ForwardHealth
Wisconsin serving you

Update
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Affected Programs: BadgerCare Plus, Medicaid
To: Ambulatory Surgery Centers, Blood Banks, Dentists, Dispensing Physicians, End-Stage Renal Disease Service Providers, Family Planning Clinics, Federally Qualified Health Centers, Home Health Agencies, Hospital Providers, Nurse Midwives, Nurse Practitioners, Nursing Homes, Pharmacies, Physician Assistants, Physician Clinics, Physicians, Podiatrists, Rural Health Clinics, HMOs and Other Managed Care Programs

Clarification of Policy and Reimbursement for Provider-Administered Drugs

This *ForwardHealth Update* clarifies changes to administration codes submitted on claims for provider-administered drugs and provides general policy and reimbursement information about provider-administered drugs.

Effective for dates of service on and after January 1, 2009, for members enrolled in most managed care organizations (MCOs), BadgerCare Plus and Medicaid fee-for-service, not the member's MCO, reimburse providers for all "J" codes, drug-related "Q" codes, procedure code S4993 (Contraceptive pills for birth control), and a limited number of related administration codes. BadgerCare Plus and Medicaid fee-for-service continue to reimburse providers for these services for all members enrolled in fee-for-service.

Drugs and Administration Codes Reimbursed by Fee-for-Service

Effective for dates of service (DOS) on and after January 1, 2009, for members enrolled in BadgerCare Plus HMOs, Medicaid SSI HMOs, and most special managed care programs, BadgerCare Plus and Medicaid fee-for-service, not the member's managed care organization (MCO), reimburse providers for the following if the service is covered by BadgerCare Plus and Medicaid:

- All "J" codes.
- Drug-related "Q" codes.
- Procedure code S4993 (Contraceptive pills for birth control).
- A limited number of related administration codes. (Refer to the Attachment of this *ForwardHealth Update* for a list of administration procedure codes reimbursed by fee-for-service.)

This policy is also known as the provider-administered drugs carve-out policy. For members enrolled in most MCOs, claims for these services should be submitted to BadgerCare Plus and Medicaid fee-for-service.

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

Providers may refer to the December 2008 *Update* (2008-216), titled "Provider-Administered Drugs for Members Enrolled in Managed Care Organizations Now Reimbursed by Fee-for-Service," for more information about the provider-administered drugs carve-out policy.

Information in this *Update* applies to members enrolled in the BadgerCare Plus Standard Plan, the BadgerCare Plus Benchmark Plan, the BadgerCare Plus Core Plan

for Childless Adults, and Wisconsin Medicaid. It does not apply to SeniorCare members or members enrolled in the PACE or the Family Care Partnership.

Note: Not all policies related to provider-administered drugs are described in this *Update.* Providers should refer to the ForwardHealth Online Handbook on the ForwardHealth Portal at *www.forwardhealth.wi.gov/* for more information about these policies.

Drugs and Administration Codes Reimbursed by Managed Care Organizations

Managed care organizations are responsible for reimbursing providers for all other provider-administered drugs, such as drug claims submitted with a *Current Procedural Terminology* (CPT) code, such as CPT code 90378 (Respiratory syncytial virus immune globulin [RSV-IgIM], for intramuscular use, 50 mg, each).

Vaccines and radiopharmaceuticals and their administration fees continue to be reimbursed by a member's MCO. Managed care organizations are responsible for reimbursing providers for claims for all other administration procedure codes not listed on the Attachment, including "Q" administration codes.

Providers who receive reimbursement for drugs under a bundled rate, including inpatient and outpatient hospital providers, also continue to be reimbursed by a member's MCO.

Providers who were reimbursed a bundled rate by the member's MCO for certain services (e.g., hydration, catheter maintenance, total parenteral nutrition [TPN]) for DOS prior to January 1, 2009, should continue to be reimbursed by the member's MCO. Providers should work with the member's MCO in these situations.

Denied or Incorrectly Reimbursed Claims

Since January 1, 2009, certain claims that were included in the provider-administered drugs carve out and were submitted to BadgerCare Plus and Medicaid fee-for-service for "J" codes, drug-related "Q" codes, procedure code S4993, and a limited number of related administration codes listed in the Attachment may have been denied or reimbursed incorrectly. ForwardHealth will automatically reprocess claims that were denied or reimbursed incorrectly; reprocessed claims will appear on future Remittance Advices. Providers may also resubmit claims that were denied or reimbursed incorrectly.

Obtaining Provider-Administered Drugs

To ensure the content and integrity of the drugs administered to members, prescribers are required to obtain all drugs that will be administered in their offices. If a member is given a drug to be administered by the provider for which storage, handling, and care instructions apply and the instructions are followed incorrectly, the dose may be ineffective. Prescribers may obtain a provider-administered drug from the member's pharmacy provider if the drug is transported directly from the pharmacy to the prescriber's office. Prescribers may also obtain a drug to be administered in the prescriber's office from a drug wholesaler. Pharmacy providers should *not* dispense a drug to a member if the drug will be administered in the prescriber's office.

Reminders

A provider-administered drug is either an oral, injectible, or inhaled drug administered by a physician or a designee of the physician (e.g., nurse, nurse practitioner, physician assistant) or incidental to a physician service.

Diagnosis-Restricted Provider-Administered Drugs

A limited number of provider-administered drugs are diagnosis restricted. Providers should indicate the diagnosis code on paper and electronic claims (i.e., claims submitted on the 1500 Health Insurance Claim Form or

using the 837 Health Care Claim: Professional transaction) submitted to ForwardHealth for provider-administered drugs. If the diagnosis code is *not* indicated on a claim or if the diagnosis is outside the allowed diagnosis codes for the drug, the claim will be denied.

For claims submitted with a diagnosis other than the approved diagnoses, providers should complete and submit to ForwardHealth a Prior Authorization Request Form, F-11018 (10/08), and a Prior Authorization/"J" Code Attachment (PA/JCA), F-11034 (10/08), with clinical documentation that supports the medical necessity of the drug's use outside approved diagnoses.

Providers may refer to the Physician page of the Portal for a list of diagnosis-restricted provider-administered drugs.

Not Otherwise Classified Drugs

Providers who indicate procedure codes such as J3490 (Unclassified drugs), J3590 (Unclassified biologics), or J9999 (Not otherwise classified, antineoplastic drugs) on claims for not otherwise classified (NOC) drugs must also indicate the following on the claim:

- The National Drug Code (NDC) of the drug dispensed.
- The name of the drug.
- The quantity billed.
- The unit of issue (i.e., ea, gm, or ml).

If this information is not included on the claim or if there is a more specific Healthcare Common Procedure Coding System (HCPCS) procedure code for the drug, the claim will be denied. Compound drugs that do not include a drug approved by the Food and Drug Administration (e.g., 17 alpha hydroxyprogesterone caproate) will be denied.

Providers may refer to the Online Handbook on the Portal for more information about NOC drugs.

Deficit Reduction Act Requirements

Providers are required to comply with the requirements of the federal Deficit Reduction Act of 2005 (DRA) and submit NDCs with HCPCS and CPT procedure codes for provider-administered drugs. Section 1927(a)(7)(B) of the Social Security Act requires NDCs to be indicated on all claims submitted to ForwardHealth, including Medicare crossover claims.

Providers may refer to the July 2008 *Update* (2008-126), titled "National Drug Codes Required on Claims for Physician-Administered Drugs," for more information about the DRA.

ATTACHMENT
Administration Procedure Codes

For provider-administered drugs administered to members enrolled in most managed care organizations (MCOs), the *Current Procedural Terminology* administration procedure codes below should be indicated on claims submitted for reimbursement to BadgerCare Plus and Medicaid fee-for-service, not to the member's MCO. Claims for administration procedure codes not indicated on the table below should be submitted to the member's MCO for reimbursement. Only services that are covered by ForwardHealth are reimbursed.

Code	Description
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular
96373	intra-arterial
96374	intravenous push, single or initial substance/drug
96375	each additional sequential intravenous push of a new substance/drug
96376	each additional sequential intravenous push of the same substance/drug provided in a facility
96379	Unlisted therapeutic, prophylactic, or diagnostic intravenous or intra-arterial injection or infusion