To:

Blood Banks

Dentists

Dispensing Physicians

Federally Qualified Health Centers

Inpatient Hospital Providers

Nurse Practitioners

Nursing Homes

Pharmacies

Physician Assistants

Physician Clinics

Physicians

Podiatrists

Outpatient Hospital Providers

Rural Health Clinics

HMOs and Other Managed Care Programs

Diagnosis Code Restrictions and Quantity Limits for Altabax™, Bactroban®, and Mupirocin

This *Wisconsin Medicaid and BadgerCare Update* revises the diagnosis code restrictions and establishes quantity limits for Altabax™, Bactroban®, and mupirocin. Information about claim submission and prior authorization are also included. Information in this *Update* applies to Wisconsin Medicaid and BadgerCare recipients and Wisconsin SeniorCare participants.

Wisconsin Medicaid is revising diagnosis code restrictions and establishing quantity limits for Altabax™, Bactroban®, and mupirocin for Wisconsin Medicaid and BadgerCare recipients and Wisconsin SeniorCare participants.

Diagnosis Code Restrictions

Effective for claims processed on and after September 1, 2007, Wisconsin Medicaid has revised diagnosis code restrictions for the following drugs:

- Altabax™ ointment, 1 percent.

- Bactroban® cream, 2 percent.

- Bactroban® nasal ointment, 2 percent.

- Mupirocin ointment, 2 percent.

The following are new diagnosis code restrictions:

Drug Name	Diagnosis Code	Description
Altabax™ ointment, 1%	684	Impetigo
Bactroban® cream, 2%	680-6829, 685-6869	Infections of skin and subcutaneous tissue
Bactroban® nasal ointment, 2%	V090	Methicillin-resistant staphylococcus aureus (MRSA)
mupirocin ointment, 2%	684	Impetigo
	680-6829, 685-6869	Infections of skin and subcutaneous tissue
	V090	Methicillin-resistant staphylococcus aureus (MRSA)

Note: Wisconsin Medicaid will no longer reimburse for the Centany™ Ointment Kit for dates of service (DOS) on and after September 1, 2007.

Prior Authorization

If the prescriber writes a prescription with a diagnosis outside the Wisconsin Medicaid-allowed diagnoses for a drug, the pharmacy provider is required to submit a paper prior authorization (PA) request to Wisconsin Medicaid. The *prescriber* is required to complete the Prior Authorization/Drug Attachment (PA/DGA), HCF 11049 (06/03), and attach peer-reviewed medical literature to support the proven efficacy of the requested use of the drug. The prescriber should send the PA/DGA and supporting documentation to the pharmacy where the recipient intends to fill his or her prescription. The *pharmacy provider* then completes the Prior Authorization/Request Form (PA/RF), HCF 11018 (10/03), and submits the forms and supporting documentation to Wisconsin Medicaid. Refer to Attachments 1 and 2 of this *Wisconsin Medicaid and BadgerCare Update* for the PA/DGA and completion instructions.

Prescriptions

Prescribers are required to indicate the diagnosis code or diagnosis description on prescriptions for all diagnosis-restricted drugs. If a diagnosis code is not indicated on the prescription, pharmacy providers should contact the prescriber to obtain the diagnosis code or diagnosis description. It is not acceptable for pharmacy providers to obtain the diagnosis code or diagnosis description from the recipient.

New Quantity Limits

Effective for DOS on and after September 1, 2007, quantities of Altabax™, Bactroban®, and mupirocin will be limited to the following.

Drug	Quantity Limit
Altabax™ ointment, 1%	30 grams per 34 days
Bactroban® cream, 2%	60 grams per 34 days
Bactroban® nasal ointment, 2%	10 grams per 34 days
mupirocin ointment, 2%	66 grams per 34 days

Claim Submission

For Drugs with New Diagnosis Code Restrictions

Pharmacy providers should submit claims for diagnosis-restricted drugs with the appropriate diagnosis code. When a claim is submitted with a missing or invalid diagnosis code, or with a code that is not a Medicaid-allowed diagnosis code, providers will receive Explanation of Benefits (EOB) code 510, which states the following:

> Denied. Prior authorization/diagnosis is required for a payment of this service. A valid PA number/diagnosis is required and/or the procedure must match the approved PA.

If this EOB response is received because the provider did not submit a Medicaid-allowed diagnosis code, a paper PA request with supporting documentation should be submitted to Wisconsin Medicaid.

For Drugs with Quantity Limits

When a claim is submitted with a quantity that exceeds the limit, providers will receive the following:

- Explanation of Benefits code 485 that states: "Quantity limits exceeded."
- National Council for Prescription Drug Programs reject code 76 that states, "Plan limitations exceeded."

The pharmacy provider should contact the prescriber to determine that it is medically necessary for a recipient to exceed the quantity limits. If it is medically necessary, the pharmacy provider is required to complete the Noncompound Drug Claim, HCF 13072 (06/03), and a Pharmacy Special Handling Request, HCF 13074 (06/06), explaining the medical necessity to exceed the quantity limits. Refer to the Medicaid Web site at *dhfs.wisconsin.gov/medicaid/* for forms and instructions.

Pharmacy providers should contact the prescriber and indicate the following information on the Pharmacy Special Handling Request:

- Complete directions for use, including the length of treatment.
- Diagnosis.
- Location, size, and severity of the area to be treated.
- Complete information regarding prior medications that have been used to treat the condition and the results, when applicable.

Data Tables

Providers may refer to the Diagnosis Restricted Drugs data table and the new Quantity Limits data table on the Pharmacy section of the Medicaid Web site for the most recent information about diagnosis code restrictions and quantity limits. These tables may be revised at any time, so providers should refer to them frequently.

Emergency Medication Dispensing Reminder

An emergency medication supply may be dispensed in situations where the pharmacy provider or prescriber deem it is medically necessary. Medications dispensed in an emergency situation do not require PA.

When drugs are dispensed in an emergency situation, providers are required to submit a Noncompound Drug Claim with a Pharmacy Special Handling Request, 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.

Providers may refer to the February 2007 *Update* (2007-14), titled "Emergency Medication Dispensing," for more information about Medicaid's emergency medication dispensing policy

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ATTACHMENT 1
Prior Authorization/Drug Attachment Completion Instructions

(A copy of the "Prior Authorization/Drug Attachment [PA/DGA] Completion Instructions" is located on the following pages

WISCONSIN MEDICAID
PRIOR AUTHORIZATION / DRUG ATTACHMENT (PA/DGA)
COMPLETION INSTRUCTIONS

Wisconsin Medicaid requires 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 PA or 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. If necessary, attach additional pages if more space is needed. Refer to the Pharmacy Handbook for service restrictions and additional documentation requirements. Provide enough information for Wisconsin Medicaid and SeniorCare medical consultants to make a reasonable judgement about the case.

Attach the completed Prior Authorization/Drug Attachment (PA/DGA) to the Prior Authorization Request Form (PA/RF) and physician prescription (if necessary) and send it to Wisconsin Medicaid. Providers may submit PA requests by fax to Wisconsin Medicaid at (608) 221-8616. Providers who wish to submit PA requests by mail may do so by submitting them to the following address:

Wisconsin Medicaid
Prior Authorization
Ste 88
6406 Bridge Rd
Madison WI 53784-0088

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 — RECIPIENT INFORMATION

Element 1 — Name — Recipient
Enter the recipient's last name, followed by his or her first name and middle initial. Use the Eligibility Verification System (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 2 — Date of Birth — Recipient
Enter the recipient's date of birth in MM/DD/YYYY format (e.g., September 8, 1996, would be 09/08/1996).

Element 3 — Recipient Medicaid Number
Enter the recipient's 10-digit Medicaid identification number. Do not enter any other numbers or letters.

SECTION II — TYPE OF REQUEST

Element 4
Indicate the start date requested for PA or the date the prescription was filled.

Element 5
Check the appropriate box to indicate if this product has been requested previously.

SECTION III — PRESCRIPTION INFORMATION
If this section is completed, providers do not need to include a copy of the prescription documentation used to dispense the product requested.

Element 6 — Drug Name
Enter the drug name.

Element 7 — Strength
Enter the strength of the drug listed in Element 6.

Element 8 — Quantity Ordered
Enter the quantity that was ordered.

Element 9 — Date Order Issued
Enter the date the order was issued.

Element 10 — Directions for Use
Enter the directions for use of the drug.

Element 11 — Daily Dose
Enter the daily dose.

Element 12 — Refills
Enter the amount of refills.

Element 13 — Name — Prescriber
Enter the name of the prescriber.

Element 14 — DEA 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 15
Indicate if "Brand Medically Necessary" is handwritten by the prescriber on the prescription order.

SECTION IV — CLINICAL INFORMATION
Include diagnostic, as well as clinical information, explaining the need for the product requested.

Element 16
List the recipient's condition the prescribed drug is intended to treat. Include *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis codes and the expected length of need. If requesting a renewal or continuation of a previous PA approval, indicate any changes to the clinical condition, progress, or known results to date. Attach another sheet if more space is required.

Element 17
Indicate source of clinical information.

Element 18
Indicate use of the product requested.

Element 19
Indicate dosage of the product requested.

Element 20 — Signature — Pharmacist or Dispensing Physician
The pharmacist / dispenser must review this information and sign this form.

Element 21 — Date Signed
Enter the month, day, and year the PA/DGA was signed (in MM/DD/YYYY format).

Element 22
Check the appropriate box indicating how the provider would like to be notified of an approved or denied PA request. Be sure to indicate a fax or telephone number if selecting either of these options.

ATTACHMENT 2
Prior Authorization/Drug Attachment

(A copy of the "Prior Authorization/Drug Attachment [PA/DGA]" is located on the following pages.

WISCONSIN MEDICAID
PRIOR AUTHORIZATION / DRUG ATTACHMENT (PA/DGA)

Providers may submit prior authorization (PA) requests by fax to Wisconsin Medicaid at (608) 221-8616; or, providers may send the completed form with attachments to: Wisconsin Medicaid, Prior Authorization, Suite 88, 6406 Bridge Road, Madison, WI 53784-0088.
Instructions: Type or print clearly. Before completing this form, read the Prior Authorization/Drug Attachment (PA/DGA) Completion Instructions (HCF 11049A).

SECTION I — RECIPIENT INFORMATION

1. Name — Recipient (Last, First, Middle Initial)	2. Date of Birth — Recipient

3. Recipient Medicaid Identification Number

SECTION II — TYPE OF REQUEST

4. Indicate the Start Date Requested / Date Prescription Filled

5. Indicate if this drug has been previously requested.

❑ This is an initial PA request for this drug, for this recipient, by this provider.
❑ This is a request to renew or extend previously prior authorized therapy using this drug.

First PA Number_____

❑ This is a request to change or add a new National Drug Code (NDC) number to a current valid PA.

First PA Number_____ NDC Number to add _____

SECTION III — PRESCRIPTION INFORMATION

6. Drug Name	7. Strength
8. Quantity Ordered	9. Date Order Issued

10. Directions for Use

11. Daily Dose	12. Refills
13. Name — Prescriber	14. Drug Enforcement Agency Number

15. "Brand Medically Necessary" is handwritten by the prescriber on the prescription order.   ❑ Yes   ❑ No

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SECTION IV — CLINICAL INFORMATION

16. List the recipient's condition the prescribed drug is intended to treat. Include *International Classification of Diseases, Ninth Revision, Clinical Modification* diagnosis code for pharmaceutical care recipients. Include the expected length of need. If requesting a renewal or continuation of a previous PA approval, indicate any changes to the clinical condition, progress, or known results to date. Attach another sheet if additional room is needed.

17. Source for Clinical Information (check one)

❑ This information was primarily obtained from the prescriber or prescription order.

❑ This information was primarily obtained from the recipient.

❑ This information was primarily obtained from some other source (specify). _____

_____

_____

18. Use (check one)

❑ Compendial standards, such as the United States Pharmacopeia Drug Information (USP DI) or drug package insert, lists the intended use identified above as an expected indication.

❑ Compendial standards, such as the USP DI, lists the intended use identified above as a [bracketed] accepted application.

❑ Compendial standards, such as the USP DI or drug package insert, lists the intended use identified above as an expected use.

❑ The intended use above is not listed in compendial standards. Peer reviewed clinical literature is attached or referenced. (Reference — include publication name, date, and page number.)

19. Dose (check one)

❑ The daily dose and duration are within compendial standards general prescribing or dosing limits for the indicated use.

❑ The daily dose and duration are **not** within compendial standards general prescribing or dosing limits for the intended use. Attach or reference peer-reviewed literature which indicates this dose is appropriate, or document the medical necessity of this dosing difference. (Reference — include publication name, date, and page number.)

20. **SIGNATURE** — Pharmacist or Dispensing Physician	21. Date Signed

22. Please notify me of approval or denial by:

❑ Fax (include Fax number) _____

❑ Telephone (include telephone number) _____

❑ No special notice needed.