

Wisconsin Medicaid and BadgerCare update

February 2007 • No. 2007-14

Wisconsin Medicaid and BadgerCare Information for Providers

To:

Blood Banks
Dentists
Dispensing Physicians
Federally Qualified Health Centers
Inpatient Hospital Providers
Nurse Practitioners
Nursing Homes
Outpatient Hospital Providers
Pharmacies
Physician Assistants
Physician Clinics
Physicians
Podiatrists
Rural Health Clinics
HMOs and Other Managed Care Programs

Emergency Medication Dispensing

This *Wisconsin Medicaid and BadgerCare Update* reminds providers about Wisconsin Medicaid's emergency medication dispensing policy and claim submission process.

This *Wisconsin Medicaid and BadgerCare Update* reminds providers about the emergency medication dispensing policy that allows providers to dispense up to a 14-day supply of a drug in situations where the pharmacy provider or prescriber deem it medically necessary. This policy overrides drug restriction policies and all prior authorization (PA) policies including the Preferred Drug List, brand medically necessary, and diagnosis restriction policies; however, other policies, such as recipient eligibility and noncovered services policies still apply. The information in this *Update* applies to Wisconsin Medicaid recipients and SeniorCare participants.

Providers may dispense up to a 14-day supply of a medication under the emergency medication dispensing policy. When subsequent refills are dispensed, all current drug restriction policies and PA policies apply.

Wisconsin Medicaid encourages pharmacy providers to dispense an emergency supply of a medication when they determine it is medically necessary or an emergency. An emergency medication supply may be dispensed if a recipient receives a prescription for a drug with

any type of restriction, including a diagnosis restriction, PA requirement, or age or sex-restriction, and the physician cannot be reached to obtain the appropriate documentation to override the restriction.

Claim Submission

When drugs are dispensed in an emergency situation, providers are required to submit a Noncompound Drug Claim form, HCF 13072 (Rev. 06/03), with a Pharmacy Special Handling Request form, HCF 13074 (Rev. 06/06), indicating the nature of the emergency. Providers should mail completed Noncompound Drug Claim and Pharmacy Special Handling Request forms as indicated on the Pharmacy Special Handling Request form. Providers may also fax these forms to Wisconsin Medicaid at (608) 221-8616.

Changes were made to the Pharmacy Special Handling Request form to allow providers to check that an emergency supply was dispensed. The Pharmacy Special Handling Request form and completion instructions are located in Attachments 1 and 2 of this *Update* for photocopying and may also be downloaded and printed from the Medicaid Web site. The Noncompound Drug Claim completion instructions and form are included in Attachments 3 and 4.

Completing Claim Forms Correctly

Providers are required to correctly complete the Pharmacy Special Handling Request form and the Noncompound Drug Claim form to receive the appropriate reimbursement for an emergency medication supply. Wisconsin Medicaid is committed to reimbursing providers for emergency medications as long as claims are properly completed and submitted with a Pharmacy Special Handling Request form.

Claims are denied when a provider does not complete the “UD” field. Providers are reminded to complete Element 17 (“UD”) on the Noncompound Drug Claim form with the appropriate unit dose value. Unit dose values may be found in the Noncompound Drug Claim Completion Instructions, HCF 13072A (Rev. 06/03).

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 and SeniorCare participants also.

Wisconsin Medicaid, BadgerCare, and SeniorCare 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

Pharmacy Special Handling Request Completion Instructions

(A copy of the "Pharmacy Special Handling Request Completion Instructions" is located on the following pages.)

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WISCONSIN MEDICAID PHARMACY SPECIAL HANDLING REQUEST COMPLETION INSTRUCTIONS

Wisconsin Medicaid requires certain information to enable Medicaid to authorize and pay for medical services provided to eligible recipients. Although these instructions refer to Medicaid recipients, all information applies 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, processing prior authorization (PA) requests, or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of Medicaid payment for the services.

The use of this form is voluntary and providers may develop their own form as long as it includes all the information on this form and is formatted exactly like this form. Refer to the Pharmacy Handbook for service restrictions and additional documentation requirements. Provide enough information for Wisconsin Medicaid, BadgerCare, or SeniorCare to make a reasonable judgment about the case. Prescribers and dispensing physicians are required to retain a completed copy of the form.

Pharmacy providers are required to complete and sign the Pharmacy Special Handling Request when appropriate. Pharmacy providers submitting paper claims that require the Pharmacy Special Handling Request may submit the paper claim form with the Pharmacy Special Handling Request to the following address:

Wisconsin Medicaid
Pharmacy Special Handling Unit
Suite 20
6406 Bridge Rd
Madison WI 53784-0020

SECTION I — PROVIDER INFORMATION

Element 1 — Wisconsin Medicaid Provider Identification Number

Enter the provider's eight-digit Wisconsin Medicaid provider identification number.

Element 2 — Telephone Number — Pharmacy Provider

Enter the telephone number, including the area code, of the pharmacy provider.

SECTION II — REASON FOR REQUEST (Choose one.)

Element 3 — Emergency Supply Dispensed

Check the box to indicate that the pharmacy dispensed an emergency supply of up to 14 days per fill.

Element 4 — Original Claim Denied

Check the box to indicate that the original claim was denied and that the pharmacy provider is resubmitting the claim for reconsideration. Include the following information:

- Date of denial.
- Authorization / Internal Control Number.
- Explanation of Benefits (EOB) Number and / or National Council for Prescription Drug Program (NCPDP) Reject Code.
- Description of issue for reconsideration.

Element 5 — National Drug Code (NDC) not on Medicaid file

Check the box to indicate that the NDC submitted on the claim is not on the Medicaid drug file. Include the following information:

- National Drug Code.
- Description of NDC.

Element 6 — Pharmacy Consultant Review

Check the box to indicate that a pharmacy consultant review is being requested. Also check a box to indicate that the pharmacy provider is requesting a review for quantity limits exceeded or “other” reason. Include the following information when requesting an “other” review:

- Explanation of review needed.
- Supporting documentation such as Remittance and Status Report or manufacturer-reviewed and/or peer-reviewed medical literature.

When requesting a review for quantity limits exceeded for triptans, include the following information:

- Complete directions for use. (“As needed” or “PRN” are not sufficient.)
- The maximum triptan dose the prescriber has established by day, week, or month.
- The migraine prophylactic medication the recipient is taking. Specify the drug name, strength, directions for use and compliance.
- Indicate other abortive analgesic headache medications the recipient is taking. Specify the drug name, strength, quantity, directions for use and how frequently the medication is being filled.
- Indicate clinical information from the prescriber regarding the frequency of headaches and either why prophylactic treatment is not being used or why prophylactic treatment has been unsuccessful in reducing the headache frequency.

SECTION III — CERTIFICATION

Element 7 — Signature — Pharmacist or Dispensing Physician

The pharmacy provider or dispensing physician is required to complete and sign this form.

Element 8 — Date Signed

Enter the month, day, and year the Pharmacy Special Handling Request was signed (in MM/DD/YYYY format).

ATTACHMENT 2

Pharmacy Special Handling Request

(A copy of the "Pharmacy Special Handling Request" is located on the following page.)

**WISCONSIN MEDICAID
PHARMACY SPECIAL HANDLING REQUEST**

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

SECTION I — PROVIDER INFORMATION

1. Wisconsin Medicaid Provider Number

2. Telephone Number — Pharmacy Provider

SECTION II — REASON FOR REQUEST (Choose one.)

3. Emergency Supply Dispensed

4. Original Claim Denied

Date of Denial _____

Authorization / Internal Control Number _____

Explanation of Benefits (EOB) Number and / or National Council for Prescription Drug Program (NCPDP) Reject Code

Description of issue for reconsideration _____

5. National Drug Code (NDC) Not on Medicaid File

NDC _____

Description _____

6. Pharmacy Consultant Review

Other: Explanation of review needed. (Provide the explanation in the space below.)

Quantity limits exceeded. (Provide the required documentation in the space below.)

Provide supporting documentation when available (e.g., Remittance and Status Report or manufacturer-reviewed and / or peer-reviewed literature).

SECTION III — CERTIFICATION

7. SIGNATURE — Pharmacist or Dispensing Physician

8. Date Signed

ATTACHMENT 3

Noncompound Drug Claim Completion Instructions

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

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WISCONSIN MEDICAID NONCOMPOUND 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 nondrug 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 (837P) transaction 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

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

Providers may enter up to four sets of drug information per recipient for Elements 9-27.

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 in the billing period must be entered.

Element 12 — Refill

Enter the refill indicator. The first two digits of the refill indicator is for 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 nonrefillable 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 the provider's 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 nonunit 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)

Enter a brief description of the drug.

Element 21 — PT LOC

Enter the appropriate two-digit NCPDP patient location code for each drug billed.

Code	Description
00	Not specified
01	Home
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* 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	Level 1 (0-5 minutes)
12	Level 2 (6-15 minutes)
13	Level 3 (16-30 minutes)
14	Level 4 (31-60 minutes)
15	Level 5 (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 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 drug 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 or in MM/DD/YYYY format.

Note: The signature may be computer generated or stamped.

ATTACHMENT 4

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
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