This *Update* has been revised since its original publication. The Explanation of Benefits code on page 5 has been revised.

ForwardHealth
Wisconsin serving you

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

Pharmacy Services Covered Under the BadgerCare Plus Basic Plan

The Department of Health Services will begin accepting applications for enrollment in the BadgerCare Plus Basic Plan on June 1, 2010, with benefits starting on July 1, 2010. This *ForwardHealth Update* describes the coverage and policies for pharmacy services under the Basic Plan.

Refer to the June 2010 *Update* (2010-42), titled "Introducing the BadgerCare Plus Basic Plan," for general information about covered and noncovered services, reimbursement, copayment, and enrollment.

Overview of BadgerCare Plus Basic Plan Implementation

In October 2009, enrollment in the BadgerCare Plus Core Plan was closed. Enrollment applications submitted to the Core Plan after the cutoff date are not processed, but the individuals are put on a waitlist.

Individuals on the waitlist for the Core Plan can begin enrolling in the BadgerCare Plus Basic Plan on June 1, 2010, with benefits starting on July 1, 2010. The Basic Plan is a self-funded plan that focuses on providing Core Plan waiting list members with access to vital, cost-effective primary and preventive care. This option will allow members to have some minimal form of coverage until space becomes available in the Core Plan and will help prevent bankruptcy due to excessive medical debt.

Member participation or non-participation in the Basic Plan does not affect an individual's status on the Core Plan waitlist.

Services for the Basic Plan will be covered under fee-for-service. Basic Plan members will not be enrolled in state-contracted HMOs.

Pharmacy Services for Basic Plan Members

Covered Pharmacy Services

The Basic Plan has a closed drug formulary. The following drugs are on the Basic Plan formulary:

- Certain generic drugs.
- A limited number of over-the-counter drugs.
- Humalog insulin.
- Humalog Mix insulin.
- Lantus insulin.
- Tamiflu.
- Relenza.

Providers may refer to the BadgerCare Plus Basic Plan National Drug Code List on the Pharmacy page of the ForwardHealth Portal at *www.forwardhealth.wi.gov/* for a list of drugs covered by the Basic Plan.

Family planning services, including oral contraceptives, are covered for Basic Plan members enrolled in the Family Planning Waiver.

All existing policies and procedures, including cost sharing, dispensing fees, reimbursement, diagnosis restrictions, and pricing policies, apply to services provided to members enrolled in the Basic Plan. Under the Basic Plan, however, prior authorization (PA) requests cannot be submitted for any pharmacy services.

Members are encouraged to fill prescriptions at one pharmacy.

Noncovered Pharmacy Services

The following are noncovered services by the Basic Plan:

- Compound drugs.
- Oral antiretrovirals.
- Oral contraceptives.
- Drugs for use outside the allowable diagnosis.
- Drugs not listed on the closed formulary.

The policy allowing a 14-day emergency medication dispensing is not applicable for members enrolled in the Basic Plan.

Members do not have appeal rights for noncovered services.

Diagnosis-Restricted Drugs

Drugs used for treatment outside approved diagnoses are considered noncovered services. Providers will receive Explanation of Benefits (EOB) code 1556, with a message stating, "This National Drug Code is not covered under the Core Plan or the Basic Plan for the diagnosis submitted," on claims submitted with diagnosis codes outside approved diagnoses. Claims for diagnosis-restricted drugs for use outside approved diagnoses may be submitted to BadgerRx Gold.

Providers should not submit a PA request for a diagnosis-restricted drug for use outside approved diagnoses. Prior authorization requests for drugs with a diagnosis outside approved diagnoses will be returned to the provider with a message stating, "The services requested are not covered under the BadgerCare Plus Basic Plan. Providers are reminded that they must adhere to the service limitations specified by the BadgerCare Plus Basic Plan."

For diagnosis-restricted drugs, allowable diagnoses for the Basic Plan are the same as the BadgerCare Plus Standard Plan.

Providers may refer to the Diagnosis Restricted Drugs data table on the Pharmacy page of the Portal for a list of approved diagnoses.

Policy Overrides for Drugs Covered by the Basic Plan

Policy override criteria apply for members enrolled in the Basic Plan. If a drug is covered by the Basic Plan, providers may request a policy override of a service limitation (i.e., for an early refill, to exceed a quantity limit, or for less than a three-month supply) for the drug.

As a reminder, pharmacy providers may dispense up to a 96-hour supply of a drug covered by the Basic Plan to a member when the Drug Authorization and Policy Override (DAPO) Center is closed and a policy override must be obtained. Providers are required to call the DAPO Center within two business days of dispensing a 96-hour supply to request a policy override. Providers may refer to the Online Handbook for more information about this policy.

Reimbursement for Pharmacy Services

Providers will be reimbursed for covered drugs provided to members at the lesser of the provider's usual and customary charge or the current Wisconsin

Medicaid rate of reimbursement, plus the current Medicaid dispensing fee.

Copayment for Pharmacy Services

Copayment for drugs covered by the Basic Plan is up to $5.00 per prescription. There is no monthly copayment upper limit for pharmacy services for members enrolled in the Basic Plan.

Under the Basic Plan, a provider has the right to deny services if the member fails to make his or her copayment.

Diabetic Supplies

The following diabetic supplies have preferred products and non-preferred products, quantity limits, and diagnosis restrictions:

- Blood glucose meters.
- Blood glucose test strips.

The following is a list of preferred manufacturers for blood glucose meters and blood glucose testing strips:

- Abbott.
- Bayer.
- Home Diagnostics, Inc.
- Lifescan.
- Roche.

Not all blood glucose meters and blood glucose test strips provided by a preferred manufacturer are preferred products. Providers may refer to the Diabetic Supply List Quick Reference on the Pharmacy page of the Portal for the list of covered diabetic supplies. To search for covered diabetic supplies, providers may refer to the Drug Search Tool on the Pharmacy page of the Portal.

Providers may refer to the Pharmacy service area of the Online Handbook for more information about diabetic supplies.

Diagnosis-Restricted Diabetic Supplies

The following diabetic supplies are diagnosis restricted:

- Batteries for blood glucose meters.
- Blood glucose calibrator solutions and chips.
- Blood glucose meters.
- Blood glucose test strips.
- Insulin syringes.
- Lancets.
- Lancet devices.
- Pen needles.
- Reagent strips.

Quantity Limits

Diabetic supplies have the following quantity limits.

Quantity Limits for Diabetic Supplies	
Batteries for meters	4 per month
Blood glucose meters	1 per every 2 years
Control solution	1 per month
Insulin pen needles	200 per month
Insulin syringes	200 per month
Lancets	200 per month
Lancet devices	1 per six months
Reagent strips	200 per month
Test strips	200 per month

Providers may dispense up to the allowed quantity to members, but may not exceed the quantity limit without requesting a quantity limit override. To request an override of quantity limits for diabetic supplies, providers may contact the DAPO Center at (800) 947-9627, option 7.

When calling the DAPO Center to request a policy override, the following information must be provided to the DAPO Center:

- Member information including member identification number and date of birth.
- Provider information including the pharmacy and the prescriber's National Provider Identifier.

- Prescription information including the diabetic supply, National Drug Code (NDC), directions for use, etc.
- Diagnosis and current diabetes medication regimen.
- Number of times per day the member is testing his or her blood sugar (using his or her blood glucose monitor).
- The reason for the override request.

For Type I diabetics, the following are examples of when providers may request a quantity limit policy override for diabetic supplies:

- The member is an uncontrolled Type 1 diabetic with episodes of hypoglycemia and is being treated by an endocrinologist or has been referred to the primary care provider by an endocrinologist.
- The member is using an insulin pump.
- The member is using a continuous glucose monitoring system.

For Type II diabetics, an example of when providers may request a quantity limit policy override for diabetic supplies is if the member is using sliding scale insulin and the override is medically warranted. Requests for quantity limit policy overrides for Type II diabetics will not be granted unless there is sufficient medical evidence to warrant the override.

All benefit plans are allowed to request quantity limit overrides. If a quantity limit exception is not approved, the service is considered noncovered and there are no appeal rights due to service limitation policy.

Noncovered Diabetic Supplies

Non-preferred diabetic supplies are noncovered services for members enrolled in the Basic Plan. Members do not have appeal rights for noncovered services.

Copayment

Copayment for all diabetic supplies is $0.50 per prescription for all benefit plans with no monthly or annual limit.

Service Limitations

The Basic Plan covers a maximum of 10 pharmacy claims per member, per calendar month, regardless of provider. Any prescription beyond the 10 claims allowed in a calendar month will be denied as noncovered services. A provider may collect payment from a member for noncovered services; however, before the service is provided, the provider should inform the member that the service is noncovered.

Claims submissions for diabetic supplies do not count towards the 10 pharmacy claims per member, per calendar month limit.

Note: For drugs for which a three-month supply can be dispensed, dispensing of the drug counts towards the 10 prescription per calendar month maximum only in the month the prescription is filled.

Members enrolled in the Basic Plan may be dispensed up to the allowed quantity of a drug, as defined on the Quantity Limit Drugs and Diabetic Supplies data table on the Pharmacy page of the Portal. If an override of the quantity limit service limitation is requested and the request does not meet service limitation override criteria, it will be a noncovered service.

The same service limitation policies apply to the recently implemented initiatives through the DAPO Center. Service limitation policies apply to the early refill Drug Utilization Review (DUR) and three-month supply initiatives.

For service limitations for the quantity limit, early refill DUR, and three-month supply initiatives, providers may refer to the Pharmacy service area of the Online Handbook on the Portal.

BadgerRx Gold

All Basic Plan members will be automatically enrolled in BadgerRx Gold. Providers should submit claims to

BadgerRx Gold for drugs that are not covered by the Basic Plan.

BadgerCare Plus does *not* coordinate benefits with BadgerRx Gold for members enrolled in the Basic Plan.

Claims submitted to the Basic Plan for noncovered drugs will be returned to providers with EOB code 1538, which states, "Denied. Member eligibility file indicates BadgerCare Plus Benchmark Plan, CorePlan or Basic Plan member. Please submit claim to BadgerRX Gold."

Providers will receive National Council for Prescription Drug Program (NCPDP) reject code 70, which states, "Product/service not covered," for real-time pharmacy claims for drugs that are not covered by the Basic Plan.

Providers may refer to the Portal for a complete list of EOB codes and descriptions.

Coordination of Benefits

Acquired Immune Deficiency Syndrome/Human Immunodeficiency Virus Drug Assistance Program Members

The Basic Plan does *not* cover drugs in the antiretroviral drug class for members enrolled in the Basic Plan. Claims for antiretroviral drugs for Basic Plan members who are also enrolled in the Acquired Immune Deficiency Syndrome/Human Immunodeficiency Virus Drug Assistance Program (ADAP) should be submitted to ADAP. For all other drugs, providers should submit claims first to the Basic Plan, then to ADAP, and then to BadgerRx Gold.

Providers with questions may call ADAP at (800) 991-5532.

Basic Plan Members Enrolled in Wisconsin Chronic Disease Program

For Basic Plan members who are also enrolled in Wisconsin Chronic Disease Program (WCDP), providers should submit claims for all covered services to the Basic Plan first and then to WCDP. For pharmacy services, if both programs deny the pharmacy claim, providers should submit the claim to BadgerRx Gold.

For More Information

Providers may refer to the BadgerCare Plus Basic Plan National Drug Code List on the Pharmacy page of the Portal and to the ePocrates Web site at *www.epocrates.com/* for a list of drugs covered by the Basic Plan.

Providers may also refer to the data tables on the Pharmacy page of the Portal and the Online Handbook for more information about policies and procedures that apply to the Basic Plan.

Providers may call Provider Services at (800) 947-9627 with questions.

The *ForwardHealth Update* is the first source of program policy and billing information for providers.

Wisconsin Medicaid, BadgerCare Plus, SeniorCare, and Wisconsin Chronic Disease Program are administered by the Division of Health Care Access and Accountability, Wisconsin Department of Health Services (DHS). The Wisconsin Well Woman Program is administered by the Division of Public Health, Wisconsin DHS.

For questions, call Provider Services at (800) 947-9627 or visit our Web site at *www.forwardhealth.wi.gov/*.

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