ForwardHealth
Wisconsin serving you

Update
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Affected Programs: BadgerCare Plus, Medicaid, SeniorCare
To: Home Health Agencies, Nurse Midwives, Nurse Practitioners, , Pharmacies, Physician Clinics, Physicians, Rural Health Clinics, Federally Qualified Health Centers, HMOs and Other Managed Care Programs

New Policies and Clarification of Certain Pharmacy Policies

This *ForwardHealth Update* clarifies certain pharmacy policies and contains two new policies.

Drugs Without a Signed Manufacturer Rebate Agreement

By federal law, pharmaceutical manufacturers who participate in state Medicaid programs must sign a rebate agreement with the Centers for Medicare and Medicaid Services (CMS). BadgerCare Plus, Medicaid, and SeniorCare will cover legend and specific categories of over-the-counter (OTC) products of manufacturers who have signed a rebate agreement.

Note: SeniorCare does not cover OTC drugs other than insulin.

Members Enrolled in the BadgerCare Plus Standard Plan, Medicaid, or SeniorCare (Levels 1 and 2a)

BadgerCare Plus, Medicaid, and SeniorCare levels 1 and 2a may cover certain Food and Drug Administration (FDA)-approved legend drugs through the prior authorization (PA) process even though the drug manufacturers did not sign rebate agreements.

To submit a PA request for a drug without a signed rebate agreement, the prescriber should complete and submit the Prior Authorization/Drug Attachment (PA/DGA), F-11049 (10/08), to the pharmacy where the drug will be dispensed. Pharmacies should complete the Prior Authorization Request Form (PA/RF), F-11018 (10/08), and submit both forms and any supporting documentation to ForwardHealth. Prior authorizations can be submitted by paper, fax, or on the Portal.

Included with the PA, the prescriber is required to submit documentation of medical necessity *and* cost-effectiveness that the non-rebated drug is the only available and medically appropriate product for treating the member. The documentation must include:

- A copy of the medical record or documentation of the medical history detailing the member's medical condition and previous treatment results.
- Documentation by the prescriber that shows why other drug products have been ruled out as ineffective or unsafe for the member's medical condition.
- Documentation by the prescriber that shows why the non-rebated drug is the most appropriate and cost-effective drug to treat the member's medical condition.

If a PA request for a drug without a signed manufacturer rebate is approved, claims for drugs without a signed rebate agreement must be submitted on paper. Providers should complete and submit the Noncompound Drug Claim form, F-13072 (10/08), indicating the actual National Drug Code (NDC) of the drug with the

Pharmacy Special Handling Request form, F-13074 (10/08).

If a PA request for a drug without a signed manufacturer rebate is denied, the service is considered noncovered.

SeniorCare (Levels 2b and 3)

Prior authorization is not available for drugs from manufacturers without a separate, signed SeniorCare rebate agreement for members in levels 2b and 3. Prior authorization requests submitted for drugs whose manufacturer has not signed a separate SeniorCare rebate agreement for members in levels 2b and 3 will be returned to the providers unprocessed, and the service will be noncovered. Members do not have appeal rights regarding returned PA requests for noncovered drugs.

The BadgerCare Plus Benchmark Plan and the BadgerCare Plus Core Plan

Prior authorization is not available for drugs that are not included on the BadgerCare Plus Benchmark Covered National Drug Code, the BadgerCare Plus Core Plan National Drug Code List, and the BadgerCare Plus Core Plan Brand Name Drugs — Quick Reference. Prior authorization requests submitted for noncovered drugs will be returned to the provider unprocessed and the service will be noncovered. Members do not have appeal rights regarding returned PA requests for noncovered drugs.

Claim Reversals

ForwardHealth is unable to electronically reverse claims at a provider's request. Providers can electronically reverse claims up to 365 days from the date of service (DOS) or submit a Adjustment/Reconsideration Request, F-13046 (10/08), form.

Compound Drugs

Providers may submit real-time claims for compound drugs with the NDC for each ingredient. If a compound drug has any noncovered ingredients, payment for those ingredients will be denied, but the rest of the ingredients will be covered, assuming other conditions are met.

The BadgerCare Plus Standard Plan, Medicaid, and SeniorCare do not cover compounded medications in dosage forms that have no proven therapeutic effect.

Compound drugs are *not* covered by the Benchmark Plan or the Core Plan.

Drugs for Erectile Dysfunction

ForwardHealth does not cover drugs to treat the condition of Erectile Dysfunction (ED). Examples of noncovered drugs for ED are Viagra® and Cialis®.

Prior Authorization and Day Supply

Drug PAs are approved based on day supply. If a claim exceeds the day supply remaining on a PA, the claim will be denied. For example, a PA was granted for an 180-day supply and 160 days supply of the drug has already been dispensed. If a claim for a 30-day supply is submitted, it will be denied; however, a claim for a 20-day supply will be reimbursed if all other billing requirements are met.

Drug Enforcement Agency Number Audits

All prescriptions for controlled substances must indicate the Drug Enforcement Agency number of the prescriber. Drug Enforcement Agency numbers are not required on claims or PAs.

Age- and Gender-Restricted Drugs

Effective for DOS on and after March 1, 2010, contraceptives will be covered for females who are 10 through 65 years of age.

ForwardHealth has adopted the gender restriction coding from First DataBank. The gender restrictions are automatically updated by First DataBank.

Brand Medically Necessary Drugs

If the brand name drug being dispensed is not on the Brand Medically Necessary Drugs That Require Prior Authorization list, providers may dispense the drug without brand medically necessary PA, if all other conditions are met. Providers should refer to the Brand Medically Necessary Drugs That Require Prior Authorization list on the Pharmacy page of the ForwardHealth Portal at *www.forwardhealth.wi.gov/* for a complete list.

Reimbursement for Brand Name Drugs

To receive brand name reimbursement, pharmacies need to do the following:

- Obtain a prescription with "Brand Medically Necessary" written in the prescriber's own handwriting.
- Complete a PA/RF to be submitted with the Prior Authorization/Brand Medically Necessary Attachment (PA/BMNA), F-11083 (10/08), completed by the prescriber.
- Obtain Brand Medically Necessary Prior Authorization.
- Submit claims with a "1" or "8" in the Dispense as Written Product Selection Code Field, as appropriate.

Brand Medically Necessary Prior Authorization

The prescriber is required to document specific details about the previous treatment(s) with generic equivalent drugs, including the dose of medication and the approximate dates the generic equivalent drugs were taken. In most circumstances, it will be necessary for a member to try more than one generic equivalent drug before a brand medically necessary PA request may be approved by ForwardHealth.

Criteria for approval of a PA request for a brand medically necessary drug include the following:

- Treatment failure(s) with the generic equivalent drug(s).
- Clinically significant adverse drug reaction(s) to the generic equivalent drug(s).
- Allergic reaction(s) to the generic equivalent drug(s).
- A medical condition that causes a contraindication to the use of the generic equivalent drug(s).

Providers may refer to the ForwardHealth Online Handbook on the Portal for more information about brand medically necessary policy.

Repackaged Drugs and Repackaging Allowances

Effective for DOS on and after March 1, 2010, the repackaging allowance is limited to drugs that are *not* considered unit dose. However, the traditional dispensing fee may be allowed for unit dose drugs.

Pharmacy providers can continue to submit the value "2" in the Submission Clarification Code field to obtain a repackaging allowance for drugs that are repackaged by the pharmacy. If this field is present on a pharmacy claim when the drug is defined as unit dose, the repackaging allowance will not be reimbursed. Providers will see Explanation of Benefit (EOB) code 9818 with the description "Repackaging allowance is not allowed for unit dose NDCs." The reject code associated with EOB code 9818 is 34 (M/I Submission Clarification Code).

As a reminder, the repackaging allowance only applies to drugs dispensed in whole units, such as capsules and tablets. The repackaging allowance is not allowed for liquids and creams.

Effective for DOS on and after March 1, 2010, repackaged manufacturers products are not covered by BadgerCare Plus, Medicaid, and SeniorCare. Providers will see EOB code 1648 with the description "Repackaged National Drug Codes (NDCs) are not

covered." The reject code associated with EOB 1648 is 70 (Product/Service Not Covered).

Member Cost Share

The approval or denial of PA does not impact member cost share responsibilities. For example, members enrolled in SeniorCare who have a $500 deductible are still responsible for meeting that deductible, regardless of PA.

Convenience and Combination Packaging

ForwardHealth does not reimburse for convenience or combination packaging. Drugs that are sold in small package sizes (e.g., single-use packages) are considered to be convenience packaging. Drugs that are sold in a package that includes a prescription drug along with a noncovered item; such as an OTC drug (fish oil), a personal care item (skin moisturizer), and a common medicine chest item (Band-Aid®) are combination packaging. In some cases, the drug may be separately reimbursable. For example, an acne agent packaged with an OTC face wash is not covered, but the acne agent maybe covered by itself.

Effective for DOS on and after April 1, 2010, convenience and combination packaging will be noncovered products. Therefore, the member must be prescribed a preferred drug or PA may be required for a non-preferred product.

Providers may refer to the Drug Search Tool on the ForwardHealth Portal at *www.forwardhealth.wi.gov/*.

Medicare Part D

Effective January 1, 2010, the CMS has posted the updated non-matched NDC list with NDCs provided by the FDA. If a drug appears on this non-matched NDC list, Medicare Part D will deny the claim for that drug. Furthermore, the Standard Plan, the Benchmark Plan, Medicaid, and SeniorCare will not be the primary payer if Medicare Part D denies the claim. For more information, visit the CMS Web site at *www.cms.hhs.gov/*.

Also, the Standard Plan, the Benchmark Plan, Medicaid, and SeniorCare will deny claims for Medicare Part D-covered drugs for dual eligibles. Claims and PA requests for Medicare Part D-covered drugs for dual eligibles must be submitted to the appropriate Medicare Part D Prescription Drug Plan (PDP). Providers are required to submit claims for SeniorCare members who are enrolled in a Medicare Part D PDP to the member's PDP and other health insurance sources before submitting claims to SeniorCare. SeniorCare is payer of last resort.

The Standard Plan, the Benchmark Plan, Medicaid, and SeniorCare are primary payers for the following categories of drugs:

- Benzodiazepines.
- Barbiturates.
- Over-the-counter products.
- Cough and cold relief.
- Weight loss drugs.
- Certain prescription vitamins (with the exception of prenatal vitamins and fluoride).

Members with a Medicare Advantage Plan

Crossover claims for Medicare Part B covered drugs for members enrolled in the Standard Plan, Medicaid, or SeniorCare with a Medicare Advantage plan will deny due to the Medicare Advantage plan being on the member's file. To be reimbursed, providers are required to submit a Pharmacy Special Handling Request and a Noncompound Drug Claim. Providers should indicate the member is enrolled in a Medicare Advantage plan and indicate the Medicare Part B covered drug on the Pharmacy Special Handling Request.

Prospective Drug Utilization Review Overrides

If a provider receives a prospective Drug Utilization Review (DUR) alert and subsequently receives an override through Drug Authorization and Policy

Override (DAPO) Center, the DUR alert pre-override/override is not required on the resubmitted claim. However, if multiple DUR alerts are received for a claim and an override from the DAPO Center is obtained for one DUR alert, the provider may be required to pre-override/override the additional prospective DUR alerts, as appropriate.

Drug Related HCPCS Codes

If a clinic's professional claim with a Healthcare Common Procedure Coding System code is received by ForwardHealth and a subsequent claim for the same drug is received from a pharmacy, having a DOS within seven days of the clinic's DOS, then the pharmacy's claim will be denied as a duplicate claim. For example, a member may receive albuterol inhalation solution in a clinic and then fill a prescription for albuterol at the pharmacy within seven days. If the first claim received is the clinic's claim, it will be paid if all billing requirements are met. The pharmacy's claim for the drug, being the second claim received, will be denied as a duplicate with EOB code 1309, which states "This drug has been paid under an equivalent code within seven days of this Date."

Reconsideration of the denied drug claim may occur if the claim was denied with EOB code 1309 and the drug therapy was due to the treatment for an acute condition. To submit a claim that was originally denied as a duplicate, pharmacies should complete and submit the Noncompound Drug Claim form along with the Pharmacy Special Handling Request form indicating the EOB code and requesting an override.

More Information

Providers may refer to the Online Handbook for more detailed information about ForwardHealth's pharmacy policies. Providers may also call Provider Services at (800) 947-9627 with questions about pharmacy policies.

Information Regarding Managed Care Organizations

This *Update* contains fee-for-service policy for members enrolled in Medicaid and BadgerCare Plus who receive pharmacy services on a fee-for-service basis only. Pharmacy services for Medicaid members enrolled in the Program of All-Inclusive Care for the Elderly (PACE) and the Family Care Partnership are provided by the member's managed care organization. Medicaid and BadgerCare Plus HMOs must provide at least the same benefits as those provided under fee-for-service.