wisconsin Medicaid update
and BadgerCare
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Wisconsin Medicaid and BadgerCare Information for Providers

To:
Blood Banks
Dispensing Physicians
Federally Qualified Health Centers
Pharmacies
Rural Health Clinics
HMOs and Other Managed Care Programs

Wisconsin Medicaid Extends Temporary Claims Submission Procedures for Medicare Part D Dual Eligibles

Due to continuing problems with Medicare Part D, Wisconsin Medicaid is extending the temporary procedures for reimbursement described in the January 2006 *Wisconsin Medicaid and BadgerCare Update* (2006-03), titled "Temporary Procedures for Submitting Claims for Dual Eligibles." These temporary procedures are effective for dates of service from January 13, 2006, through March 15, 2006, if reasonable attempts are made to submit a claim to a dual eligible's Medicare Part D Prescription Drug Program.

Due to continuing problems with Medicare Part D, Wisconsin Medicaid is extending the temporary procedures for reimbursement for the cost of drugs provided to dual eligibles for dates of service (DOS) from January 13, 2006, through March 15, 2006, if reasonable attempts are made to submit a claim to a dual eligible's Medicare Part D Prescription Drug Program (PDP).

Providers are required to submit the following forms to Wisconsin Medicaid to receive reimbursement for claims submitted as a result of problems with Medicare Part D:

- The Medicare Part D Attestation form, HCF 1094 (01/06).
- A Noncompound Drug Claim form, HCF 13072 (Rev. 06/03).

The completion instructions and Noncompound Drug Claim form are located in Attachments 1 and 2 of this *Wisconsin Medicaid and BadgerCare Update* for photocopying and may also be downloaded and printed from the Medicaid Web site. Refer to Attachment 3 for the Medicare Part D Attestation form.

Claim Submission Reminders

The Noncompound Drug Claim form and the Medicare Part D Attestation form may be used *only* for DOS on and after January 13, 2006. The forms should be complete, accurate, and signed by a pharmacy provider.

On the Medicare Part D Attestation form, providers should indicate the primary reason why reimbursement cannot be obtained from a recipient's Medicare Part D PDP in the "Reason for Request" field. If more than one reason is applicable, check only the primary reason.

Providers are reminded that the Medicare Part D Attestation form should *not* be submitted for drugs excluded by Medicare Part D. Excluded drugs include barbiturates, benzodiazepines, and

over-the-counter drugs, agents used for the symptomatic relief of cough and cold, prescription vitamin and mineral products (*except* prenatal vitamins and fluoride), and weight loss agents. Providers should submit claims for drugs excluded by Medicare Part D using the Wisconsin Medicaid real-time pharmacy Point-of-Sale system.

If a provider indicates on the Medicare Part D Attestation form that the reason for the request is a coordination of benefits issue, the other coverage code "2" (Other coverage exists — payment collected) should be indicated in Element 29 of the Noncompound Drug Claim form. The payment amount received from the PDP should be indicated in Element 31 of the Noncompound Drug Claim form. If the provider indicates on the Medicare Part D Attestation form that the reason for the request is an eligibility or billing issue, the "Other Coverage Code" field should *not* be completed unless the recipient has other commercial health insurance.

Information Regarding Medicaid HMOs

This *Update* contains Medicaid fee-for-service policy and applies to providers of services to recipients on fee-for-service Medicaid only. For Medicaid HMO or managed care policy, contact the appropriate managed care organization. Wisconsin Medicaid HMOs are required to provide at least the same benefits as those provided under fee-for-service arrangements.

The *Wisconsin Medicaid and BadgerCare Update* is the first source of program policy and billing information for providers.

Although the *Update* refers to Medicaid recipients, all information applies to BadgerCare recipients also.

Wisconsin Medicaid and BadgerCare are administered by the Division of Health Care Financing, Wisconsin Department of Health and Family Services, P.O. Box 309, Madison, WI 53701-0309.

For questions, call Provider Services at (800) 947-9627 or (608) 221-9883 or visit our Web site at *dhfs.wisconsin.gov/medicaid/*.

PHC 1250

ATTACHMENT 1
Non-compound Drug Claim Completion Instructions

(A copy of the "Non-compound Drug Claim Completion Instructions" is located on the following pages.)

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WISCONSIN MEDICAID
NON-COMPOUND DRUG CLAIM COMPLETION INSTRUCTIONS

Wisconsin Medicaid requires information to enable Medicaid to authorize and pay for medical services provided to eligible recipients. Although these claim instructions refer to Medicaid recipients, these instructions also apply to BadgerCare recipients and SeniorCare participants.

Recipients are required to give providers full, correct, and truthful information for the submission of correct and complete claims for Medicaid reimbursement. This information should include, but is not limited to, information concerning eligibility status, accurate name, address, and Medicaid identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to Medicaid administration such as determining eligibility of the applicant or processing provider claims for reimbursement. The Noncompound Drug Claim form is used by Wisconsin Medicaid, and is mandatory when submitting paper claims for noncompound drugs. Failure to supply the information requested by the form may result in denial of Medicaid payment for the services.

To avoid denial or inaccurate claim payment, use the following claim form completion instructions. Enter all required data on the claim form in the appropriate element. Do not include attachments unless instructed to do so. All elements are required unless "optional" or "not required" is indicated.

Wisconsin Medicaid recipients receive a Medicaid identification card upon being determined eligible for Wisconsin Medicaid. Always verify a recipient's eligibility before providing nonemergency services by using the Eligibility Verification System (EVS) to determine if there are any limitations on covered services and to obtain the correct spelling of the recipient's name. Refer to the Provider Resources section of the All-Provider Handbook or the Medicaid Web site at *dhfs.wisconsin.gov /medicaid/* for more information about the EVS.

Note: Submit claims for non-drug items such as, clozapine management services, disposable medical supplies, durable medical equipment, and enteral nutrition products, on the CMS 1500 claim form or 837 Health Care Claim: Professional transaction (837P) using nationally recognized five-digit procedure codes.

SECTION I — PROVIDER INFORMATION

Element 1 — Name — Provider
Enter the name of the billing provider.

Element 2 — Wisconsin Medicaid Provider Number
Enter the billing provider's eight-digit Medicaid provider number.

Element 3 — Address — Provider (Street, City, State, Zip Code)
Enter the address, including the street, city, state, and Zip code of the billing provider.

Element 4
Do not write in this space. This element is reserved for future Medicaid use.

SECTION II — RECIPIENT INFORMATION

Element 5 — Cardholder Identification Number — Recipient
Enter the recipient's 10-digit Medicaid identification number. Do not enter any other numbers or letters.

Element 6 — Name — Recipient (Last, First, Middle Initial)
Enter the recipient's name from the recipient's Medicaid identification card. Use the EVS to obtain the correct spelling of the recipient's name. If the name or spelling of the name on the Medicaid identification card and the EVS do not match, use the spelling from the EVS.

Element 7 — Date of Birth — Recipient
Enter the recipient's date of birth in MM/DD/YY format (e.g., May 21, 1980 would be 05/21/80) or in MM/DD/YYYY format (e.g., July 14, 1953, would be 07/14/1953).

Element 8 — Sex — Recipient
Enter "0" for unspecified, "1" for male, and "2" for female.

SECTION III — CLAIM INFORMATION

Element 9 — Prescriber Number
Enter the nine-character Drug Enforcement Agency (DEA) number of the prescribing provider. This number must be two alpha characters followed by seven numeric characters. If the DEA number cannot be obtained or the prescriber does not have a DEA number, use one of the following default codes:

- XX5555555 — Prescriber's DEA number cannot be obtained.
- XX9999991 — Prescriber does not have a DEA number.

These codes must *not* be used for prescriptions for controlled substances.

Element 10 — Date Prescribed
Enter the date shown on the prescription in MM/DD/YY or MM/DD/YYYY format.

Element 11 — Date Filled
Enter the date that the prescription was filled or refilled in MM/DD/YY or MM/DD/YYYY format. When billing unit dose services, the last date of service (DOS) in the billing period must be entered.

Element 12 — Refill
Enter the refill indicator. The first two digits of the refill indicator is the refill being billed. This must be "00" if the date prescribed equals the date filled. The second element is the total refills allowed (e.g., the second refill of a six-refill prescription would be "02/06.") A non-refillable prescription would be "00/00." Enter "99" in the second element if the prescription indicates an unlimited number of refills.

Element 13 — NDC
Enter the 11-digit National Drug Code (NDC) or Medicaid-assigned 11-digit procedure code for the item being billed. (Use the NDC indicated on the product.)

Element 14 — Days' Supply
Enter the estimated days' supply of tablets, capsules, fluid cc's, etc. that has been prescribed for the recipient. This must be a whole number greater than zero (e.g., if a prescription is expected to last for five days, enter "5").

Note: Days' supply is not the duration of treatment, but the expected number of days the drug will be used.

Element 15 — Qty
Enter the metric decimal quantity in the specified unit of measure according to the Wisconsin Medicaid Drug File. Quantities billed should be rounded to two decimal places (i.e., nearest hundredth).

Element 16 — Charge
Enter the total charge for each line item. The charge should represent your usual and customary fee.

Element 17 — UD
Enter one of the following National Council for Prescription Drug Programs (NCPDP) single-numeric indicators when billing for unit dose (UD) drugs and non-unit dose drugs. (This field is required for *all* pharmacy claims.)

Indicator	Description
0	Not specified
1	Not Unit Dose
2	Manufacturer Unit Dose
3	Pharmacy Unit Dose

Element 18 — Prescription Number
Enter the prescription number. Each legend and over-the-counter drug billed must have a unique prescription number.

Element 19 — DAW
Enter the appropriate one-digit NCPDP dispense as written (DAW) code:

Code	Description
0	No Product Selection Indicated
1	Substitution Not Allowed by Prescriber
8	Substitution Allowed — Generic Drug Not Available in Marketplace

Element 20 — Drug Description (optional)

Element 21 — PT LOC
Enter the appropriate two-digit NCPDP patient location code for each drug billed.

Code	Description
00	Not specified
01	Home [IV-IM Services Only]
04	Long Term/Extended Care
07	Skilled Care Facility
10	Outpatient

Element 22 — Diagnosis Code
This element is required when billing for a drug in which Wisconsin Medicaid requires a diagnosis or when billing for Pharmaceutical Care (PC) services. If the diagnosis of the drug is different than that of the PC services, enter the diagnosis code of the drug from the *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) coding structure. Enter all digits of the diagnosis code, including the preceding zeros.

Element 23 — Level of Effort
This element is required when billing for PC services. Refer to the Drug Utilization Review and Pharmaceutical Care section of the Pharmacy Handbook for PC information. Enter the NCPDP code from the following list that corresponds with the time required to perform the PC service.

Code	Description
11	0-5 minutes
12	6-15 minutes
13	16-30 minutes
14	31-60 minutes
15	More than 60 minutes

Element 24 — Reason for Service
This element is required when billing for Drug Utilization Review (DUR) or PC services. Refer to the Drug Utilization Review and Pharmaceutical Care section of the Pharmacy Handbook for DUR and PC information and applicable PC values.

Element 25 — Professional Service
This element is required when billing for DUR or PC services. Refer to the Drug Utilization Review and Pharmaceutical Care section of the Pharmacy Handbook for DUR and PC information and applicable PC values.

Element 26 — Result of Service
This element is required when billing for DUR or PC services. Refer to the Drug Utilization Review and Pharmaceutical Care section of the Pharmacy Handbook for DUR and PC information and applicable PC values.

Element 27 — Sub Clar Code
Enter NCPDP submission clarification code "2" to indicate repackaging.

Element 28 — Prior Authorization Number
If prior authorization (PA) has been obtained, enter the seven-digit number in this element. Do not attach a copy of the PA request to the claim. Services authorized under multiple PA requests must be billed on separate claims.

Element 29 — Other Coverage Code
Wisconsin Medicaid is usually the payer of last resort for Medicaid-covered services. (Refer to the Coordination of Benefits section of the All-Provider Handbook for more information.) Prior to submitting a claim to Wisconsin Medicaid, providers must verify whether a recipient has other health insurance coverage (e.g., commercial health insurance, HMO, or Medicare).

If a recipient has Medicare and other insurance coverage, the provider is required to bill both prior to submitting a claim to Wisconsin Medicaid. Enter one of the NCPDP other coverage (OC) codes that best describes the recipient's situation:

Value	Description
0	Not specified
1	No other coverage identified
2	Other coverage exists — payment collected
3	Other coverage exists — this claim not covered
4	Other coverage exists — payment not collected
5	Managed care plan denial
6	Other coverage denied — not a participating provider
7	Other coverage exists — not in effect at time of service

Element 30 — Total Charges
Enter the total charges for this claim.

Element 31 — Other Coverage Amount
When applicable, enter the amount paid by commercial health insurance. This is required when the other coverage code in Element 29 indicates "2."

Note: Pharmacies may also include the Medicare-paid amount in this field for claims that fail to automatically crossover from Medicare to Wisconsin Medicaid within 30 days.

Element 32 — Patient Paid
When applicable for SeniorCare claims, enter the recipient's out-of-pocket expense due to other coverage, including Medicare. Do not enter a recipient's expected copayment for Wisconsin Medicaid or SeniorCare.

Element 33 — Net Billed
Enter the balance due by subtracting any other insurance amount and patient paid amount from the amount in Element 30.

Element 34 — Certification
The provider or the authorized representative must sign this element. The month, day, and year the form is signed must also be entered in MM/DD/YY format (e.g., November 20, 2003, would be 11/20/03) or in MM/DD/YYYY format (e.g., January 5, 2004, would be 01/05/2004).

Note: The signature may be computer generated or stamped.

ATTACHMENT 2
Noncompound Drug Claim

(A copy of the "Noncompound Drug Claim" form is located on the following page.)

WISCONSIN MEDICAID
NONCOMPOUND DRUG CLAIM

Instructions: Type or print clearly. Before completing this form, read the Noncompound Drug Claim Completion Instructions (HCF 13072A).
Return form to: Wisconsin Medicaid, 6406 Bridge Road, Madison, WI 53784-0002.

SECTION I — PROVIDER INFORMATION

1. Name — Provider	2. Wisconsin Medicaid Provider Number
3. Address — Provider (Street, City, State, Zip Code)	4. Reserved for future Medicaid use (Do not write in this space)

SECTION II — RECIPIENT INFORMATION

5. Cardholder Identification Number — Recipient	6. Name — Recipient (Last, First, Middle Initial)	7. Date of Birth — Recipient	8. Sex — Recipient

SECTION III — CLAIM INFORMATION

9. Prescriber Number	10. Date Prescribed	11. Date Filled	12. Refill	13. NDC	14. Days' Supply	15. Qty	16. Charge $
17. UD	18. Prescription Number	19. DAW	20. Drug Description				21. PT LOC
22. Diagnosis Code	23. Level of Effort	24. Reason for Service	25. Professional Service	26. Result of Service	27. Sub Clar Code		

9. Prescriber Number	10. Date Prescribed	11. Date Filled	12. Refill	13. NDC	14. Days' Supply	15. Qty	16. Charge $
17. UD	18. Prescription Number	19. DAW	20. Drug Description				21. PT LOC
22. Diagnosis Code	23. Level of Effort	24. Reason for Service	25. Professional Service	26. Result of Service	27. Sub Clar Code		

9. Prescriber Number	10. Date Prescribed	11. Date Filled	12. Refill	13. NDC	14. Days' Supply	15. Qty	16. Charge $
17. UD	18. Prescription Number	19. DAW	20. Drug Description				21. PT LOC
22. Diagnosis Code	23. Level of Effort	24. Reason for Service	25. Professional Service	26. Result of Service	27. Sub Clar Code		

9. Prescriber Number	10. Date Prescribed	11. Date Filled	12. Refill	13. NDC	14. Days' Supply	15. Qty	16. Charge $
17. UD	18. Prescription Number	19. DAW	20. Drug Description				21. PT LOC
22. Diagnosis Code	23. Level of Effort	24. Reason for Service	25. Professional Service	26. Result of Service	27. Sub Clar Code		

28. Prior Authorization Number		29. Other Coverage Code	
30. Total Charges $	31. Other Coverage Amount $	32. Patient Paid $	33. Net Billed $

34. Certification
I certify the services and items for which reimbursement is claimed on this claim form were provided to the above named recipient pursuant to the prescription of a licensed physician, podiatrist, or dentist. Charges on this claim form do not exceed my (our) usual and customary charge for the same services or items when provided to persons not entitled to receive benefits under Wisconsin Medicaid, SeniorCare, and BadgerCare.
I understand that any payment made in satisfaction of this claim will be derived from federal and state funds and that any false claims, statements or documents, or concealment of a material fact may be subject to prosecution under applicable federal or state law.

SIGNATURE — Pharmacist or Dispensing Physician	Date Signed

ATTACHMENT 3
Medicare Part D Attestation

(A copy of the "Medicare Part D Attestation" form is located on the following page.)

DEPARTMENT OF HEALTH AND FAMILY SERVICES **STATE OF WISCONSIN**
Division of Health Care Financing
HCF 1094 (01/06)

MEDICARE PART D ATTESTATION

Instructions: Providers may submit the Medicare Part D Attestation and paper drug claim to: Wisconsin Medicaid, Pharmacy Special Handling Unit, Suite 20, 6406 Bridge Road, Madison, WI 53784-0020. Type or print clearly.

NOTE: Providers should make sure claims were submitted to the appropriate payer. Medicare Part B continues to cover physician-administered drugs, including injectable, intravenous, and oral drugs for the treatment of cancer.

SECTION I — PROVIDER INFORMATION	
Wisconsin Medicaid Provider Number	Telephone Number — Provider

SECTION II — MEDICAID RECIPIENT INFORMATION	
Name — Medicaid Recipient (Last, First, Middle Initial)	Recipient Medicaid Identification Number

SECTION III — REASON FOR REQUEST

Check the box before the statement that best describes the situation for the named recipient. Choose one.

❑ Eligibility Issue.

- Could not determine recipient's Medicare Part D eligibility after a reasonable attempt to do all of the following:
  - ✓ Request a Medicare Prescription Drug Plan (PDP) card or PDP acknowledgement letter from the recipient.
  - ✓ Perform an E1 transaction to identify a Medicare Part D plan.
  - ✓ Call the dedicated Medicare Pharmacy Hotline at (866) 835-7595 to identify or confirm the recipient's PDP.

❑ Billing Issue.

- Could not get payment resolution from Medicare Part D PDP.
- The Medicare Part D PDP is not honoring the federally required transition policy and is denying coverage of a non-formulary drug needed by the recipient.
- Submitted the claim to the Point-of-Sale (POS) Contractor, Wellpoint, and Wellpoint denied the claim.

❑ Coordination of Benefits Issue.

- The Medicare Part D PDP is returning incorrect cost sharing amount for a dual eligible. (Cost sharing for a dual eligible should never exceed a $5.00 copayment on a single prescription.)

SECTION IV — CERTIFICATION

I attest that I have attempted to follow the Medicare Part D policies and processes to submit a claim to Medicare Part D PDP for the above dual eligible, but all good faith efforts have failed to result in approval or appropriate payment of the claim for services by Medicare Part D.

SIGNATURE — Pharmacist	Date Signed