wisconsin Medicaid update and BadgerCare

June 2007 ● No. 2007-44

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

Modification of Temporary Claim Submission Procedures for Medicare Part D Dual Eligibles

In January 2006, Wisconsin Medicaid implemented temporary claim submission procedures to reimburse pharmacy providers for drugs provided to Medicare Part D dual eligibles for dates of service on and after January 13, 2006. Wisconsin Medicaid is modifying the claim submission procedures using the procedures listed in this *Wisconsin Medicaid and BadgerCare Update*.

Background

In January 2006, Wisconsin Medicaid implemented temporary claim submission procedures to reimburse pharmacy providers for drugs provided to Medicare Part D dual eligibles for dates of service (DOS) on and after January 13, 2006. The procedures were put in place due to the continuing problems with Medicare Part D and to assist pharmacy providers who made reasonable attempts but were unsuccessful when submitting a claim for payment to a dual eligible's Prescription Drug Plan (PDP). (A PDP includes not only the stand alone Medicare Part D PDPs, but also Medicare Advantage prescription drug plans [MA-PDs].) Providers may refer to the January 2006 *Wisconsin Medicaid and BadgerCare Update* (2006-18), titled "Wisconsin Medicaid Extends Temporary Claim Submission Procedures for Medicare Part D Dual Eligibles," for information about this process. Policies and procedures in this *Update* apply only to Wisconsin Medicaid and BadgerCare recipients. These policies and procedures do not apply to SeniorCare participants.

Wisconsin Medicaid is modifying the temporary claim submission process using the procedures outlined below. For claims received on and after July 2, 2007, regardless of DOS, providers should *discontinue* using the Medicare Part D Attestation form, HCF 1094 (01/06). Claims submitted to Wisconsin Medicaid on and after July 2, 2007, with the Medicare Part D Attestation form will not receive special handling and claims will be denied.

For a recipient who is prescribed a drug *not* included on a Medicare Part D PDP's formulary, the pharmacy provider should work with the recipient's physician to change the drug to a PDP formulary drug or obtain a PDP formulary exception. Wisconsin Medicaid will not cover drugs that are not included on a PDP's formulary. In addition, Wisconsin Medicaid is discontinuing the temporary claim submission procedures for this situation.

Note: Wisconsin Medicaid will continue to cover drugs that are excluded from Medicare Part D coverage for dual eligibles. These drugs include barbiturates, benzodiazepines, over-the-

counter drugs, agents used for the symptomatic relief of cough and cold, prescription vitamins and minerals (*except* prenatal vitamins and fluoride), and weight loss agents. These claims can be sent directly to Wisconsin Medicaid following appropriate claim submission procedures.

Prescription Drug Plan Enrollment Situations

Pharmacy providers should use the information below to determine if a recipient is enrolled in a PDP.

If a Recipient's Enrollment in Prescription Drug Plan is Not Determined

For recipients who do not know the PDP in which they are enrolled, the pharmacy provider is required to do the following:

- Send the National Council for Prescription Drug Programs (NCPDP) eligibility verification E1 transaction to NDCHealth to verify the Medicare Part D PDP in which the recipient is enrolled. If the eligibility verification returns the PDP in which the recipient is enrolled, submit the claim to the PDP.
- Call the dedicated Medicare Pharmacy Hotline at (866) 835-7595 for assistance.

If it is determined that a recipient is dually eligible but a PDP cannot be identified, the pharmacy provider should submit the claim to Wellpoint through Medicare's Point-of-Sale facilitated enrollment solution. Instructions for submitting claims to Wellpoint can be found in the Point-of-Sale Enrollment of Dual Beneficiaries on the Centers for Medicare and Medicaid Services (CMS) Web site at *www.cms.hhs.gov/PrescriptionDrugCovGenIn/Downloads/POSFacilitatedEnrollmentWeb.pdf*.

If a Recipient's Enrollment in a Prescription Drug Plan Is Determined

If the recipient presents a Medicare Part D PDP card, or if an NCPDP eligibility verification E1 transaction has provided the PDP in which the recipient is enrolled, and the pharmacy provider has questions about how the PDP has processed the claim (e.g., the claim is returning incorrect copayment information), the pharmacy provider should do the following:

- Contact the PDP.
- Call 1-800-MEDICARE if the PDP is not responsive.

Determining Enrollment in a Prescription Drug Plan

If a recipient indicates he or she is enrolled in a PDP, but the effective date for the PDP is a future date, the pharmacy provider and the recipient should contact the PDP or CMS to determine the effective date or to request retroactive enrollment.

Claim Submission

If, after following the previous steps, a resolution with the recipient's PDP has *not* been reached, the pharmacy provider may contact Provider Services at (800) 947-9627 or (608) 221-9883 to receive a verification number. Providers are required to receive a verification number from Provider Services to submit a claim to Wisconsin Medicaid. Provider Services may be contacted between the hours of 8:30 a.m. and 6 p.m. on Mondays and Wednesdays through Fridays, and 9:30 a.m. and 6 p.m. on Tuesdays.

To be considered for reimbursement, claims that are assigned verification numbers must be submitted to Wisconsin Medicaid on paper by September 30, 2007. Verification numbers will be issued through August 31, 2007; however, Wisconsin Medicaid will accept claims

If it is determined that a recipient is dually eligible but a PDP cannot be identified, the pharmacy provider should submit the claim to Wellpoint through Medicare's Point-of-Sale facilitated enrollment solution.

submitted with verification numbers through September 30, 2007. Verification numbers are assigned per DOS, per recipient.

After a verification number is assigned, the provider will receive a verification number form from Wisconsin Medicaid. The provider is required to sign the form and submit it to Wisconsin Medicaid with the appropriate claim form *and* a Pharmacy Special Handling Request form, HCF 13074 (Rev. 06/06).

Pharmacy providers may complete the Pharmacy Special Handling Request form, check the box in Element 3 ("Emergency Supply Dispensed"), and indicate the verification number in the space provided. Providers should also submit a completed Noncompound Drug Claim form, HCF 13072 (Rev. 06/03), or a Compound Drug Claim form, HCF 13073 (Rev. 06/03), with the Pharmacy Special Handling Request.

Submit claims to the following address:

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

Note: This claim submission process will end on August 31, 2007. Wisconsin Medicaid will not accept Medicare Part D Attestation forms or issue a verification number for Medicare Part D claims for dual eligibles with dates of process on and after September 1, 2007. Therefore, pharmacy providers must work closely with PDPs to resolve outstanding issues for dual eligibles.

Refer to Attachments 1 through 6 of this *Update* for the Pharmacy Special Handling Request form and completion instructions, the Noncompound Drug Claim form and completion instructions, and the Compound Drug Claim form and completion instructions.

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
Pharmacy Special Handling Request Completion Instructions

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

DEPARTMENT OF HEALTH AND FAMILY SERVICES **STATE OF WISCONSIN**
Division of Health Care Financing
HCF 13074A (06/06)

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
Ste 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.)

DEPARTMENT OF HEALTH AND FAMILY SERVICES **STATE OF WISCONSIN**
Division of Health Care Financing
HCF 13074 (Rev. 06/06)

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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DEPARTMENT OF HEALTH AND FAMILY SERVICES **STATE OF WISCONSIN**
Division of Health Care Financing HFS 106.03(1), Wis. Admin. Code
HCF 13072A (Rev. 06/03)

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” is located on the following page.)

DEPARTMENT OF HEALTH AND FAMILY SERVICES | **STATE OF WISCONSIN**
Division of Health Care Financing | HFS 106.03(1), Wis. Admin. Code
HCF 13072 (Rev. 06/03)

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 5
Compound Drug Claim Completion Instructions

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

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WISCONSIN MEDICAID
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 Compound Drug Claim form is used by Wisconsin Medicaid, and is mandatory when submitting paper claims for compound 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 *www.dhfs.state.wi.us/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 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
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.

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 — 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 14 — Quantity Dispensed
Enter the metric decimal quantity reflecting the total number of compound units dispensed.

Note: The quantity may not always equal the total of compound ingredient quantities.

Element 15 — Prescription Number
Enter the prescription number for the entire compound.

Element 16 — PT LOC
Enter the appropriate two-digit National Council for Prescription Drug Programs (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 17 — Diagnosis Code
This element is required when billing for any drug within the compound in which Wisconsin Medicaid requires a diagnosis. Enter a diagnosis code from the *International Classification of Diseases, Ninth Revision, Clinical Modification* coding structure in this element. Refer to the Covered Services and Reimbursement section of the Pharmacy Handbook for more information.

Element 18 — Level of Effort
Enter the NCPDP level of effort code from the following list that corresponds with the time required to prepare the compound.

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)

SECTION IV — COMPOUND INGREDIENTS
Indicate up to 25 compound ingredients using the following guidelines:

Ingredient NDC	Indicate the 11-digit National Drug Code (NDC) for the item being billed. (Use the NDC indicated on the product.)
Ingredient Quantity	Indicate the exact fractional metric quantity for the component ingredient used in the compound. Quantity billed should be rounded to two decimal places (i.e., nearest hundredth).
Ingredient Cost	Indicate the cost for the component ingredient used in the compound. The charge should represent the provider's usual and customary fee for the compound component.

Element 19 — Prior Authorization Number
This element is required when any drug within the compound requires prior authorization (PA). Enter the seven-digit number from the approved PA form in Element 19. Do not attach a copy of the PA to the claim.

Element 20 — 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 21 — Total Charges
Enter the total charges for this claim.

Element 22 — Other Coverage Amount
When applicable, enter the amount paid by commercial health insurance. This is required when the OC code in Element 20 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 23 — Patient Paid Amount
When applicable on 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 24 — Net Billed
Enter the balance due by subtracting any other insurance amount and patient paid amount from the amount in Element 21.

Element 25 — 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 or MM/DD/YYYY format.

Note: The signature may be computer generated or stamped.

ATTACHMENT 6
Compound Drug Claim

(A copy of the “Compound Drug Claim” is located on the following page.)

DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Health Care Financing
HCF 13073 (Rev. 06/03)

STATE OF WISCONSIN
HFS 106.03(1), Wis. Admin. Code

WISCONSIN MEDICAID
COMPOUND DRUG CLAIM

Instructions: Type or print clearly. Before completing this form, read the Compound Drug Claim Completion Instructions (HCF 13073A).
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. Days' Supply	14. Quantity Dispensed

15. Prescription Number	16. PT LOC	17. Diagnosis Code	18. Level of Effort

SECTION IV — COMPOUND INGREDIENTS

	Ingredient NDC	Ingredient Quantity	Ingredient Cost		Ingredient NDC	Ingredient Quantity	Ingredient Cost
1.			$	14.			$
2.			$	15.			$
3.			$	16.			$
4.			$	17.			$
5.			$	18.			$
6.			$	19.			$
7.			$	20.			$
8.			$	21.			$
9.			$	22.			$
10.			$	23.			$
11.			$	24.			$
12.			$	25.			$
13.			$	19. Prior Authorization Number		20. Other Coverage Code	

21. Total Charges	22. Other Coverage Amount	23. Patient Paid Amount	24. Net Billed
$	$	$	$

25. 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