical justification for prescribing Xeljanz XR instead of Xeljanz. The clinical information must document why the member cannot use Xeljanz, including why it is medically necessary that the member receive Xeljanz XR instead of Xeljanz. Members currently taking Xeljanz XR who had previous claims for Xeljanz XR paid by ForwardHealth will be allowed to receive PA request approval as long as the PA request demonstrates that the member is currently stable on Xeljanz XR and has been adherent with treatment.

A copy of the member's medical records must be submitted with all PA requests for non-preferred drugs. Medical records should document the following:

- The member's medical condition being treated
- Details regarding previous medication use
- The member's current treatment plan

Submitting PA Requests for Cytokine and CAM Antagonist Drugs for RA

PA requests for non-preferred cytokine and CAM antagonist drugs must be completed, signed, and dated by the prescriber. PA requests for non-preferred cytokine and CAM antagonist drugs used to treat RA must be submitted using the Prior Authorization Drug Attachment for Cytokine and CAM Antagonist Drugs for RA, JIA, and Psoriatic Arthritis form and the PA/RF.

The PA form must be sent to the pharmacy where the prescription will be filled. The prescriber may send the PA form to the pharmacy, or the member may carry the PA form with the prescription to the pharmacy. 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.

PA requests for non-preferred cytokine and CAM antagonist drugs used to treat RA may be submitted on the Portal, by fax, or by mail (but **not** using the STAT-PA system).

Clinical Criteria for Cytokine and CAM Antagonist Drugs for JIA

Enbrel and Humira are preferred drugs used to treat JIA. Preferred drugs do not require PA.

Actemra subQ solution and Orencia subQ solution are non-preferred drugs used to treat JIA.

Clinical criteria for approval of a PA request for non-preferred cytokine and CAM antagonist drugs used to treat JIA are **all** of the following:

- The member has JIA.
- The prescription is written by a rheumatologist or through a rheumatology consultation.
- The prescriber has indicated if the member has attempted any of the following drugs for JIA: azathioprine, leflunomide, methotrexate, or sulfasalazine.
- The prescriber has indicated what other drug therapies the member has attempted for JIA (for example, NSAIDs, glucocorticoids, or IV immunomodulators such as infliximab).
- At least **one** of the following is true:
  - The member has taken **two** preferred cytokine and CAM antagonist drugs for **at least three** consecutive months each and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction.
  - The member has taken Enbrel or Humira along with one or more disease-modifying antirheumatic drugs for **at least three** consecutive months, and the member continues to have moderate to severe disease activity.
- The prescriber has indicated the clinical reason(s) why a non-preferred cytokine and CAM antagonist drug is being requested.

A copy of the member's medical records must be submitted with all PA requests for non-preferred drugs. Medical records should document the following:

- The member's medical condition being treated
- Details regarding previous medication use
- The member's current treatment plan

Clinical Criteria for Systemic JIA

Actemra subQ solution is a non-preferred drug that has been indicated by the FDA (Food and Drug Administration) for the clinical condition of systemic JIA.

Clinical criteria for approval of a PA request for Actemra subQ solution used to treat systemic JIA are **both** of the following:

- The member has systemic JIA.
- The prescription is written by a rheumatologist or through a rheumatology consultation.

A copy of the member's medical records must be submitted with all PA requests for non-preferred drugs. Medical records should document the following:

- The member's medical condition being treated

- Details regarding previous medication use
- The member's current treatment plan

Submitting PA Requests for Cytokine and CAM Antagonist Drugs for JIA and Systemic JIA

PA requests for non-preferred cytokine and CAM antagonist drugs must be completed, signed, and dated by the prescriber. PA requests for non-preferred cytokine and CAM antagonist drugs used to treat JIA and systemic JIA must be submitted using the Prior Authorization Drug Attachment for Cytokine and CAM Antagonist Drugs for RA, JIA, and Psoriatic Arthritis form and the PA/RF.

The PA form must be sent to the pharmacy where the prescription will be filled. The prescriber may send the PA form to the pharmacy, or the member may carry the PA form with the prescription to the pharmacy. 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.

PA requests for non-preferred cytokine and CAM antagonist drugs used to treat JIA and systemic JIA may be submitted on the Portal, by fax, or by mail (but **not** using the STAT-PA system).

Clinical Criteria Cytokine and CAM Antagonist Drugs for Ulcerative Colitis

Humira is a preferred drug used to treat ulcerative colitis. Preferred drugs do not require PA.

Simponi, Stelara, Xeljanz, and Xeljanz XR are non-preferred drugs used to treat ulcerative colitis.

Clinical criteria for approval of a PA request for non-preferred cytokine and CAM antagonist drugs used to treat ulcerative colitis are **all** of the following:

- The member has ulcerative colitis.
- The prescription is written by a gastroenterologist or through a gastroenterology consultation.
- The prescriber has indicated if the member has attempted any of the following drugs for ulcerative colitis: 6MP, azathioprine, or oral aminosalicylates (balsalazide, mesalamine, olsalazine, or sulfasalazine).
- The prescriber has indicated what other drugs the member has attempted for ulcerative colitis (for example, antibiotics, glucocorticoids, or IV immunomodulators such as infliximab).
- The member has taken **one** preferred cytokine and CAM antagonist drug for **at least three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction.
- The prescriber has indicated the clinical reason(s) why a non-preferred cytokine and CAM antagonist drug is being requested.

  Note: The prescriber is required to submit detailed clinical justification for prescribing Xeljanz XR instead of Xeljanz. The clinical information must document why the member cannot use Xeljanz, including why it is medically necessary that the member receive Xeljanz XR instead of Xeljanz. Members currently taking Xeljanz XR who had previous claims for Xeljanz XR paid by ForwardHealth will be allowed to receive PA request approval as long as the PA request demonstrates that the member is currently stable on Xeljanz XR and has been adherent with treatment.

A copy of the member's medical records must be submitted with all PA requests for non-preferred drugs. Medical records should document the following:

- The member's medical condition being treated
- Details regarding previous medication use
- The member's current treatment plan

Submitting PA Requests for Cytokine and CAM Antagonist Drugs for Ulcerative Colitis

PA requests for non-preferred cytokine and CAM antagonist drugs must be completed, signed, and dated by the prescriber. PA requests for non-preferred cytokine and CAM antagonist drugs used to treat ulcerative colitis must be submitted using the Prior Authorization Drug Attachment for Cytokine and CAM Antagonist Drugs for Crohn's Disease and Ulcerative Colitis form and the PA/RF.

The PA form must be sent to the pharmacy where the prescription will be filled. The prescriber may send the PA form to the pharmacy, or the member may carry the PA form with the prescription to the pharmacy. 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.

PA requests for non-preferred cytokine and CAM antagonist drugs used to treat ulcerative colitis may be submitted on the Portal, by fax, or by mail (but **not** using the STAT-PA system).

Cytokine and CAM Antagonist Drug for Uveitis

Humira is a preferred drug used to treat uveitis. Preferred drugs do not require PA.

Topic #9877

Fentanyl Mucosal Agents

Note: The Preferred Drug List Quick Reference provides the most current list of preferred and non-preferred drugs in this drug class.

PA (Prior authorization) requests for 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 (07/13)). PA requests for fentanyl mucosal agents may be submitted using the STAT-PA (Specialized Transmission Approval Technology-Prior Authorization) system, on the ForwardHealth Portal, by fax, or by mail.

PA requests for fentanyl mucosal agents may be approved for up to a maximum of 183 days.

Clinical Criteria for Fentanyl Mucosal Agents

Clinical criteria for approval of a PA request for a fentanyl mucosal agent are **all** of 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(s).
- The member has breakthrough cancer pain that is not relieved by other short-acting opioid analgesic drugs.

Topic #20617

Glucocorticoids, Oral

Note: The Preferred Drug List Quick Reference provides the most current list of preferred and non-preferred drugs in this class.

Emflaza

Clinical PA (prior authorization) is required for Emflaza.

Note: The superiority of Emflaza over prednisone in the treatment of DMD (Duchenne muscular dystrophy) has not been established. There is also no quality evidence to support a clinically significant difference in the corticosteroid-induced side effect profiles of Emflaza and prednisone. Studies evaluating the difference in weight gain between Emflaza and prednisone are conflicting and the majority of studies are of poor quality. Prednisone is possibly associated with greater weight gain in the first 12 months of treatment; however, there appears to be no significant difference in weight gain with longer term use of prednisone compared with Emflaza.

The following will **not** be considered as criteria to support the need for a non-preferred glucocorticoids, oral drug:

- Nonadherence to previous glucocorticoid therapies
- Member or prescriber preference

PA requests for Emflaza must be completed and signed by the prescriber. PA requests for Emflaza should be submitted using Section VI (Clinical Information for Drugs With Specific Criteria Addressed in the ForwardHealth Online Handbook) of the PA/DGA (Prior Authorization Drug Attachment, F-11049 (07/16)) form and the PA/RF (Prior Authorization Request Form, F-11018 (05/2013)).

A copy of the member's medical records must be submitted with all PA requests for Emflaza. Medical records should document the following:

- The member's medical condition being treated
- Details regarding previous medication use
- The member's current treatment plan

PA requests for Emflaza may be submitted on the Portal, by fax, or by mail (but **not** using the STAT-PA (Specialized Transmission Approval Technology-Prior Authorization) system).

Clinical Criteria for Emflaza

Clinical criteria that must be documented for approval of a PA request for Emflaza are **all** of the following:

- The member has a diagnosis of DMD.
- The member is 2 years of age and older.
- The prescription is written by or through consultation with a neurologist
- The dose requested is consistent with the FDA (Food and Drug Administration)-recommended daily dosage based on the member's weight (approximately 0.9 mg/kg/day).
- At least **one** of the following is true:
  - The member has experienced a clinically significant glucocorticoid adverse drug reaction with an adequate trial of prednisone that has required a dose reduction or discontinuation of prednisone.
  - The member's BMI (body mass index) is considered obese and the member has experienced a rapid weight gain of at least 20 percent or greater over a six-month period while taking prednisone.

Renewal PA requests for members who have DMD must meet the clinical criteria for initial PA requests for Emflaza and have documentation to support that the member has experienced an improvement or resolution of the initial glucocorticoid adverse effects experienced with prednisone. The member must also continue to take a dose consistent with the FDA-recommended daily dosage based on the member's weight (approximately 0.9 mg/kg/day).

If clinical criteria for Emflaza are met, initial PA requests may be approved for up to 92 days. Renewal PA requests for Emflaza may be approved for up to 183 days.

Note: All renewal PA requests require the member to be adherent with the prescribed treatment regimen. A copy of the current medical records must be included with the PA request.

Topic #20639

Gout Agents

Note: The Preferred Drug List Quick Reference provides the most current list of preferred and non-preferred drugs in this class.

Topic #3509

Grandfathering Overview

If a BadgerCare Plus, Medicaid, or SeniorCare member is grandfathered on a brand name drug and a generic equivalent is available, grandfathering of the brand name drug for the member will be discontinued once the brand name drug is added to the BMN (brand medically necessary) list on the Brand Medically Necessary Drugs and Brand Before Generic Drugs data table.

If medically appropriate for the member, providers should request BMN PA (prior authorization) for the member to continue taking the brand name drug.

If a BadgerCare Plus, Medicaid, or SeniorCare member is grandfathered on a generic drug, PA is not required until further notice.

Topic #12897

Grandfathering for Alzheimer's Agents

Galantamine tablets, galantamine solution, and galantamine ER will be grandfathered for BadgerCare Plus, 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.

Topic #12917

Grandfathering for Anticonvulsants

Equetro is a non-preferred anticonvulsant drug; however, BadgerCare Plus, 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 BadgerCare Plus, Medicaid, and SeniorCare members who are not grandfathered on the drug.

Topic #10658

Grandfathering for Antiparkinson's Agents

Generic ropinirole ER is a non-preferred drug; however, BadgerCare Plus, Medicaid, and SeniorCare members who are currently taking ropinirole ER will be grandfathered. If ropinirole ER becomes a preferred drug in the antiparkinson's agents drug class, then grandfathering of ropinirole ER will end for all members.

PA (prior authorization) is required for ropinirole ER for BadgerCare Plus, Medicaid, and SeniorCare members who have not previously taken the drug.

Topic #10659

Grandfathering for Antipsychotics

As a result of safety concerns, thioridazine is a non-preferred drug; however, BadgerCare Plus, 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.

Topic #10977

Grandfathering for Cytokine and Cell Adhesion Molecule Antagonist Drugs

Kineret is a non-preferred drug; however, BadgerCare Plus, 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.

Topic #10661

Grandfathering for Pancreatic Enzymes

Creon

Creon is a non-preferred drug; however, BadgerCare Plus, 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, BadgerCare Plus, 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 BadgerCare Plus, 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.

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.

Topic #11857

Grandfathering for Pulmonary Arterial Hypertension

Drugs

Adcirca

BadgerCare Plus, Medicaid, and SeniorCare members who are currently taking Adcirca are grandfathered until a generic becomes available. After the generic becomes available, grandfathering of Adcirca will end for all members.

Tracleer

Members who are currently taking Tracleer are grandfathered until a generic becomes available. After the generic becomes available, grandfathering of Tracleer will end for all members.

Topic #10662

Grandfathering for Stimulants

Note: For more information about this drug class, providers may refer to the Stimulants drug class topic.

Grandfathering for Stimulants

BadgerCare Plus, Medicaid, and SeniorCare members who were grandfathered on certain amphetamine formulations for DOS (dates of service) on and after January 1, 2017, and remained eligible for grandfathering throughout 2019, will no longer be grandfathered for DOS on and after January 1, 2020, if **one** of the following is true:

- Members without other primary insurance on file with ForwardHealth have no claim activity for grandfathered amphetamine formulations for DOS in the last six months of 2019.
- Members with other primary insurance on file with ForwardHealth have no claim activity for grandfathered amphetamine formulations for DOS in calendar year 2019.

When a pharmacy claim is submitted in real-time for a member who is not eligible to be grandfathered on an amphetamine product, the pharmacy 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, informing the pharmacy that the drug requires PA (prior authorization).

Note: Grandfathering a member overrides the PDL (Preferred Drug List) PA policy only. Other policies, such as member enrollment eligibility, diagnosis restriction, quantity limit, and noncovered service policies continue to apply.

The table below lists all of the amphetamine formulations that are eligible for grandfathering and provides the applicable grandfathering details.

Drugs Eligible for Grandfathering	Details
Dexedrine Spansule Dextroamphetamine tablet Dexedrine tablet Dextroamphetamine capsule	Eligible members identified to be taking any one of these four products are grandfathered to allow any one of these formulations. Note: For Dexedrine tablets and dextroamphetamine tablets, an approved PA request is not required for any child 6 years of age or younger.

ER	
Amphetamine salt combo (immediate release)	Eligible members identified to be taking this product are grandfathered to **allow generic immediate release amphetamine salt combo or generic amphetamine salt combo ER only.** Note: An approved PA request is not required for any child 6 years of age or younger.
Amphetamine salt combo ER	Eligible members identified to be taking this product are grandfathered to **allow generic amphetamine salt combo ER or generic immediate release amphetamine salt combo only.**
Zenzedi	Eligible members identified to be taking this product are grandfathered to allow this formulation only. Note: An approved PA request is not required for any child 6 years of age or younger.
Evekeo	Eligible members identified to be taking this product are grandfathered to allow this formulation only. Note: An approved PA request is not required for any child 6 years of age or younger.
Methamphetamine	Eligible members identified to be taking this product are grandfathered to allow this formulation only.

Note: Brand name Adderall and brand name Adderall XR require BMN (brand medically necessary) PA. Members are not grandfathered for any brand name Adderall or brand name Adderall XR products. In addition to meeting established BMN criteria, PA requests for Adderall or Adderall XR must also meet the clinical criteria for non-preferred stimulants.

Drugs in this class are diagnosis restricted. A ForwardHealth-allowed diagnosis code must be indicated on claims (and PA requests when applicable) for all stimulant drugs.

Topic #1988

Growth Hormone Drugs

Note: The Preferred Drug List Quick Reference provides the most current list of preferred and non-preferred drugs in this drug class.

All growth hormone prescriptions must be written by an endocrinologist or through an endocrinology consultation, except prescriptions written for Serostim or Zorbtive.

Note: ForwardHealth will consider the entire clinical record for the PA (prior authorization) request determination decision.

PA requests for the following growth hormone drugs must be submitted on the PA/PDL for Growth Hormone Drugs (Prior Authorization/Preferred Drug List (PA/PDL) for Growth Hormone Drugs, F-11092 (07/20)) form:

- Serostim
- Zorbtive
- Growth hormone drugs for children and adolescents

- Growth hormone drugs for adults

The PA form must be sent to the pharmacy where the prescription will be filled. The prescriber may send the PA form to the pharmacy, or the member may carry the PA form with the prescription to the pharmacy. 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.

Pharmacy providers are required to submit the completed PA/PDL for Growth Hormone Drugs form and a completed PA/RF (Prior Authorization Request Form, F-11018 (05/13)) to ForwardHealth.

Clinical Criteria for Serostim

ForwardHealth covers Serostim for members with AIDS wasting disease or cachexia.

If clinical criteria for Serostim are met, initial PA requests for Serostim may be approved for up to 365 days. PA requests for Serostim must be submitted on the PA/PDL for Growth Hormone Drugs form and may be submitted to ForwardHealth using the STAT-PA (Specialized Transmission Approval Technology-Prior Authorization) system, on the Portal, by fax, or by mail.

Clinical Criteria for Zorbtive

ForwardHealth covers Zorbtive for members with short bowel syndrome with dependence on parenteral nutrition. Members are limited to a 28-day course of the drug to reduce dependence on parenteral nutrition.

PA requests for Zorbtive must be submitted on the PA/PDL for Growth Hormone Drugs form and may be submitted to ForwardHealth using the STAT-PA system, on the Portal, by fax, or by mail.

Clinical Criteria for Growth Hormone Drug Coverage for Children and Adolescents

ForwardHealth covers growth hormone drugs for children and adolescents for the following indications:

- The member has a history of panhypopituitarism involving at least two pituitary hormone deficiencies, not including growth hormone, and a history of hypothalamic-pituitary structural lesion(s).
- The member has a history of cranial irradiation, tumor, or other structural midline lesion, in addition to a decreasing growth velocity and a low IGF-1 (insulin-like growth factor-1) measurement below the age- and gender-specific lower limit of normal with normal thyroid function and adequate nutrition.
- The member has growth failure or short stature associated with one of the following congenital conditions that have an FDA (Food and Drug Administration)-approved indication for growth hormone use:
  - Noonan syndrome
  - Prader-Willi syndrome
  - SHOX gene deficiency disorder
  - Turner syndrome
- The member has growth failure or short stature associated with chronic renal insufficiency in pre-kidney transplant members.
- An SGA (small for gestational age) member is 2 years of age or older with a height that remains more than two standard deviations below the mean for chronological age and gender on a clinically appropriate growth chart. SGA is defined as infants with a birth weight below the 10th percentile for gestational age. Other causes for short stature must have been excluded, such as the following: growth inhibiting medication, chronic disease, other congenital conditions, thyroid disease, or under-nutrition. ForwardHealth will consider the entire clinical record for the PA request determination decision.
- The member has growth failure or short stature for children and adolescents with growth hormone deficiency including **all** of the following:
  - The member's height is more than two standard deviations below the mean for chronological age and gender on a

clinically appropriate growth chart.

- Other causes for short stature must have been excluded, such as the following: growth inhibiting medication, chronic disease, other congenital conditions, thyroid disease, or under-nutrition. If IGF-1 levels are low, IGF-BP3 (insulin-like growth factor-binding protein 3) testing should be considered and under-nutrition should be evaluated and addressed before proceeding with growth hormone stimulation testing. If the results of the IGF-1/IGF-BP3 and bone age are normal, best clinical practice would indicate growth hormone stimulation testing is not necessary since growth hormone deficiency can effectively be excluded without the need for further testing due to recognized limitations of growth hormone stimulation testing and risk of false positive results.
- The member has failed to respond to at least two validated growth hormone stimulation tests performed using a well-standardized protocol, demonstrating a growth hormone peak response of less than 10 ng/mL after stimulation with a pharmacologic agent such as insulin, arginine, clonidine, or glucagon.

Growth Hormone Stimulation Testing Requirements for Children and Adolescents

Growth hormone stimulation testing should be conducted after an overnight fast, using a well-standardized protocol, and should be conducted for the appropriate duration of time specific to the agents used to ensure the peak growth hormone level is captured. Both stimulation tests can be administered on the same day. When growth hormone stimulation testing has been performed, complete testing results must be submitted with the PA request, including the following:

- Confirmation that the member was fasting
- The type of stimulation test and the dose of stimulating agent
- A copy of the medical notes taken during the entire testing procedure, including vital signs and blood glucose levels
- The time and results from each blood sample taken
- The provider interpretation of the testing results

For members with thyroid deficiency, ForwardHealth only accepts results of the growth hormone stimulation tests that are performed after thyroid deficiency is adequately treated because growth hormone secretion may be subnormal merely as a result of hypothyroidism.

Growth hormone stimulation testing performed in a non-validated or sub-standard manner will not be considered by ForwardHealth to be an acceptable growth hormone stimulation test.

Growth hormone testing can provide useful information, but due to the recognized limitations of growth hormone stimulation testing and the risk of false positive results, ForwardHealth will consider the results of the growth hormone stimulation testing in the context of the entire clinical record for the PA request determination decision.

Documentation Requirements for PA Requests for Growth Hormone for Children and Adolescents

Detailed documentation of the medical work-up and testing used to determine the need for growth hormone treatment must be submitted with the PA request, including the following:

- Detailed endocrinology and medical work-up, including medical problem list, current medication list, and medication history
- Height and weight measurements over time plotted on the most clinically appropriate growth chart(s) for age and gender, including growth velocity, growth percentiles, and Z-scores
- Copies of the most recent IGF-1 and IGF-BP3 lab reports
- Bone age results
- TSH (thyroid-stimulating hormone) level
- Nutritional assessment
- Any other relevant testing, such as advanced imaging of the hypothalamic-pituitary region, if performed

PA requests for growth hormone drugs for children and adolescents must be submitted on the PA/PDL for Growth Hormone Drugs form. PA requests for growth hormone drugs for children and adolescents may be submitted using the STAT-PA system when the member meets **both** of the following:

- The member has growth failure or short stature associated with one of the following congenital conditions:
  - Noonan syndrome
  - Prader-Willi syndrome
  - SHOX gene deficiency disorder
  - Turner syndrome
- The member is less than 14 years of age

All other PA requests for preferred or non-preferred growth hormone drugs may be submitted on the Portal, by fax, or by mail, but **not** using the STAT-PA system.

If clinical criteria for growth hormone drugs are met, initial PA requests may be approved for up to 183 days.

All renewal PA requests require the member to be adherent with the prescribed treatment regimen. A copy of the current endocrinology clinic notes, including clinically appropriate height and weight growth charts for age and gender, the most current IGF-1 and/or IGF-BP3 lab testing results, growth velocity, and the most current bone age report, must be included with the PA request. Renewal PA requests may be approved for up to 365 days.

Conditions Not Covered for Growth Hormone Treatment for Children and Adolescents

ForwardHealth does not cover growth hormone treatment for the following conditions or circumstances:

- Member has closed epiphyses.
- Growth velocity is less than 2 cm/year while on growth hormone treatment, or growth velocity does not demonstrate a significant increase while on growth hormone treatment.
- Bone age is greater than 14 years for a female and 16 years for a male.
- Mid-parental height is achieved using the following equation.

  Mid-parental height = (father's height + mother's height) ÷ 2, + 2.5 inches (male) or - 2.5 inches (female)
- Therapy is not compliant with prescribed growth hormone therapy.
- Member has idiopathic short stature, which is a growth failure or short stature not associated with growth hormone deficiency or disease state.
- Member is post kidney transplant.

Clinical Criteria for Growth Hormone Drug Coverage for Adults

ForwardHealth covers growth hormone drugs for adults for the following indications:

- The member has a history of panhypopituitarism during childhood involving at least two other pituitary hormone deficiencies, not including growth hormone, and treatment with a growth hormone drug during childhood.
- The member has a history of hypopituitarism during childhood involving at least one other pituitary hormone deficiency, not including growth hormone, and treatment with a growth hormone drug during childhood. The diagnosis of growth hormone deficiency must be confirmed with an IGF-1 measurement below the age- and gender-specific lower limit of normal after stopping growth hormone for at least three months and at least one standard appropriate growth hormone stimulation test demonstrating a growth hormone peak response of less than the established adult reference values of the specific stimulation tests performed.
- The member has a history of treatment with a growth hormone drug during childhood without evidence of other pituitary hormone deficiencies. The diagnosis of growth hormone deficiency must be confirmed with an IGF-1 measurement below the age- and gender-specific lower limit of normal after stopping growth hormone treatment for at least three months and at least two standard appropriate growth hormone stimulation tests demonstrating a growth hormone peak response of less than the established adult reference values of the specific stimulation tests performed.
- The member has a history of a head injury, hypothalamic-pituitary structural lesion(s), or cranial irradiation and evidence of panhypopituitarism involving at least three other pituitary hormone deficiencies, not including growth hormone.

- The member has a history of a head injury, hypothalamic-pituitary structural lesion(s), or cranial irradiation and evidence of hypopituitarism with at least one other pituitary hormone deficiency, not including growth hormone. Growth hormone deficiency must be confirmed with an IGF-1 measurement below the age- and gender-specific lower limit of normal and at least one standard appropriate growth hormone stimulation test demonstrating a growth hormone peak response of less than the established adult reference values of the specific stimulation tests performed.
- The member has a history of a head injury, hypothalamic-pituitary structural lesion(s), or cranial irradiation without evidence of other pituitary hormone deficiencies. Growth hormone deficiency must be confirmed with an IGF-1 measurement below the age- and gender-specific lower limit of normal and at least two standard appropriate growth hormone stimulation tests demonstrating a growth hormone peak response of less than the established adult reference values of the specific stimulation tests performed.

Note: For individuals being treated for growth hormone deficiency due to trauma or subarachnoid hemorrhage, growth hormone deficiency must be reconfirmed at one year after the event for therapy to continue. If retesting does not confirm growth hormone deficiency, continued treatment will not be approved.

ForwardHealth does not cover growth hormone drugs for members who do not comply with their prescribed growth hormone therapy.

Growth Hormone Stimulation Testing Requirements for Adults

Growth hormone stimulation testing should not be considered in adults without suggestive history of growth hormone deficiency such as a history of growth hormone deficiency diagnosed in childhood, hypothalamic pituitary disease, or cranial irradiation. In cases where there is suggestive history of growth hormone deficiency and a serum IGF-1 concentration below the age- and gender-specific lower limit of normal, growth hormone stimulation testing may be considered.

Growth hormone stimulation testing should be conducted after an overnight fast, using a well-standardized protocol, and should be conducted for the appropriate duration of time specific to the agents used to ensure the peak growth hormone level is captured. When two growth hormone stimulation tests are required, both stimulation tests can be administered on the same day. When growth hormone stimulation testing has been performed, complete testing results must be submitted with the PA request, including the following:

- Confirmation that the member was fasting
- The type of stimulation test and the dose of the stimulating agent
- A copy of the medical notes taken during the entire testing procedure, including vital signs and blood glucose levels
- The time and results from each blood sample taken
- The provider interpretation of the testing results

For members with thyroid deficiency, ForwardHealth only accepts results of the growth hormone stimulation tests that are performed after thyroid deficiency is adequately treated because growth hormone secretion may be subnormal merely as a result of hypothyroidism.

Growth hormone stimulation testing performed in a non-validated or sub-standard manner will not be considered by ForwardHealth to be an acceptable growth hormone stimulation test.

Growth hormone deficiency in an adult could be considered if the member has failed to respond to validated growth hormone stimulation testing performed using a well-standardized protocol, demonstrating a growth hormone peak response of less than the established level of the agent(s) given. Examples of agents commonly used in adult growth hormone stimulation testing include insulin, glucagon, and macimorelin. The peak response determining growth hormone deficiency for an adult differs based on the agent used, including the following:

- Insulin tolerance test: A growth hormone peak response of less than 5 mcg/L at every time point during the hypoglycemic phase of the test (If adequate hypoglycemia is not achieved [<40 mg/dL], then growth hormone deficiency cannot be diagnosed.)

- Glucagon test: A growth hormone peak response of less than 3 mcg/L at every time point during testing for members with a BMI (body mass index) less than 25 kg/m^2 or a growth hormone peak response of less than 1 mcg/L at every time point during testing in patients with a BMI greater than or equal to 25 kg/m^2
- Macimorelin-stimulation test: A growth hormone peak response of less than 2.8 ng/mlµg/L for members with a BMI of 40 kg/m^2 or less. Strong CYP3A4 (cytochrome P450 3A4) inducers should be discontinued with sufficient washout time prior to testing with macimorelin. Strong CYP3A4 inducers may reduce the plasma macimorelin concentrations and may lead to false positive test results. (Note: The safety and diagnostic performance of macimorelin have not been established with a BMI greater than 40 kg/m^2.)

Growth hormone testing can provide useful information, but due to the recognized limitations of growth hormone stimulation testing and the risk of false positive results, ForwardHealth will consider the results of the growth hormone stimulation testing in the context of the entire clinical record for the PA request determination decision.

Note: Following the recommendation of the 2019 "American Association of Clinical Endocrinologists and American College of Endocrinology Guidelines for Management of Growth Hormone Deficiency in Adults and Patients Transitioning From Pediatric to Adult Care," ForwardHealth will not accept arginine stimulation testing for adults. The arginine stimulation tests have shown to exhibit a low sensitivity and specificity for adults and have not been systematically evaluated and validated.

Documentation Requirements for PA Requests for Growth Hormone for Adults

Detailed documentation of the medical work-up and testing used to determine the need for growth hormone treatment must be submitted with the PA request, including the following:

- Detailed endocrinology and medical work-up, including medical problem list, current medication list, and medication history
- Copies of the most recent IGF-1 lab reports
- TSH level
- Nutrition assessment
- Any other relevant testing, such as advanced imaging of the hypothalamic-pituitary region, if performed

PA requests for growth hormone drugs for adults must be submitted on the PA/PDL for Growth Hormone Drugs form. PA requests for growth hormone drugs may be submitted on the Portal, by fax, or by mail (but **not** using the STAT-PA system).

If clinical criteria for growth hormone drugs are met, initial PA requests may be approved for up to 183 days.

All renewal PA requests require the member to be adherent with the prescribed treatment regimen. A copy of the current endocrinology clinic notes, including the most current IGF-1 lab testing results, must be included with the PA request. Renewal PA requests may be approved for up to 365 days.

Topic #15517

H2 Antagonists

Note: The Preferred Drug List Quick Reference provides the most current list of preferred and non-preferred drugs in this drug class.

Famotidine Suspension

PA (Prior authorization) is not required for famotidine suspension for BadgerCare Plus and Medicaid members who are 18 years of age or younger. For BadgerCare Plus, Medicaid, and SeniorCare members 19 years of age or older, PA is required for famotidine suspension.

Topic #21637

Headache Agents, Acute Treatment

Note: The Preferred Drug List Quick Reference provides the most current list of preferred and non-preferred drugs in the headache agents, acute treatment drug class.

All drugs in the headache agents, acute treatment drug class are non-preferred and require PA (prior authorization).

PA requests for headache agents, acute treatment drugs must be completed, signed, and dated by the prescriber. PA requests for headache agents, acute treatment drugs must be submitted on the Prior Authorization Drug Attachment for Headache Agents, Acute Treatment (F-02666 (07/20)) form.

The PA form must be sent to the pharmacy where the prescription will be filled. The prescriber may send the PA form to the pharmacy, or the member may carry the PA form with the prescription to the pharmacy. 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.

Pharmacy providers are required to submit the completed Prior Authorization Drug Attachment for Headache Agents, Acute Treatment form and a completed PA/RF (Prior Authorization Request Form, F-11018 (05/13)) to ForwardHealth.

PA requests for headache agents, acute treatment drugs may be submitted on the Portal, fax, or by mail (but **not** using the STAT-PA (Specialized Transmission Approval Technology-Prior Authorization) system).

Note: Emgality 100 mg has separate PA submission requirements.

Clinical Criteria for Headache Agents, Acute Treatment Drugs

The clinical criteria for approval of a PA request for headache agents, acute treatment drugs (excluding Emgality 100 mg) are **all** of the following:

- The member is 18 years of age or older.
- The prescriber has evaluated and diagnosed the member as having a history of migraines, with or without aura, according to ICHD-3 (International Classification of Headache Disorders, 3rd edition) diagnostic criteria.
- One of the following is true:
  - The member has experienced an unsatisfactory therapeutic response or a clinically significant adverse drug reaction with at least **two** preferred drugs from the headache agents, triptans non-injectable drug class.
  - The member has a medical condition(s) that prevents the use of triptans.

A copy of the member's medical records must be submitted with all PA requests for headache agents, acute treatment drugs. Medical records must document the member?s medical work-up for migraines including complete problem and medication lists.

Starting a member on a medication by using manufacturer-provided samples or manufacturer patient assistance programs will not be considered as previous medication history for PA review.

If the clinical criteria for headache agents, acute treatment drugs are met, PA requests may be approved for up to 365 days.

Submitting PA Requests for Emgality 100 mg

PA requests for Emgality 100 mg must be completed, signed, and dated by the prescriber. PA requests for Emgality 100 mg must be submitted using Section VI (Clinical Information for Drugs With Specific Criteria Addressed in the ForwardHealth Online Handbook) of the PA/DGA (Prior Authorization/Drug Attachment, F-11049 (07/16)) form and the PA/RF. Clinical

documentation supporting the use of Emgality 100 mg must be submitted with the PA request.

The PA form must be sent to the pharmacy where the prescription will be filled. The prescriber may send the PA form to the pharmacy, or the member may carry the PA form with the prescription to the pharmacy. 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.

PA requests for Emgality 100 mg may be submitted on the Portal, by fax, or by mail (but **not** using the STAT-PA system).

Clinical Criteria for Emgality 100 mg

Clinical criteria that must be documented for approval of an initial PA request for Emgality 100 mg are **all** of the following:

- The member is 18 years of age or older.
- The prescriber has evaluated and diagnosed the member as having episodic cluster headaches, according to the ICHD-3, diagnostic criteria.
- The member's current frequency of cluster headache attacks during an episode has been documented.
- The prescriber is required to indicate the member's current episodic cluster headache medications (including drug name[s], dose, and dosing frequency).
- The member must be compliant with the prescribed episodic cluster headache treatment regimen.
- The member and prescriber have agreed to follow the established Emgality episodic cluster headache dosing recommendations (300 mg [administered as three consecutive injections of 100 mg each] at the onset of the cluster period, and then monthly until the end of the cluster period) as outlined in the FDA (Food and Drug Administration)-approved patient labeling.

A copy of the member's current medical records must be submitted with all PA requests (initial, initial renewal, and subsequent renewal) for Emgality 100 mg. Medical records must document the member's medical work-up for episodic cluster headaches including complete problem and medication lists.

Starting a member on a medication by using manufacturer-provided samples or manufacturer patient assistance programs will not be considered as previous medication history for PA review.

If clinical criteria for Emgality 100 mg are met, initial PA requests may be approved for up to 183 days.

Initial Renewal PA Requests for Emgality 100 mg

Clinical criteria that must be documented for approval of initial renewal PA requests for Emgality 100 mg are **all** of the following:

- The member's current frequency of cluster headache attacks during an episode has been documented.
- The prescriber is required to indicate the member's current episodic cluster headache medications (including drug name[s], dose, and dosing frequency).
- The member must be compliant with the prescribed episodic cluster headache treatment regimen.
- The member experienced a clinically significant decrease in the frequency of cluster headache attacks during an episode compared to their baseline prior to initiation of treatment with Emgality 100 mg.
- The member and prescriber will continue to follow the established Emgality episodic cluster headache dosing recommendations (300 mg [administered as three consecutive injections of 100 mg each] as the onset of the cluster period, and then monthly until the end of the cluster period) as outlined in the FDA-approved patient labeling.

Initial renewal PA requests for Emgality 100 mg may be approved for up to 183 days.

Subsequent Renewal PA Requests for Emgality 100 mg

Clinical criteria that must be documented for approval of subsequent renewal PA requests for Emgality 100 mg are **all** of the

following:

- The member's current frequency of cluster headache attacks during an episode has been documented.
- The prescriber is required to indicate the member's current episodic cluster headache medications (including drug name[s], dose, and dosing frequency).
- The member must be compliant with the prescribed episodic cluster headache treatment regimen.
- The member has sustained a clinically significant decrease in the frequency of cluster headache attacks during an episode compared to their baseline prior to initiation of treatment with Emgality 100 mg.
- The member and prescriber will continue to follow the established Emgality episodic cluster headache dosing recommendations (300 mg [administered as three consecutive injections of 100 mg each] at the onset of the cluster period, and then monthly until the end of the cluster period) as outlined in the FDA-approved patient labeling.

Subsequent renewal PA requests for Emgality 100 mg may be approved for up to 183 days.

Topic #21117

Headache Agents, Preventative Treatment

Note: The Preferred Drug List Quick Reference provides the most current list of preferred and non-preferred drugs in this drug class.

Preferred drugs in the headache agents, preventative treatment drug class do not require PA (prior authorization).

Submitting PA Requests for Headache Agents, Preventative Treatment Drugs

PA requests for headache agents, preventative treatment drugs must be completed, signed, and dated by the prescriber. PA requests for headache agents, preventative treatment drugs should be submitted using the Prior Authorization Drug Attachment for Headache Agents, Preventative Treatment (F-02667 (07/20)) form. Clinical documentation supporting the use of headache agents, preventative treatment drugs must be submitted with the PA request.

The PA form must be sent to the pharmacy where the prescription will be filled. The prescriber may send the PA form to the pharmacy, or the member may carry the PA form with the prescription to the pharmacy. 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.

Pharmacy providers are required to submit the completed Prior Authorization Drug Attachment for Headache Agents, Preventative Treatment form and a completed PA/RF (Prior Authorization Request Form, F-11018 (05/13)) to ForwardHealth.

PA requests for headache agents, preventative treatment drugs may be submitted on the Portal, by fax, or by mail (but **not** using the STAT-PA (Specialized Transmission Approval Technology-Prior Authorization) system).

Clinical Criteria for Non-Preferred Headache Agents, Preventative Treatment Drugs

The clinical criteria for approval of an initial PA request for non-preferred headache agents, preventative treatment drugs are **all** of the following:

- The member is 18 years of age or older.
- The prescriber has evaluated and diagnosed the member as having a history of migraines, with or without aura, according to ICHD-3 (International Classification of Headache Disorders, 3rd edition) diagnostic criteria.

- The member is compliant with the prescribed headache medication treatment regimen and continues to experience four or more migraine headache days per month.
- The member's current prescribed migraine medication treatment regimen must be documented. The prescriber is required to indicate the member's current migraine preventative and rescue medications (drug name[s], dose, and dosing frequency) including Botox (if applicable).
- The member has taken Ajovy for **at least three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction.
- The member has taken Emgality 120 mg for **at least three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction.

A copy of the member's current medical records must be submitted with all PA requests (initial, initial renewal, and subsequent renewal) for non-preferred headache agents, preventative treatment drugs. Medical records must document the member's medical work-up for migraines including complete problem and medication lists.

Starting a member on a medication by using manufacturer-provided samples or manufacturer patient assistance programs will not be considered as previous medication history for PA review.

If clinical criteria for non-preferred headache agents, preventative treatment drugs are met, initial PA requests may be approved for up to 183 days.

Initial Renewal PA Requests for Non-Preferred Headache Agents, Preventative Treatment Drugs

Clinical criteria that must be documented for approval of initial renewal PA requests for non-preferred headache agents, preventative treatment drugs are **all** of the following:

- The member experienced a clinically significant decrease in the number of migraine days per month and/or a decrease in migraine duration compared to their baseline prior to initiation of treatment with a headache agents, preventative treatment drug.
- The member's current prescribed migraine medication treatment regimen has been documented. The prescriber is required to indicate the member's current migraine preventative and rescue medications (drug name[s], dose, and dosing frequency) including Botox (if applicable).
- The member has been compliant with their prescribed migraine medication treatment regimen.

Initial renewal PA requests for non-preferred headache agents, preventative treatment drugs may be approved for up to 365 days.

Subsequent Renewal PA Requests for Non-Preferred Headache Agents, Preventative Treatment Drugs

Clinical criteria that must be documented for approval of subsequent renewal PA requests for non-preferred headache agents, preventative treatment drugs are **all** of the following:

- The member has sustained a clinically significant decrease in the number of migraine days per month and/or a decrease in migraine duration compared to their baseline prior to initiation of treatment with a headache agents, preventative treatment drug.
- The current number of headache days per month, the number of migraine days per month, and the average migraine duration (in hours) must be documented.
- The member's current prescribed migraine headache medication treatment regimen has been documented. The prescriber is required to indicate the member's current migraine preventative and rescue medications (drug name[s], dose, and dosing frequency) including Botox (if applicable).
- The member has been compliant with their prescribed migraine medication treatment regimen.

Subsequent renewal PA requests for non-preferred headache agents, preventative treatment drugs may be approved for up to

365 days.

Topic #9878

Headache Agents, Triptans Non-Injectable

Note: The Preferred Drug List Quick Reference provides the most current list of preferred and non-preferred drugs in this drug class.

Non-preferred drugs in the headache agents, triptans non-injectable drug class require PA (prior authorization). Preferred drugs do not require PA.

PA requests for non-preferred headache agents, triptans non-injectable drugs must be submitted on the PA/PDL for Headache Agents, Triptans Non-Injectable (Prior Authorization/Preferred Drug List for Headache Agents, Triptans Non-Injectable, F-02668 (07/20)) form.

The PA form must be sent to the pharmacy where the prescription will be filled. The prescriber may send the PA form to the pharmacy, or the member may carry the PA form with the prescription to the pharmacy. 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.

Pharmacy providers are required to submit the completed PA/PDL for Headache Agents, Triptans Non-Injectable form and a completed PA/RF (Prior Authorization Request Form, F-11018 (05/13)) to ForwardHealth.

PA requests for headache agents, triptans non-injectable drugs may be submitted using the STAT-PA (Specialized Transmission Approval Technology-Prior Authorization) system, on the Portal, by fax, or by mail.

Clinical Criterion for Non-Preferred Headache Agents, Triptans Non-Injectable Drugs

The **sole clinical criterion** for approval of a PA request for non-preferred headache agents, triptans non-injectable drugs is that the member has experienced an unsatisfactory therapeutic response or a clinically significant adverse drug reaction with at least **three** preferred drugs from the headache agents, triptans non-injectable drug class.

If the clinical criterion for non-preferred headache agents, triptans non-injectable drugs is met, PA requests may be approved for up to 365 days.

Topic #18297

Hepatitis C Agents

Note: The Preferred Drug List Quick Reference provides the most current list of preferred and non-preferred drugs in this drug class.

Preferred drugs in the hepatitis C agents drug class do not require PA (prior authorization).

PA requests for non-preferred hepatitis C agents must be completed, signed, and dated by the prescriber. PA requests for hepatitis C agents should be submitted using the Prior Authorization Drug Attachment for Hepatitis C Agents (F-01247 (07/20)) form.

The PA form must be sent to the pharmacy where the prescription will be filled. The prescriber may send the PA form to the

pharmacy, or the member may carry the PA form with the prescription to the pharmacy. The pharmacy provider will use the completed PA form to submit a PA request to ForwardHealth. Prescriber should **not** submit the PA form to ForwardHealth.

Pharmacy providers are required to submit the completed Prior Authorization Drug Attachment for Hepatitis C Agents form and a completed PA/RF (Prior Authorization Request Form, F-11018 (05/13)) to ForwardHealth.

PA requests for non-preferred hepatitis C agents may be submitted on the Portal, by fax, or by mail (but **not** using the STAT-PA (Specialized Transmission Approval Technology-Prior Authorization) system).

Pharmacy Provider-Specific PA Requests for Hepatitis C Agents

PA requests for non-preferred hepatitis C agents are approved as pharmacy provider-specific. This approach is used to ensure continuity of care for members approved for treatment with these complex drug therapies. When a PA request is approved for drugs in this class, the pharmacy provider will be notified of the pharmacy provider-specific PA status via the decision notice letter. ForwardHealth recommends that the pharmacy provider inform the member of the pharmacy provider-specific PA requirement. The pharmacy provider should explain to the member that the drug therapy authorized must be dispensed by the pharmacy provider approved under the PA request.

Pharmacy providers should not submit PA requests for non-preferred hepatitis C agents if they do not intend to also dispense the entire drug therapy approved under the PA request to the member. If the member needs to discontinue receiving the drug from the approved pharmacy provider once the approved treatment has begun, the pharmacy provider is required to contact Provider Services. Provider Services will work with the pharmacy provider on the approved PA request to ensure the member does not experience a disruption of therapy, and if necessary, will facilitate the transfer of the PA to a new pharmacy provider.

Clinical Information That Must Be Documented on PA Requests for Hepatitis C Agents

A copy of the member's medical records that document the following must be submitted with the PA request:

- HCV (hepatitis C virus) assessment and treatment plan
- Current history and physical, including complete problem and medication list
- Lab tests (performed within the last six months) for:
  - Albumin
  - CBC (complete blood count)
  - INR (international normalized ratio)
  - Liver function panel
  - Serum creatinine
  - HCV-RNA (HCV-ribonucleic acid) level
- HCV genotype and subtype
- HCV clinical data and medication treatment history, including the following:
  - Likely source of the HCV infection and date diagnosed
  - Liver biopsy, imaging studies, or blood assay tests to determine hepatic fibrosis
  - History of previous hepatitis C drug therapy including medication name(s), dates taken, and treatment results (for example, null response, partial response, or relapse)
- If the member has cirrhosis, documentation of the following clinical assessments:
  - CTP (Child-Turcotte-Pugh) class and score
  - HCC (hepatocellular carcinoma) status based on an imaging study performed within the last six months
  - Presence or treatment of any of the following:
    - Ascites
    - Hepatic encephalopathy
    - Portal hypertension
    - HCC

If the required documentation is not submitted with the PA request, the PA request will be considered incomplete and will be returned to the provider, or it may be denied.

Clinical Criteria for Hepatitis C Agents

The requested non-preferred hepatitis C agent is being prescribed in a manner consistent with the FDA (Food and Drug Administration)-approved product labeling.

Note: Only eight weeks of Harvoni treatment will be approved for treatment-naive members who have HCV genotype 1 infection without cirrhosis, have an HCV-RNA level less than 6 million IU/mL, and are HIV uninfected.

The clinical criteria for approval of a PA request for non-preferred hepatitis C drugs are **all** of the following:

- The member is unable to take the preferred hepatitis C agent drugs due to **one** of the following:
  - There is a clinically significant drug interaction with another drug the member is taking and the preferred drugs.
  - The member has a medical condition(s) that prevents the use of the preferred drugs.
- The member does not have a significant or uncontrolled concurrent disease that would significantly reduce their life expectancy or limit adherence (for example, cardiovascular disease, cancer, pulmonary disease).
- For PA requests for Sovaldi, Vosevi, or Zepatier, the member does not have cirrhosis with moderate liver functional compromise (that is, CTP class B).
- The member does not have cirrhosis with severe liver functional compromise (that is, CTP class C). Currently, there is no evidence to support that HCV treatment of members with end-stage liver disease impacts morbidity or mortality. The severity of liver damage present in decompensated liver disease makes it unlikely that treating the underlying infection would lead to meaningful liver function improvement. The only definitive treatment for end-stage liver disease is a liver transplant.

In addition to meeting all of the above clinical criteria and HCV treatment program requirements, **Zepatier** requests for members with HCV genotype 1a infection must be tested for the presence of NS5A (nonstructural protein 5A) resistance-associated polymorphisms.

For members who have received a liver transplant, ForwardHealth will consider the requested HCV treatment regimen based on the member's entire medical record. The level of clinical evidence for the requested HCV treatment regimen will be considered. If there is low clinical evidence of the treatment's effectiveness, the PA request will be denied.

For members who have received prior HCV treatment, ForwardHealth will consider the requested HCV treatment regimen based on the member's entire medical record in addition to the HCV treatment history and response (for example, null response, partial response, or relapse). The level of clinical evidence for the requested HCV treatment regimen will be considered. If there is low clinical evidence of the treatment's effectiveness, the PA request will be denied.

Topic #8858

Hypoglycemics, Glucagon-Like Peptide Agents

Note: The Preferred Drug List Quick Reference provides the most current list of preferred and non-preferred drugs in this drug class.

Preferred drugs in the hypoglycemics, GLP-1 (glucagon-like peptide) agents drug class do not require PA (prior authorization).

PA requests for non-preferred GLP-1 agents must be completed, signed, and dated by the prescriber. PA requests for non-preferred GLP-1 agents must be submitted using the Prior Authorization Drug Attachment for GLP-1 Agents (Prior Authorization Drug Attachment for Glucagon-Like Peptide Agents, F-00238 (07/20)) form.

The PA form must be sent to the pharmacy where the prescription will be filled. The prescriber may send the PA form to the pharmacy, or the member may carry the PA form with the prescription to the pharmacy. 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.

Pharmacy providers are required to submit the completed Prior Authorization Drug Attachment for GLP-1 Agents form and a completed PA/RF (Prior Authorization Request Form, F-11018 (05/13)) to ForwardHealth.

PA requests for non-preferred GLP-1 agents may be submitted on the Portal, by fax, or by mail (but **not** using the STAT-PA (Specialized Transmission Approval Technology-Prior Authorization) system).

PA requests for non-preferred GLP-1 agents may be initially approved for up to 183 days. PA requests may be approved for up to 365 days if the member has been using a non-preferred GLP-1 agent for at least 183 days and the member has been adherent with treatment.

Clinical Criteria for Non-Preferred Glucagon-Like Peptide Agents

Clinical criteria for approval of a PA request for a non-preferred GLP-1 agent are **all** of the following:

- The member is 18 years of age or older.
- The member has type 2 diabetes mellitus.
- The member does not currently have pancreatitis or have a history of pancreatitis.
- The member's HbA1c (hemoglobin A1c) was measured within the past six months.
- If the member is **not** currently using a GLP-1 agent, their most recent HbA1c is 6.5 percent or greater.

Note: Members currently taking a non-preferred GLP-1 agent who have had a previous PA request for that agent approved by ForwardHealth will be allowed to continue to receive PA request approval as long as they meet the above requirements. Members also are required to have been adherent with treatment.

For members new to ForwardHealth (that is, members who have been granted eligibility for ForwardHealth within the past month), or for those who do not have a previously approved GLP-1 agent PA request, in addition to meeting all of the above clinical criteria, the member must have previously received treatment with **at least two** preferred GLP-1 agents.

One of the following must be documented for **at least two** of the preferred GLP-1 agents:

- The member has taken the maximum dose of a preferred GLP-1 agent for at least three consecutive months and experienced an unsatisfactory therapeutic response.
- The member experienced a clinically significant adverse drug reaction with a preferred GLP-1 agent.

The following will **not** be considered as criteria to support the need for a non-preferred GLP-1 agent:

- Nonadherence to previous GLP-1 treatment
- Member fear of needles
- Member or prescriber preference for the use of an oral agent
- Member or prescriber preference for the use of a non-preferred GLP-1 agent
- Member or prescriber preference for a less frequent dosing schedule

Note: ForwardHealth will only consider use of exenatide (Byetta/Bydureon Pen) as one of the preferred GLP-1 agent treatments.

Hypoglycemics, Glucagon-Like Peptide Agents—Combinations

Soliqua and Xultophy

Soliqua and Xultophy are non-preferred drugs in the hypoglycemics, GLP-1 agents—combinations drug class.

PA requests for Soliqua and Xultophy must be completed and signed by the prescriber. PA requests for Soliqua and Xultophy should be submitted using Section VI of the PA/DGA (Prior Authorization/Drug Attachment, F-11049 (07/16)) form and the PA/RF. Clinical documentation supporting the use of Soliqua and Xultophy must be submitted with the PA request.

PA requests for Soliqua and Xultophy may be submitted on the Portal, by fax, or by mail (but **not** using the STAT-PA system).

If clinical criteria for hypoglycemics, GLP-1 agents—combinations drugs are met, initial PA requests may be approved for up to 183 days. Renewal PA requests may be approved for up to 365 days.

Note: Starting a member on a medication by using manufacturer-provided samples or manufacturer patient assistance programs will not be considered as previous medication history for PA review.

Clinical Criteria for Soliqua

Clinical criteria that must be documented for approval of a PA request for Soliqua are **all** of the following:

- The member is 18 years of age or older.
- The member has type 2 diabetes mellitus.
- The member does not currently have pancreatitis or have a history of pancreatitis.
- The member does not currently have gastroparesis or have a history of gastroparesis.
- The member's target HbA1c treatment goal has been provided.
- The member's current HbA1c (measured within the past three months) has been provided.
- The member is not taking any meal-time insulin.
- The member has used Lantus concurrently with Adlyxin for **at least three** consecutive months and reached their target HbA1c treatment goal. **Both** of the following dose requirements must be met:
  - Lantus dose must be less than or equal to 60 units taken once daily.
  - Adlyxin dose must be less than or equal to 20 mcg taken once daily.
- PA requests for Soliqua will only be considered for once daily dosing. PA requests for twice daily dosing will be denied.

A copy of the member's diabetes management medical records must be provided to demonstrate the member meets the clinical criteria listed above.

Clinical Criteria for Xultophy

Clinical criteria that must be documented for approval of a PA request for Xultophy are **all** of the following:

- The member is 18 years of age or older.
- The member has type 2 diabetes mellitus.
- The member does not currently have pancreatitis or have a history of pancreatitis.
- The member does not currently have gastroparesis or have a history of gastroparesis.
- The member's target HbA1c treatment goal has been provided.
- The member's current HbA1c (measured within the past three months) has been provided.
- The member is not taking any meal-time insulin.
- The member has used Tresiba concurrently with Victoza for **at least three** consecutive months and reached their target HbA1c treatment goal. **Both** of the following dose requirements must be met:
  - A Tresiba dose must be less than or equal to 50 units taken once daily.
  - A Victoza dose must be less than or equal to 1.8 mcg taken once daily.
- PA requests for Xultophy will only be considered for once daily dosing. PA requests for twice daily dosing will be denied.

A copy of the member's diabetes management medical records must be provided to demonstrate the member meets the clinical

criteria listed above.

Topic #19357

Hypoglycemics, Insulins Long-Acting

Note: The Preferred Drug List Quick Reference provides the most current list of preferred and non-preferred drugs in this drug class.

PA (prior authorization) requests for non-preferred hypoglycemics, insulins long-acting drugs must be completed and signed by the prescriber. PA requests for non-preferred hypoglycemics, insulins long-acting drugs must be submitted using the PA/PDL for Hypoglycemics, Insulin — Long-Acting form and the PA/RF (Prior Authorization Request Form, F-11018 (05/13)).

PA requests for non-preferred hypoglycemics, insulins long-acting drugs may be submitted on the Portal, by fax, or by mail (but **not** using the STAT-PA (Specialized Transmission Approval Technology-Prior Authorization) system).

Clinical Criteria for Non-Preferred Hypoglycemics, Insulins Long-Acting Drugs

Clinical criteria that must be documented for approval of a PA request for a non-preferred hypoglycemics, insulins long-acting drug are **all** of the following:

- The member has diabetes.
- The member is unable to use Lantus® due to **one** of the following:
  - The member has used Lantus® for at least six consecutive months and was unable to obtain adequate fasting glucose control.
  - The member has used Lantus® and experienced continued episodes of hypoglycemia.
- The member is unable to use Levemir® due to **one** of the following:
  - The member has used Levemir® for at least six consecutive months and was unable to obtain adequate fasting glucose control.
  - The member has used Levemir® and experienced continued episodes of hypoglycemia.
- The member's diabetes treatment regimen was adjusted to optimize glycemic control or reduce hypoglycemia and the member was compliant with their diabetes treatment regimen and blood glucose monitoring schedule. (Insulin regimen adjustment options should include basal dose escalation, splitting the daily basal dose, adjusting the basal dosing time, and the addition or dose escalation of meal-time insulin.)

Note: Members who are using greater than or equal to 80 units per day of Lantus® or Levemir® are not required to attempt both products.

In addition to meeting the above clinical criteria, the following must be documented:

- The member's current diabetes treatment regimen
- The member's previous diabetes treatment regimen(s)
- The member's proposed diabetes treatment regimen to include the non-preferred long-acting insulin (initial PA request only)
- The glycemic treatment goals the prescriber has established for the member, such as HbA1c (hemoglobin A1c) and FBG (fasting blood glucose)

The following will **not** be considered as criteria to support the need for a non-preferred hypoglycemics, insulins long-acting drug:

- Non-adherence to previous diabetes treatment regimen

- Member or prescriber preference for the use of a non-preferred long-acting insulin
- Member or prescriber preference for a smaller injection volume

If clinical criteria for a non-preferred hypoglycemics, insulins long-acting drug are met, initial PA requests may be approved for up to a maximum of 183 days. Medical records must be submitted to support the need for a non-preferred long-acting insulin.

Renewal PA requests may be approved for up to a maximum of 365 days. A copy of the member's diabetes management medical records must be submitted demonstrating an improvement in the member's glycemic control. Examples include a decrease in HbA1c, improved FBG, and decreased hypoglycemia.

Topic #8857

Immunomodulators, Atopic Dermatitis

Note: The Preferred Drug List Quick Reference provides the most current list of preferred and non-preferred drugs in this drug class.

The following will **not** be considered as criteria to support the need for a non-preferred immunomodulators, atopic dermatitis agent:

- Nonadherence to previous topical therapies
- Member or prescriber preference
- The use of samples to start a member on a medication

Dupixent

PA (prior authorization) requests for Dupixent must be completed, signed, and dated by the prescriber. PA requests for Dupixent must be submitted using Section VI (Clinical Information for Drugs With Specific Criteria Addressed in the ForwardHealth Online Handbook) of the PA/DGA (Prior Authorization/Drug Attachment, F-11049 (07/16)) form. Clinical documentation supporting the use of Dupixent must be submitted with the PA request.

The PA form must be sent to the pharmacy where the prescription will be filled. The prescriber may send the PA form to the pharmacy, or the member may carry the PA form with the prescription to the pharmacy. 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.

Pharmacy providers are required to submit the completed PA/DGA form and a completed PA/RF (Prior Authorization Request Form, F-11018 (05/13)) to ForwardHealth.

PA requests for Dupixent may be submitted on the Portal, by fax, or by mail (but **not** using the STAT-PA (Specialized Transmission Approval Technology-Prior Authorization) system).

PA requests will not be considered for Dupixent that will be administered in a medical office or medical facility.

Conditions for Which PA Requests for Use of Dupixent Will Be Considered for Review

PA requests for Dupixent will only be approved for use to treat the following identified clinical conditions:

- CRSwNP (chronic rhinosinusitis with nasal polyposis)
- Moderate to severe atopic dermatitis
- Moderate to severe asthma with an eosinophilic phenotype
- Oral corticosteroid dependent asthma

Clinical Criteria for Dupixent for Members With CRSwNP

Clinical criteria that must be documented for approval of a PA request for Dupixent for members with CRSwNP are **all** of the following:

- The member is 18 years of age or older.
- The member has CRSwNP.
- The following documentation must be submitted:
  - Size and location of nasal polyps
  - Severity of nasal congestion
  - Past nasal surgery history
  - Plans for future nasal surgery
- The prescription is written by or through consultation with an allergist or an ear, nose, and throat specialist.
- The member has been adherent to and maintained on a maximized CRSwNP treatment regimen, including an INCS (intranasal corticosteroid) for at least three months prior to requesting Dupixent. Documentation should include the CRSwNP drug treatment names, doses, and start dates.
- The member will not use Dupixent in combination with other interleukin receptor antagonists (for example, Cinqair, Fasenra, or Nucala) or Xolair.

A copy of the member's medical records must be submitted with all PA requests for Dupixent. Medical records should document the following:

- The member's medical condition being treated
- Details regarding previous medication use
- The member's current treatment plan

If clinical criteria for Dupixent are met, initial PA requests may be approved for up to 183 days. Renewal PA requests for Dupixent may be approved for up to 365 days.

Renewal PA requests for members who have CRSwNP must meet the clinical criteria for initial PA requests for Dupixent. Renewal requests must include copies of the current medical records demonstrating that the member had a significant reduction in nasal polyp size or severity of congestion compared to the member's baseline prior to the initiation of Dupixent, and that the member has not had recent nasal polyp surgery. Members must also continue to take their maximized CRSwNP treatment regimen, including the INCS, during treatment with Dupixent.

Note: All renewal PA requests require the member to be adherent to the prescribed treatment regimen.

Clinical Criteria for Dupixent for Members With Moderate to Severe Atopic Dermatitis

Clinical criteria that must be documented for approval of a PA request for Dupixent for members with moderate to severe atopic dermatitis are **all** of the following:

- The member is 6 years of age or older.
- The member has moderate to severe atopic dermatitis. Documentation must include the approximate BSA (body surface area) involved and the area(s) affected.
- The prescription is written by or through consultation with a dermatologist, an allergist, or an immunologist.
- Exacerbating factors that may contribute to the member's atopic dermatitis, such as member non-compliance with therapy, environmental factors, dietary factors, and other similar dermatologic conditions, have been ruled out.
- **At least one** of the following is true:
  - The member has a recent history (within six months of the clinical visit when Dupixent was first prescribed) of use of at least a medium potency topical corticosteroid for at least two months and experienced an unsatisfactory therapeutic response.
  - The member has used at least a medium potency corticosteroid and experienced a clinically significant adverse drug

reaction.
- **At least one** of the following is true:
  - The member has a recent history (within six months of the clinical visit when Dupixent was first prescribed) of topical calcineurin inhibitor use for at least two months and experienced an unsatisfactory therapeutic response.
  - The member used a topical calcineurin inhibitor and experienced a clinically significant adverse drug reaction.
- The member will not use Dupixent in combination with other interleukin receptor antagonists (for example, Cingair, Fasenra, or Nucala) or Xolair.

A copy of the member's medical records must be submitted with all PA requests for Dupixent. Medical records should document the following:

- The member's medical condition being treated
- Details regarding previous medication use
- The member's current treatment plan

If clinical criteria for Dupixent are met, initial PA requests for Dupixent may be approved for up to 183 days. Renewal PA requests for Dupixent may be approved for up to 365 days.

Renewal PA requests for members who have moderate to severe atopic dermatitis (eczema) must meet the clinical criteria for initial PA requests for Dupixent. Renewal requests must include copies of the current medical records demonstrating the member has had a significant reduction in the area(s) affected and/or severity of atopic dermatitis.

Note: All renewal PA requests require the member to be adherent to the prescribed treatment regimen.

Clinical Criteria for Dupixent for Members With Moderate to Severe Asthma With an Eosinophilic Phenotype

Clinical criteria that must be documented for approval of a PA request for Dupixent for members with moderate to severe asthma with an eosinophilic phenotype are **all** of the following:

- The member is 12 years of age or older.
- The member has moderate to severe asthma with an eosinophilic phenotype. A baseline blood eosinophil count of greater than 150 cells/mcL within the previous three months must be documented.
- The prescription is written by or through consultation with an asthma specialist (for example, an allergist, an immunologist, or a pulmonologist).
- **At least one** of the following is true:
  - The member has a history of two or more asthma exacerbations that required treatment with systemic corticosteroids or an emergency department visit or hospitalization for the treatment of asthma in the past year. Documentation should include the approximate dates and what interventions took place for each exacerbation.
  - The member's baseline FEV1 (forced expiratory volume in one second) is less than 80 percent predicted. A baseline FEV1 percent predicted from the previous three months must be documented.
- The member has been adherent to and maintained on a maximized asthma treatment regimen, including a high-dose ICS (inhaled corticosteroid) in combination with a LABA (long-acting beta-agonist) for at least three months prior to requesting Dupixent. Documentation should include the ICS and LABA names, doses, and start dates.
- Exacerbating factors that may contribute to the member's asthma, such as member non-compliance with therapy, environmental factors, dietary factors, and other similar respiratory conditions, have been ruled out.
- The member will not use Dupixent in combination with other interleukin receptor antagonists (for example, Cinqair, Fasenra, or Nucala) or Xolair.

A copy of the member's medical records must be submitted with all PA requests for Dupixent. Medical records should document the following:

- The member's medical condition being treated

- Details regarding previous medication use
- The member's current treatment plan

If clinical criteria for Dupixent are met, initial PA requests for Dupixent may be approved for up to 183 days. Renewal PA requests for Dupixent may be approved for up to 365 days.

Renewal PA requests for members who have moderate to severe asthma with an eosinophilic phenotype must meet the clinical criteria for initial PA requests for Dupixent. Renewal requests must include copies of the current medical records demonstrating the member had a decrease in the number of asthma exacerbations or an increase in FEV1 percent predicted compared to their baseline prior to initiation of Dupixent. Members must also continue to take their maximized asthma treatment regimen, including an ICS and a LABA, during treatment with Dupixent.

Note: All renewal PA requests require the member to be adherent to the prescribed treatment regimen.

Clinical Criteria for Dupixent for Members With Oral Corticosteroid Dependent Asthma

Clinical criteria that must be documented for approval of a PA request for Dupixent for members with oral corticosteroid dependent asthma are **all** of the following:

- The member is 12 years of age or older.
- The member has oral corticosteroid dependent asthma.
- The prescription is written by or through consultation with an asthma specialist (for example, an allergist, an immunologist, or a pulmonologist).
- The member has been adherent and maintained on a maximized asthma treatment regimen, including a high-dose ICS in combination with a LABA for at least three months prior to requesting Dupixent. Documentation should include the ICS and LABA names, doses, and start dates.
- The member has required daily oral corticosteroid treatment for at least three months prior to requesting Dupixent. Documentation should include the oral corticosteroid name, daily dose, and start date.
- Exacerbating factors that may contribute to the member's asthma, such as member non-compliance with therapy, environmental factors, dietary factors, and other similar respiratory conditions, have been ruled out.
- The member will not use Dupixent in combination with other interleukin receptor antagonists (for example, Cinqair, Fasenra, Nucala) or Xolair.

A copy of the member's medical records must be submitted with all PA requests for Dupixent. Medical records should document the following:

- The member's medical condition being treated
- Details regarding previous medication use
- The member's current treatment plan

If clinical criteria for Dupixent are met, initial PA requests for Dupixent may be approved for up to 183 days. Renewal PA requests for Dupixent may be approved for up to 365 days.

Renewal PA requests for members who have oral corticosteroid dependent asthma must meet the clinical criteria for initial PA requests for Dupixent. Renewal requests must include copies of the current medical records demonstrating the member's daily oral corticosteroid dose has decreased, while maintaining asthma control compared to their baseline prior to initiation of Dupixent. Members must also continue to take their maximized asthma treatment regimen, including an ICS and a LABA, during treatment with Dupixent.

Note: All renewal PA requests require the member to be adherent to the prescribed treatment regimen.

Eucrisa

PA requests for Eucrisa must be completed, signed, and dated by the prescriber. PA requests for Eucrisa should be submitted using the PA/PDL for Eucrisa (Prior Authorization/Preferred Drug List for Eucrisa, F-02572 (07/20)) form. Clinical documentation supporting the use of Eucrisa must be submitted with the PA request.

The PA form must be sent to the pharmacy where the prescription will be filled. The prescriber may send the PA form to the pharmacy, or the member may carry the PA form with the prescription to the pharmacy. 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.

Pharmacy providers are required to submit the completed PA/PDL for Eucrisa form and a completed PA/RF to ForwardHealth.

PA requests for Eucrisa may be submitted using the STAT-PA system, on the Portal, by fax, or by mail.

Clinical Criteria for Eucrisa

Clinical criteria that must be documented for approval of a PA request for Eurcrisa are **all** of the following:

- The member has atopic dermatitis.
- At least **one** of the following is true:
  - The member used a topical steroid for at least two consecutive months and experienced an unsatisfactory therapeutic response.
  - The member used a topical steroid and experienced a clinically significant adverse drug reaction.
- At least **one** of the following is true:
  - The member used Elidel or Protopic for at least two consecutive months and experienced an unsatisfactory therapeutic response.
  - The member used Elidel or Protopic and experienced a clinically significant adverse drug reaction.

If clinical criteria for Eucrisa are met, initial PA requests for Eucrisa may be approved for up to 365 days.

Topic #10660

Intranasal Rhinitis Agents

Nasonex is a non-preferred drug in the intranasal rhinitis agents drug class. PA (prior authorization) for Nasonex is not required for members 6 years of age or younger. Once a member reaches 7 years of age, PA is required.

Topic #21617

Lipotropics, Adenosine Triphosphate–Citrate Lyase Inhibitors

Note: The Preferred Drug List Quick Reference provides the most current list of preferred and non-preferred drugs in this drug class.

All drugs in the lipotropics, ACL inhibitors drug class are non-preferred and require PA (prior authorization).

PA requests for lipotropics, ACL inhibitors drugs must be completed and signed by the prescriber. PA requests for lioptropics, ACL inhibitors drugs should be submitted using Section VI (Clinical Information for Drugs With Specific Criteria Addressed in the ForwardHealth Online Handbook) of the PA/DGA (Prior Authorization/Drug Attachment, F-11049 (07/16)) form.

The PA form must be sent to the pharmacy where the prescription will be filled. The prescriber may send the PA form to the

pharmacy, or the member may carry the PA form with the prescription to the pharmacy. The pharmacy provider will use the completed PA form to submit a PA request to ForwardHealth. The prescriber should **not** submit the PA form to ForwardHealth.

Pharmacy providers are required to submit the completed PA/DGA form and a completed PA/RF (Prior Authorization Request Form, F-11018 (05/13)) to ForwardHealth.

Clinical documentation supporting the use of a lipotropics, ACL inhibitor drug also must be submitted with the PA request.

PA requests for lipotropics, ACL inhibitors drugs may be submitted on the on the Portal, by fax, or by mail (but **not** using the STAT-PA (Specialized Transmission Approval Technology-Prior Authorization) system).

The following must be submitted with initial PA requests for lipotropics, ACL inhibitors drugs:

- Medical records demonstrating that the member has clinical ASCVD (atherosclerotic cardiovascular disease) or HeFH (heterozygous familial hypercholesterolemia).
- Current lipid panel lab report
- Documentation of the member's current lipid-lowering drug therapies, including the following:
  - Drug name and dosage
  - Dates taken
  - Lipid panel report prior to and during drug therapy (including dates taken)

Conditions for Which PA Requests for Use of Lipotropics, Adenosine Triphosphate–Citrate Lyase Inhibitors Drugs Will Be Considered for Review

ForwardHealth will only consider PA requests for lipotropics, ACL inhibitors drugs to treat the following identified clinical conditions:

- Clinical ASCVD
- HeFH

Clinical Criteria for Lipotropics, Adenosine Triphosphate–Citrate Lyase Inhibitors Drugs for Members With Clinical Atherosclerotic Cardiovascular Disease

The clinical criteria for approval of an initial PA request for lipotropics, ACL inhibitors drugs for members with clinical ASCVD are **all** of the following:

- The member has clinical ASCVD, as evidenced by **one** of the following:
  - The member has cardiovascular disease, which is supported by a history of one of the following:
    - Myocardial infarction (heart attack)
    - Coronary revascularization
    - Angina pectoris
  - The member has a history of non-hemorrhagic stroke.
  - The member has symptomatic peripheral arterial disease as evidenced by one of the following:
    - Intermittent claudication with an ankle-brachial index of less than 0.85
    - Peripheral arterial revascularization procedure or amputation due to atherosclerotic disease
- The member must have taken a maximized statin regimen for **at least three continuous months** with failure to reach an LDL (low-density lipoprotein) less than or equal to 70 mg/dL. If additional lipid lowering is required, ezetimibe 10 mg daily with a maximized statin regimen must be attempted for **at least three continuous months** with failure to reach an LDL less than or equal to 70 mg/dL. The member must continue to take the maximally tolerated dose of a statin during treatment

with a lipotropics, ACL inhibitor drug.

Initial and Renewal PA Requests for Lipotropics, Adenosine Triphosphate–Citrate Lyase Inhibitors Drugs for Members With Clinical Atherosclerotic Cardiovascular Disease

If the clinical criteria for lipotropics, ACL inhibitors drugs for members with clinical ASCVD are met, initial PA requests may be approved for up to 120 days.

Renewal PA requests may be approved for up to 365 days.

Renewal PA requests for lipotropics, ACL inhibitors drugs for members who have clinical ASCVD must meet the clinical criteria for initial PA requests and demonstrate evidence of LDL reduction of at least 30 to 50 percent from the pre-treatment baseline or a decrease to 100 mg/dL or less. Members also must continue to take the maximally tolerated dose of a statin during treatment with a lipotropics, ACL inhibitor drug.

All renewal PA requests require the member to be adherent with the prescribed treatment regimen. A copy of the current lipid panel report (within the past 30 days) must be included with the PA request.

Clinical Criteria for Lipotropics, Adenosine Triphosphate–Citrate Lyase Inhibitors Drugs for Members With Heterozygous Familial Hypercholesterolemia

The clinical criteria for approval of an initial PA request for lipotropics, ACL inhibitors drugs for members with HeFH are **all** of the following:

- The member has HeFH, as evidenced by clinical documentation that supports a **definitive** diagnosis of HeFH using either WHO (World Health Organization) criteria (Dutch Lipid Clinic Network clinical criteria with a score greater than eight) or Simon Broome diagnostic criteria.
- The member must have taken a maximized statin regimen for **at least three continuous months** with failure to reach an LDL less than or equal to 100 mg/dL. If additional lipid lowering is required, ezetimibe 10 mg daily with a maximized statin regimen must be attempted for **at least three continuous months** with failure to reach an LDL less than or equal to 100 mg/dL. The member must continue to take the maximally tolerated dose of a statin during treatment with a lipotropics, ACL inhibitor drug.

Initial and Renewal PA Requests for Lipotropics, Adenosine Triphosphate–Citrate Lyase Inhibitors Drugs for Members With Heterozygous Familial Hypercholesterolemia

If the clinical criteria for lipotropics, ACL inhibitors drugs for members with HeFH are met, initial PA requests may be approved for up to 120 days.

Renewal PA requests may be approved for up to 365 days.

Renewal PA requests for lipotropics, ACL inhibitors drugs for members who have HeFH must meet the clinical criteria for initial PA requests and demonstrate evidence of LDL reduction of at least 30 to 50 percent from the pre-treatment baseline or a decrease to 130 mg/dL or less. Members also must continue to take the maximally tolerated dose of a statin during treatment with a lipotropics, ACL inhibitor drug.

All renewal PA requests require the member to be adherent with the prescribed treatment regimen. A copy of the current lipid panel report (within the past 30 days) must be included with the PA request.

Topic #7817

Lipotropics, Omega-3 Acids

Note: The Preferred Drug List Quick Reference provides the most current list of preferred and non-preferred drugs in this drug class.

Non-preferred drugs in the lipotropics, omega-3 acids drug class require clinical PA (prior authorization).

PA requests for non-preferred lipotropics, omega-3 acids must be completed, signed, and dated by the prescriber. PA requests for non-preferred lipotropics, omega-3 acids must be submitted using the Prior Authorization Drug Attachment for Lipotropics, Omega-3 Acids (F-00162 (05/2020)) form.

The PA form must be sent to the pharmacy where the prescription will be filled. Prescribers should **not** submit the PA form to ForwardHealth. The prescriber may send the PA form to the pharmacy, or the member may carry the PA form with the prescription to the pharmacy.

The pharmacy provider will use the Prior Authorization Drug Attachment for Lipotropics, Omega-3 Acids form completed by the prescriber and a PA/RF (F-11018 (05/2013)) completed by the pharmacy to submit a PA request to ForwardHealth.

PA requests for non-preferred lipotropics, omega-3 acids may be submitted on the Portal, by fax, or by mail (but **not** using the STAT-PA (Specialized Transmission Approval Technology-Prior Authorization) system).

Clinical Criteria for Non-Preferred Lipotropics, Omega-3 Acids for Severe Hypertriglyceridemia

Clinical criteria for approval of a PA request for non-preferred lipotropics, omega-3 acids for severe hypertriglyceridemia are all of the following:

- The member is 18 years of age or older.
- One of the following is true:
  - The member currently has a triglyceride level of 500 mg/dL or greater.
  - The member has had a triglyceride level of 500 mg/dL or greater in the past.
- The member has taken the maximum dose of a preferred lipotropic, omega-3 acid **for at least four consecutive months** and one of the following is true:
  - The member failed to achieve at least a 30 percent decrease in triglyceride level from the baseline level.
  - The member's triglyceride level remained at 500 mg/dL or greater.

The following will **not** be considered as criteria to support the need for non-preferred lipotropics, omega-3 acids for severe hypertriglyceridemia:

- Nonadherence to previous lipotropics, omega-3 acids treatment
- Member or prescriber preference for the use of non-preferred lipotropics, omega-3 acids

A current lipid panel report completed within the past 60 days must be submitted with all PA requests. Initial PA requests for non-preferred lipotropics, omega-3 acids for severe hypertriglyceridemia may be approved for up to 183 days. Renewal PA requests may be approved for up to 365 days.

Clinical Criteria for Non-Preferred Lipotropics, Omega-3 Acids for ASCVD Risk Reduction

Clinical criteria for approval of a PA request for non-preferred lipotropics, omega-3 acids for ASCVD risk reduction are all of

the following::

- The member is 18 years of age or older.
- The member must have taken a maximized statin regimen **for at least three consecutive months** with failure to reach a triglyceride level of less than 150 mg/dL. The member must continue to take the maximized statin regimen along with the non-preferred lipotropic, omega-3 acid.
- One of the following is true:
  - The member has clinical ASCVD, as evidenced by **one** of the following:
    - The member has CAD (coronary artery disease), which is supported by a history of myocardial infarction (heart attack), coronary revascularization, or angina pectoris.
    - The member has a history of non-hemorrhagic stroke.
    - The member has symptomatic peripheral arterial disease as evidenced by intermittent claudication with an ABI (ankle-brachial index) of less than 0.85, peripheral arterial revascularization procedure, or amputation due to atherosclerotic disease.
  - The member has diabetes mellitus and two or more of the following ASCVD risk factors:
    - Congestive heart failure
    - Current smoker
    - eGFR (estimated glomerular filtration rate) less than 60 mL/min/1.73 m2
    - Hypertension
    - Obesity

The following will **not** be considered as criteria to support the need for non-preferred lipotropics, omega-3 acids for ASCVD risk reduction:

- Nonadherence to previous lipotropics, omega-3 acids treatment
- Member or prescriber preference for the use of non-preferred lipotropics, omega-3 acids

Medical records that support the clinical criteria and a current lipid panel report completed within the past 60 days must be submitted with initial PA requests. Initial PA requests for non-preferred lipotropics, omega-3 acids for ASCVD risk reduction may be approved for up to 183 days.

A current lipid panel report completed within the past 60 days must be submitted with renewal PA requests. Renewal PA requests require the member to continue taking a maximized statin regimen during treatment with the non-preferred lipotropics, omega-3 acid. Renewal PA requests for non-preferred lipotropics, omega-3 acids for ASCVD risk reduction may be approved for up to 365 days.

Topic #19317

Lipotropics, Other

Note: The Preferred Drug List Quick Reference provides the most current list of preferred and non-preferred drugs in this drug class.

Lipotropics, Apo-B Inhibitors

Clinical PA (prior authorization) is required for lipotropics, apo-B (apolipoprotein B) inhibitors Juxtapid and Kynamro.

PA requests for Juxtapid and Kynamro must be completed and signed by the prescriber. PA requests for Juxtapid and Kynamro should be submitted using Section VI of the PA/DGA (Prior Authorization/Drug Attachment, F-11049 (07/16)) form and the PA/RF (Prior Authorization Request Form, F-11018 (05/13)).

Clinical documentation supporting the use of Juxtapid or Kynamro must also be submitted with the PA request.

PA requests for Juxtapid and Kynamro may be submitted on the Portal, by fax, or by mail. PA requests for Juxtapid and Kynamro may **not** be submitted using the STAT-PA (Specialized Transmission Approval Technology-Prior Authorization) system.

Clinical Criteria for Juxtapid and Kynamro

Clinical criteria that must be documented for approval of an initial PA request for Juxtapid or Kynamro are **both** of the following:

- The member has HoFH (homozygous familial hypercholesterolemia).
- The member has taken the highest available dose or maximally tolerated dose of a high potency statin (atorvastatin or Crestor) combined with Repatha and Zetia for at least three continuous months with failure to reach an LDL (low-density lipoprotein) level of 100 mg/dL or less, or the member has had a clinically significant adverse drug reaction, clinically significant drug interaction, or medical condition preventing the member from using these drugs.

Note: The member's inability to use one or more of the previously described drug therapies does not preclude the requirement for the member to use all of the above drug therapies for which the member does not have a clinically significant adverse drug reaction, clinically significant drug interaction, or medical condition preventing the member from using a specific drug.

The following medical records must be included with the initial PA request to demonstrate the member meets these criteria:

- Medical records demonstrating that the member has HoFH
- Current lipid panel lab report
- Documentation of the member's current and previous lipid lowering drug therapies, including the following:
  - Drug name and dosage
  - Dates taken
  - Lipid panel report prior to and during drug therapy (including dates taken)
  - Reasons for discontinuation if drug therapy was discontinued

If the member is not able to use the highest available dose or maximally tolerated dose of a high potency statin due to prior treatment history with significant skeletal muscle-related symptoms (e.g., pain, weakness) during statin treatment, documentation must demonstrate that a causal relationship has been established between statin use and skeletal muscle-related symptoms. Documentation must demonstrate **all** of the following:

- Skeletal muscle-related symptoms resolved after discontinuation of statin.
- Skeletal muscle-related symptoms occurred when rechallenged at a lower dose of the same statin.
- Skeletal muscle-related symptoms occurred after switching to an alternative statin.
- Non-statin causes of significant skeletal muscle-related symptoms were ruled out.

If clinical criteria for Juxtapid or Kynamro are met, initial PA requests will be approved for up to a maximum of 120 days. For renewal requests, if the member's LDL level decreased by at least 25 percent from baseline or decreased to 100 mg/dL or less, PA requests may be approved for an additional 183 days of treatment.

Note: All renewal PA requests require the member to be adherent with the prescribed treatment regimen. A copy of a current lipid panel report (within the past 30 days) must be included with the PA request.

Topic #18737

Lipotropics, PCSK9 Inhibitors

Note: The Preferred Drug List Quick Reference provides the most current list of preferred and non-preferred drugs in this drug

class.

PA (prior authorization) is required for all lipotropics, PCSK9 (proprotein convertase subtilisin/kexin type 9) inhibitors.

PA requests for lipotropics, PCSK9 inhibitors must be completed, signed, and dated by the prescriber. The PA form must be sent to the pharmacy where the prescription will be filled. The prescriber may send the PA form to the pharmacy, or the member may carry the PA form with the prescription to the pharmacy. 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.

PA requests for lipotropics, PCSK9 inhibitors should be submitted using the Prior Authorization Drug Attachment for Lipotropics, PCSK9 Inhibitors (F-02505 (07/19)) form and the PA/RF (Prior Authorization Request Form, F-11018 (05/13)). Clinical documentation supporting the use of a lipotropics, PCSK9 inhibitor also must be submitted with the PA request.

PA requests for lipotropics, PCSK9 inhibitors may be submitted on the Portal, by fax, or by mail (but **not** using the STAT-PA (Specialized Transmission Approval Technology-Prior Authorization) system).

The following must be submitted with initial PA requests for PCSK9 inhibitors:

- Medical records demonstrating that the member has clinical ASCVD (atherosclerotic cardiovascular disease), HeFH (heterozygous familial hypercholesterolemia), or HoFH (homozygous familial hypercholesterolemia)
- Current lipid panel lab report
- Documentation of the member's current and previous ezetimibe, PCSK9 inhibitor, and statin drug therapies, including the following for each trial:
  - Drug name(s) and dosage
  - Dates taken
  - Lipid panel report prior to and during drug therapy (including dates taken)
  - Reasons for discontinuation if drug therapy was discontinued

Conditions for Which PA Requests for Use of Praluent Will Be Considered for Review

ForwardHealth will only consider PA requests for Praluent to treat the following identified clinical conditions:

- Clinical ASCVD
- HeFH

Note: Studies demonstrating reduction in cardiovascular events for PCSK9 inhibitors have only been conducted in patients with established cardiovascular disease taking a regimen of moderate- to high-intensity statins.

Clinical Criteria for Praluent for Members With Clinical Atherosclerotic Cardiovascular Disease

Clinical criteria for approval of an initial PA request for Praluent for members with clinical ASCVD are **all** of the following:

- The member has clinical ASCVD, as evidenced by **one** of the following:
  - The member has CAD (coronary artery disease), which is supported by a history of one of the following:
    - Myocardial infarction (heart attack)
    - Coronary revascularization
    - Angina pectoris
  - The member has a history of non-hemorrhagic stroke.
  - The member has symptomatic peripheral arterial disease as evidenced by one of the following:
    - Intermittent claudication with an ABI (ankle-brachial index) of less than 0.85
    - Peripheral arterial revascularization procedure or amputation due to atherosclerotic disease

- The member attempted to maximize treatment with statins and ezetimibe prior to requesting Praluent. The member must have taken a maximized statin regimen for **at least three continuous months** with failure to reach an LDL (low-density lipoprotein) less than or equal to 70 mg/dL. If additional lipid lowering is required, ezetimibe 10 mg daily with a maximized statin regimen must be attempted for **at least three continuous months** with failure to reach an LDL less than or equal to 70 mg/dL.

  Note: Members who are not taking a maximized statin regimen, which includes atorvastatin, rosuvastatin, or simvastatin, are required to attempt a second statin in order to establish a maximum treatment regimen.

- The member must continue to take the maximized statin regimen during treatment with Praluent unless one of the following applies:
  - The member's statin therapy dosing was limited by a rise in transaminases greater than three times the upper limit of normal. Liver function testing (against a timeline of statin dosing) should accompany the PA request.
  - The member is statin intolerant due to significant skeletal muscle symptoms. Statin intolerance must be established through trials with **at least three** different statins (with one regimen containing pravastatin, fluvastatin, or rosuvastatin) and must include the following documentation:
    - Non-statin causes of significant skeletal muscle-related symptoms (for example, fibromyalgia, hypothyroidism, recent exercise, vitamin D deficiency) were ruled out.
    - Skeletal muscle-related symptoms resolved after discontinuation of the statin.
    - Skeletal muscle-related symptoms recurred after being rechallenged with the original statin at a lower dose.
    - Drug-drug interactions that can increase systemic statin exposure or exacerbate medication-related side effects must have been considered and amended.

Renewal PA Requests for Praluent for Members With Clinical Atherosclerotic Cardiovascular Disease

If clinical criteria for Praluent for members with clinical ASCVD are met, initial PA requests may be approved for up to 120 days.

Renewal PA requests may be approved for up to 365 days.

Renewal PA requests for Praluent for members who have clinical ASCVD must meet the clinical criteria for initial PA requests and demonstrate evidence of LDL reduction of at least 30 to 50 percent from pre-treatment baseline or a decrease to 100 mg/dL or less. Members also must continue to take the maximized treatment regimen (statin and/or ezetimibe) during treatment with Praluent.

All renewal PA requests require the member to be adherent with the prescribed treatment regimen. A copy of the current lipid panel report (within the past 30 days) must be included with the PA request.

Clinical Criteria for Praluent for Members With Heterozygous Familial Hypercholesterolemia

Clinical criteria for approval of an initial PA request for Praluent for members with HeFH are **all** of the following:

- The member is 18 years of age or older.
- The member has been diagnosed by a specialist in cardiology or lipid management.
- The member has HeFH, as evidenced by clinical documentation that supports a **definitive** diagnosis of HeFH using either WHO (World Health Organization) criteria (Dutch Lipid Clinic Network clinical criteria with a score greater than eight) or Simon Broome diagnostic criteria.
- The member attempted to maximize treatment with statins and ezetimibe prior to requesting Praluent. The member must have taken a maximized statin regimen for **at least three continuous months** with failure to reach an LDL less than or equal to 100 mg/dL. If additional lipid lowering is required, ezetimibe 10 mg daily with a maximized statin regimen must be attempted for **at least three continuous months** with failure to reach an LDL less than or equal to 100 mg/dL.

  Note: Members who are not taking a maximized statin regimen, which includes atorvastatin, rosuvastatin, or simvastatin, are

required to attempt a second statin in order to establish a maximum treatment regimen.

- The member must continue to take the maximized statin regimen during treatment with Praluent unless one of the following applies:
  - The member's statin therapy dosing was limited by a rise in transaminases greater than three times the upper limit of normal. Liver function testing (against a timeline of statin dosing) should accompany the PA request.
  - The member is statin intolerant due to significant skeletal muscle symptoms. Statin intolerance must be established through trials with **at least three** different statins (with one regimen containing pravastatin, fluvastatin, or rosuvastatin) and must include the following documentation:
    - Non-statin causes of significant skeletal muscle-related symptoms (for example, fibromyalgia, hypothyroidism, recent exercise, vitamin D deficiency) were ruled out.
    - Skeletal muscle-related symptoms resolved after discontinuation of the statin.
    - Skeletal muscle-related symptoms recurred after being rechallenged with the original statin at a lower dose.
    - Drug-drug interactions that can increase systemic statin exposure or exacerbate medication-related side effects must have been considered and amended.

Renewal PA Requests for Praluent for Members With Heterozygous Familial Hypercholesterolemia

If clinical criteria for Praluent for members with HeFH are met, initial PA requests may be approved for up to 120 days.

Renewal PA requests may be approved for up to 365 days.

Renewal PA requests for Praluent for members who have HeFH must meet the clinical criteria for initial PA requests and demonstrate evidence of LDL reduction of at least 30 to 50 percent from pre-treatment baseline or a decrease to 130 mg/dL or less. Members also must continue to take the maximized treatment regimen (statin and/or ezetimibe) during treatment with Praluent.

All renewal PA requests require the member to be adherent with the prescribed treatment regimen. A copy of the current lipid panel report (within the past 30 days) must be included with the PA request.

Conditions for Which PA Requests for Use of Repatha Will Be Considered for Review

ForwardHealth will only consider PA requests for Repatha to treat the following identified clinical conditions:

- Clinical ASCVD
- HeFH
- HoFH

Note: Studies demonstrating reduction in cardiovascular events for PCSK9 inhibitors have only been conducted in patients with established cardiovascular disease taking a regimen of moderate- to high-intensity statins.

Clinical Criteria for Repatha for Members With Clinical Atherosclerotic Cardiovascular Disease

Clinical criteria for approval of an initial PA request for Repatha for members with clinical ASCVD are **all** of the following:

- The member has clinical ASCVD, as evidenced by **one** of the following:
  - The member has CAD, which is supported by a history of one of the following:
    - Myocardial infarction (heart attack)
    - Coronary revascularization
    - Angina pectoris
  - The member has a history of non-hemorrhagic stroke.

    - The member has symptomatic peripheral arterial disease, as evidenced by one of the following:
        - Intermittent claudication with an ABI of less than 0.85
        - Peripheral arterial revascularization procedure or amputation due to atherosclerotic disease
- The member attempted to maximize treatment with statins and ezetimibe prior to requesting Repatha. The member must have taken a maximized statin regimen for **at least three continuous months** with failure to reach an LDL less than or equal to 70 mg/dL. If additional lipid lowering is required, ezetimibe 10 mg daily with a maximized statin regimen must be attempted for **at least three continuous months** with failure to reach an LDL less than or equal to 70 mg/dL.

  Note: Members who are not taking a maximized statin regimen, which includes atorvastatin, rosuvastatin, or simvastatin, are required to attempt a second statin in order to establish a maximum treatment regimen.

- The member must continue to take the maximized statin regimen during treatment with Repatha unless one of the following applies:
    - The member's statin therapy dosing was limited by a rise in transaminases greater than three times the upper limit of normal. Liver function testing (against a timeline of statin dosing) should accompany the PA request.
    - The member is statin intolerant due to significant skeletal muscle symptoms. Statin intolerance must be established through trials with **at least three** different statins (with one regimen containing pravastatin, fluvastatin, or rosuvastatin) and must include the following documentation:
        - Non-statin causes of significant skeletal muscle-related symptoms (for example, fibromyalgia, hypothyroidism, recent exercise, vitamin D deficiency) were ruled out.
        - Skeletal muscle-related symptoms resolved after discontinuation of the statin.
        - Skeletal muscle-related symptoms recurred after being rechallenged with the original statin at a lower dose.
        - Drug-drug interactions that can increase systemic statin exposure or exacerbate medication-related side effects must have been considered and amended.

Renewal PA Requests for Repatha for Members With Clinical Atherosclerotic Cardiovascular Disease

If clinical criteria for Repatha for members with clinical ASCVD are met, initial PA requests may be approved for up to 120 days.

Renewal PA requests may be approved for up to 365 days.

Renewal PA requests for Repatha for members who have clinical ASCVD must meet the clinical criteria for initial PA requests and demonstrate evidence of LDL reduction of at least 30 to 50 percent from pre-treatment baseline or a decrease to 100 mg/dL or less. Members also must continue to take the maximized treatment regimen (statin and/or ezetimibe) during treatment with Repatha.

All renewal PA requests require the member to be adherent with the prescribed treatment regimen. A copy of the current lipid panel report (within the past 30 days) must be included with the PA request.

Clinical Criteria for Repatha for Members With Heterozygous Familial Hypercholesterolemia

Clinical criteria for approval of an initial PA request for Repatha for members with HeFH are **all** of the following:

- The member is 18 years of age or older.
- The member has been diagnosed by a specialist in cardiology or lipid management.
- The member has HeFH, as evidenced by clinical documentation that supports a **definitive** diagnosis of HeFH using either WHO criteria (Dutch Lipid Clinic Network clinical criteria with a score greater than eight) or Simon Broome diagnostic criteria.
- The member attempted to maximize treatment with statins and ezetimibe prior to requesting Repatha. The member must have taken a maximized statin regimen for **at least three continuous months** with failure to reach an LDL less than or equal to 100 mg/dL. If additional lipid lowering is required, ezetimibe 10 mg daily with a maximized statin regimen must be attempted for **at least three continuous months** with failure to reach an LDL less than or equal to 100 mg/dL.

Note: Members who are not taking a maximized statin regimen, which includes atorvastatin, rosuvastatin, or simvastatin, are required to attempt a second statin in order to establish a maximum treatment regimen.

- The member must continue to take the maximized statin regimen during treatment with Repatha unless one of the following applies:
  - The member's statin therapy dosing was limited by a rise in transaminases greater than three times the upper limit of normal. Liver function testing (against a timeline of statin dosing) should accompany the PA request.
  - The member is statin intolerant due to significant skeletal muscle symptoms. Statin intolerance must be established through trials with **at least three** different statins (with one regimen containing pravastatin, fluvastatin, or rosuvastatin) and must include the following documentation:
    - Non-statin causes of significant skeletal muscle-related symptoms (for example, fibromyalgia, hypothyroidism, recent exercise, vitamin D deficiency) were ruled out.
    - Skeletal muscle-related symptoms resolved after discontinuation of the statin.
    - Skeletal muscle-related symptoms recurred after being rechallenged with the original statin at a lower dose.
    - Drug-drug interactions that can increase systemic statin exposure or exacerbate medication-related side effects must have been considered and amended.

Renewal PA Requests for Repatha for Members With Heterozygous Familial Hypercholesterolemia

If clinical criteria for Repatha for members with HeFH are met, initial PA requests may be approved for up to 120 days.

Renewal PA requests may be approved for up to 365 days.

Renewal PA requests for Repatha for members who have HeFH must meet the clinical criteria for initial PA requests and demonstrate evidence of LDL reduction of at least 30 to 50 percent from pre-treatment baseline or a decrease to 130 mg/dL or less. Members also must continue to take the maximized treatment regimen (statin and/or ezetimibe) during treatment with Repatha.

All renewal PA requests require the member to be adherent with the prescribed treatment regimen. A copy of the current lipid panel report (within the past 30 days) must be included with the PA request.

Clinical Criteria for Repatha for Members With Homozygous Familial Hypercholesterolemia

Repatha is FDA-approved as an adjunct to diet and other LDL-lowering therapies (for example, statins, ezetimibe, LDL apheresis) for the treatment of members with HoFH who require additional lowering of LDL cholesterol. Clinical criteria for approval of an initial PA request for Repatha for members with HoFH are **all** of the following:

- The member is 13 years of age or older.
- One of the following is true:
  - The member has genetic confirmation of **two** of the following mutant alleles at the LDL receptor:
    - Apo-B (apolipoprotein-B)
    - PCSK9
    - ARH (autosomal recessive hypercholesterolemia) adaptor protein gene locus
  - The member has an untreated LDL-C (low-density lipoprotein cholesterol) greater than 500 mg/dL **or** a total treated LDL-C greater than or equal to 300 mg/dL **and one** of the following:
    - Cutaneous tendinous xanthoma(s) before 10 years of age
    - Untreated LDL-C levels of greater than or equal to 190 mg/dL in both parents
- The member must have attempted to maximize treatment with LDL-lowering therapies prior to requesting Repatha. The member must have received maximized LDL-lowering therapies for **at least three** continuous months with failure to reach an LDL level of 130 mg/dL or less.
- The member must continue to take the maximized LDL-lowering therapies during treatment with Repatha.

Renewal PA Requests for Repatha for Members With Homozygous Familial Hypercholesterolemia

If clinical criteria for Repatha for members with HoFH are met, initial PA requests may be approved for up to 120 days.

Renewal PA requests may be approved for up to 365 days.

Renewal PA requests for Repatha for members who have HoFH must meet the clinical criteria for initial PA requests and demonstrate evidence of LDL reduction of at least 30 to 50 percent from pre-treatment baseline or a decrease to 160 mg/dL or less. Members also must continue to take the maximized LDL-lowering therapies during treatment with Repatha.

All renewal PA requests require the member to be adherent with the prescribed treatment regimen. A copy of the current lipid panel report (within the past 30 days) must be included with the PA request.

Topic #10997

Multiple Sclerosis Agents, Immunomodulators

Note: The Preferred Drug List Quick Reference provides the most current list of preferred and non-preferred drugs in this drug class.

Preferred drugs in the MS (multiple sclerosis) agents, immunomodulators drug class do not require PA (prior authorization).

PA requests for non-preferred immunomodulators to treat MS must be completed, signed, and dated by the prescriber. PA requests for non-preferred immunomodulators to treat MS must be submitted on the Prior Authorization Drug Attachment for MS Agents, Immunomodulators (Prior Authorization Drug Attachment for Multiple Sclerosis Agents, Immunomodulators, F-00805 (07/20)) form.

The PA form must be sent to the pharmacy where the prescription will be filled. The prescriber may send the PA form to the pharmacy, or the member may carry the PA form with the prescription to the pharmacy. 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.

Pharmacy providers are required to submit the completed Prior Authorization Drug Attachment for MS Agents, Immunomodulators form and a completed PA/RF (Prior Authorization Request Form, F-11018 (05/13)) to ForwardHealth.

Pharmacy providers may submit PA requests for non-preferred immunomodulators on the Portal, by fax, or by mail (but **not** using the STAT-PA (Specialized Transmission Approval Technology-Prior Authorization) system).

If clinical criteria for non-preferred immunomodulators for treatment of MS are met, initial PA requests may be approved for up to 183 days. Renewal PA requests may be approved for up to 365 days.

Clinical Criteria for Members Currently Being Treated With the Requested Non-Preferred Interferon Agent

The clinical criteria for approval of a PA request for a non-preferred interferon agent (interferon, MS agent, immunomodulator) for members currently being treated with the requested non-preferred interferon agent are **all** of the following:

- The member and prescriber are following established monitoring guidelines outlined in the FDA (Food and Drug Administration)-approved patient labeling.
- The member has been adherent with the interferon agent treatment regimen.
- The member's MS is stable and well-controlled, without having disease-progressing symptoms.

In addition to **all** of the above clinical criteria, **one** of the following must be true:

- The member is new to ForwardHealth (that is, the member has been granted eligibility for ForwardHealth within the past month) and has taken the requested non-preferred drug continuously for the last 30 days or longer and had a measurable therapeutic response. (Note: Medical records must be provided to demonstrate the member meets this criterion.)
- The member had an approved PA issued by ForwardHealth that recently expired for the requested non-preferred drug, and the member has taken the requested non-preferred drug continuously for the last 30 days or longer and had a measurable therapeutic response.

Note: Starting a member on a medication by using manufacturer-provided samples or manufacturer patient assistance programs will not be considered as previous medication history for PA review.

Clinical Criteria for Members Not Currently Being Treated With the Requested Non-Preferred Interferon Agent

The clinical criteria for approval of a PA request for a non-preferred interferon agent for members not currently being treated with the requested non-preferred interferon agent are that the member must experience an unsatisfactory therapeutic response or a clinically significant adverse drug reaction to **at least two** preferred interferon agents.

PA requests must include detailed documentation regarding why the member has previously discontinued preferred interferon agent treatments.

Note: Medical records must be provided to demonstrate the member meets this criterion.

The following will **not** be considered as criteria to support the need for a non-preferred interferon agent:

- Nonadherence to previous MS treatment
- Member or prescriber preference for the use of a non-preferred interferon agent
- Member or prescriber preference for a less frequent dosing schedule

Clinical Criteria for Members Currently Being Treated With the Requested Non-Preferred Oral Agent

The clinical criteria for approval of a PA request for a non-preferred oral agent (oral MS agent, immunomodulator) for members currently being treated with the requested non-preferred oral agent are **all** of the following:

- The member and prescriber are following established monitoring guidelines outlined in the FDA-approved product labeling.
- The member has been adherent with the oral agent treatment regimen.
- The member's MS is stable and well-controlled, without disease-progressing symptoms.

In addition to **all** of the above clinical criteria, **one** of the following must be true:

- The member is new to ForwardHealth (that is, the member has been granted eligibility for ForwardHealth within the past month) and has taken the requested non-preferred drug continuously for the last 30 days or longer and had a measurable therapeutic response. (Note: Medical records must be provided to demonstrate the member meets this criterion.)
- The member had an approved PA issued by ForwardHealth that recently expired for the requested non-preferred drug, and the member has taken the requested non-preferred drug continuously for the last 30 days or longer and had a measurable therapeutic response.

Note: Starting a member on a medication by using manufacturer-provided samples or manufacturer patient assistance programs will not be considered as previous medication history for PA review.

Clinical Criteria for Members Not Currently Being Treated With the Requested Non-Preferred Oral Agent

The clinical criteria for approval of a PA request for a non-preferred oral agent for members not currently being treated with the requested non-preferred oral agent are **all** of the following:

- The requested non-preferred oral agent is being prescribed in a manner consistent with the FDA-approved product labeling.
- The member is unable to take Aubagio due to **one** of the following:
  - The member experienced a clinically significant adverse drug reaction.
  - There is a clinically significant drug interaction with another drug the member is taking.
  - The member has a medical condition(s) that prevents use of the drug.
- The member is unable to take Gilenya due to **one** of the following:
  - The member experienced a clinically significant adverse drug reaction.
  - There is a clinically significant drug interaction with another drug the member is taking.
  - The member has a medical condition(s) that prevents use of the drug.
- The member is unable to take Tecfidera due to **one** of the following:
  - The member experienced a clinically significant adverse drug reaction.
  - There is a clinically significant drug interaction with another drug the member is taking.
  - The member has a medical condition(s) that prevents use of the drug.

PA requests must include detailed documentation regarding why the member is unable to take or has previously discontinued treatment with Aubagio, Gilenya, and Tecfidera.

Note: Medical records must be provided to demonstrate the member meets these criteria.

The following will **not** be considered as criteria to support the need for a non-preferred oral agent:

- Nonadherence to previous MS treatment
- Member or prescriber preference for the use of a non-preferred oral agent

Clinical Criteria for Glatopa

The prescriber must submit detailed clinical justification for prescribing Glatopa instead of the preferred agents, Copaxone 20 mg and Copaxone 40 mg. This clinical information must document why the member cannot use Copaxone 20 mg and Copaxone 40 mg, including why it is medically necessary that the member receive Glatopa instead of Copaxone 20 mg and Copaxone 40 mg.

Topic #9857

Multiple Sclerosis Agents, Other

Note: The Preferred Drug List Quick Reference provides the most current list of preferred and non-preferred drugs in this drug class.

Ampyra

PA (prior authorization) requests for Ampyra must be completed and signed by prescribers. PA requests for Ampyra should be submitted using the PA/DGA (Prior Authorization/Drug Attachment, F-11049 (07/16)) form and the PA/RF (Prior Authorization Request Form, F-11018 (05/13)). PA requests for Ampyra may be submitted on the ForwardHealth Portal, by fax, or by mail (but **not** using the STAT-PA (Specialized Transmission Approval Technology-Prior Authorization) system).

Clinical Criteria for Ampyra

Clinical criteria that must be documented for approval of initial PA requests for Ampyra are **all** of the following:

- The member has MS (multiple sclerosis).
- The member has an MS-related walking impairment.
- The member has a CrCl (creatinine clearance) greater than or equal to 50 mL/min.
- The member is ambulatory.
- Results of a timed 25-foot walk test (within the past three months) include the following:
  - Date of the test
  - Walking time
  - Assistive devices the member uses (if any)

Current medical records documenting the member's walking ability and timed 25-foot walk test must be submitted with the PA request.

Initial PA requests for Ampyra may be approved for up to a maximum of 183 days.

Clinical criteria that must be documented for approval of initial renewal PA requests for Ampyra are **all** of the following:

- The member has a CrCl greater than or equal to 50 mL/min.
- The member is ambulatory.
- Results of a timed 25-foot walk test (within the past three months) include the following:
  - Date of the test
  - Walking time
  - Assistive devices the member uses (if any)
- The results of the timed 25-foot walk test have improved or the prescriber has documented how the member's ability to walk has improved since starting Ampyra.
- The member has been compliant with Ampyra therapy.

Current medical records documenting the member's walking ability and timed 25-foot walk test must be submitted with the PA request.

Initial renewal PA requests for Ampyra may be approved for up to a maximum of 365 days.

Clinical criteria that must be documented for approval of subsequent renewal PA requests for Ampyra are **all** of the following:

- The member has a CrCl greater than or equal to 50 mL/min.
- The member is ambulatory.
- Results of a timed 25-foot walk test (within the past six months) include the following:
  - Date of the test
  - Walking time
  - Assistive devices the member uses (if any)
- The member has been compliant with Ampyra therapy.

Current medical records documenting the member's walking ability and timed 25-foot walk test must be submitted with the PA request.

Subsequent renewal PA requests for Ampyra may be approved for up to a maximum of 365 days.

Topic #2328

Non-Steroidal Anti-Inflammatory Drugs

PA (prior authorization) requests for non-preferred NSAIDs (non-steroidal anti-inflammatory drugs) must be completed and signed by the prescriber and submitted using the PA/PDL for NSAIDs (Prior Authorization/Preferred Drug List for Non-Steroidal Anti-Inflammatory Drugs, F-11077 (01/2018)) form.

PA requests for non-preferred NSAIDs may be submitted using the STAT-PA (Specialized Transmission Approval Technology-Prior Authorization) system, on the Portal, by fax, or by mail.

Clinical Criterion for NSAIDs

The clinical criterion for approval of a PA request for a non-preferred NSAID requires 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.)

If the clinical criterion for a non-preferred NSAID is met, PA requests may be approved for up to 365 days.

Topic #8917

Opioid Dependency Agents

Note: The Preferred Drug List Quick Reference provides the most current list of preferred and non-preferred drugs in this drug class.

The opioid dependency agents drug class contains the following subclasses:

- Opioid dependency agents—buprenorphine
- Opioid dependency agents—methadone
- Opioid dependency agents—rescue agent
- Opioid dependency and alcohol abuse/dependency agents

Opioid Dependency Agents—Buprenorphine

Drugs in the opioid dependency agents—buprenorphine drug class **are** diagnosis restricted.

PA (prior authorization) requests for non-preferred drugs in the opioid dependency agents—buprenorphine drug class must be submitted on the PA/PDL for Opioid Dependency Agents — Buprenorphine (Prior Authorization/Preferred Drug List for Opioid Dependency Agents — Buprenorphine, F-00081 (07/20)) form.

PA is not required for preferred drugs in the opioid dependency agents—buprenorphine drug class.

Note: The policy for obtaining provider-administered drugs applies to Sublocade.

Submitting PA Requests for Opioid Dependency Agents—Buprenorphine

The PA form must be sent to the pharmacy where the prescription will be filled. The prescriber may send the PA form to the pharmacy, or the member may carry the PA form with the prescription to the pharmacy. 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.

Pharmacy providers are required to submit the completed PA/PDL for Opioid Dependency Agents — Buprenorphine form and a

completed PA/RF (Prior Authorization Request Form, F-11018 (05/13)) to ForwardHealth.

PA requests for buprenorphine tablets without naloxone for BadgerCare Plus, Medicaid, and SeniorCare members may be submitted using the STAT-PA (Specialized Transmission Approval Technology-Prior Authorization) system, on the Portal, by fax, or by mail.

PA requests for non-preferred buprenorphine-naloxone drugs may be submitted on the Portal, by fax, or by mail (but **not** using the STAT-PA system).

PA requests for non-preferred buprenorphine-naloxone drugs may be approved for up to 365 days.

PA requests for buprenorphine tablets without naloxone (for pregnant women only) may be approved for the lesser of one of the following:

- Up to 14 days past the member's expected due date entered on the PA/PDL for Opioid Dependency Agents—Buprenorphine form
- Up to 300 days

Buprenorphine tablets without naloxone (for pregnant women only) are available through an expedited emergency supply request, which may be granted for up to a 14-day supply.

Clinical Criteria for Opioid Dependency Agents—Buprenorphine

Clinical criteria for opioid dependency agents—buprenorphine are **all** of the following:

- The member has a diagnosis of opioid type dependence.
- The member is 16 years of age or older.
- The prescriber has a valid DATA 2000 (Drug Addiction Treatment Act of 2000) waiver allowing them to prescribe buprenorphine-based agents for opioid dependency treatment.
- The member is not taking other opioids, tramadol, or carisoprodol.

Clinical Criteria for Buprenorphine Tablets Without Naloxone

Buprenorphine tablets without naloxone are a non-preferred drug in the opioid dependency agents—buprenorphine drug class.

Clinical criteria for approval of a PA request for buprenorphine tablets without naloxone are **both** of the following:

- The member meets the clinical criteria for opioid dependency agents—buprenorphine.
- The member is pregnant and the prescriber has indicated the member's expected delivery date.

Clinical Criteria for Non-Preferred Buprenorphine-Naloxone Drugs

The clinical criteria for approval of a PA request for non-preferred buprenorphine-naloxone drugs are **both** of the following:

- The member meets the clinical criteria for opioid dependency agents—buprenorphine.
- The prescriber prescriber has submitted detailed clinical justification for prescribing a non-preferred buprenorphine-naloxone drug instead of **buprenorphine-naloxone tablets, Suboxone film, and Zubsolv**, including clinical information explaining why the member cannot use buprenorphine-naloxone tablets, Suboxone film, and Zubsolv and why it is medically necessary that the member receive a non-preferred buprenorphine-naloxone drug instead of buprenorphine-naloxone tablets, Suboxone film, and Zubsolv.

Opioid Dependency Agents—Methadone

Methadone dispersible tablets and methadone oral concentrate are preferred drugs in the opioid dependency agents—methadone drug class; PA is not required.

Drugs in the opioid dependency agents—methadone drug class **are** diagnosis restricted.

Opioid Dependency Agents—Rescue Agent

Naloxone syringe, naloxone vial, and Narcan nasal spray are preferred drugs in the opioid dependency agents—rescue agent drug class; PA is not required.

Drugs in the opioid dependency agents—rescue agent drug class **are not** diagnosis restricted.

Opioid Dependency and Alcohol Abuse/Dependency Agents

Vivitrol injection and naltrexone tablets are preferred drugs in the opioid dependency and alcohol abuse/dependency agents drug class; PA is not required.

Drugs in the opioid dependency and alcohol abuse/dependency agents drug class **are** diagnosis restricted.

Note: The policy for obtaining provider-administered drugs applies to Vivitrol injection.

Topic #19877

Otic Antibiotics

Ciprodex and ofloxacin are non-preferred drugs in the otic antibiotics drug class; however, PA (prior authorization) for Ciprodex or ofloxacin is not required for members who are 6 years of age or younger. Once a member reaches 7 years of age, PA is required.

Topic #20877

Prenatal Vitamins

In the prenatal vitamins drug class on the Preferred Drug List Quick Reference, ForwardHealth lists only the preferred generic and brand name drugs. Non-preferred drugs in the prenatal vitamins drug class will not be listed.

Drugs not listed in the prenatal vitamins drug class on the Preferred Drug List Quick Reference are one of the following:

- Considered to be non-preferred and require PA (prior authorization)
- Noncovered (for example, drugs without signed manufacturer rebate agreements, convenience or combination packaged drugs, and drugs produced under NDCs (National Drug Codes) identified as terminated by CMS (Centers for Medicare and Medicaid Services))

Providers may use the Drug Search Tool to determine the most current covered prenatal vitamins and their preferred or non-preferred status.

Convenience and combination packaged drugs are not covered by ForwardHealth.

Expedited Emergency Supply for Prenatal Vitamins

Prenatal vitamins are available through an expedited emergency supply PA request, which may be granted for up to a 100-day supply.

Topic #8877

Proton Pump Inhibitors

Note: The Preferred Drug List Quick Reference provides the most current list of preferred and non-preferred drugs in this drug class.

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 (07/15)) or the PA/PDL for PPI Orally Disintegrating Tablets (Prior Authorization/Preferred Drug List for Proton Pump Inhibitor Orally Disintegrating Tablets, F-00433 (07/13)).

PA requests for PPI drugs may be submitted using the STAT-PA (Specialized Transmission Approval Technology-Prior Authorization) system, on the ForwardHealth Portal, by fax, or by mail.

Clinical Criteria for Non-preferred Proton Pump Inhibitor Capsules and Tablets

The clinical criterion for approval of a PA request for a non-preferred PPI capsule or tablet is that the member has experienced an unsatisfactory therapeutic response or a clinically significant adverse drug reaction with **at least two** preferred PPI capsules or tablets.

Clinical Criteria for Non-preferred Proton Pump Inhibitor Orally Disintegrating Tablets

Clinical Criteria for Members Who Can Take Oral Suspensions

- At least **one** of the following is true:
  - The member has experienced an unsatisfactory therapeutic response or a clinically significant adverse drug reaction on any dosage form of esomeprazole.
  - There is a clinically significant drug interaction between another drug the member is taking and esomeprazole.
- At least **one** of the following is true:
  - The member has experienced an unsatisfactory therapeutic response or a clinically significant adverse drug reaction on any dosage form of omeprazole.
  - There is a clinically significant drug interaction between another drug the member is taking and omeprazole.
- At least **one** of the following is true:
  - The member has experienced an unsatisfactory therapeutic response or a clinically significant adverse drug reaction on any dosage form of pantoprazole.
  - There is a clinically significant drug interaction between another drug the member is taking and pantoprazole.

Note: Pantoprazole criteria do **not** apply to members under 5 years of age. Only esomeprazole criteria and omeprazole criteria apply to members under 5 years of age.

ForwardHealth covers only the prescription form of esomeprazole; over-the-counter esomeprazole is not covered.

Clinical Criteria for Members Who Cannot Take Oral Suspensions

Clinical criteria for approval of a PA request for PPI orally disintegrating tablets for members who **cannot** take oral suspensions are **both** of the following:

- The member has a medical condition(s) that prevents the use of PPI suspensions.
- Member preference is **not** the reason why the member is unable to take PPI suspensions.

Topic #18817

Sedative Hypnotics

Note: The Preferred Drug List Quick Reference provides the most current list of preferred and non-preferred drugs in this drug class.

PA (prior authorization) requests for Belsomra or Dayvigo must be completed, signed, and dated by the prescriber. PA requests for Belsomra or Dayvigo must be submitted using the PA/PDL for Belsomra and Dayvigo (Prior Authorization/Preferred Drug List for Belsomra and Dayvigo, F-01673 (09/20)) form.

The PA form must be sent to the pharmacy where the prescription will be filled. The prescriber may send the PA form to the pharmacy, or the member may carry the PA form with the prescription to the pharmacy. 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.

Pharmacy providers are required to submit the completed PA/PDL for Belsomra and Dayvigo form and a completed PA/RF (Prior Authorization Request Form, F-11018 (05/13)) to ForwardHealth.

PA requests for Belsomra or Dayvigo may be submitted using the STAT-PA (Specialized Transmission Approval Technology-Prior Authorization) system, on the Portal, by fax, or by mail.

Clinical Criteria for Belsomra and Dayvigo

Clinical criteria for approval of a PA request for Belsomra **or** Dayvigo are **all** of the following:

- The member is 18 years of age or older.
- The member does not have narcolepsy.
- **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 drugs from the sedative hypnotics drug class.
  - The member has a medical history of substance abuse or misuse.

If the clinical criteria for Belsomra **or** Dayvigo are met, PA requests may be approved for up to 365 days.

Topic #16357

Stimulants

Note: The Preferred Drug List Quick Reference provides the most current list of preferred and non-preferred drugs in this drug class.

Note: Some drugs in the stimulants drug class are grandfathered. For more information about grandfathering in this drug class,

providers may refer to the Grandfathering for Stimulants topic.

Drugs in this class are diagnosis restricted. A ForwardHealth-allowed diagnosis code must be indicated on claims (and PA (prior authorization) requests when applicable) for all stimulant drugs.

PA requests for non-preferred stimulants must be submitted on the PA/PDL for Non-Preferred Stimulants (Prior Authorization/Preferred Drug List for Non-Preferred Stimulants, F-01672 (01/17)) form.

Amphetamine salt combo, Dexedrine tablets, dextroamphetamine solution, dextroamphetamine tablets, Evekeo, and Zenzedi are non-preferred drugs; however, PA for amphetamine salt combo, Dexedrine tablets, dextroamphetamine solution, dextroamphetamine tablets, Evekeo, or Zenzedi is not required for members who are 6 years of age or younger. Once a member reaches 7 years of age, PA will be required.

Clinical Criteria for Non-Preferred Stimulants

Non-Preferred stimulants require PA.

Clinical criteria for approval of a PA request for a non-preferred stimulant are **both** of the following:

- At least **one** of the following is true:
  - The member took Vyvanse for at least 60 consecutive days with a minimum of one dosage adjustment and experienced an unsatisfactory therapeutic response.
  - The member took Vyvanse and experienced a clinically significant adverse drug reaction.
- At least **one** of the following is true:
  - The member took a methylphenidate stimulant for at least 60 consecutive days with a minimum of one dosage adjustment and experienced an unsatisfactory therapeutic response.
  - The member took a methylphenidate stimulant and experienced a clinically significant adverse drug reaction.
  - The member took a dexmethylphenidate stimulant for at least 60 consecutive days with a minimum of one dosage adjustment and experienced an unsatisfactory therapeutic response.
  - The member took a dexmethylphenidate stimulant and experienced a clinically significant adverse drug reaction.

Submitting PA Requests for Non-Preferred Stimulants

PA requests for non-preferred stimulants must be completed and signed by the prescriber and must be submitted using the PA/PDL for Non-Preferred Stimulants form.

PA requests for non-preferred stimulants (except for generic Concerta ER or methamphetamine requests) may be submitted using the STAT-PA (Specialized Transmission Approval Technology-Prior Authorization) system, on the Portal, by fax, or by mail.

Methamphetamine

PA requests for methamphetamine should be submitted using Section VI (Clinical Information for Drugs With Specific Criteria Addressed in the ForwardHealth Online Handbook) of the PA/DGA (Prior Authorization/Drug Attachment, F-11049 (07/16)) form and the PA/RF (Prior Authorization Request Form, F-11018 (05/13)).

PA requests for methamphetamine may be submitted on the Portal, by fax, or by mail (but **not** using the STAT-PA system).

Clinical Criteria for Methamphetamine

Clinical criteria that must be documented for approval of a PA request for methamphetamine are **all** of the following:

- The member is 6–17 years of age.
- The member has had neuropsychological/psychological assessment that supports a diagnosis of ADHD (attention-deficit hyperactivity disorder).
- The prescriber has provided documented and objective evidence (supplied by third-party, unrelated adult observers) of functioning deficits secondary to ADHD in at least **two** of the following domains of functioning:
  - Home
  - Work
  - School
  - Community
- At least **one** of the following is true:
  - The member took Vyvanse for at least 60 consecutive days with a minimum of one dosage adjustment and experienced an unsatisfactory therapeutic response.
  - The member took Vyvanse and experienced a clinically significant adverse drug reaction.
- At least **one** of the following is true:
  - The member took a methylphenidate stimulant for at least 60 consecutive days with a minimum of one dosage adjustment and experienced an unsatisfactory therapeutic response.
  - The member took a methylphenidate stimulant and experienced a clinically significant adverse drug reaction.
- At least **one** of the following is true:
  - The member took a dexmethylphenidate stimulant for at least 60 consecutive days with a minimum of one dosage adjustment and experienced an unsatisfactory therapeutic response.
  - The member took a dexmethylphenidate stimulant and experienced a clinically significant adverse drug reaction.

PA requests must include medical records to support the above criteria have been met, including documentation of all past and current treatments that have been attempted (both pharmacologic and non-pharmacologic).

If clinical criteria for methamphetamine are met, PA requests will be approved for up to 183 days.

Stimulants and Stimulants, Related Agents - Wake Promoting Quantity Limits

Quantity limits apply to armodafinil, modafinil, Sunosi, and all preferred and non-preferred stimulants, with the exception of liquid dosage forms. Quantity limits do not apply to liquid dosage forms of stimulants. When a claim is submitted with a quantity that exceeds the limit, the claim will be denied.

Armodafinil, modafinil, Sunosi, and stimulants (with the exception of liquid dosage forms) have a cumulative quantity limit of 136 units per month for drugs in the stimulants drug class and the stimulants, related agents - wake promoting drug class. Members are limited to a combined total of 136 units (tablets, capsules, or patches) per month, an exception being members with narcolepsy. Members with narcolepsy are allowed a quantity limit override to receive up to 136 units of stimulants in addition to 250 mg of armodafinil or 400 mg of modafinil or 150 mg of Sunosi per day.

The Quantity Limit Drugs and Diabetic Supplies data table contains the most current quantity limits.

Overriding the Stimulants and Stimulants, Related Agents - Wake Promoting Quantity Limit Policy

Prior to requesting a quantity limit policy override, the pharmacy provider should contact the prescriber to determine whether or not it is medically appropriate for a member to exceed the quantity limit.

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.

Note: Providers are reminded that they may dispense up to the allowed quantity limit without contacting the DAPO Center.

Pharmacy providers may request a quantity limit policy override for members enrolled in BadgerCare Plus, Medicaid, or SeniorCare.

A quantity limit override request for drugs in the stimulants drug class and the stimulants, related agents - wake promoting drug class is limited to a one-month override and may be approved for the following situations:

- Lost or stolen medication
- Vacation supply
- Medication and/or dosage change by the prescriber

In addition, pharmacy providers may request a quantity limit policy override for members with narcolepsy. Members with narcolepsy are allowed a quantity limit override to receive up to 136 units of stimulants in addition to 250 mg of armodafinil or 400 mg of modafinil or 150 mg of Sunosi per day.

If the member does not meet the policy for a stimulants quantity limit override through the DAPO Center, and the claim submitted exceeds the allowed stimulants quantity limit, the claim will be denied and the service will be a noncovered service. Members do not have appeal rights for noncovered services.

Topic #19878

Stimulants, Related Agents - Wake Promoting

Armodafinil and modafinil are preferred drugs in the stimulants, related agents - wake promoting drug class; PA (prior authorization) is not required. Sunosi is a non-preferred drug in the stimulants, related agents - wake promoting class and does require PA.

Non-Preferred Stimulants, Related Agents - Wake Promoting

PA requests for non-preferred drugs in the stimulants, related agents - wake promoting class must be completed, signed, and dated by the prescriber. The PA form must be sent to the pharmacy where the prescription will be filled. The prescriber may send the PA form to the pharmacy, or the member may carry the PA form with the prescription to the pharmacy. 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.

PA requests for non-preferred drugs in the stimulants, related agents - wake promoting class should be submitted using the Prior Authorization Drug Attachment for Non-Preferred Stimulants, Related Agents - Wake Promoting (F-02537 (11/2019)) form and the PA/RF (Prior Authorization Request Form, F-11018 (05/13)).

PA requests for non-preferred drugs in the stimulants, related agents - wake promoting class may be submitted on the Portal, by fax, or by mail (but not using the STAT-PA (Specalized Transmission Approval Technology-Prior Authorization) system).

Conditions for Which PA Requests for Non-Preferred Stimulants, Related Agents - Wake Promoting Drugs Will Be Considered for Review

PA requests for non-preferred drugs in the stimulants, related agents - wake promoting class will only be approved for use to treat the following identified clinical conditions:

- EDS (excessive daytime sleepiness) associated with narcolepsy
- EDS associated with OSA (obstructive sleep apnea)

Clinical criteria for approval of PA requests for non-preferred drugs in the stimulants, related agents - wake promoting class for

members with narcolepsy are **all** of the following:

- The member is 18 years of age or older.
- The member has EDS associated with narcolepsy.
- An overnight PSG (polysomnogram) sleep study and MSLT (multiple sleep latency test) have been performed for the member using standard protocols, and the prescribing provider has submitted medical record documentation supporting a clinical correlation between the test results and a diagnosis of narcolepsy.
- The overnight PSG test results and provider interpretation have been submitted with the PA request and include documentation of the following:
  - The member's total sleep time was at least 360 minutes.
  - The member experienced minimal sleep interruptions (for example, respiratory events or periodic leg movements).
  - The provider interpretation indicates that an adequate night's sleep was achieved.
- The MSLT results and provider interpretation have been submitted with the PA request and include documentation of the following:
  - The MSLT was conducted the morning after the overnight PSG.
  - The average sleep latency for all naps was eight minutes or less.
  - The member achieved at least two SOREMP (sleep onset rapid eye movement period)s. (A SOREMP within 15 minutes of sleep onset on the preceding nocturnal PSG may replace one of the SOREMPs on the MSLT.)
- The member is not currently taking any other drugs in the stimulants, related agents - wake promoting class.
- The member is not taking any sedative hypnotics.
- For members currently taking CNS (central nervous system) depressants (for example, anxiolytics, barbiturates, or opioids), the prescriber has evaluated the CNS depressants and determined they are not contributing to the member's EDS.
- **At least one** of the following is true:
  - The member has tried armodafinil and experienced an unsatisfactory therapeutic response after the medication had been titrated to a maximum recommended daily dose.
  - The member experienced a clinically significant adverse drug reaction with armodafinil.
  - The member has a medical condition that prevents treatment with armodafinil.
  - There is a clinically significant drug interaction with another medication the member is taking and armodafinil.
- **At least one** of the following is true:
  - The member has tried modafinil and experienced an unsatisfactory therapeutic response after the medication had been titrated to a maximum recommended daily dose.
  - The member experienced a clinically significant adverse drug reaction with modafinil.
  - The member has a medical condition that prevents treatment with modafinil.
  - There is a clinically significant drug interaction with another medication the member is taking and modafinil.

If initial clinical criteria for non-preferred drugs in the stimulants, related agents - wake promoting class for members with narcolepsy are met, PA requests may be approved for up to a maximum of 183 days. Renewal PA requests for non-preferred drugs in the stimulants, related agents - wake promoting class may be approved for up to a maximum of 365 days.

Clinical Criteria for Non-Preferred Stimulants, Related Agents - Wake Promoting Drugs for Members With OSA

Clinical criteria for approval of PA requests for non-preferred drugs in the stimulants, related agents - wake promoting class for members with OSA are all of the following:

- The member is 18 years of age or older.
- The member has EDS associated with OSA.
- The member has had an overnight PSG sleep study with an AHI (apnea-hypopnea index) greater than or equal to five events per hour, confirming the member has OSA. The date of the PSG and the resulting AHI must be included with the PA request.
- The member is not currently taking any other drugs in the stimulants class **or** the stimulants, related agents - wake promoting class.

- The member is currently using CPAP (continuous positive airway pressure) and will continue to use CPAP in combination with the non-preferred stimulants, related agents - wake promoting drug.
- **At least one** of the following is true:
  - The member has tried armodafinil and experienced an unsatisfactory therapeutic response after the medication had been titrated to a maximum recommended daily dose.
  - The member experienced a clinically significant adverse drug reaction with armodafinil.
  - The member has a medical condition that prevents treatment with armodafinil.
  - There is a clinically significant drug interaction with another medication the member is taking and armodafinil.
- **At least one** of the following is true:
  - The member has tried modafinil and experienced an unsatisfactory therapeutic response after the medication had been titrated to a maximum recommended daily dose.
  - The member experienced a clinically significant adverse drug reaction with modafinil.
  - The member has a medical condition that prevents treatment with modafinil.
  - There is a clinically significant drug interaction with another medication the member is taking and modafinil.

Note: If requested by ForwardHealth, the provider is required to submit the test results and provider interpretation for the PSG.

If initial clinical criteria for non-preferred drugs in the stimulants, related agents - wake promoting class for members with OSA are met, PA requests may be approved for up to a maximum of 183 days. Renewal PA requests for non-preferred stimulants, related agents - wake promoting drugs may be approved for up to a maximum of 365 days.

Dose Limit for Armodafinil

A dose limit applies to armodafinil. The dose limit for armodafinil is 250 mg per day.

ForwardHealth will not consider dose limit overrides for armodafinil.

Dose Limit for Modafinil

A dose limit applies to modafinil. The dose limit for modafinil is 400 mg per day.

ForwardHealth will not consider dose limit overrides for modafinil.

Dose Limit for Sunosi

A dose limit applies to Sunosi. The dose limit for Sunosi is 150 mg per day.

ForwardHealth will not consider dose limit overrides for Sunosi.

Stimulants and Stimulants, Related Agents - Wake Promoting Quantity Limits

Quantity limits apply to armodafinil, modafinil, Sunosi, and all preferred and non-preferred stimulants, with the exception of liquid dosage forms. Quantity limits do not apply to liquid dosage forms of stimulants. When a claim is submitted with a quantity that exceeds the limit, the claim will be denied.

Armodafinil, modafinil, Sunosi, and stimulants (with the exception of liquid dosage forms) have a cumulative quantity limit of 136 units per month for drugs in the stimulants drug class and the stimulants, related agents - wake promoting drug class. Members are limited to a combined total of 136 units (tablets, capsules, or patches) per month, an exception being members with narcolepsy. Members with narcolepsy are allowed a quantity limit override to receive up to 136 units of stimulants in addition to 250 mg of armodafinil per day or 400 mg of modafinil per day or 150 mg of Sunosi per day.

The Quantity Limit Drugs and Diabetic Supplies data table contains the most current quantity limits.

Overriding the Stimulants and Stimulants, Related Agents - Wake Promoting Quantity Limit Policy

Prior to requesting a quantity limit policy override, the pharmacy provider should contact the prescriber to determine whether or not it is medically appropriate for a member to exceed the quantity limit.

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.

Note: Providers are reminded that they may dispense up to the allowed quantity limit without contacting the DAPO Center.

Pharmacy providers may request a quantity limit policy override for members enrolled in BadgerCare Plus, Medicaid, or SeniorCare.

A quantity limit override request for drugs in the stimulants drug class and the stimulants, related agents - wake promoting drug class is limited to a one-month override and may be approved for the following situations:

- Lost or stolen medication
- Vacation supply
- Medication and/or dosage change by the prescriber

In addition, pharmacy providers may request a quantity limit policy override for members with narcolepsy. Members with narcolepsy are allowed a quantity limit override to receive up to 136 units of stimulants in addition to 250 mg of armodafinil per day or 400 mg of modafinil per day or 150 mg of Sunosi per day.

If the member does not meet the policy for a stimulants quantity limit override through the DAPO Center and the claim submitted exceeds the allowed stimulants quantity limit, the claim will be denied and the service will be a noncovered service. Members do not have appeal rights for noncovered services.

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 (05/13)), PA/HIAS1 (Prior Authorization for Hearing Instrument and Audiological Services 1, F-11020 (05/13)), 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 Wis. Admin. Code § DHS 107.02(3)(e).

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 Wis. Admin Code § DHS 101.03(96m), "medically necessary" is a service under Wis. Admin. Code 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 Wisconsin DHS (Department of Health Services)
- Standards of practice
- Professional knowledge
- Scientific literature

Services Requiring Prior Authorization

Topic #17397

Crinone

PA (prior authorization) requests for Crinone may be approved for the treatment of secondary amenorrhea.

Although Crinone is also indicated for use in ART (assisted reproductive technology) treatment, ForwardHealth does not cover infertility treatment, including ART.

PA requests for Crinone for the treatment of secondary amenorrhea must be submitted using Section VI (Clinical Information for Drugs with Specific Criteria Addressed in the ForwardHealth Online Handbook) of the PA/DGA (Prior Authorization/Drug Attachment, F-11049 (07/16)) and the PA/RF (Prior Authorization Request Form, F-11018 (05/13)).

PA requests for Crinone for the treatment of secondary amenorrhea may be submitted on the ForwardHealth Portal, by fax, or by mail. PA requests for Crinone may **not** be submitted using the STAT-PA (Specialized Transmission Approval Technology-Prior Authorization) system.

Clinical Criteria for Crinone

Crinone may be used for the treatment of the following conditions:

- Secondary amenorrhea
- Prevention of preterm labor in women with a current singleton pregnancy and either short cervical length or a history of preterm labor

Although Crinone is also indicated for use in ART treatment, ForwardHealth does not cover infertility treatment, including ART.

For Members Who Have Secondary Amenorrhea

Secondary amenorrhea is the cessation of menses for six or more months in a woman who previously had normal menstrual cycles. Women who are pregnant, breastfeeding, or in menopause are not considered to have secondary amenorrhea.

Clinical criteria that must be documented for approval of a PA request for Crinone for members who have secondary amenorrhea are **all** of the following:

- The member has secondary amenorrhea.
- The member's last menstrual cycle occurred more than six months ago.
- The member is **not** being treated for infertility.
- The member is not pregnant or breastfeeding.
- The member is not in menopause.
- The member is currently receiving estrogen therapy.

Crinone 4% will only be approved for every-other-day dosing up to a total of six doses.

In women who fail to respond to a trial of Crinone 4%, Crinone 8% will only be approved for every-other-day dosing up to a total of six doses.

Crinone 8% for Women with a Current Singleton Pregnancy and Either Short Cervical Length or a History of Preterm Labor

ForwardHealth covers Crinone 8% for daily dosing through 36 weeks gestation in women with a current singleton pregnancy and either short cervical length or a history of preterm labor.

PA is not required for coverage of Crinone 8% in these situations; however, providers are required instead to follow the procedures for Diagnosis-Restricted Drugs.

Topic #20897

Cystic Fibrosis Drugs Containing Ivacaftor

Clinical PA (prior authorization) is required for all cystic fibrosis drugs containing ivacaftor.

PA requests for cystic fibrosis drugs containing ivacaftor will only be approved for **one cystic fibrosis drug containing ivacaftor per member**. ForwardHealth does not cover treatment with more than one cystic fibrosis drug containing ivacaftor.

PA requests for cystic fibrosis drugs containing ivacaftor should be submitted using Section VI (Clinical Information for Drugs With Specific Criteria Addressed in the ForwardHealth Online Handbook) of the PA/DGA (Prior Authorization/Drug Attachment, F-11049 (07/16)) form.

PA requests for cystic fibrosis drugs containing ivacaftor may be submitted on the Portal, by fax, or by mail (but **not** using the STAT-PA (Specialized Transmission Approval Technology-Prior Authorization) system).

Clinical criteria that must be documented for approval of a PA request for cystic fibrosis drugs containing ivacaftor are **all** of the following:

- The member has cystic fibrosis.
- The member's age is consistent with the FDA (Food and Drug Administration)-approved indication for the use of the specific cystic fibrosis drug containing ivacaftor.
- The member has a gene mutation consistent with the FDA-approved indication for the use of the specific cystic fibrosis drug containing ivacaftor. (*Note:* A copy of the gene mutation test results must be included with an initial PA request.)

A copy of the member's medical records must be submitted with all PA requests for cystic fibrosis drugs containing ivacaftor. Medical records should document the following:

- Current progress notes related to the member's cystic fibrosis treatment plan
- A copy of the member's current pulmonary function test results

Initial PA requests for cystic fibrosis drugs containing ivacaftor may be approved for up to 183 days.

Renewal PA requests require that the member has been adherent with their entire cystic fibrosis medication regimen and that there is documentation demonstrating the member has experienced clinical improvement with the prescribed cystic fibrosis drug containing ivacaftor. Renewal PA requests may be approved for up to a maximum of 365 days.

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 BadgerCare Plus, Wisconsin Medicaid, and SeniorCare:

- Alitretinoin gel (when used to treat Kaposi's sarcoma lesions)
- BBG (brand before generic) drugs
- BMN (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 Wisconsin 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 (05/13)) 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 #21198

Endari

Endari requires clinical PA (prior authorization).

Note: The Select High Cost, Orphan, and Accelerated Approval Drugs data table identifies select high cost, orphan, and accelerated approval drugs and interim billing and coverage information for these drugs. The table also identifies which drugs have specific PA or policy requirements. For specific questions about the billing or coverage of high cost, orphan, and accelerated approval drugs listed in the Select High Cost, Orphan, and Accelerated Approval Drugs data table, providers may contact Provider Services or email DHSOrphanDrugs@dhs.wisconsin.gov.

Clinical Criteria for Endari

Clinical criteria that must be documented for approval of a PA request for Endari are **all** of the following:

- The member has been diagnosed with SCD (sickle cell disease).
- The member is 5 years of age or older.
- The member's current weight is provided.
- The dose requested is consistent with the FDA (Food and Drug Administration)-recommended daily dosage (5 to 15 g twice daily based on body weight).
- The prescription is written by a hematologist or a provider who specializes in SCD.
- The prescriber has documented the frequency of sickle cell crisis experienced by the member in the past 12 months, with evidence of at least one sickle cell crisis in the past year. Documentation should include the type of crisis, the approximate dates, and what interventions took place. Sickle cell crisis is defined as **one or more** of the following:
  - The member had an emergency room visit/medical facility visit for sickle cell disease-related pain treated with parenteral opioid or parenteral ketorolac.
  - The member had acute chest syndrome.
  - The member had priapism.
  - The member had splenic sequestration.
  - The member had a venous thromboembolism, myocardial infarction, stroke, or transient ischemic attack thought to be related to SCD.
  - The member had dactylitis or bone infarction.
- **At least one** of the following is true:
  - The member has experienced an unsatisfactory therapeutic response or a clinically significant adverse drug reaction with hydroxyurea.
  - There is a clinically significant drug interaction between another drug(s) the member is taking and hydroxyurea.
  - The member has a medical condition(s) that prevents the use of hydroxyurea.
- A copy of the member's medical records must be submitted and should document the following:
  - The medical record contains sufficient documentation to satisfy the clinical coverage criteria above.
  - The medical record contains details regarding previous medication use.
  - The medical record describes the member's current treatment plan.

The following will **not** be considered as criteria to support the need for Endari:

- Nonadherence to previous therapies for SCD
- Member or prescriber preference

If clinical criteria for Endari are met, initial PA requests may be approved for up to 183 days. Renewal PA requests for Endari may be approved for up to 365 days.

Renewal PA Requests

Renewal PA requests for members who have SCD must meet the clinical criteria for initial PA requests for Endari and have documentation to support that the member has experienced a reduction in the number of sickle cell crises since starting Endari treatment. All renewal PA requests require the member to be adherent with the prescribed treatment regimen. A copy of the current medical records must be included with the PA request.

Submitting PA Requests for Endari

For PA requests for Endari, the prescriber is required to complete, sign, and date the PA/DGA (Prior Authorization/Drug Attachment, F-11049 (07/16)) form, using Section VI (Clinical Information for Drugs With Specific Criteria Addressed in the ForwardHealth Online Handbook) of the form. The prescriber is required to send the completed PA/DGA form to the pharmacy where the prescription will be filled. The pharmacy provider is required to complete a PA/RF (Prior Authorization Request Form, F-11018 (05/13)) and submit it, along with the PA/DGA form received from the prescriber, to ForwardHealth using the PA submission option most appropriate for the drug.

PA requests for Endari may be submitted on the Portal, by fax, or by mail (but **not** using the STAT-PA (Specialized Transmission Approval Technology-Prior Authorization) system).

Topic #13678

Fertility and Impotence Drugs

According to Wis. Admin. Code §§ DHS 107.10(2)(f) and DHS 107.10(2)(g), the following drugs require PA (prior authorization):

- Drugs identified by the Wisconsin 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 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 (07/16)) and the drug is being used to treat a condition unrelated to fertility or impotence.

Topic #17857

Hetlioz

PA (prior authorization) requests for Hetlioz must be submitted using Section VI (Clinical Information for Drugs with Specific Criteria Addressed in the ForwardHealth Online Handbook) of the PA/DGA (Prior Authorization/Drug Attachment, F-11049 (07/16)) and the PA/RF (Prior Authorization Request Form, F-11018 (05/13)).

PA requests for Hetlioz may be submitted on the Portal, by fax, or by mail. PA requests for Hetlioz may not be submitted using the STAT-PA (Specialized Transmission Approval Technology-Prior Authorization) system.

Clinical Criteria for Hetlioz®

Clinical criteria that must be documented for approval of a PA request for Hetlioz are both of the following:

- The member is totally blind.
- The member has Non-24 (Non-24-hour sleep-wake disorder).

Clinical documentation and medical records must be submitted with the PA request to support the member's condition of total blindness and Non-24. Initial PA requests for Hetlioz may be approved for up to a maximum of 183 days.

Renewal PA requests may be approved for up to a maximum of 365 days. Medical records must be submitted demonstrating clinical improvement and must reflect patient compliance with medication use and safety precautions for Hetlioz.

Topic #21397

Jynarque

Jynarque requires clinical PA (prior authorization).

Note: The Select High Cost, Orphan, and Accelerated Approval Drugs data table identifies select high cost, orphan, and accelerated approval drugs and interim billing and coverage information for these drugs. The table also identifies which drugs have specific PA or policy requirements. For specific questions about the billing or coverage of high cost, orphan, and accelerated approval drugs listed in the Select High Cost, Orphan, and Accelerated Approval Drugs data table, providers may contact Provider Services or email DHSOrphanDrugs@dhs.wisconsin.gov.

Clinical Criteria for Jynarque

The following clinical criteria must be met and documented for approval of a PA request for Jynarque:

- The member has ADPKD (autosomal dominant polycystic kidney disease).
- The member is 18 years of age or older.
- The prescription is written by, or in consultation with, a nephrologist or kidney transplant specialist.
- The member has an eGFR (estimated glomerular filtration rate) equal to or greater than 25 mL/min per 1.73 m2.
- The member has a high risk for progression to ESRD (end-stage renal disease) due to **one** or more of the following:
  - A confirmed annual eGFR decline of at least 5 mL/min/1.73 m2 in one year
  - A confirmed annual eGFR decline of at least 2.5 mL/min/1.73 m2 per year over a period of five years
  - A greater than 5 percent increase in total kidney volume per year on at least three repeated measurements (via MRI or CT (computed tomography), each at least six months apart)
  - A truncated PDK (polycystic kidney disease)1 mutation and early clinical signs (that is, hypertension, macroscopic hematuria, cyst infection, or flank pain before the age of 35)
  - A Mayo classification (height adjusted total kidney volume by CT or MRI and age) of class 1C, 1D, and 1E
  - Documentation of average kidney length greater than 16.5 cm per ultrasonography, CT, or MRI

A copy of the member's medical records must be submitted and should sufficiently document:

- The information listed in the clinical coverage criteria.
- Details regarding previous medication use.
- The member's current treatment plan.

Note: The safety and efficacy of Jynarque in adults over the age of 55 is not yet known.

If clinical criteria for Jynarque are met, initial PA requests may be approved for up to 183 days. Renewal PA requests for Jynarque may be approved for up to 365 days.

Renewal PA Requests

Requests for renewal must meet the clinical criteria for initial PA approval and have documentation to support that there has been a decrease in the member's kidney disease progression. In order to confirm the necessary adherence, the claims history and medical records will be reviewed for all renewal requests. A copy of the pertinent medical records must be included with the PA

request.

Submitting PA Requests for Jynarque

PA requests for Jynarque must be submitted using the PA/DGA (Prior Authorization/Drug Attachment, F-11049 (07/16)) form.

PA requests for Jynarque must be completed, signed, and dated by the prescriber. PA requests for Jynarque should be submitted using using Section VI (Clinical Information for Drugs With Specific Criteria Addressed in the ForwardHealth Online Handbook) of the PA/DGA form.

The prescriber is required to send the completed PA/DGA form to the pharmacy where the prescription will be filled. The pharmacy provider is required to complete a PA/RF (Prior Authorization Request Form, F-11018 (05/13)) and submit it, along with the PA/DGA form received from the prescriber, to ForwardHealth using the PA submission option most appropriate for the drug.

PA requests for Jynarque may be submitted on the Portal, by fax, or by mail (but **not** using the STAT-PA (Specialized Transmission Approval Technology-Prior Authorization) system).

Topic #21199

Luxturna

Luxturna requires clinical PA (prior authorization).

Note: The Select High Cost, Orphan, and Accelerated Approval Drugs data table identifies select high cost, orphan, and accelerated approval drugs and interim billing and coverage information for these drugs. The table also identifies which drugs have specific PA or policy requirements. For specific questions about the billing or coverage of high cost, orphan, and accelerated approval drugs listed in the Select High Cost, Orphan, and Accelerated Approval Drugs data table, providers may contact Provider Services or email DHSOrphanDrugs@dhs.wisconsin.gov.

Clinical Criteria for Luxturna

Clinical criteria that must be documented for approval of a PA request for Luxturna are **all** of the following:

- The member has a confirmed diagnosis of an inherited retinal dystrophy due to biallelic RPE65 mutations.
- The member has sufficient viable retinal cells (defined as an area of retinal thickness greater than 100 microns within the posterior pole) as measured by OCT (optical coherence tomography).
- The member has remaining light perception in the eye(s) that will receive treatment.
- Luxturna is prescribed and administered by an ophthalmologist or retinal surgeon with experience providing subretinal injections.

If clinical criteria for Luxturna are met, PA requests may be approved on a unilateral basis for up to four weeks (one lifetime dose per eye). For consideration of continued therapy on the second eye, **all** of the following must apply:

- All clinical criteria for initial PA request approval must be met.
- Administration is planned within a close interval to the treatment of the first eye, but at least six days apart.
- The PA request is not for a repeat treatment of a previously treated eye.

Submitting PA Requests for Luxturna

For PA requests for Luxturna, the prescriber is required to complete, sign, and date the PA/DGA (Prior Authorization/Drug

Attachment, F-11049 (07/16)) form, using Section VI (Clinical Information for Drugs With Specific Criteria Addressed in the ForwardHealth Online Handbook) of the form. The prescriber is required to send the completed PA/DGA form to the pharmacy where the prescription will be filled. The pharmacy provider is required to complete a PA/RF (Prior Authorization Request Form, F-11018 (05/13)) and submit it, along with the PA/DGA form received from the prescriber, to ForwardHealth using the PA submission option most appropriate for the drug.

PA requests for Luxturna may be submitted on the Portal, by fax, or by mail (but **not** using the STAT-PA (Specialized Transmission Approval Technology-Prior Authorization) system).

Topic #17877

Misoprostol

PA (prior authorization) requests for misoprostol must be submitted using Section VI (Clinical Information for Drugs with Specific Criteria Addressed in the ForwardHealth Online Handbook) of the PA/DGA (Prior Authorization/Drug Attachment, F-11049 (07/16)) and the PA/RF (Prior Authorization Request Form, F-11018 (05/13)).

PA requests for misoprostol may be submitted on the Portal, by fax, or by mail. PA requests for misoprostol may not be submitted using the STAT-PA (Specialized Transmission Approval Technology-Prior Authorization) system.

Clinical Criteria for Misoprostol

Clinical criteria that must be documented for approval of a PA request for misoprostol are all of the following:

- The member is currently taking at least one NSAID (Nonsteroidal Anti-inflammatory Drug).
- The member is not pregnant.
- Misoprostol is being prescribed to reduce the risk of an NSAID-induced gastrointestinal ulcer.

Misoprostol may be approved for up to a maximum of 365 days.

Note: ForwardHealth does not cover misoprostol when used in conjunction with gynecological procedures.

Topic #21200

Palynziq

Palynziq requires clinical PA (prior authorization).

Note: The Select High Cost, Orphan, and Accelerated Approval Drugs data table identifies select high cost, orphan, and accelerated approval drugs and interim billing and coverage information for these drugs. The table also identifies which drugs have specific PA or policy requirements. For specific questions about the billing or coverage of high cost, orphan, and accelerated approval drugs listed in the Select High Cost, Orphan, and Accelerated Approval Drugs data table, providers may contact Provider Services or email DHSOrphanDrugs@dhs.wisconsin.gov.

Clinical Criteria for Palynziq

Clinical criteria that must be documented for approval of a PA request for Palynziq for the treatment of adult members 18 years of age or older with a documented diagnosis of PKU (phenylketonuria) are **all** of the following:

- The member has blood Phe (phenylalanine) levels greater than 600 micromole/L on existing management (for example,

restriction of dietary Phe and protein intake).
- **At least one** of the following is true:
  - The member has experienced an unsatisfactory therapeutic response or a clinically significant adverse drug reaction with sapropterin (Kuvan).
  - There is a clinically significant drug interaction between another drug(s) the member is taking and sapropterin (Kuvan).
  - The member has a medical condition(s) that prevents the use of sapropterin (Kuvan).
- Blood Phe levels will be obtained every four weeks until a maintenance dose is established. The drug dose should be titrated to the lowest effective dose. Once a maintenance dose is established, Phe levels will be monitored every six months.
- A copy of the member's medical records must be submitted and should document the following:
  - The medical record contains sufficient documentation to satisfy the clinical coverage criteria above.
  - The medical record contains details regarding previous medication use.
  - The medical record describes the member's current treatment plan.

If clinical criteria for Palynziq are met, initial PA requests may be approved for up to 183 days. Renewal PA requests for Palynziq may be approved for up to 365 days.

In addition to meeting the clinical criteria for initial PA request approval, renewal PA requests for Palynziq require the submission of medical records (for example, chart notes, laboratory values) with the most recent results to demonstrate at least one of the following:

- The member has achieved at least a 20 percent reduction in blood Phe level from pretreatment baseline.
- The member has achieved a blood Phe level less than or equal to 600 micromole/L.

Submitting PA Requests for Palynziq

For PA requests for Palynziq, the prescriber is required to complete, sign, and date the PA/DGA (Prior Authorization/Drug Attachment, F-11049 (07/16)) form, using Section VI (Clinical Information for Drugs With Specific Criteria Addressed in the ForwardHealth Online Handbook) of the form. The prescriber is required to send the completed PA/DGA form to the pharmacy where the prescription will be filled. The pharmacy provider is required to complete a PA/RF (Prior Authorization Request Form, F-11018 (05/13)) and submit it, along with the PA/DGA form received from the prescriber, to ForwardHealth using the PA submission option most appropriate for the drug.

PA requests for Palynziq may be submitted on the Portal, by fax, or by mail (but **not** using the STAT-PA (Specialized Transmission Approval Technology-Prior Authorization) system).

Topic #19817

Personal Continuous Glucose Monitoring Devices and Accessories

PA (prior authorization) is required for coverage of personal continuous glucose monitoring devices and accessories.

Prior Authorization Approval Criteria

PA requests for personal continuous glucose monitoring devices and accessories may be approved for members who meet all of the following criteria:

- Have Type 1 diabetes mellitus
- Are 25 years of age or older

- Require and are compliant with intensive insulin treatment or an insulin pump and adequate self-monitoring of blood glucose (with at least four finger sticks per day)
- Have the motivation to use a personal continuous glucose monitoring device on a near-daily basis and have the ability and readiness, as assessed by their medical team that includes an endocrinologist, to make appropriate adjustments to their treatment regimen from the trending information obtained from the continuous glucose monitoring device
- Have successfully completed a 72-hour trial using a professional continuous glucose monitoring device, where available, that was found to be both clinically meaningful (i.e., alterations in medical management resulted) and tolerated by the member
- Are receiving in-depth diabetes education and are in regular close contact with their diabetes management team

and

- There is documentation available supporting hypoglycemic unawareness (which may include nocturnal asymptomatic hypoglycemia) with recurrent, ongoing hypoglycemia (<50 mg/dL) or a significant risk for hypoglycemia (i.e., HbA1c (hemoglobin A1c) ≤ 7.0 or other predisposing condition/comorbidity).

or

- The member has not been able to achieve optimal glycemic control as defined by the treating endocrinologist despite compliance with a carefully managed regimen, including four finger sticks a day.

ForwardHealth does not cover personal continuous glucose monitoring devices for members diagnosed with Type 2 diabetes.

Note: Evidence for successful use of a personal continuous glucose monitoring device is not as strong in children, adolescents, and young adults. However, ForwardHealth **will consider** coverage of a personal continuous glucose monitoring device on a **case-by-case basis** for members under 25 years old who meet the above criteria despite appropriate modifications in insulin regimen and compliance with frequent self-monitoring of their blood glucose (with at least four finger sticks per day). Success of a personal continuous glucose monitoring device is highly dependent on compliance, especially for members under 25 years old. Documentation for members under 25 years old must include an assessment by an endocrinologist or diabetes nurse educator of readiness of the member to use the device on a near-daily basis, as well as clear documentation that the member is compliant with self-monitoring as described above.

Prior Authorization Documentation

All of the following must be included as part of a PA request for personal continuous glucose monitoring devices and/or accessories:

- A completed PA/RF (Prior Authorization Request Form, F-11018 (05/13))
- A completed PA/DMEA (Prior Authorization/Durable Medical Equipment Attachment, F-11030 (07/12))
- Documentation of the member's diagnosis of Type 1 diabetes mellitus
- A written prescription from an endocrinologist or, in cases of joint management, from a licensed medical professional on the member's medical team that includes an endocrinologist
- The member's HbA1c levels for the preceding 12 months
- Documentation of the member's ability to recognize and express symptoms of hypoglycemia
- Documentation of any significant episodes of hypoglycemia in the preceding 12 months
- The following information about the continuous glucose monitoring device:
  - Name of the manufacturer of the device
  - Make of the device
  - Statement regarding whether or not the device is FDA (Food and Drug Administration)-approved
- A description of the member's compliance with a physician-ordered diabetic treatment plan, including regular self-monitoring and multiple alterations in insulin administration regimens
- Documentation of member and/or caregiver in-person training and available ongoing support in sensor placement, transmitter hookup, and monitor calibration, and an assessment from an endocrinologist or, in cases of joint management,

from a licensed medical professional on the member's medical team that includes an endocrinologist of the member's ability to self-manage treatment according to information obtained from the monitor
- Documentation that the member has undergone a 72-hour trial use of a glucose monitor, when available, and will be able to tolerate and appropriately use the device and information obtained to alter management accordingly

Topic #7877

Prior Authorization Requests and Amendments for Synagis

Synagis requires PA (prior authorization). Prescribers or their designees, **not** pharmacy providers, are required to submit PA requests for Synagis. Synagis administered in a hospital does not require PA.

PA requests for Synagis may be submitted beginning October 1 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 their 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 are required to request PA for Synagis using one of the following options:

- DAPO (Drug Authorization and Policy Override) Center
- ForwardHealth Portal
- Fax
- Mail

A prescriber, or their designees, should have all PA information completed before calling the DAPO Center to obtain PA.

Prescribers are required to retain a copy of the PA form and any supporting documentation.

Prior Authorization Requests Submitted by Fax or Mail

If a prescriber or their 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 (05/13)) for physician services
- Prior Authorization Drug Attachment for Synagis (F-00142 (10/14))
- 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.

Prescribers are required to sign and date each PA request form when submitting the request on paper.

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:

- DAPO Center
- Portal
- 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

The following conditions will be considered for approval of a PA request:

- CLD (Chronic lung disease) of prematurity
- CHD (Congenital heart disease)
- Heart transplant
- Pre-term infants
- Pulmonary Abnormalities and Neuromuscular Disease
- Immunocompromised

Chronic Lung Disease of Prematurity

For children younger than 12 months of age at the start of the RSV (Respiratory syncytial virus) season, PA requests must document that the child meets **all** of the following criteria:

- Gestational age at delivery is younger than 32 weeks (i.e., zero days through 31 weeks, six days)
- Required oxygen greater than 21 percent for at least the first 28 days after birth

For children between 12 and 24 months of age at the start of the RSV season, PA requests must document that the child meets **all** of the following criteria:

- Gestational age at delivery is younger than 32 weeks (i.e., zero days through 31 weeks, six days).
- Required oxygen greater than 21 percent for at least the first 28 days after birth.
- Required medical support (corticosteroid, diuretic, or supplemental oxygen) during the six-month period before the start of the RSV season

Congenital Heart Disease

PA requests must document that the child is younger than 12 months of age at the start of the RSV season and has hemodynamically significant CHD.

Heart Transplant

PA requests must document that the child is younger than 24 months of age at the start of the RSV season and will undergo cardiac transplantation during the RSV season.

Pre-term Infants

PA requests must document that the child was born before 29 weeks gestation (i.e., zero days through 28 weeks, six days) and is younger than 12 months of age at the start of the RSV season.

Pulmonary Abnormalities and Neuromuscular Disease

PA requests must document that the child meets all of the following criteria:

- The child is younger than 12 months of age at the start of the RSV season.
- The child has a neuromuscular disease or congenital anomaly that impairs the ability to clear secretions from the upper airway because of an ineffective cough.

Immunocompromised

PA requests must document that the child meets all of the following criteria:

- The child is younger than 24 months of age at the start of the RSV season.
- The child is profoundly immunocompromised. Immunodeficiency may be a result of, but not limited to, any of the following conditions:
  - AIDS (Acquired Immune Deficiency Syndrome)
  - Solid organ transplant
  - Stem cell transplant
  - Receiving chemotherapy

Prior Authorization Approval

A maximum of five doses of Synagis will be approved. For children born during the RSV season, fewer than five monthly doses will be needed. The following table includes the weight range, the rounded calculated Synagis dose, and the number of 50 mg units of Synagis. This information is used for the adjudication of PA requests to determine the allowed billing units per dose.

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.

PA requests for Synagis may be submitted beginning October 1 of each year with an earliest possible PA grant date of November 1 and latest PA expiration date of the following April 30.

If any child receiving monthly Synagis prophylaxis experiences a breakthrough RSV hospitalization, monthly prophylaxis will be discontinued.

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 (01/15)):

- Benzphetamine
- Diethylpropion
- Phendimetrazine
- Phentermine
- Contrave
- Evekeo
- Qysmia
- Saxenda
- Xenical

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 has not had bariatric surgery.
- The prescriber has evaluated and determined that the member does not have any medical or medication contraindications

to treatment with the anti-obesity drug being requested.
- For controlled substance anti-obesity drugs, the member does not have a medical history of substance abuse or misuse.
- 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.

ForwardHealth does not cover the following:

- Brand name (that is, innovator) anti-obesity drugs if an FDA (Food and Drug Administration)-approved generic equivalent is available
- Any brand name innovator phentermine products
- OTC (over-the-counter) anti-obesity drugs

ForwardHealth will return PA requests for the above-listed drugs as noncovered services.

Clinical Criteria for 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 up to a maximum of three months. If the member meets a weight loss goal of at least 10 pounds of their weight from baseline 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 of their weight from baseline 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 any controlled substance anti-obesity drug.

ForwardHealth allows only two weight loss attempts with this group of drugs (benzphetamine, diethylpropion, phendimetrazine, and phentermine) during a member's lifetime. Additional PA requests will not be approved. ForwardHealth will return additional PA requests to the provider as noncovered services. Members do not have appeal rights for noncovered services.

Clinical Criteria for Contrave

If clinical criteria for anti-obesity drugs are met, initial PA requests for Contrave will be approved for up to a maximum of three months. If the member meets a weight loss goal of at least five percent of their weight from baseline, PA may be requested for an additional six months of treatment. If the member's weight remains below baseline, a final PA renewal period of three months of Contrave may be approved. PA requests for Contrave 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 their weight from baseline during the initial three-month approval, or if the member's weight does not remain below baseline, or if the member has completed 12 months of continuous Contrave treatment, the member must wait six months before PA can be requested for Contrave.

ForwardHealth allows only two weight loss attempts with Contrave during a member's lifetime. Additional PA requests will not be approved. ForwardHealth will return additional PA requests to the provider as noncovered services. Members do not have appeal rights for noncovered services.

Clinical Criteria for Evekeo

If clinical criteria for anti-obesity drugs are met, initial PA requests for Evekeo will be approved for up to a maximum of one month. The maximum length of continuous drug therapy for Evekeo is one month.

After the member has completed one month of Evekeo treatment, the member must wait six months before PA can be requested for any controlled substance anti-obesity drug.

ForwardHealth allows only two weight loss attempts with Evekeo during a member's lifetime. Additional PA requests will not be approved. ForwardHealth will return additional PA requests to the provider as noncovered services. Members do not have appeal rights for noncovered services.

Clinical Criteria for Qysmia

If clinical criteria for anti-obesity drugs are met, initial PA requests for Qysmia will be approved for up to a maximum of six months. If the member meets a weight loss goal of at least five percent of their 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 their 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 any controlled substance anti-obesity drug.

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. Members do not have appeal rights for noncovered services.

Clinical Criteria for Saxenda

If clinical criteria for anti-obesity drugs are met, initial PA requests for Saxenda will be approved for up to a maximum of six months. If the member meets a weight loss goal of at least 5 percent of their weight from baseline, PA may be requested for an additional six months of treatment. Prior authorization requests for Saxenda may be approved for up to a maximum treatment period of 12 continuous months of drug therapy.

If the member does not meet a weight loss goal of at least 5 percent of their weight from baseline during the initial six-month approval, or if the member has completed 12 months of continuous Saxenda treatment, the member must wait six months before PA can be requested for Saxenda.

ForwardHealth allows only two weight loss attempts with Saxenda during a member's lifetime. Additional PA requests will not be approved. ForwardHealth will return additional PA requests to the provider as noncovered services. Members do not have appeal rights for noncovered services.

Clinical Criteria for Xenical

If clinical criteria for anti-obesity drugs are met, initial PA requests for Xenical will be approved for up to a maximum of six months. If the member meets a weight loss goal of at least 10 pounds of their weight from baseline during the first six months of treatment, PA may be requested for an additional six months of treatment. If the member's weight remains below baseline, 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, or if the member's weight does not remain below baseline, 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. Members do not have appeal rights for noncovered services.

Submitting Prior Authorization Requests for Anti-obesity Drugs

Prescribers or their designees are required to request PA for anti-obesity drugs using one of the following options:

- DAPO (Drug Authorization and Policy Override) Center
- Portal
- Fax
- Mail

A prescriber, or their designees, should have all PA information completed before calling the DAPO Center to obtain PA.

Prescribers are required to retain a copy of the PA form and any supporting documentation.

If a prescriber or their 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 Drug Attachment for Anti-obesity Drugs
- Supporting documentation, as appropriate

The Prior Authorization Fax Cover Sheet (F-01176 (12/11)) is available on the Forms page of the Portal for providers submitting the forms and documentation by fax.

Prescribers are reminded that they are required to sign and date each PA request form when submitting the request on paper.

Topic #12997

Prior Authorization for Drugs Outside ForwardHealth-Allowed Diagnoses

PA (prior authorization) requests for drugs outside the ForwardHealth-allowed diagnoses must be submitted on paper using a PA/RF (Prior Authorization Request Form, F-11018 (05/13)) and a PA/DGA (Prior Authorization/Drug Attachment, F-11049 (07/16)). The prescriber is required to complete the appropriate section(s) of the PA/DGA as it pertains to the drug being requested 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.

Topic #21201

Select High Cost, Orphan, or Accelerated Approval Drugs

Prior Authorization Requirements for Select High Cost, Orphan, or Accelerated Approval Drugs

Select high cost, orphan, or accelerated approval drugs may require PA (prior authorization), but in some cases, ForwardHealth will not establish drug-specific clinical criteria. For PA requests for select high cost, orphan, or accelerated approval drugs without drug-specific clinical criteria, the prescriber is required to complete, sign, and date the PA/DGA (Prior Authorization/Drug

Attachment, F-11049 (07/16)) form, using Section VII (Clinical Information for Other Drug Requests) of the form. The prescriber is required to send the completed PA/DGA form to the pharmacy where the prescription will be filled. The pharmacy provider is required to complete a PA/RF (Prior Authorization Request Form, F-11018 (05/13)) and submit it, along with the PA/DGA form received from the prescriber, to ForwardHealth using the PA submission option most appropriate for the drug.

If a high cost, orphan, or accelerated approval drug requires PA, but drug-specific clinical criteria are not established, PA requests for these drugs require the submission of medical records (for example, chart notes, laboratory values) to support that the drug being prescribed is for an FDA (Food and Drug Administration)-approved indication and is medically necessary as defined by Wis. Admin. Code § DHS 101.03(96m). The drug must be prescribed in a dose and manner consistent with FDA-approved product labeling. These PA requests will be reviewed on a case-by-case basis for medical necessity.

PA requests for these drugs may be submitted on the Portal, by fax, or by mail (but **not** using the STAT-PA (Specialized Transmission Approval Technology-Prior Authorization) system).

Note: For specific questions about the billing or coverage of high cost, orphan, and accelerated approval drugs listed in the Select High Cost, Orphan, and Accelerated Approval Drugs data table, providers may contact Provider Services or email DHSOrphanDrugs@dhs.wisconsin.gov.

Clinical Criteria for Select High Cost, Orphan, or Accelerated Approval Drugs

The Select High Cost, Orphan, and Accelerated Approval Drugs data table identifies high cost, orphan, and accelerated approval drugs that require PA to support that use will be for an FDA-approved indication; PA requests for these drugs will be reviewed on a case-by-case basis for medical necessity.

As new high cost, orphan, and accelerated approval drugs enter the market, ForwardHealth will use the Select High Cost, Orphan, and Accelerated Approval Drugs data table to identify whether or not these drugs require PA. For drugs that require PA, the table will indicate whether or not the drugs have drug-specific PA clinical criteria.

Topic #20177

Spinraza

Spinraza, a drug used to treat SMA (spinal muscular atrophy), requires clinical PA (prior authorization). Spinraza is reimbursed separately from physician and clinical services associated with the administration of Spinraza. Providers should submit claims for Spinraza to ForwardHealth using a noncompound drug claim. The pharmacy provider is required to establish a delivery process with the prescriber to ensure that Spinraza is delivered directly to the prescriber or an agent of the prescriber. Pharmacy providers may only submit a claim to ForwardHealth for Spinraza that has been administered to a member. If Spinraza has been dispensed for a member but the dose is not administered to the member, the prescriber is responsible for notifying the dispensing pharmacy. If ForwardHealth has paid the dispensing pharmacy for any portion of the dispensing of Spinraza that is not administered to the member, the dispensing pharmacy is responsible for reversing any claims submitted to ForwardHealth.

Note: The Select High Cost, Orphan, and Accelerated Approval Drugs data table identifies select high cost, orphan, and accelerated approval drugs and interim billing and coverage information for these drugs. The table also identifies which drugs have specific PA or policy requirements. For specific questions about the billing or coverage of high cost, orphan, and accelerated approval drugs listed in the Select High Cost, Orphan, and Accelerated Approval Drugs data table, providers may contact Provider Services or email DHSOrphanDrugs@dhs.wisconsin.gov.

Clinical Criteria for Spinraza

The following clinical criteria must be met and documented for approval of a PA request for Spinraza:

- Spinraza must be prescribed by a neurologist, pulmonologist, or other physician with expertise in treating SMA.

- The member has SMA type 1, 2, or 3, which has been confirmed by genetic testing (5q SMN1 (survival motor neuron 1): homozygous mutation, homozygous gene deletion, or compound heterozygote).
- The member has **at least two** copies of the SMN2 (survival motor neuron 2) gene.
- The prescriber must submit exam values of **at least one** of the following exams (based on member age and motor ability) to establish a baseline motor ability:
  - HINE (Hammersmith Infant Neurological Examination) (infant to early childhood)
  - HFMSE (Hammersmith Functional Motor Scale — Expanded)
  - RULM (Revised Upper Limb Module) test (non-ambulatory members)
  - CHOP INTEND (Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorders)
  - 6MWT (six-minute walk test) (ambulatory members)
- The prescriber indicates the member's pulmonary status, including any requirement for ventilator support.

ForwardHealth will consider coverage for Spinraza on a case-by-case basis if any of the following circumstances are present for the member:

- Complete paralysis of the limbs
- Ventilator dependent for 16 or more hours per day (including non-invasive respiratory support)
- Pre-symptomatic infants who have not yet developed symptoms but have undergone genetic studies indicating a high likelihood of developing type 1, 2, or 3 SMA disease (that is, less than three copies of the SMN2 gene)

A copy of the member's medical records must be submitted and should sufficiently document:

- The information listed in the clinical coverage criteria.
- Details regarding previous medication use.
- The member's current treatment plan.

ForwardHealth will deny PA requests for Spinraza if any of the following circumstances are present:

- The member is currently involved in a clinical trial for Spinraza.
- The member has received treatment with Zolgensma.
- The member is diagnosed with a non-SMN1 variant of SMA.

Initial PA requests for Spinraza to treat SMA may be approved for up to 210 days to allow for up to five doses of Spinraza.

Renewal PA Requests

In addition to meeting the clinical criteria for initial PA request approval, renewal PA requests for Spinraza require the submission of medical records (for example, chart notes, laboratory values) with the most recent results (less than one month prior to the submission of the renewal PA request) documenting a positive clinical response to Spinraza therapy **from pretreatment baseline status** as demonstrated by **one** or more of the following exams:

- HINE that demonstrates the following:
  - Improvement or maintenance of previous improvement of at least a two-point (or maximal score) increase in the ability to kick **or** improvement or maintenance of previous improvement of at least a one-point increase in any other HINE milestone (for example, head control, rolling, sitting, crawling), excluding voluntary grasp
  - Net positive improvement in condition, defined as improvement of previous improvement from the pretreatment baseline in a majority of the HINE motor milestones **or** achievement or maintenance of any new motor milestone(s) from the pretreatment baseline when the member would otherwise be unexpected to do so (for example, sit unassisted, stand, walk)
- HFMSE that demonstrates **one** of the following:
  - Improvement or maintenance of previous improvement of at least a three-point increase in score from pretreatment baseline
  - Achievement and maintenance of any new motor milestone(s) from pretreatment baseline when the member would

otherwise be unexpected to do so
- RULM test that demonstrates **one** of the following:
  - Improvement or maintenance of previous improvement of at least a two-point increase in score from pretreatment baseline
  - Achievement and maintenance of any new motor milestone(s) from pretreatment baseline when the member would otherwise be unexpected to do so
- CHOP INTEND that demonstrates **one** of the following:
  - Improvement or maintenance of previous improvement of at least a four-point increase in score from pretreatment baseline
  - Achievement and maintenance of any new motor milestone(s) from pretreatment baseline when the member would otherwise be unexpected to do so

Renewal PA requests for Spinraza used to treat SMA may be approved for up to a maximum of 365 days.

Submitting PA Requests for Spinraza

PA requests for Spinraza must be submitted using the PA/DGA (Prior Authorization/Drug Attachment, F-11049 (07/16)) form.

PA requests for Spinraza must be completed, signed, and dated by the prescriber. PA requests for Spinraza should be submitted using Section VI (Clinical Information for Drugs With Specific Criteria Addressed in the ForwardHealth Online Handbook) of the PA/DGA form.

The prescriber is required to send the completed PA/DGA form to the pharmacy where the prescription will be filled. The pharmacy provider is required to complete a PA/RF (Prior Authorization Request Form, F-11018 (05/13)) and submit it, along with the PA/DGA form received from the prescriber, to ForwardHealth using the PA submission option most appropriate for the drug.

PA requests for Spinraza may be submitted on the Portal, by fax, or by mail (but **not** using the STAT-PA (Specialized Transmission Approval Technology-Prior Authorization) system).

Topic #19840

Strensiq

Strensiq requires clinical PA (prior authorization). PA requests for Strensiq must be submitted using Section VI (Clinical Information for Drugs With Specific Criteria Addressed in the ForwardHealth Online Handbook) of the PA/DGA (Prior Authorization/Drug Attachment, F-11049 (07/16)) form and the PA/RF (Prior Authorization Request Form, F-11018 (05/13)).

The PA form must be sent to the pharmacy where the prescription will be filled. The prescriber may send the PA form to the pharmacy, or the member may carry the PA form with the prescription to the pharmacy. 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.

PA requests for Strensiq may be submitted on the Portal, by fax, or by mail (but **not** using the STAT-PA (Specialized Transmission Approval Technology-Prior Authorization) system).

Clinical Criteria for Strensiq

PA requests for Strensiq will only be approved for use to treat the following identified clinical conditions:

- Perinatal/infantile-onset HPP (hypophosphatasia)
- Juvenile-onset HPP

Clinical criteria that must be documented for approval of an initial PA request for Strensiq are **all** of the following:

- The member has perinatal/infantile-onset HPP or juvenile-onset HPP.
- The member was 18 years of age or younger at the onset of signs and/or symptoms of HPP.
- The member's current weight is provided.
- The member has clinical manifestations consistent with HPP (e.g., skeletal abnormalities, respiratory problems, hypercalcemia, seizures).
- Findings on radiographic imaging support the diagnosis of HPP (e.g., infantile rickets, alveolar bone loss, osteoporosis, low bone mineral content for age).
- The prescription is written by an endocrinologist or a provider who specializes in HPP.
- The member has a documented history of HPP-related skeletal abnormalities.
- The member has a serum alkaline phosphatase below the age-adjusted normal range.
- The member has a plasma pyridoxal-5'-phosphate level above the upper limit of normal.
- The member has a documented tissue-nonspecific alkaline phosphatase gene mutation.

Medical records must be provided to demonstrate the member meets the clinical criteria previously listed.

Note: A copy of the gene mutation testing must be included with an initial PA request.

If clinical criteria for Strensiq are met, initial PA requests may be approved for up to a maximum of 183 days.

Clinical criteria that must be documented for approval of an **initial renewal** PA request for Strensiq are **all** of the following:

- The member meets the clinical criteria for an initial PA request approval for Strensiq.
- The member has responded to treatment with Strensiq as evidenced by improvement in respiratory status, growth, or radiographic findings compared to their baseline prior to initiation of treatment with Strensiq.

Medical records must be provided to demonstrate that the member meets the clinical criteria previously listed.

Initial renewal PA requests for Strensiq may be approved for up to a maximum of 365 days.

Clinical criteria that must be documented for approval of a **subsequent renewal** PA request for Strensiq are **all** of the following:

- The member meets the clinical criteria for an initial PA request approval for Strensiq.
- The member has responded to treatment with Strensiq as evidenced by a sustained improvement in respiratory status, growth, or radiographic findings compared to their baseline prior to initiation of treatment with Strensiq.

Medical records must be provided to demonstrate that the member meets the clinical criteria previously listed.

Subsequent renewal PA requests for Strensiq may be approved for up to a maximum of 365 days.

Topic #21417

Takhzyro

Takhzyro requires clinical PA (prior authorization).

Note: The Select High Cost, Orphan, and Accelerated Approval Drugs data table identifies select high cost, orphan, and accelerated approval drugs and interim billing and coverage information for these drugs. The table also identifies which drugs have specific PA or policy requirements. For specific questions about the billing or coverage of high cost, orphan, and accelerated approval drugs listed in the Select High Cost, Orphan, and Accelerated Approval Drugs data table, providers may contact

Provider Services or email DHSOrphanDrugs@dhs.wisconsin.gov.

Clinical Criteria for Takhzyro

The following clinical criteria must be met and documented for approval of a PA request for Takhzyro:

- The member has type I or type II HAE (hereditary angioedema).
- The member is 12 years of age or older.
- The member has no signs of current acute angioedema but has a history of clinical symptoms and signs consistent with HAE.
- The member requires HAE prophylaxis as evidenced due to **one** or more of the following:
  - A history of at least one severe HAE attack per month (defined as an attack that significantly interrupts daily activities despite short-term treatment)
  - Disabling symptoms for at least five days per month
  - A history of laryngeal angioedema
- HAE is documented based on evidence of a low C4 level, plus **one** of the following:
  - A low C1-INH (C1 esterase inhibitor) antigenic level (C1-INH antigenic level below the lower limit of normal as defined by the laboratory performing the test)
  - A normal C1-INH antigenic level and a low C1-INH functional level (C1-INH functional level below the lower limit of normal as defined by the laboratory performing the test)
- Medications known to cause angioedema (for example, angiotensin-converting enzyme inhibitors, estrogens, angiotensin II receptor blockers) have been evaluated and discontinued when appropriate.
- The member has failed treatment with **all** the following:
  - 17 alpha-alkylated androgens (for example, danazol and stanozolol)
  - Anti-fibrinolytic agents (for example, aminocaproic acid, tranexamic acid) for HAE prophylaxis
  - Haegarda for HAE prophylaxis
- Takhzyro must be prescribed by, or in consultation with, an allergist, immunologist, hematologist, or a physician who specializes in HAE or related disorders.
- Takhzyro must not be used in combination with any other HAE prophylactic agents.

A copy of the member's medical records must be submitted and should sufficiently document:

- The frequency, severity, and duration of the HAE attacks.
- The information listed in the clinical coverage criteria.
- Details regarding previous medication use.
- The member's current treatment plan.

Note: A failure of treatment is defined by the member experiencing either an unsatisfactory therapeutic response, a clinically significant adverse drug reaction, or a clinically significant drug interaction, or the member has a medical condition(s) that prevents the use of 17 alpha-alkylated androgens, anti-fibrinolytic agents, or Haegarda.

If the clinical criteria for Takhzyro are met, initial PA requests may be approved for up to 183 days. Renewal PA requests for Takhzyro may be approved for up to 365 days.

Renewal PA Requests

Renewal PA requests must meet the clinical criteria for initial PA requests for Takhzyro and have documentation to support that the member has experienced a reduction in the frequency of HAE attacks versus baseline and/or significant improvement in the severity or duration of attacks since starting Takhzyro treatment. In order to confirm the necessary adherence, the claims history and medical records will be reviewed for all renewal requests. A copy of the pertinent medical records must be included with the PA request.

Submitting PA Requests for Takhzyro

PA requests for Takhzyro must be submitted using the PA/DGA (Prior Authorization/Drug Attachment, F-11049 (07/16)) form.

PA requests for Takhzyro must be completed, signed, and dated by the prescriber. PA requests for Takhzyro should be submitted using Section VI (Clinical Information for Drugs With Specific Criteria Addressed in the ForwardHealth Online Handbook) of the PA/DGA form.

The prescriber is required to send the completed PA/DGA form to the pharmacy where the prescription will be filled. The pharmacy provider is required to complete a PA/RF (Prior Authorization Request Form, F-11018 (05/13)) and submit it, along with the PA/DGA form received from the prescriber, to ForwardHealth using the PA submission option most appropriate for the drug.

PA requests for Takhzyro may be submitted on the Portal, by fax, or by mail (but **not** using the STAT-PA (Specialized Transmission Approval Technology-Prior Authorization) system).

Topic #13017

Types of Drugs that Require Prior Authorization

The following are types of drugs that require PA (prior authorization):

- BBG (brand before generic) drugs
- BMN (brand medically necessary) drugs
- Diagnosis-restricted drugs
- Drugs outside approved diagnoses
- PDL (Preferred Drug List) drugs
- Drugs requiring clinical evaluation

Topic #21437

Wakix

Wakix requires clinical PA (prior authorization).

PA requests for Wakix must be completed, signed, and dated by the prescriber. PA requests for Wakix must be submitted using Prior Authorization Drug Attachment for Wakix (Prior Authorization Drug Attachment for Wakix, F-02573 (01/20)) form and the PA/RF (Prior Authorization Request Form, F-11018 (05/13)).

The PA form must be sent to the pharmacy where the prescription will be filled. The prescriber may send the PA form to the pharmacy, or the member may carry the PA form with the prescription to the pharmacy. 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.

PA requests for Wakix may be submitted on the Portal, by fax, or by mail (but **not** using the STAT-PA (Specialized Transmission Approval Technology-Prior Authorization) system).

Clinical Criteria for Wakix

PA requests for Wakix will only be approved for use to treat EDS (excessive daytime sleepiness) associated with narcolepsy.

Clinical criteria for approval of a PA request for Wakix are **all** of the following:

- The member has narcolepsy.
- The member is 18 years of age or older.
- The prescriber has reviewed the member's current medication list to evaluate for potential drug interactions (for example, CYP2D6 (cytochrome P450 2D6) inhibitors, CYP3A4 (cytochrome P450 3A4) inducers, and drugs that increase the QT interval).
- The member is not currently taking any sedative hypnotics.
- For members currently taking CNS (central nervous system) depressants (for example, anxiolytics, barbiturates, opioids), the prescriber has evaluated the CNS depressants and determined they are not contributing to the member's daytime sleepiness.
- An overnight PSG (polysomnogram) sleep study and MSLT (multiple sleep latency test) have been performed for the member using standard protocols, and the prescribing provider has submitted medical record documentation supporting a clinical correlation between the test results and a diagnosis of narcolepsy.
- The overnight PSG test results and provider interpretation have been submitted with the PA request and include documentation of the following:
  - Total sleep time documented is at least 360 minutes.
  - The member experienced minimal sleep interruptions (for example, respiratory events, periodic leg movements).
  - Provider interpretation indicates an adequate night's sleep was achieved.
- The MSLT results and provider interpretation have been submitted with the PA request and include documentation of the following:
  - The MSLT was conducted the morning after the overnight PSG.
  - Average sleep latency for all naps is eight minutes or less.
  - The member achieved at least two SOREMPs (sleep-onset rapid eye movement periods). A SOREMP period within 15 minutes of sleep onset on the preceding nocturnal PSG may replace one of the SOREMPs on the MSLT.
- The member has EDS that interferes with normal activities on a daily basis.
- An ESS (Epworth sleepiness scale) questionnaire, MWT (maintenance of wakefulness test), or MSLT has been performed for the member, confirming that the member has EDS. (Note: Test results for the ESS questionnaire, the MWT, and/or the MSLT must be submitted with the PA request.)
- The prescriber ruled out or treated the member for other causes of EDS including the following:
  - Other sleep disorders, including sleep apnea
  - Chronic pain or illness that disrupts normal sleep patterns
  - Mood disorders such as depression
  - Caffeine or nicotine use causing poor quality of nighttime sleep
- **At least one** of the following is true:
  - The member has experienced an unsatisfactory therapeutic response or a clinically significant adverse drug reaction with a stimulant.
  - The member has a medical condition that prevents treatment with a stimulant.
  - There is a clinically significant drug interaction between another medication the member is taking and stimulants.
- **At least one** of the following is true:
  - The member has experienced an unsatisfactory therapeutic response that occurred after the medication had been titrated to a maximum recommended daily dose or experienced a clinically significant adverse drug reaction with armodafinil or modafinil.
  - The member has a medical condition that prevents treatment with armodafinil or modafinil.
  - There is a clinically significant drug interaction between another medication the member is taking and armodafinil or modafinil.

Initial PA requests for Wakix may be approved for up to 183 days.

In addition to documenting the previously listed clinical information on the Prior Authorization Drug Attachment for Wakix form, medical records must be submitted with the PA request to support the member's condition of EDS associated with narcolepsy.

Renewal PA requests may be approved for up to 365 days. Medical records must be submitted demonstrating clinical

improvement, including a decrease in the member's EDS. A decrease in a member's EDS must be supported by an ESS questionnaire, MWT, or MSLT. Medical records must also reflect patient compliance with medication use.

Topic #16437

Xyrem

Xyrem requires clinical PA (prior authorization).

Providers are required to submit PA requests for Xyrem on the Prior Authorization Drug Attachment for Xyrem (F-01430 (01/19)) form.

PA requests for Xyrem may be submitted on the Portal, by fax, or by mail (but **not** using the STAT-PA (Specialized Transmission Approval Technology-Prior Authorization) system).

Quantity limits apply to Xyrem. Members are limited to a maximum nightly dose of 18 mL (9 g) of Xyrem, which is equivalent to 540 mL (270 g) of Xyrem per month.

Clinical Criteria for Xyrem

PA requests for Xyrem will only be approved for use to treat the following symptoms of narcolepsy:

- Cataplexy
- EDS (excessive daytime sleepiness)

Narcolepsy With Cataplexy

Clinical criteria for approval of a PA request for Xyrem to treat narcolepsy with cataplexy are **all** of the following:

- The member has narcolepsy with cataplexy.
- The member is at least 7 years of age.
- The member does not have a succinic semialdehyde dehydrogenase deficiency.
- The prescriber has counseled the member on the contraindication between Xyrem and alcohol.
- The member has agreed to be abstinent from alcohol while being treated with Xyrem.
- The member does not have a history of substance abuse, addiction, or diversion.
- The member is not currently taking any sedative hypnotics.
- For members currently taking CNS (central nervous system) depressants (e.g., anxiolytics, barbiturates, opioids), the prescriber has evaluated the CNS depressants and determined they are not contributing to the member's daytime sleepiness.
- An overnight PSG (polysomnogram) sleep study and MSLT (multiple sleep latency test) have been performed for the member using standard protocols, and the prescribing provider has submitted medical record documentation supporting a clinical correlation between the test results and a diagnosis of narcolepsy with cataplexy.
- The overnight PSG test results and provider interpretation have been submitted with the PA request and include documentation of the following:
  - Total sleep time documented is at least 360 minutes.
  - The member experienced minimal sleep interruptions (e.g., respiratory events, periodic leg movements).
  - Provider interpretation indicates an adequate night's sleep was achieved.
- The MSLT results and provider interpretation have been submitted with the PA request and include documentation of the following:
  - The MSLT was conducted the morning after the overnight PSG.
  - Average sleep latency for all naps is eight minutes or less.
  - The member achieved at least two SOREMPs (sleep-onset rapid eye movement periods). A SOREMP within 15

minutes of sleep onset on the preceding nocturnal PSG may replace one of the SOREMPs on the MSLT.

- **At least one** of the following is true:
  - The member has experienced an unsatisfactory therapeutic response or a clinically significant adverse drug reaction with a stimulant.
  - The member has a medical condition that prevents treatment with a stimulant.
  - There is a clinically significant drug interaction with another medication the member is taking and a stimulant.
- **At least one** of the following is true:
  - The member has experienced an unsatisfactory therapeutic response that occurred after the medication had been titrated to a maximum recommended daily dose or experienced a clinically significant adverse drug reaction with armodafinil or modafinil.
  - The member has a medical condition that prevents treatment with armodafinil or modafinil.
  - There is a clinically significant drug interaction with another medication the member is taking and armodafinil or modafinil.
- The member has experienced an unsatisfactory therapeutic response or a clinically significant adverse drug reaction to **at least one** of the following:
  - TCA (tricyclic antidepressant)
  - SSRI (selective serotonin reuptake inhibitor)
  - SNRI (serotonin-norepinephrine reuptake inhibitor)

Initial PA requests for Xyrem to treat narcolepsy with cataplexy may be approved for up to a maximum of 183 days.

In addition to documenting the previously listed clinical information on the Prior Authorization Drug Attachment for Xyrem, medical records must be submitted with the PA request to support the member's condition of narcolepsy with cataplexy.

Renewal PA requests may be approved for up to a maximum of 365 days. Medical records must be submitted demonstrating clinical improvement, including a decrease in cataplexy or a decrease in the member's EDS. A decrease in a member's EDS must be supported by an ESS (Epworth sleepiness scale), MWT (maintenance of wakefulness test), or MSLT. Medical records must also reflect patient compliance with medication use and safety precautions for Xyrem.

Narcolepsy Without Cataplexy

Clinical criteria for approval of a PA request for Xyrem to treat narcolepsy without cataplexy are **all** of the following:

- The member has narcolepsy without cataplexy.
- The member is at least 7 years of age.
- The member does not have a succinic semialdehyde dehydrogenase deficiency.
- The prescriber has counseled the member on the contraindication between Xyrem and alcohol.
- The member has agreed to be abstinent from alcohol while being treated with Xyrem.
- The member does not have a history of substance abuse, addiction, or diversion.
- The member is not currently taking any sedative hypnotics.
- For members currently taking CNS depressants (e.g., anxiolytics, barbiturates, opioids), the prescriber has evaluated the CNS depressants and determined they are not contributing to the member's daytime sleepiness.
- An overnight PSG sleep study and MSLT have been performed for the member using standard protocols, and the prescribing provider has submitted medical record documentation supporting a clinical correlation between the test results and a diagnosis of narcolepsy with cataplexy.
- The overnight PSG test results and provider interpretation have been submitted with the PA request and include documentation of the following:
  - Total sleep time documented is at least 360 minutes.
  - The member experienced minimal sleep interruptions (e.g., respiratory events, periodic leg movements).
  - Provider interpretation indicates an adequate night's sleep was achieved.
- The MSLT results and provider interpretation have been submitted with the PA request and include documentation of the following:
  - The MSLT was conducted the morning after the overnight PSG.

    - Average sleep latency for all naps is eight minutes or less.
    - The member achieved at least two SOREMPs. A SOREMP within 15 minutes of sleep onset on the preceding nocturnal PSG may replace one of the SOREMPs on the MSLT.
- The member has EDS that interferes with normal activities on a daily basis.
- An ESS questionnaire, MWT, or MSLT has been performed for the member, confirming that the member has EDS. (*Note:* Test results for the ESS, MWT, and/or MSLT must be submitted with the PA request.)
- The prescriber ruled out or treated the member for other causes of EDS, including the following:
    - Other sleep disorders, including sleep apnea.
    - Chronic pain or illness that disrupts normal sleep patterns.
    - Mood disorders such as depression.
    - Caffeine or nicotine use causing poor quality of nighttime sleep.
- **At least one** of the following is true:
    - The member has experienced an unsatisfactory therapeutic response or a clinically significant adverse drug reaction with a stimulant.
    - The member has a medical condition that prevents treatment with a stimulant.
    - There is a clinically significant drug interaction with another medication the member is taking and a stimulant.
- **At least one** of the following is true:
    - The member has experienced an unsatisfactory therapeutic response that occurred after the medication had been titrated to a maximum recommended daily dose or experienced a clinically significant adverse drug reaction with armodafinil or modafinil.
    - The member has a medical condition that prevents treatment with armodafinil or modafinil.
    - There is a clinically significant drug interaction with another medication the member is taking and armodafinil or modafinil.

Initial PA requests for Xyrem to treat narcolepsy without cataplexy may be approved for up to a maximum of 183 days.

In addition to documenting the previously listed clinical information on the Prior Authorization Drug Attachment for Xyrem, medical records must be submitted with the PA request to support the member's condition of narcolepsy without cataplexy.

Renewal PA requests may be approved for up to a maximum of 365 days. Medical records must be submitted demonstrating clinical improvement, including a decrease in the member's EDS. A decrease in a member's EDS must be supported by an ESS, MWT, or MSLT. Medical records must also reflect patient compliance with medication use and safety precautions for Xyrem.

Topic #21377

Zolgensma

Zolgensma requires clinical PA (prior authorization).

Note: Select High Cost, Orphan, and Accelerated Approval Drugs data table identifies select high cost, orphan, and accelerated approval drugs and interim billing and coverage information for these drugs. The table also identifies which drugs have specific PA or policy requirements. For specific questions about the billing or coverage of high cost, orphan, and accelerated approval drugs listed in the Select High Cost, Orphan, and Accelerated Approval Drugs data table, providers may contact Provider Services or email DHSOrphanDrugs@dhs.wisconsin.gov.

Clinical Criteria for Zolgensma

The following clinical criteria must be met and documented for approval of a PA request for Zolgensma:

- The member is less than 2 years old.
- The member has SMA (spinal muscular atrophy), type 1, 2, or 3, which has been confirmed, by genetic testing (5q SMN1 (survival motor neuron 1): homozygous mutation, homozygous gene deletion, or compound heterozygote).

- The member has **at least two** copies of the SMN2 (survival motor neuron 2) gene.
- The member does not have advanced SMA including, but not limited to, any of the following:
  - Complete paralysis of the limbs
  - Ventilator dependent for 16 or more hours per day (including non-invasive respiratory support)
- Zolgensma must be prescribed by a neurologist, pulmonologist, or other physician with expertise in treating SMA.
- The prescriber must submit the most recent pre-treatment AAV9 (anti-adeno-associated virus 9) antibody testing, demonstrating a titer ratio of less than 50 to 1.
- Members that receive treatment with Zolgensma will not be eligible for subsequent treatment with Spinraza.

Note: If a member already has a current approved PA request for Spinraza, ForwardHealth will end date the Spinraza PA request upon approval of Zolgensma.

A copy of the member's medical records must be submitted and should sufficiently document:

- The information listed in the clinical coverage criteria.
- Details regarding previous medication use.
- The member's current treatment plan.

Note: ForwardHealth covers one treatment per lifetime with Zolgensma for pediatric members less than 2 years of age.

Submitting PA Requests for Zolgensma

PA requests for Zolgensma must be submitted using the PA/DGA (Prior Authorization/Drug Attachment, F-11049 (07/16)) form.

PA requests for Zolgensma must be completed, signed, and dated by the prescriber. PA requests for Zolgensma should be submitted using Section VI (Clinical Information for Drugs With Specific Criteria Addressed in the ForwardHealth Online Handbook) of the PA/DGA form.

The prescriber is required to send the completed PA/DGA form to the pharmacy where the prescription will be filled. The pharmacy provider is required to complete a PA/RF (Prior Authorization Request Form, F-11018 (05/13)) and submit it, along with the PA/DGA form received from the prescriber, to ForwardHealth using the PA submission option most appropriate for the drug.

PA requests for Zolgensma may be submitted on the Portal, by fax, or by mail (but **not** using the STAT-PA (Specialized Transmission Approval Technology-Prior Authorization) system).

Situations Requiring New Requests

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 their 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, they 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 (05/13)) 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 at 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 (05/13)) or the PA/HIAS1 (Prior Authorization for Hearing Instrument and Audiological Services 1, F-11020 (05/13)) 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 PA 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 PA 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 PA 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 PA 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 (07/12)) 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 (05/13)) 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" PA 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 PA 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 PA 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 #1416

STAT-PA

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.

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 (07/15)) 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 (05/13)). 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:

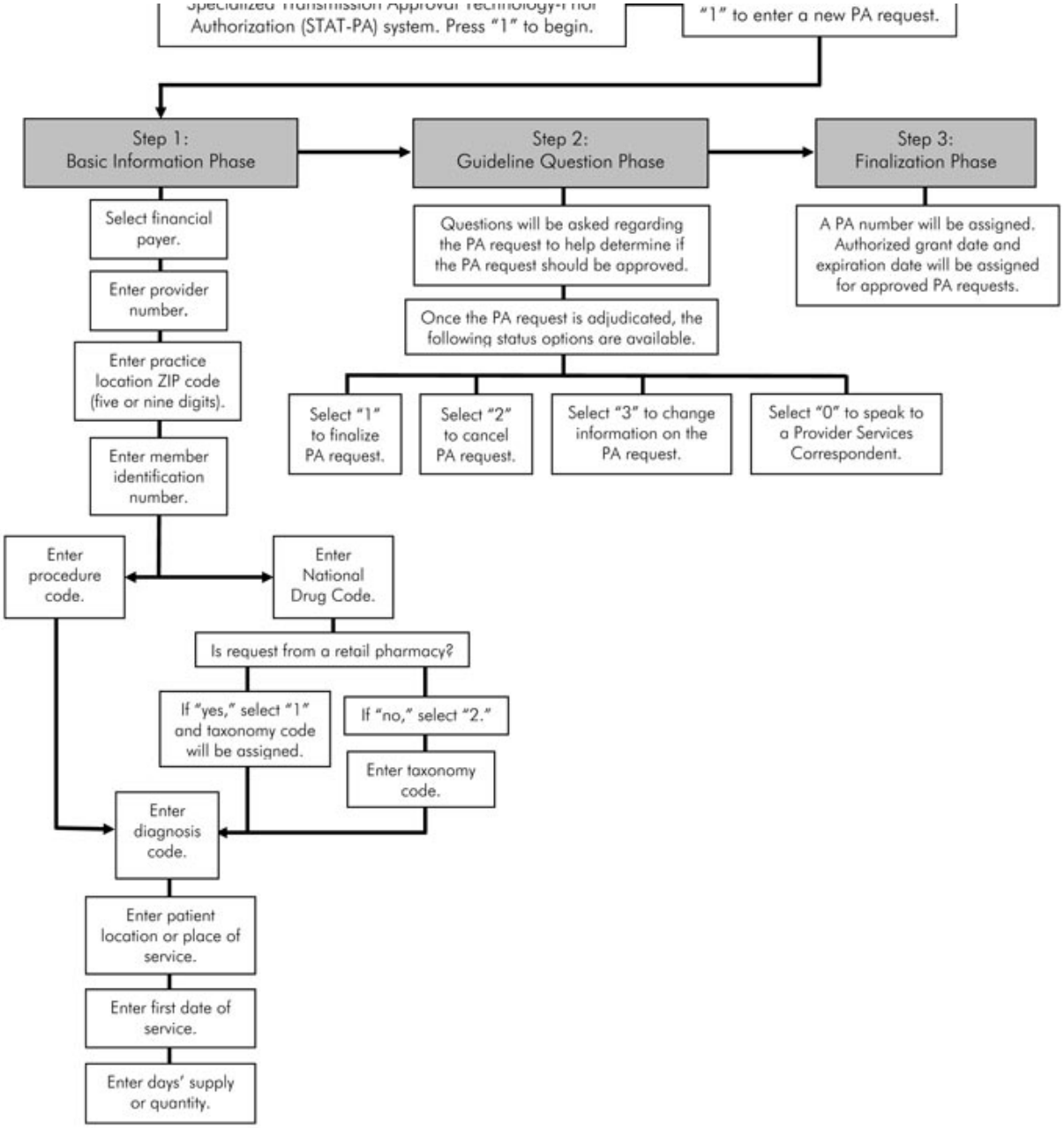
1. Obtain the member's ForwardHealth identification card, beige paper or white paper EE (Express Enrollment) card, or SeniorCare identification card, and verify enrollment. Enrollment verification may be done by submitting a real-time claim for the drug or by using one of the other enrollment verification 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.

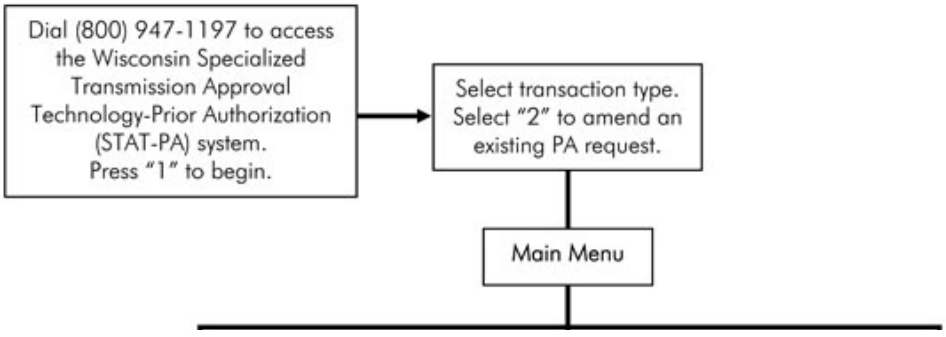
STAT-PA Quick Reference Guide

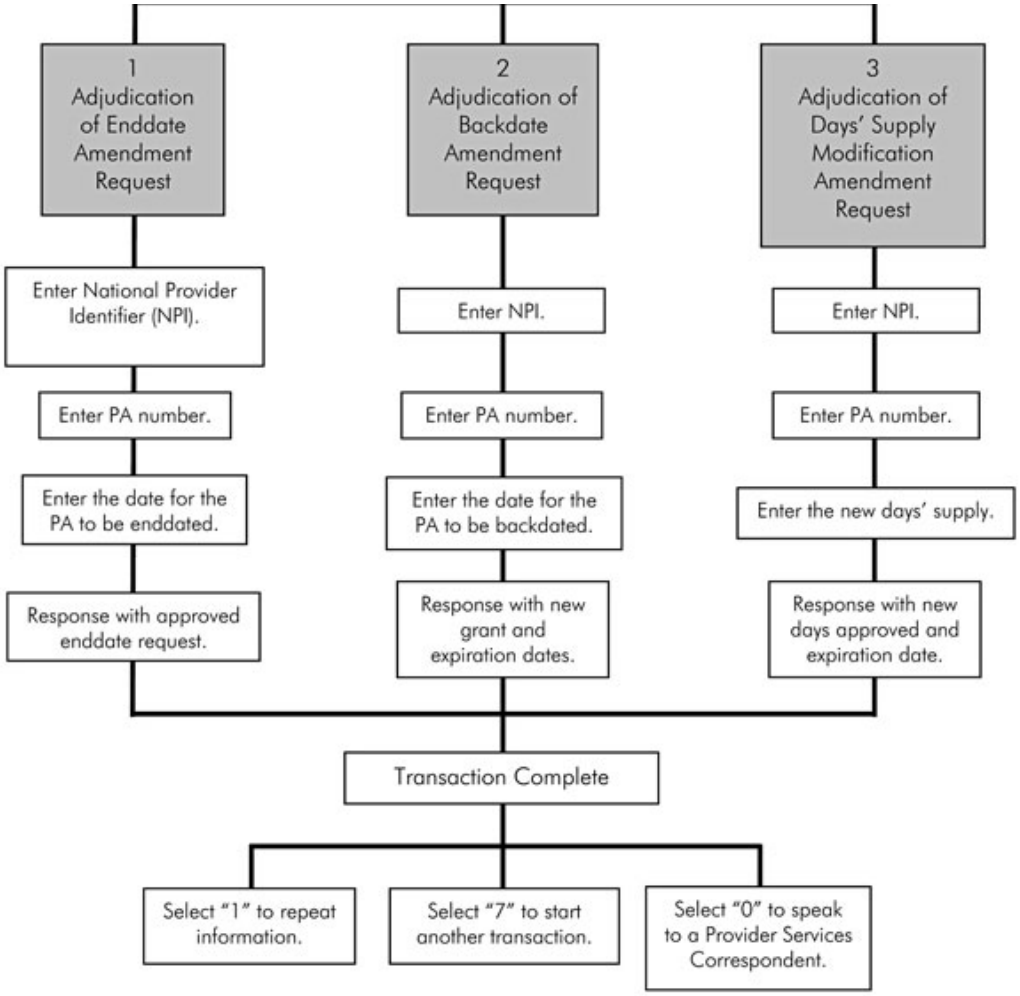
Dial (800) 947-1197 to access the Wisconsin Specialized Transmission Approval Technology Prior

Select transaction type. Select



STAT-PA Drug Amendment Quick Reference Guide




1
Adjudication of Enddate Amendment Request
Enter National Provider Identifier (NPI).
Enter PA number.
Enter the date for the PA to be enddated.
Response with approved enddate request.
2
Adjudication of Backdate Amendment Request
Enter NPI.
Enter PA number.
Enter the date for the PA to be backdated.
Response with new grant and expiration dates.
3
Adjudication of Days' Supply Modification Amendment Request
Enter NPI.
Enter PA number.
Enter the new days' supply.
Response with new days approved and expiration date.
Transaction Complete
Select "1" to repeat information.
Select "7" to start another transaction.
Select "0" to speak to a Provider Services Correspondent.

Provider Enrollment and Ongoing Responsibilities

7

Archive Date:12/01/2020

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 Wisconsin DHS (Department of Health Services) has the right to inspect, review, audit, and reproduce provider records pursuant to Wis. Admin. Code § DHS 106.02(9)(e). The DHS 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 DHS staff member(s).

Wisconsin Medicaid reimburses providers $0.06 per page for the cost of reproducing records requested by the DHS to conduct a compliance audit. A letter of request for records from the DHS 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 DHS and a provider, such as reproduction costs for submitting PA requests and claims.

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

The reproduction of records requested by the PRO (Peer Review Organization) under contract with the DHS 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 their 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 C.F.R. Parts 160 and 164 and § 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 U.S. HHS (Department of Health and Human Services). According to 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) website.

For more information regarding securing PHI, providers may refer to Health Information Privacy on the HHS website.

Wisconsin Confidentiality Laws

Wis. Stat. § 134.97 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.

Wis. Stat. § 146.836 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 Wis. Stat. § 134.97(1)(e), 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

Wis. Stat.§§ 134.97 and 134.98, 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, Wis. Stat. § 34.97(4) 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 § 13410(d) of the HITECH Act, which amends 42 USC § 1320d-5, and Wis. Stat. §§ 134.97(3), (4) and 146.84.

Topic #201

Financial Records

According to Wis. Admin. Code § DHS 106.02(9)(c), 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 Wis. Admin. Code § DHS (Department of Health Services) 106.02(9)(b), 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 Wis. Stat. § 146.83, 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 Wis. Stat. § 146.81(4), 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.

The Wisconsin DHS (Department of Health Services) adjusts the amounts a provider may charge for providing copies of a member's health care records yearly per Wis. Stat. § 146.83(3f)(c).

Topic #16157

Policy Requirements for Use of Electronic Signatures on Electronic Health Records

For ForwardHealth policy areas where a signature is required, electronic signatures are acceptable as long as the signature meets the requirements. When ForwardHealth policy specifically states that a handwritten signature is required, an electronic signature will not be accepted. When ForwardHealth policy specifically states that a written signature is required, an electronic signature will be accepted.

Reimbursement for services paid to providers who do not meet all electronic signature requirements may be subject to recoupment.

Electronic Signature Definition

An electronic signature, as stated in Wis. Stats. § 137.11(8), is "an electronic sound, symbol, or process attached to or logically associated with a record and executed or adopted by a person with the intent to sign the record."

Some examples include:

- Typed name (performer may type their complete name)
- Number (performer may type a number unique to them)
- Initials (performer may type initials unique to them)

All examples above must also meet all of the electronic signature requirements.

Benefits of Using Electronic Signatures

The use of electronic signatures will allow providers to:

- Save time by streamlining the document signing process.
- Reduce the costs of postage and mailing materials.
- Maintain the integrity of the data submitted.
- Increase security to aid in non-repudiation.

Electronic Signature Requirements

By following the general electronic signature requirements below, the use of electronic signatures provides a secure alternative to written signatures. These requirements align with HIPAA (Health Insurance Portability and Accountability Act of 1996) Privacy Rule guidelines.

General Requirements

When using an electronic signature, all of the following requirements must be met:

- The electronic signature must be under the sole control of the rendering provider. Only the rendering provider or designee has the authority to use the rendering provider's electronic signature. Providers are required to maintain documentation that shows the electronic signature that belongs to each rendering provider if a numbering or initial system is used (e.g., what number is assigned to a specific rendering provider). This documentation must be kept confidential.
- The provider is required to have current policies and procedures regarding the use of electronic signatures. The Wisconsin

DHS (Department of Health Services) recommends the provider conduct an annual review of policies and procedures with those using electronic signatures to promote ongoing compliance and to address any changes in the policies and procedures.

- The provider is required to conduct or review a security risk analysis in accordance with the requirements under 45 CFR s. 164.308(a)(1).
- The provider is required to implement security updates as necessary and correct identified security deficiencies as part of its risk management process.
- The provider is required to establish administrative, technical, and physical safeguards in compliance with the HIPAA Security Rule.

Electronic Health Record Signature Requirements

An EHR (electronic health record) that utilizes electronic signatures must meet the following requirements:

- The certification and standard criteria defined in the Health Information Technology Initial Set of Standards, Implementation Specifications, Certification Criteria for Electronic Health Record Technology Final Rule (45 CFR Part 170) and any revisions including, but not limited to, the following:
  - Assign a unique name and/or number for identifying, tracking user identity, and establishing controls that permit only authorized users to access electronic health information.
  - Record actions related to electronic health information according to the standard set forth in 45 CFR s. 170.210.
  - Enable a user to generate an audit log for a specific time period. The audit log must also have the ability to sort entries according to any of the elements specified in the standard 45 CFR s. 170.210.
  - Verify that a person or entity seeking access to electronic health information is the one claimed and is authorized to access such information.
  - Record the date, time, patient identification, and user identification when electronic health information is created, modified, accessed, or deleted. An indication of which action(s) occurred and by whom must also be recorded.
  - Use a hashing algorithm with a security strength equal to or greater than SHA-1 (Secure Hash Algorithm 1) as specified by the NIST (National Institute of Standards and Technology) in FIPS PUB 180-3 (October 2008) to verify that electronic health information has not been altered. (Providers unsure whether or not they meet this guideline should contact their IT (Information Technology) and/or security/privacy analyst.)
- Ensure the EHR provides:
  - Nonrepudiation — assurance that the signer cannot deny signing the document in the future
  - User authentication — verification of the signer's identity at the time the signature was generated
  - Integrity of electronically signed documents — retention of data so that each record can be authenticated and attributed to the signer
  - Message integrity — certainty that the document has not been altered since it was signed
  - Capability to convert electronic documents to paper copy — the paper copy must indicate the name of the individual who electronically signed the form as well as the date electronically signed
- Ensure electronically signed records created by the EHR have the same back-up and record retention requirements as paper records.

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 Wis. Admin. Code § DHS 106.02(9)(a). 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 Wis. Admin. Code § DHS 106.02(9)(d), 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 Wisconsin DHS (Department of Health Services) periodically reviews provider records. 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 Wisconsin Medicaid may come from a variety of individuals including attorneys, insurance adjusters, and members. Providers are required to notify ForwardHealth when releasing billing information or medical claim records relating to charges for covered services except in the following instances:

- 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 a member, the provider is required to do the following:

1. Send a copy of the requested billing information or medical claim records to the requestor.

2. Send a letter containing the following information to ForwardHealth:
    - Member's name
    - Member's ForwardHealth identification number or SSN (Social Security number), if available
    - Member's DOB (date of birth)
    - DOS (date of service)
    - Entity requesting the records, including name, address, and telephone number

    The letter must be sent to the following address:

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

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 is required to 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) § 4311, a dual eligible has the right to request and receive an itemized statement from their 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 Wisconsin 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 #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 5 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 C.F.R. 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 Wisconsin 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 of 1990, any provider that operates an existing public accommodation has four specific requirements:

1. Remove barriers to make their 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 contractors' services.

When contracting services, providers are required to ensure contracted agencies are qualified to provide services, meet all ForwardHealth and program requirements, and maintain records in accordance with the requirements for the provision of services.

Medicaid requirements do not relieve contracted agencies of their own regulatory requirements. Contracted agencies are required to continue to meet their own regulatory requirements, in addition 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 their 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

Changes That Require ForwardHealth Notification

Providers are required to notify ForwardHealth of any changes to their demographic information, including the following, as they occur:

- Address(es) — practice location and related information, mailing, PA (prior authorization), and/or financial

  Note: Health care providers who are federally required to have an NPI (National Provider Identifier) 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.

- Business name
- Contact name
- Federal Tax ID number (IRS (Internal Revenue Service) number)
- Group affiliation
- Licensure
- NPI
- 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 or cancellation of provider file if 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.

Notifying ForwardHealth of Changes

Providers can notify ForwardHealth of changes using the demographic maintenance tool.

Providers Enrolled in Multiple Programs

If demographic information changes, providers enrolled in multiple programs (e.g., Wisconsin Medicaid and WCDP (Wisconsin Chronic Disease Program)) will need to change the demographic information for each program. By toggling between accounts using the Switch Organization function of the Portal, providers who have a Portal account for each program can change their information for each program using the demographic maintenance tool. The Account User Guide provides specific information about switching organizations.

Providers Licensed or Certified by the Division of Quality Assurance

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 emailing Lisa.Imhof@dhs.wisconsin.gov.

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 C.F.R. Parts 430-498 and Parts 1000-1008 (Public Health)
- Wisconsin Law and Regulation:
  - Law — Wis. Stat. §§ 49.43-49.499, 49.665, and 49.473
  - Regulation — Wis. Admin. Code chs. 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 Wisconsin DHS (Department of Health Services). Within DHS, DMS (Division of Medicaid Services) 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 — Wis. Stat. §§ 49.43-49.499 and 49.665
  - Regulation — Wis. Admin. Code chs. DHS 101, 102, 103, 104, 105, 106, 107, and 108
- SeniorCare Law and Regulation:
  - Law — Wis. Stat. § 49.688
  - Regulation — Wis. Admin. Code ch. 109

Topic #17097

Licensure Information

Licensed providers are required to keep all licensure information, including license number, grant and expiration dates, and physical location as applicable (e.g., hospital providers), current with ForwardHealth.

If providers do not keep their licensure information, including their license number, current with ForwardHealth, any of the following may occur:

- Providers' enrollment may be deactivated. As a result, providers would not be able to submit claims or PA (prior authorization) requests or be able to function as prescribing/referring/ordering providers, if applicable, until they update their licensure information.
- Providers may experience a lapse in enrollment. If a lapse occurs, providers may need to re-enroll, which may result in another application fee being assessed.

Providers may change the grant and expiration dates for their current license(s) and enter information for a new license(s), such as the license number, licensing state, and grant and expiration dates, using the demographic maintenance tool. After entering information for their new license(s), some providers (e.g., out-of-state providers) will also be required to upload a copy of their license using the demographic maintenance tool. Provided licensure information must correspond with the information on file with the applicable licensing authority.

In some cases, ForwardHealth will need to verify licensure information with the applicable licensing authority, which may take up to 10 business days after submission. Providers updating their license information should plan accordingly so that they do not experience any of the indicated interruptions in enrollment. If provided licensure information (e.g., grant and expiration dates) does not correspond with the licensing authority's information, the licensing authority's information will be retained and will display in the demographic maintenance tool once verified by ForwardHealth.

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 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 855-699-6289. Refer to the RAC website for additional information regarding HMS RAC activities.

Topic #13277

Reporting Suspected Waste, Fraud, and Abuse

The Wisconsin 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.

Wisconsin Stat. § 49.49 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 website
- 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, 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

Wis. Admin. Code ch. N8 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

Wisconsin Stats. § 146.87, 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 Wis. Stats. § 146.87, 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)
- BBG (brand before generic) drugs that require PA

- BMN (brand medically necessary) drugs that require PA
- Diagnosis-restricted drugs
- Age-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 (for example, 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 BadgerCare Plus, 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 provide a handwritten signature and date on the form. PA request forms may be faxed or mailed to the pharmacy provider, or the member may carry the form with the prescription to the pharmacy provider. The pharmacy provider will use the completed form to submit a PA request to ForwardHealth. 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.

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 CMS (Centers for Medicare & 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 BadgerCare Plus, 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.

Prescribers are required to complete the appropriate section(s) of the PA/DGA (Prior Authorization/Drug Attachment, F-11049 (07/16)) as it pertains to the drug being requested.

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 (04/17)) form indicating the actual NDC (National Drug Code) of the drug with the Pharmacy Special Handling Request (F-13074 (04/14)) 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.

Prospective Drug Utilization Review System

The federal OBRA (Omnibus Budget Reconciliation Act) of 1990 (42 C.F.R. 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 prospective 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 disease 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 a prospective DUR 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 phone calls or faxes, related to prescribed drugs from pharmacy providers.

Drugs With Three-Month Supply Requirement

ForwardHealth has identified a list of three-month supply drugs:

- Certain drugs are required to be dispensed in a three-month supply.
- Additional drugs are allowed 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 copays
- Requiring fewer trips to the pharmacy
- Allowing the member to obtain a larger quantity of generic, maintenance drugs for chronic conditions (for example, 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 (for example, 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 (that is, PRN (pro re nata)) 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 Wis. Admin. Code §§ DHS 105.02(4) and 105.02(7), and Wis. Stats. § 450.11(2), 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 Wis. Stats. § 961.38(2). 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, ICF/IIDs (Intermediate Care Facilities for Individuals with Intellectual Disabilities), 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 ForwardHealth 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 Wisconsin Medicaid.

Topic #1965

Therapeutic Pharmaceutical Agents-Certified Optometrists Requirements

In accordance with Wis. Admin. Code ch. SPS 10.01(10), 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 their 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 their own NPI in the Prescriber ID field.

More information about DEA numbers and NPIs is available.

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 ForwardHealth 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 been working toward ACA compliance by implementing some new requirements for providers and provider screening processes. To meet federally mandated requirements, ForwardHealth is implementing changes in phases, the first of which began in 2012. A high-level list of the changes included under ACA is as follows:

- Providers are assigned a risk level of limited, moderate, or high. Most of the risk levels have been established by the federal CMS (Centers for Medicare and Medicaid Services) based on an assessment of potential fraud, waste, and abuse for each provider type.
- Providers are screened according to their assigned risk level. Screenings are conducted during enrollment, reenrollment, and revalidation.
- Certain provider types are subject to an application fee. This fee has been federally mandated and may be adjusted annually. The fee is used to offset the cost of conducting screening activities.
- Providers are required to undergo revalidation every three years.
- All physicians and other professionals who prescribe, refer, or order services are required to be enrolled as a participating Medicaid provider.
- Payment suspensions are imposed on providers based on a credible allegation of fraud.
- Providers are required to submit personal information about all persons with an ownership or controlling interest, agents, and managing employees at the time of enrollment, re-enrollment, and revalidation.

Topic #194

In-State Emergency Providers and Out-of-State Providers

ForwardHealth requires all in-state emergency providers and out-of-state providers who render services to BadgerCare Plus, Medicaid, or SeniorCare members to be enrolled in Wisconsin Medicaid. Information is available regarding the enrollment options for in-state emergency providers and out-of-state providers.

In-state emergency providers and out-of-state providers who dispense covered outpatient drugs will be assigned a professional dispensing fee reimbursement rate of $10.51.

Topic #193

Materials for New Providers

On an ongoing basis, providers should refer to the Online Handbook for the most current BadgerCare Plus, Medicaid, and ADAP (Wisconsin AIDS Drug Assistance Program) information. Future changes to policies and procedures are published in *ForwardHealth Updates*.

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 using the demographic maintenance tool.

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 website.

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

Provider Type

Providers who want to add a provider type or change their current provider type are required to complete a new enrollment application for each provider type they want to add or change to because they need to meet the enrollment criteria for each provider type.

Provider Specialty

Providers who have the option to add or change a provider specialty can do so using the demographic maintenance tool. After adding or changing a specialty, providers may be required to submit documentation to ForwardHealth, either by uploading through the demographic maintenance tool or by mail, supporting the addition or change.

Providers should contact Provider Services with any questions about adding or changing a specialty.

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 their 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 Wis. Stat. chs. 450 and 961, Wis. Admin. Code chs. Phar 1 through 14 and chs. CSB 1 and 2
- As a physician, currently licensed to practice medicine and surgery according to Wis. Stat. §§ 448.05 and 448.07, and Wis. Admin. Code chs. Med 1, Med 2, Med 3, Med 4, Med 5, and Med 14

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 Wis. Stat. ch. 450, Wisconsin Medicaid does not enroll individual pharmacists.

Pharmacies that change ownership or locations are required to notify ForwardHealth of all changes, including a new license number, within 35 calendar days **after** the effective date of the change. 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 formula without separate enrollment. The DME service area, the DMS service area, and the Enteral Nutrition Formula 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 C.F.R. 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. 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 federal 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 website. The federal CMS (Centers for Medicare and Medicaid Services) website 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. 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.

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 website.

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 Wis. Admin. Code § DHS 106.05.

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:

Wisconsin Medicaid
Provider Enrollment
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 Wisconsin DHS (Department of Health Services) action or inaction for which due process is

required under Wis. Stat. ch. 227, may request a hearing by writing to the DHA (Division of Hearings and Appeals).

A provider who wishes to contest the DMS (Division of Medicaid Services)'s notice of intent to recover payment (e.g., to recoup for overpayments discovered in an audit by DMS) 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 Wis. Admin. Code ch. DHS 106 for detailed instructions on how to file an appeal.

If a timely request for a hearing is not received, 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 DMS (Division of Medicaid Services) will consider applications for, a discretionary waiver or variance of certain rules in Wis. Admin. Code chs. DHS 102, 103, 104, 105, 107, and 108. Rules that are not considered for a discretionary waiver or variance are included in Wis. Admin. Code § DHS 106.13.

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

Requirements

A request for a waiver or variance may be made at any time; however, all applications must be made in writing to the DMS. 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 DMS may also require additional information from the provider or the member prior to acting on the request.

Application

The DMS 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 Medicaid Services
Waivers and Variances
PO Box 309
Madison WI 53701-0309

Sanctions

Topic #211

Intermediate Sanctions

According to Wis. Admin. Code § DHS 106.08(3), the Wisconsin DHS (Department of Health Services) may impose intermediate sanctions on providers who violate certain requirements. Common examples of sanctions that 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, DHS will issue a written notice to the provider in accordance with Wis. Admin. Code § DHS 106.12.

Any sanction imposed by DHS may be appealed by the provider under Wis. Admin. Code § DHS 106.12. Providers may appeal a sanction by writing to the DHA (Division of Hearings and Appeals).

Topic #212

Involuntary Termination

The Wisconsin DHS (Department of Health Services) may suspend or terminate the Medicaid enrollment of any provider according to Wis. Admin. Code § DHS 106.06.

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

- 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 DHS. Refer to Wis. Admin. Code § DHS 106.07 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 § 1320a-7b(d) or Wis. Stat. § 49.49(3m).

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

Topic #214

Withholding Payments

The Wisconsin 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, 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.

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

8

Archive Date:12/01/2020

Reimbursement:Amounts

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, Medicaid, or ADAP (Wisconsin AIDS Drug Assistance Program)) 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, Medicaid, or ADAP.

Topic #694

Billing Service and Clearinghouse Contracts

According to Wis. Admin. Code § DHS 106.03(5)(c)2, 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 #20080

Brand or Generic Status of a National Drug Code

ForwardHealth uses the following information to determine the brand or generic status of an NDC (National Drug Code):

- NADAC (National Average Drug Acquisition Cost) Classification for Rate Setting
- Manufacturer's label name of the product

Brand Status of a National Drug Code

An NDC's brand status is assigned using the Classification for Rate setting field on the NADAC file. The federal CMS (Centers for Medicare and Medicaid Services) provides the NADAC file, which is available on the Medicaid website. An NDC with a value of "B" or "B-ANDA" is assigned a brand status. If an NDC is not on the NADAC file, brand status is determined by the market or label name. If the NDC market or label name is different than the active ingredient(s), the NDC is considered a brand; e.g., Adderall (active ingredients amphetamine and dextroamphetamine) and Norco (active ingredients acetaminophen and hydrocodone) have a brand status.

Generic Status of a National Drug Code

An NDC's generic status is assigned using the Classification for Rate Setting field on the NADAC file. An NDC with a value of "G" will be assigned a generic status. If an NDC is not on the NADAC file, generic status is determined by the market or label

name. If the NDC market or label name is based on the active ingredient(s), the NDC will be considered a generic; e.g., digoxin and omeprazole have a generic status.

Topic #1351

Covered Outpatient Drug Reimbursement

Definition of Covered Outpatient Drugs

Covered outpatient drugs are drugs that are treated as prescribed drugs for the purposes of § 1905(a)(12) of the Social Security Act (42 U.S.C. § 1396d[a][12]) and meet the definition of a covered outpatient drug as found in 42 C.F.R. § 447.502. The AAC (Actual Acquisition Cost) reimbursement requirements for covered outpatient drugs set forth in the Code of Federal Regulations do **not** include, in part, diabetic supplies, provider-administered drugs, or specialty drugs not purchased through the federal 340B Program (340B Drug Pricing Program).

Ingredient Cost

ForwardHealth reimburses covered outpatient drugs according to a separate ingredient cost and a professional dispensing fee. Ingredient cost reimbursement is based on AAC; as defined by 42 C.F.R. § 447.502, AAC is "the agency's determination of the pharmacy providers' actual prices paid to acquire drug products marketed or sold by specific manufacturers."

ForwardHealth uses the NADAC (National Average Drug Acquisition Cost) to reimburse ingredient cost for covered outpatient drugs, excluding drugs purchased through the federal 340B Program. CMS (Centers for Medicare and Medicaid Services) has stated the NADAC is an appropriate benchmark to establish AAC reimbursement. The NADAC is provided by CMS and calculated by a CMS vendor, Myers and Stauffer LC, a national certified public accounting firm. Myers and Stauffer LC conducts surveys of retail community pharmacy prices, including drug ingredient costs, to develop the NADAC pricing benchmark. NADAC pricing is available on the Medicaid website. The NADAC prices are updated on a weekly basis.

NADAC pricing review requests or notifications of recent drug price changes that may not be reflected in the posted NADAC file should be directed to the NADAC Help Desk. The NADAC Help Desk may be contacted through the following means:

- Telephone (toll-free): 855-457-5264
- Email: info@mslcrps.com
- Fax: 844-860-0236

ForwardHealth will not accept drug price review requests, disputes, or notifications of recent drug price changes for NADAC pricing.

Providers will be reimbursed at the lesser of the covered outpatient drug's NADAC rate, plus a professional dispensing fee, or the billed amount. If a covered outpatient drug does not have a NADAC rate available, then the provider will be reimbursed at the lesser of the drug's WAC (Wholesale Acquisition Cost) or SMAC (State Maximum Allowed Cost), if available, plus a professional dispensing fee, or the billed amount.

Providers will receive an informational EOB (Explanation of Benefits) code on each detail on pharmacy noncompound and compound claims identifying the pricing benchmark used.

If an NDC does not have a NADAC, WAC or SMAC rate on file, the claim will be denied.

State Maximum Allowed Cost Policy

Under Wisconsin's State Medicaid Plan approved by CMS, Wisconsin Medicaid and WCDP (Wisconsin Chronic Disease

Program) may assign SMACs to establish an upper limit for payment of brand or generic versions of the same drug (federal legend or OTC drugs), regardless of manufacturer. SMAC rates are set by using best estimates of prices currently in the marketplace in comparison to NADAC and WAC as stated in the approved Wisconsin State Plan.

Topic #20081

Covered Outpatient Drug Reimbursement: 340B Drug Pricing Program

Definition of the 340B Drug Pricing Program

The 340B Program (340B Drug Pricing Program) is a federal program that requires drug manufacturers to provide outpatient drugs to eligible covered entities at significantly reduced prices. Section 340B(a)(4) of the Public Health Services Act specifies which covered entities are eligible to participate in the 340B Program. The 340B Program enables covered entities to fully utilize federal resources, reaching more eligible patients and providing more comprehensive services.

Providers may determine if they are an eligible organization/covered entity to participate in the 340B Program, and if so, may register with the 340B Program through the HRSA (Health Resources & Services Administration) website. Upon enrollment in the 340B Program, covered entities must determine whether they will use drugs purchased through the 340B Program for their Medicaid members (carve-in) or purchase drugs for their Medicaid members through other mechanisms (carve-out). Covered entities who carve-in must be listed on the HRSA 340B MEF (Medicaid Exclusion File), which is used to assist states and manufacturers in determining which drugs are not subject to Medicaid rebates. Covered entity providers who carve-in are subject to 340B Program reimbursement.

340B Ingredient Cost Reimbursement

The Covered Outpatient Drugs Final Rule, 42 C.F.R. § 447.502, requires state Medicaid programs to reimburse drugs acquired through the 340B Program at their AAC (Actual Acquisition Cost). Because NADAC (National Average Drug Acquisition Cost) pricing is not applicable for covered outpatient drugs purchased through the 340B Program, ForwardHealth uses calculated 340B ceiling prices to determine a maximum ingredient cost of drugs purchased through the 340B Program, including specialty drugs purchased through the 340B Program, and to comply with the 340B AAC requirements in the rule. The federal CMS (Centers for Medicare and Medicaid Services) has stated that ceiling price is an appropriate AAC benchmark for drugs purchased through the 340B Program.

The 340B ceiling price refers to the maximum amount a manufacturer can charge a covered entity for the purchase of a covered outpatient drug through the 340B Program. The 340B ceiling price is statutorily defined as the AMP (Average Manufacturer Price) reduced by the rebate percentage, which is commonly referred to as the URA (Unit Rebate Amount). HRSA maintains the official 340B ceiling prices, which are not available to state Medicaid programs or the public due to confidentiality protections. However, CMS performs the URA calculations based on manufacturer-reported pricing data and specific methodology determined by law. CMS provides the URA and pricing data to states quarterly. ForwardHealth uses this information to determine the calculated 340B ceiling price. ForwardHealth does not adjust claims if manufacturers retroactively change AMP or URA.

Providers are required to submit their AAC when they dispense drugs purchased through the 340B Program to ForwardHealth members. Providers who dispense 340B inventory to ForwardHealth members will be reimbursed at the lesser of the calculated 340B ceiling price or the provider-submitted 340B AAC.

When a calculated 340B ceiling price is not available for a drug, ForwardHealth will reimburse at the lesser of WAC (Wholesale Acquisition Cost) minus 50 percent or the provider-submitted 340B AAC.

Contract Pharmacies

Drugs acquired through the federal 340B Program and dispensed by 340B contract pharmacies are not covered by ForwardHealth. A 340B contract pharmacy must carve-out ForwardHealth from its 340B operation and purchase all drugs billed to ForwardHealth outside of the 340B Program.

Topic #1349

Covered Outpatient Drug Reimbursement: Professional Dispensing Fees

Per 42 C.F.R. § 447.502, the professional dispensing fee is designed to reflect professional services and costs associated with delivering a covered outpatient drug to a ForwardHealth member. BadgerCare Plus, Medicaid, SeniorCare, ADAP (Wisconsin AIDS Drug Assistance Program), and WCDP (Wisconsin Chronic Disease Program) reimburse the same professional dispensing fee reimbursement rates, based on a dispensing provider's annual prescription volume for all prescriptions dispensed, for services provided. These fees include the following:

- Professional dispensing fee (Services covered under the professional dispensing fee include record keeping, patient profile preparation, prospective DUR (Drug Utilization Review), and counseling.)
- A compound drug add-on of $7.79

Additionally, BadgerCare Plus, Medicaid, and SeniorCare reimburse a repackaging allowance of $0.015 per unit billed to the professional dispensing fee for oral drugs in a solid form that are not considered unit dose.

Professional Dispensing Fee Reimbursement Rates

A professional dispensing fee is usually paid once per member, per service, per month, per provider, depending on the prescriber's prescription.

The following table lists the professional dispensing fee reimbursement rates that include overall annual prescription volume and associated professional dispensing fees:

Total Annual Prescription Volume	Professional Dispensing Fee
0–34,999	$15.69
35,000+	$10.51

Professional Dispensing Fee Surveys

ForwardHealth periodically conducts mandatory professional dispensing fee surveys as part of an ongoing process to ensure up-to-date professional dispensing fee reimbursement rates that accurately reflect the costs associated with dispensing covered outpatient drugs to ForwardHealth members.

Prescription Volume Attestation

Providers are required to attest to their overall annual prescription volume on a yearly basis. The annual attestation process is mandatory for all providers and organizations that dispense covered outpatient drugs. ForwardHealth uses providers' self-reported annual prescription volumes to assign professional dispensing fee reimbursement rates. If providers do not self-report annual prescription volume, ForwardHealth will automatically assign the lowest professional dispensing fee reimbursement rate.

Providers are subject to audit at ForwardHealth's discretion.

Newly Enrolled Providers

ForwardHealth assigns a professional dispensing fee reimbursement rate of $10.51 to newly enrolled providers who have not yet completed the annual prescription volume attestation process.

Out-of-State Providers and In-State Emergency Providers

ForwardHealth assigns a professional dispensing fee reimbursement rate of $10.51 to out-of-state providers and in-state emergency providers.

Compound Drug Add-on

A claim submitted for a compound drug for BadgerCare Plus, Medicaid, and SeniorCare will be reimbursed at the provider's assigned professional dispensing fee reimbursement rate plus a compound add-on of $7.79.

Repackaged Drugs and Repackaging Allowances

The repackaging allowance is limited to oral drugs in a solid form that are not considered unit dose. However, the professional dispensing fee may be allowed for unit dose drugs.

Pharmacy providers can obtain a repackaging allowance for oral drugs in a solid form 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 an 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, or SeniorCare.

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 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 #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, SeniorCare, and WCDP (Wisconsin Chronic Disease Program). 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)
- 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

Note: Reimbursement information for drugs purchased through the 340B Program (340B Drug Pricing Program) is not available on the Drug Search Tool. HRSA (Health Resources and Services Administration) maintains the official 340B ceiling prices, which are not available to the public due to confidentiality protections.

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, label name, or manufacturer.
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 #20577

Immunizations Covered for Children

Most allowable vaccines provided to members 18 years of age or younger are available through the federal VFC (Vaccines for Children) Program at no cost to providers. In order to receive vaccines at no cost, providers are required to enroll in the VFC Program. For enrollment information, refer to the VFC Program website.

If an allowable vaccine is available through the VFC Program, Wisconsin Medicaid will reimburse only an administration fee to the pharmacy. For allowable vaccines that are not available through the VFC Program, Wisconsin Medicaid reimbursement will include an amount for the vaccine plus the administration fee. Providers may refer to the interactive maximum allowable fee schedule for current reimbursement rates.

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 #7437

State And Specialty Maximum Allowed Cost Drug Pricing Review

To request a review of SMAC (State Maximum Allowed Cost) and specialty drug pricing, pharmacy providers are required to complete, sign, and submit the State and Specialty Maximum Allowed Cost Drug Pricing Review Request (F-00030 (04/17)) form certifying that the price listed is the AAC (Actual Acquisition Cost) of the drug after rebates or discounts from a wholesaler or supplier. The pharmacy must also submit an invoice having a product date of purchase within 60 days of submitting the request. The invoice must include the following:

- Date of purchase
- Purchased price
- Purchaser
- 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.)
- Wholesaler/supplier name

The State and Specialty 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 and Specialty Pharmacy Drug Reimbursement Rates data table.

ForwardHealth will return any review requests for products reimbursed using WAC (Wholesale Acquisition Cost), calculated 340B ceiling price, or NADAC (National Average Drug Acquisition Cost) rates.

Providers may request CMS (Centers for Medicare and Medicaid Services) NADAC pricing review by submitting a review request form, available on the Medicaid website, to the NADAC Help Desk, which may be contacted through the following means:

- Telephone (toll-free): 855-457-5264
- Email: info@mslcrps.com
- Fax: 844-860-0236

Topic #12297

Wholesale Acquisition Cost

ForwardHealth diabetic supplies and specialty drugs not purchased through the 340B Program (340B Drug Pricing Program) will use the EAC (Estimated Acquisition Cost) based on WAC (Wholesale Acquisition Cost) reimbursement. As defined by 42 C.F.R. § 447.502, EAC is the state's best estimate of the prices generally and currently paid by providers for a drug marketed or sold by manufacturers or labelers in the package size of the drug most frequently purchased by providers. These products are excluded from the AAC (Actual Acquisition Cost) reimbursement requirements for covered outpatient drugs set forth in 42 C.F.R. § 447.502.

Specialty Drug Definition

ForwardHealth defines specialty drugs as drugs requiring comprehensive patient care services, clinical management, and product support services. The definition includes the following criteria:

- Drugs prescribed for complex, chronic, or rare medical conditions
- Drugs not routinely stocked at a majority of retail community pharmacies
- Drugs that require special handling, storage, inventory, or distribution
- Drugs that require complex education and treatment maintenance

ForwardHealth identifies drug classes in which the majority of the drugs do not have an available NADAC (National Average Drug Acquisition Cost) as specialty drugs.

Specialty Wholesale Acquisition Cost

An EAC is established for specialty pharmacy drugs by therapeutic class. The EAC is based on the WAC plus or minus a specified percent. The State and Specialty Pharmacy Drug Reimbursement Rates data table provides a list of specialty pharmacy drugs, EAC, and effective dates.

For BadgerCare Plus and Medicaid, specialty drugs purchased through the 340B Program are reimbursed according to 340B ingredient cost reimbursement.

Diabetic Supplies

The EAC for diabetic supplies is WAC plus two percent.

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.
- Other health insurance (for example, commercial health insurance, Medicare, Medicare Advantage Plans) payments made to the member.
- Spenddown.
- Charges for a private room in a nursing home if meeting the requirements stated in Wis. Admin. Code § DHS 107.09(4)(k), or in a hospital if meeting the requirements stated in Wis. Admin. Code § DHS 107.08(3)(a)2.
- 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 and Medicaid

The BadgerCare Plus and Medicaid copay amount for legend NDCs (National Drug Codes) with a generic status and compounded products is $1.00, while the copay amount for legend NDCs with a brand status is $3.00, up to a maximum copay of $12.00 per member, per provider, per calendar month. The copay amount for OTC (over-the-counter) drugs (excluding iron supplements for pregnant or lactating women) and diabetic supplies 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 copay a member may be required to pay in a calendar month. However, member copay amounts for OTC drugs, DMS, or DME may change to a different copay level if the maximum allowable fee for the drug or supply changes. Providers should collect copay 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 copay amounts.

SeniorCare

The SeniorCare copay amount for legend NDCs with a generic status and compounded products is $5.00, while the copay amount for legend NDCs with a brand status is $15.00.

Copay for Brand Name Drugs Preferred Over Generic Drugs

ForwardHealth generally applies a generic copay to a brand name drug when a drug that previously required BMN (brand medically necessary) PA (prior authorization) becomes a preferred drug on the PDL (Preferred Drug List) and the available generic equivalents are non-preferred drugs.

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 to brand pricing.

For drugs included in this policy, ForwardHealth will automatically apply the generic copay 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 (Dispense As Written)/Product Selection code on claims to ensure the generic copay deduction.

The Preferred Drug List Quick Reference includes the most current list of drugs for which ForwardHealth automatically applies the generic copay to 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 and BadgerCare Plus Copay Exemptions

According to Wis. Admin. Code § DHS 104.01(12)(a), and 42 C.F.R. (Code of Federal Regulations) § 447.56, providers are prohibited from collecting any copays from the following Medicaid and BadgerCare Plus members:

- Children under age 19
- American Indians or Alaskan Natives, regardless of age or income level, who are receiving or have ever received items and services either directly from an Indian health care provider or through referral under contract health services (Note: Until further notice, Wisconsin Medicaid and BadgerCare Plus will apply this exemption policy for **all** services regardless of whether a tribal health care provider or a contracted entity provides the service. Providers may not collect copay from any individual identified in the EVS (Enrollment Verification System) as an American Indian or Alaskan Native.)
- Terminally ill individuals receiving hospice care
- Nursing home residents
- Members enrolled in Wisconsin Well Woman Medicaid
- Individuals eligible through EE (Express Enrollment)

The following services do not require copays from any member enrolled in Wisconsin Medicaid or BadgerCare Plus:

- Behavioral treatment
- Care coordination services (prenatal and child care coordination)
- CRS (Community Recovery Services)
- Crisis intervention services
- CSP (community support program) services
- Comprehensive community services
- COVID-19-related care
- Emergency services for medical conditions that meet the prudent layperson standard (the prudent layperson standard is defined by 42 C.F.R. (Code of Federal Regulations) § 438.114, and may be expanded to include a psychiatric emergency involving a significant risk or serious harm to oneself or others, a substance abuse emergency in which there is significant risk of serious harm to a member or others or there is likelihood of return to substance abuse without immediate treatment, or emergency dental care, which is defined as an immediate service needed to relieve the patient from pain, an acute infection, swelling, trismus, fever, or trauma)
- EMTALA (Emergency Medical Treatment and Labor Act)-required medical screening exam and stabilization services
- Family planning services and supplies, including sterilizations
- HealthCheck services
- Home care services (home health, personal care, and PDN (private duty nurse) services)
- Hospice care services
- Immunizations, including approved vaccines recommended to adults by the ACIP (Advisory Committee on Immunization Practices)
- Independent laboratory services
- Injections
- Pregnancy-related services
- Preventive services with an A or B rating* from the USPSTF (U.S. Preventive Services Task Force)**, including tobacco cessation services
- SBS (school-based services)
- Substance abuse day treatment services
- Surgical assistance
- Targeted case management services

Note: Providers may not impose cost sharing for health-care acquired conditions or other provider-preventable services as defined in federal law under 42 C.F.R. § 447.26(b).

* Providers are required to add CPT (Current Procedural Terminology) modifier 33 to identify USPSTF services that are not specifically identified as preventive in nature. The definition for modifier 33 reads as follows:

> When the primary purpose of the service is the delivery of an evidence based service in accordance with a U.S. Preventive Services Task Force A or B rating in effect and other preventive services identified in preventive services mandates (legislative or regulatory), the service may be identified by adding 33 to the procedure. For separately reported services specifically identified as preventive, the modifier should not be used.

Since many of the USPSTF recommendations are provided as part of a regular preventive medicine visit, ForwardHealth will not deduct a copayment for these services (CPT procedure codes 99381–99387 and 99391–99397).

** The USPSTF recommendations include screening tests, counseling, immunizations, and preventive medications for targeted populations. These services must be provided or recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice.

Topic #233

Limitations

Providers should verify that they are collecting the correct copay for services as some services have monthly or annual copay limits. Providers may not collect member copays in amounts that exceed copay limits.

Monthly Copay Limits

Per the federal limitations on premiums and cost sharing in 42 C.F.R. § 447.56(f), the combined amount of Medicaid premiums and copays a BadgerCare Plus or Medicaid member incurs each month may not exceed 5 percent of the member's monthly household income. To comply with federal limitations on premiums and cost sharing, ForwardHealth calculates each member's monthly premium and copay limit, which is a maximum allowable copay amount based on monthly income, for individual members. Members within the same household may have different individual copay limits, and children under age 19 are exempt from copays.

Providers must determine whether or not a BadgerCare Plus or Medicaid member is exempt from paying copays or has reached their monthly copay limit by accessing the Enrollment Verification System and receiving the message "No Copay" in response to an enrollment query.

Member Notification

Each member receives a letter in the mail that states their individual monthly copay limit. If a member has a change, such as a change in income or marital status, they will receive a letter with the updated individual monthly copay limit.

When a member reaches their monthly copay limit before the end of the month, they will receive a letter that informs them that they have met their copay limit for that month, and copays will resume on the first day of the following month.

Copay Collection

Once a member meets their individual monthly copay limit, copays will no longer be deducted from the provider's reimbursement. This is true even if subsequent claim adjustments reduce the member's incurred copay amount to below their monthly limit.

Providers may not collect copays from members who have met their individual monthly copay limit.

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 member who fails to make a copayment.

Wis. Stat. § 49.45(18) 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 and Medicare Cost plans
- 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 is the payer of last resort for any covered services. Therefore, the provider is required to make a reasonable effort to exhaust all other existing 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.

Reimbursement 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 Wisconsin 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 Wis. Admin. Code § DHS 107.10(4):

- 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 (Centers for Medicare and Medicaid Services)
- Less-than-effective drugs as identified by CMS 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 signed a federal drug 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 Wis. Admin. Code § DHS 107.10(3)
- 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 BMN (brand medically necessary) handwritten by the prescriber on the prescription or on a separate order attached to the original prescription
- For members in levels 2b and 3, drugs produced by manufacturers who have not signed a SeniorCare rebate agreement

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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Archive Date:12/01/2020

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 ForwardHealth 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 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 email, 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 their 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 (date 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 (e.g., Medicaid, WCDP, or WWWP) or to the service area (e.g., 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:

- Member enrollment — for member enrollment inquiries and verification
- Claim and PA status — for claim and PA status inquiries
- Pharmacy — for drug claim, policy, and drug authorization inquiries
- Dental — for dental inquiries
- Policy — for all policy questions except those for pharmacy and dental
- Provider enrollment — for provider enrollment and revalidation questions
- EHR (Electronic Health Record) — for EHR inquiries

Walk-in Appointments

Walk-in appointments offer face-to-face assistance for providers at the Provider Services office. Providers must schedule an appointment in advance by contacting Provider Services at 800-947-9627. Appointments for in-person provider assistance are available Monday through Friday, 7:30 a.m.-4:00 p.m. (CST), except for state-observed holidays. Providers without an appointment may not receive in-person assistance and may have to schedule an appointment for a later date.

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 DMS (Division of Medicaid Services) 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-01016 (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 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.

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 Standard 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 Standard 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 Standard Time)***
For providers, trading partners, billing services, and clearinghouses with technical questions about the following: • Electronic transactions. • Companion documents. • Provider Electronic Solutions (PES) software.		
Managed Care Provider Appeals	**(800) 760-0001, Option 1**	**Monday through Friday, 7:00 a.m. to 6:00 p.m. (Central Standard Time)***
To assist BagderCare Plus and Medicaid Supplemental Security Income (SSI) managed care providers with questions regarding their appeal status and other general managed care provider appeal information.		
Managed Care Ombudsman Program	**(800) 760-0001**	**Monday through Friday, 7:00 a.m. to 6:00 p.m. (Central Standard 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, 8:00 a.m. to 6:00 p.m. (Central Standard Time)***
To assist ForwardHealth members or persons calling on behalf of members with program information and requirements, enrollment, finding certified providers, and resolving concerns.		
Wisconsin AIDS Drug Assistance Program (ADAP)	**(800) 991-5532**	**Monday through Friday, 8:00 a.m. to 4:30 p.m.**

		(Central Standard Time)*
To assist ADAP providers and members, or persons calling on behalf of members, with program information and requirements, enrollment, finding enrolled 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, ADAP (Wisconsin AIDS Drug Assistance Program), 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 email 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 Eligibility & Benefit Inquiry and 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, ADAP (Wisconsin AIDS Drug Assistance Program), 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 Eligibility & Benefit Inquiry and 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 Acknowledgment for Health Care Insurance). 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 health insurance (for example, commercial health insurance, Medicare, Medicare Advantage Plans) 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

Copay Information

No Copay

If a member is enrolled in BadgerCare Plus or Wisconsin Medicaid and is exempt from paying copays 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, Wisconsin Medicaid, or SeniorCare and is required to pay a copay, 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.

Copay

If a member is enrolled in BadgerCare Plus, Wisconsin Medicaid, or SeniorCare and is required to pay a copay, 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

Non-Emergent Copay

If a member is enrolled in BadgerCare Plus and is eligible for the $8 non-emergent copay, 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, "Member Eligible for Non-Emergent Copay" or "Eligible for Non-Emergent Copay"

The messages "Member Eligible for Non-Emergent Copay" and "Eligible for Non-Emergent Copay" indicate that a member is a BadgerCare Plus childless adult and they are eligible for the copay if they do not meet the prudent layperson standard and seek and receive additional post-stabilization care in the emergency department after being informed of the $8 copay and availability of alternative providers with lesser or no cost share.

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 their 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 copays (BadgerCare Plus and Medicaid 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 they are 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 BadgerCare Plus 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 Tuberculosis-Related Medicaid 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 website. 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 website 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 their 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 their 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 (National Provider Identifier) 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 User Guides page of the Portal for more detailed instructions on performing these functions.

Topic #16737

Demographic Maintenance Tool

The demographic maintenance tool allows providers to update information online that they are required to keep current with ForwardHealth. To access the demographic maintenance tool, providers need a ForwardHealth Portal account. After logging into their Portal account, providers should select the Demographic Maintenance link located in the Home Page box on the right side of the secure Provider home page.

Note: The Demographic Maintenance link will only display for administrative accounts or for clerk accounts that have been assigned the Demographic Maintenance role. The Account User Guide provides specific information about assigning roles.

The demographic maintenance tool contains general panels which are available to all or most providers as well as specific panels which are only available to certain provider types and specialties. The Demographic Maintenance Tool User Guide provides further information about general and provider-specific panels.

Uploading Supporting Documentation

Providers can upload enrollment-related supporting documentation (e.g., licenses, certifications) using the demographic maintenance tool. Documents in the following formats can be uploaded:

- JPEG (Joint Photographic Experts Group) (.jpg or .jpeg)
- PDF (Portable Document Format) (.pdf)

To avoid delays in processing, ForwardHealth strongly encourages providers to upload their documents.

Submitting Information

After making **all** their changes, providers are required to submit their information in order to save it. After submitting information, providers will receive one of the following messages:

- "Your information was **updated** successfully." This message indicates that providers' files were immediately updated with the changed information.
- "Your information was **uploaded** successfully." This message indicates that ForwardHealth needs to verify the information before providers' files can be updated. Additionally, an Application Submitted panel will display and indicate next steps.

Verification

ForwardHealth will verify changes within 10 business days of submission. If the changes can be verified, ForwardHealth will update providers' files. In some cases, providers may receive a Change Notification letter indicating what information ForwardHealth updated. Providers should carefully review the Provider File Information Change Summary included with the letter to verify the accuracy of the changes. If any of the changes are inaccurate, providers can correct the information using the demographic maintenance tool. Providers may contact Provider Services if they have questions regarding the letter.

Regardless of whether or not providers are notified that their provider files were updated, changed information is not considered approved until 10 business days after the information was changed. If the changes cannot be verified within 10 business days, ForwardHealth will notify providers by mail that their provider files were not updated, and providers will need to make corrections using the demographic maintenance tool.

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:

1. Access the Portal and log into their secure account by clicking the Provider link/button.
2. Click on the Designate 835 Receiver link on the right-hand side of the secure home page.
3. Enter the identification number of the trading partner that is to receive the 835 in the Trading Partner ID field.
4. 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 email). 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, they 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 their 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 login is required to access the secure area of the Portal to submit or retrieve account and member information that 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 codes and managed care and Medicare information
- Provider search function for retrieving provider information such as the 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 gives providers access to all policy and billing information for Wisconsin Medicaid, BadgerCare Plus, ADAP (Wisconsin AIDS Drug Assistance Program), and WCDP (Wisconsin Chronic Disease Program). A secure ForwardHealth Portal account is not required to use the Online Handbook, as it is available to all Portal visitors.

Revisions to Online Handbook information are incorporated after policy changes have been issued in *ForwardHealth Updates*, typically on the policy effective date. The Online Handbook also links to the Communication Home page, which takes users to ForwardHealth Updates, user guides, and other communication pages.

The Online Handbook 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
- Covered and Noncovered Services
- 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 **Online Handbooks** under the Policy and Communication heading.
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 searching 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 **Search**.

ForwardHealth Publications Archive Area

The Handbook Archives page allows providers to view 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 **Communication Home** link under the Policy and Communication heading.
3. Click the **Online Handbooks** link on the left sidebar menu.
4. Click on the **ForwardHealth Handbook Archives** link at the bottom of the page.

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, they have complete access to all functions within the specific secure area of their 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 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.

ForwardHealth Communications

ForwardHealth Updates announce changes in policy and coverage, PA (prior authorization) requirements, and claim submission requirements. They communicate new initiatives from the Wisconsin DHS (Department of Health Services) or new requirements from the federal CMS (Centers for Medicare and Medicaid Services) and the Wisconsin state legislature.

Updates reflect current policy at the time of publication; this information may change over time and be revised by a subsequent *Update*. *Update* information is added to the ForwardHealth Online Handbook after the *Update* is posted, unless otherwise noted.

Providers should refer to the Online Handbook for current information. The Online Handbook is the source for current ForwardHealth policy and contains provider-specific information for various services and benefits.

Training

Providers can register for all scheduled trainings and view online trainings via the 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 email) 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 Resources 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 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).
- Email subscription service for *Updates*. Providers can register for email subscription to receive notifications of new provider publications via email. 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 PA 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 other health insurance (for example, commercial health insurance, Medicare, Medicare Advantage Plans), 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 Partners 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 Partners 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 HPE MyRoom. MyRoom 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 #478

Accessing ForwardHealth Communications

ForwardHealth Updates announce changes in policy and coverage, prior authorization requirements, and claim submission requirements. They communicate new initiatives from the Wisconsin Department of Health Services or new requirements from the federal Centers for Medicare and Medicaid Services and the Wisconsin state legislature.

Updates reflect current policy at the time of publication; this information may change over time and be revised by a subsequent *Update*. *Update* information is added to the Online Handbook after the *Update* is posted, unless otherwise noted.

Providers should refer to the *ForwardHealth Online Handbook* for current information. The Online Handbook is the source for current ForwardHealth policy and contains provider-specific information for various services and benefits.

Topic #4458

Electronic Notifications from ForwardHealth

ForwardHealth sends electronic messaging via Portal Account messaging and e-mail subscription messaging to notify of newly released *ForwardHealth Updates*. ForwardHealth also uses electronic messaging to communicate training opportunities and other timely information. Providers who have established a ForwardHealth Portal account automatically receive notifications from ForwardHealth in their Portal Messages inbox. Providers and other interested parties may register to receive e-mail subscription notifications.

E-mail Subscription

When registering for e-mail subscription, providers and other interested parties are able to select, by program (Wisconsin Medicaid, BadgerCare Plus, ADAP (Wisconsin AIDS Drug Assistance Program), or WCDP (Wisconsin Chronic Disease Program)), provider type (e.g., physician, hospital, DME (durable medical equipment) vendor), and/or specific information of interest, (Trading Partner and ICD-10 (International Classification of Diseases, 10th Revision) Project Information) to designate what information they would like to receive. Any number of staff or other interested parties from an organization may sign up for an e-mail subscription and may select multiple subscription options.

Registering for E-mail Subscription

Users may sign up for an e-mail subscription by following these steps:

1. Click the Register for E-mail Subscription link on the ForwardHealth Portal home page.
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.

The selected subscriptions will load and a confirmation message will appear at the top of the page.

Topic #4460

Full Text Publications Available

Providers without internet access may call Provider Services to request that a paper copy of a *ForwardHealth Update* be mailed to them. To expedite the call, correspondents will ask providers for the *Update* number. Providers should allow seven to 10 business days for delivery.

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 member ID, if available, that exists on the DOS or within the DOS range selected will be listed.
- Commercial health 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
  - Request enrollment information for the same member using a different financial payer
  - Hear another member's enrollment information using the same financial payer
  - Hear another member's enrollment information using a different financial payer
  - 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 financial payer (program, i.e., Wisconsin Medicaid, WCDP (Wisconsin Chronic Disease Program), or WWWP (Wisconsin Well Woman Program)) and 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.

PA 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 (International Classification of Diseases) procedure 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.

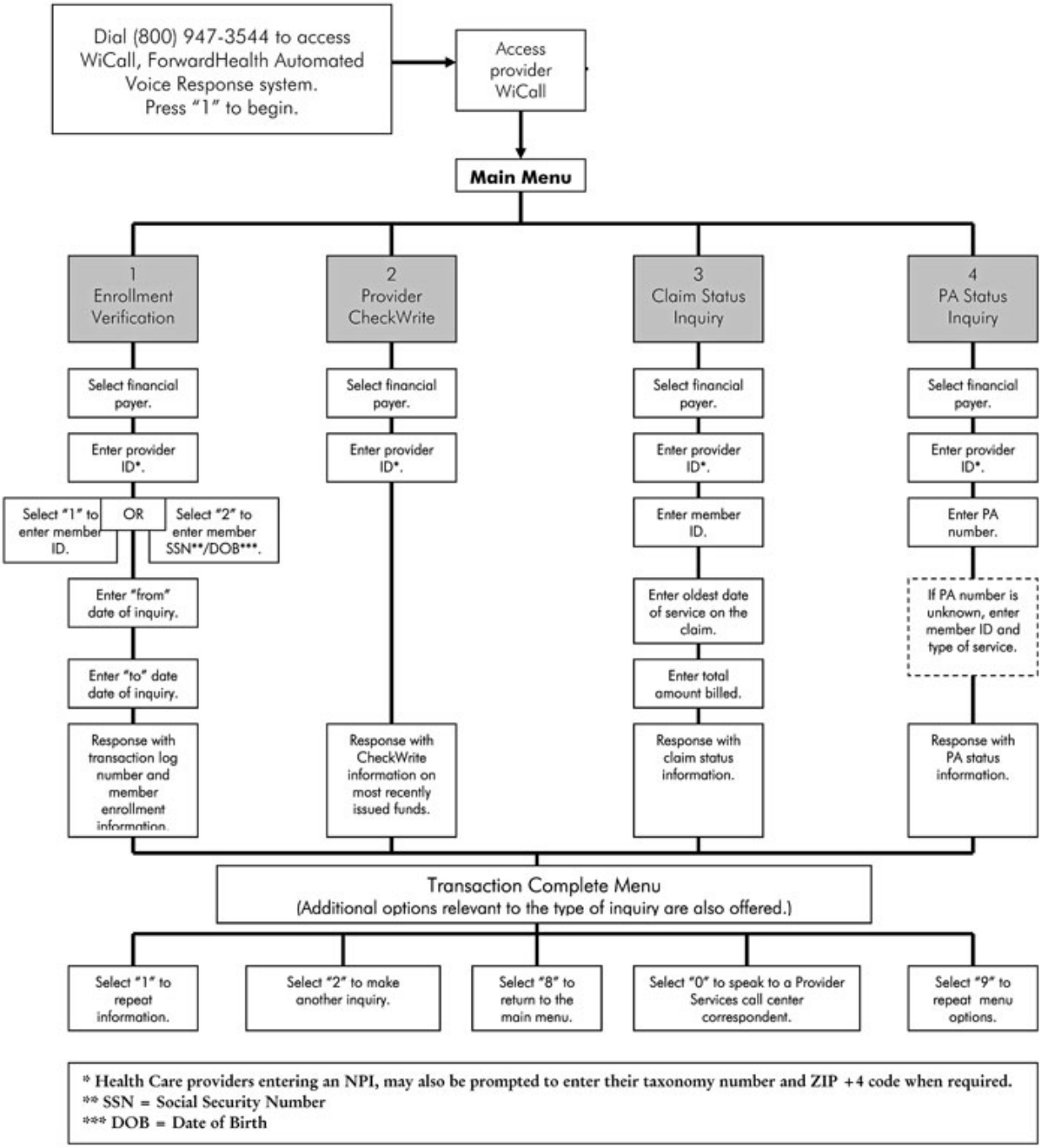
Note: PA information for BadgerCare Plus and SeniorCare is available by selecting the Medicaid option.

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