ForwardHealth
Wisconsin serving you

Update
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Affected Programs: BadgerCare Plus, Medicaid, SeniorCare, Wisconsin Chronic Disease Program
To: Blood Banks, Federally Qualified Health Centers, Individual Medical Supply Providers, Medical Equipment Vendors, Pharmacies, Physician Clinics, Physicians, Podiatrists, HMOs and Other Managed Care Programs

Changes to Claims for Drugs and Diabetic Supplies Resulting from Implementation of the National Council for Prescription Drug Programs Telecommunication Standard Version D.0

This *ForwardHealth Update* outlines changes to compound and noncompound drug claims resulting from the transition to National Council for Prescription Drug Programs telecommunication standard version D.0. The changes listed in this *Update* will be effective for all claims received on and after an implementation date that will be published in a separate *Update*.

This *ForwardHealth Update* outlines changes to compound and noncompound drug claims resulting from the transition to Health Insurance Portability and Accountability Act of 1996 (HIPAA) National Council for Prescription Drug Programs (NCPDP) telecommunication standard version D.0. Although federal HIPAA legislation is targeted at standardizing electronic health care transactions, the new HIPAA standards will also affect certain aspects of paper claim submission.

Following implementation, the billing and policy changes listed in this *Update* will be required for all providers submitting compound and noncompound drug claims for drugs and diabetic supplies. A separate *Update* will announce the effective date for these changes. This *Update* also includes information on claims processing during a dual processing period and how adjustments will be handled following implementation.

With the implementation of NCPDP version D.0, significant changes will occur for providers who submit compound and noncompound drug claims. Pharmacy providers are strongly encouraged to work with their software vendors to ensure their claims processing systems are compliant with the requirements of NCPDP version D.0.

Note: Every code used, even if the code is being used in a non-required field, is required to be a valid code whether from a national code set or from an implementation guide code set. Claims with an invalid code will be denied by ForwardHealth.

Claim Submission Changes

The following information about claim submission changes apply to the types of claims indicated.

Cardholder ID

If the member identification number submitted on a claim is not the most current member ID on file with ForwardHealth, the claim will be denied and the Cardholder ID (302-C2) field on the claim response will include the current member ID.

The change to the Cardholder ID field applies to claims submitted via the Point-of-Sale (POS) system and using Provider Electronic Solutions (PES) software.

Dispense As Written

On claims for drugs excluded from brand medically necessary prior authorization (PA) requirements, Dispense As Written (DAW) code "9" (Substitution Allowed By Prescriber but Plan Requests Brand — Patient's Plan Requested Brand Product To Be Dispensed) will replace DAW code "6" (Override).

Providers receive the brand estimated acquisition cost for the innovator drug and generic estimated acquisition cost for the non-innovator drug. Drugs may be excluded from brand medically necessary PA policy when, due to federal and supplemental rebates, their generic equivalents are more costly for BadgerCare Plus, Medicaid, and SeniorCare than their brand name counterparts.

Prescribers do not need to indicate "Brand Medically Necessary" on prescriptions for preferred, brand name drugs excluded from brand medically necessary PA requirements. In addition, if a prescription is written for a generic drug, pharmacy providers may dispense the brand name drug without contacting the prescriber, unless there is a clinically appropriate reason not to dispense the brand name drug.

Members pay the generic drug copayment, not the brand-name copayment for drugs for which ForwardHealth has indicated that a preferred brand name drug is less costly than its non-preferred generic counterpart and DAW code "9" is indicated on claims.

This change applies to claims submitted via the real-time POS system, the ForwardHealth Portal, using PES software, and on paper.

Free Text

In response to provider requests, providers will receive Explanation of Benefits (EOB) descriptions and not EOB numbers in the Additional Message Information (526-FQ) field. For more information about free text fields, providers may refer to the ForwardHealth Payer Sheet: National Council for Prescription Drug Programs (NCPDP) Version D.0, P-00272 (06/11), on the ForwardHealth Portal at *www.forwardhealth.wi.gov/*.

Providers are encouraged to work with their software vendors to ensure that information returned in free text fields appear correctly.

The change from EOB numbers to EOB descriptions applies to claims submitted via the POS system and PES software.

Note: Due to the length of the Additional Message Information field, certain EOB descriptions will be modified to fit the available field space. Not all EOB descriptions will be modified.

Group ID

ForwardHealth will be using the Group ID (301-C1) field instead of the Plan ID (524-F0) field for providers to indicate the appropriate payer for compound and noncompound drug claims. On claims for Wisconsin Medicaid, BadgerCare Plus, and SeniorCare members, "TXIX" should be indicated and on claims for Wisconsin Chronic Disease Program (WCDP) members, "WCDP" should be indicated. Pharmacy providers are reminded to check this field on all POS claims to ensure the claim is being submitted to the correct ForwardHealth program for payment.

The change from Plan ID to Group ID applies to claims submitted via the POS system and using PES software.

Other Amount Claimed Submitted

ForwardHealth does not reimburse for charges (i.e., postage, shipping, administrative costs) indicated in the Other Amount Claimed Submitted (480-H9) field. Claims will be denied if a provider indicates a charge in the Other Amount Claimed Submitted field.

On claims for which a charge is indicated in the Other Amount Claimed Submitted field, providers will receive EOB code 1249, which states "Other amount submitted not reimbursable." For more information about EOB codes, refer to the Claim Response Transactions section of this *Update*.

The change to the Other Amount Claimed Submitted field applies only to POS claims.

Other Coverage Code

Other coverage codes "5" (Managed Care Plan Denial), "6" (Other Coverage Denied—Not a Participating Provider), and "7" (Other Coverage Exists — Not in Effect at Time of Service) will be discontinued following implementation of NCPDP version D.0. Providers should no longer indicate a value of "5," "6," or "7" in the Other Coverage Code (308-C8) field to indicate other insurance information for other payers. Instead, providers may indicate one of the following other coverage codes:

- 0 — Not specified by patient.
- 1 — No other coverage.
- 2 — Other Coverage Exists — Payment Collected.
- 3 — Other Coverage Billed — This Claim Not Covered.
- 4 — Other Coverage Exists — Payment not Collected.

If other coverage code "2" is indicated, providers are required to indicate the amount reimbursed by commercial health insurance, Medicare Part B, or Medicare Part D in the Other Payer Amount Paid (431-DV) field. If other coverage code "3" is indicated, providers are required to include the Other Payer Reject Code (472-6E) field.

The change to the Other Coverage Code field applies to claims submitted via the POS system, the Portal, using PES software, and on paper.

Claim Submission Requirements

When submitting claims with information about other insurance or payments to ForwardHealth, providers are required to include specific coordination of benefits (COB) information based on the results of the claim submission to other insurance sources. Some or all of the information below may be automatically populated by the pharmacy software; however, if the software does not automatically populate this information, pharmacy providers are required to enter the information before submitting the claim to ForwardHealth.

If a service is covered by other insurance and payment is collected, providers are required to indicate a value of "2" in the Other Coverage Code field and information in the following NCPDP fields for each other insurance source:

- 338-5C (Other Payer Coverage Type).
- 339-6C (Other Payer ID Qualifier) with a value of "99."
- 340-7C (Other Payer ID).
- 342-HC (Other Payer Amount Paid Qualifier) with a value of "07."
- 431-DV (Other Payer Amount Paid) with the amount paid by other insurance sources.
- 443-E8 (Other Payer Date) with the payment date from other insurance sources.

If a service is covered by other insurance and payment is *not* collected, providers are required to indicate a value of "4" in the Other Coverage Code field and information in the following NCPDP fields for each other insurance source:

- 338-5C (Other Payer Coverage Type).
- 339-6C (Other Payer ID Qualifier) with a value of "99."
- 340-7C (Other Payer ID). Providers may refer to the payer sheet for a list of valid values for the other payer ID field.
- 342-HC (Other Payer Amount Paid Qualifier) with a value of "07."
- 431-DV (Other Payer Amount Paid) with an amount of "0."
- 443-E8 (Other Payer Date) with the date the claim was submitted to other insurance sources.

If a member is covered by SeniorCare and providers indicate a value of "2" or "4" in the Other Coverage Code field, providers are required to indicate information in the following NCPDP fields for each other insurance source:

- 351-NP (Other Payer Patient Responsibility Amount Qualifier) with a value of "06."
- 352-NQ (Other Payer Patient Responsibility Amount) with the patient responsibility amount reported by the other insurance sources.
- 353-NR (Other Payer Patient Responsibility Amount Count).

If a service is not covered by other insurance, providers are required to indicate a value of "3" in the Other Coverage Code field and information in the following NCPDP fields for each other insurance source:

- 338-5C (Other Payer Coverage Type).
- 339-6C (Other Payer ID Qualifier) with a value of "99."
- 340-7C (Other Payer ID). Providers may refer to the payer sheet for a list of valid values for the other payer ID field.
- 443-E8 (Other Payer Date) with the denial date.
- 471-5E (Other Payer Reject Count) with the number of reject codes following.
- 472-6E (Reject Code) with the reject code(s) provided by the other insurance source.

Providers may refer to the payer sheet for valid values accepted by ForwardHealth for NCPDP fields.

An updated list of COB examples is available in the Electronic Claims Submission topic (topic #2333) in the Claims section of the Online Handbook.

Special Packaging Indicator

The Unit Dose (429-DT) field will be renamed the Special Packaging Indicator (429-DT) field.

Under the NCPDP telecommunication standard version 5.1, providers are required to indicate a submission clarification code value of "2" (other override) in the Submission Clarification Code (420-DK) field to request a repackaging allowance. Following implementation of NCPDP version D.0, the submission clarification code will no longer be appropriate for requesting the repackaging allowance. To indicate that repackaging has occurred for non-unit dose drugs, providers are required to indicate a value of "4" (custom packaging) or "5" (multi-drug compliance packaging) in the Special Packaging Indicator field. Any other valid value indicated in the special packaging indicator field will not be used to determine reimbursement for repackaging.

If a value of"4" or "5" is indicated in the Special Packaging Indicator field for a drug that is not packaged by the manufacturer in individual unit doses, ForwardHealth will add $0.015 per unit billed to the dispensing fee for repackaging.

On claims for which the special packaging indicator is invalid, providers will receive EOB code 0310, which states "The special packaging indicator/unit dose indicator is invalid."

Following implementation, the submission clarification code (formerly Element 25) field will be removed from the Noncompound Drug Claim form, F-13072 (09/11).

The change to the Special Packaging Indicator field applies to claims submitted via the POS system, the Portal, using PES software, and on paper.

Claim Response Transactions

The NCPDP has further defined appropriate use of reject codes. As a result, following implementation of NCPDP version D.0, providers may see more specific reject codes used to further define errors on compound and noncompound drug claim response transactions.

In addition, the claim response format for POS and PES claims will be modified to include an EOB description instead of an EOB code following implementation of NCPDP version D.0. Claim submission policies and reasons for claim denials remain unchanged. Providers may refer to the EOB description(s) received on the claim response for more information about a claim denial.

Noncompound Drug Claim and Compound Drug Claim Form

The Noncompound Drug Claim and the Compound Drug Claim, F-13073 (09/11), forms have been revised as a result of NCPDP version D.0 changes. Providers may refer to Attachments 1 through 4 of this *Update* for the revised Noncompound Drug Claim and Compound Drug Claim completion instructions and forms. Providers may also refer to the Forms page of the Portal for the revised claim forms and completion instructions.

Providers may refer to the September 2011 *Update* (2011-59), titled "Effective Dates for the Implementation of HIPAA Version 5010 Standard and the NCPDP Telecommunication Standard Version D.0," for the date when the use of the revised Noncompound Drug Claim form and Compound Drug Claim form is required.

Provider Electronic Solutions Software

Following implementation, changes will be made to PES software. Providers may refer to the September 2011 *Update* (2011-58), titled "Announcing Provider Electronic Solutions Software Version 3.0," for more information about changes to PES software, including changes to the PES Manual, resulting from the implementation of NCPDP version D.0.

Patient Location Will Change to Place of Service

With the implementation of NCPDP version D.0, the Patient Location (307-C7) field has been redefined as the Place of Service (POS) (307-C7) field with a new set of values. For all federal legend drugs, over-the-counter drugs, and diabetic supplies, ForwardHealth accepts the following place of service code values:

- 01 — Pharmacy.
- 13 — Assisted Living Facility.
- 14 — Group Home.
- 32 — Nursing Facility.
- 34 — Hospice.
- 50 — Federally Qualified Health Center.
- 65 — End-Stage Renal Disease Treatment Facility.
- 72 — Rural Health Clinic.

The redefining of patient location to place of service applies to claims submitted via the POS system, the Portal, using PES software, and on paper.

Drugs for Nursing Facility Members

If a member is in a nursing facility, providers should indicate the appropriate POS on the claim. This will exempt the member from the three-month supply of drugs policy. When serving a member in a nursing facility, pharmacy providers are *not* required to contact the Drug Authorization and Policy Override Center to obtain an override to dispense less than a three-month supply of drugs.

Claims for Assisted Living Facility, Group Home, and Nursing Facility Members

Real-time claims for assisted living facility, group home, and nursing facility members are reviewed through the prospective Drug Utilization Review (DUR) system; however, they do not require a response to obtain reimbursement since claims submission for these members does not always occur at the same time the drug is dispensed. The assisted living facility, group home, or nursing facility pharmacist consultant is responsible for prospective DUR. Although assisted living facility, group home, and nursing facility claims are exempt from denial, an informational alert will be received on POS claims.

Coordination of Benefits Changes

Other Payer-Patient Responsibility Amount for SeniorCare Claims

The Other Payer-Patient Responsibility Amount (352-NQ) field will replace the Patient Paid Amount Submitted (433-DX) field used for SeniorCare claims processing. Providers are required to indicate the amount (e.g., copayment, deductible) for which a member is responsible to another payer in the Other Payer-Patient Responsibility Amount field. An amount must be indicated in the Other Payer-Patient Responsibility Amount field if another payer's patient pay amount is greater than zero.

For SeniorCare claims with an amount indicated in the Other Payer-Patient Responsibility Amount field, qualifier "06" should be indicated in the Other Payer-Patient Responsibility Amount Qualifier field (351-NP).

The change regarding the replacement of the Patient Paid Amount Submitted field with the Other Payer-Patient Responsibility Amount field applies to claims submitted via the POS system and using PES software. The Other Payer-Patient Responsibility Amount may be submitted multiple times on POS claims and one time on PES claims.

The change regarding qualifier "06" applies only to POS claims.

Reimbursement

Copayment Exemptions

The Copay Exempt (Element 8) field has been added as a new field on the Noncompound Drug Claim form and the Compound Drug Claim form. Nursing facility members enrolled in the BadgerCare Plus Standard Plan or Wisconsin Medicaid are exempt from copayment for drugs on the date of discharge from a nursing facility. A value of "4" may be indicated in the copay exempt field so copayment is not deducted from the claim. This situation is the only valid use of this field.

The addition of the Copay Exempt field applies only to paper claims. This field currently exists on Portal claims.

Note: On real-time claims for drugs submitted for nursing facility members on the date of discharge, the copayment exemption should be indicated in the PA Type field.

If a member has a copayment or other cost sharing obligation, the copayment or cost sharing will continue to be automatically deducted from the amount of reimbursement.

Sales Tax

ForwardHealth does not reimburse for sales tax. Claims will be denied if a sales tax amount greater than zero is indicated in the Flat Sales Tax Amount Submitted (481-HA) field or Percentage Sales Tax Amount Submitted (482-GE) field.

Providers will receive EOB code 1247, which states "Tax amount nonreimbursable" on claims that are denied for sales tax.

The change to the Flat Sales Tax Amount Submitted field and the Percentage Sales Tax Amount Submitted field applies only to POS claims.

New Payer Sheet

With the implementation of NCPDP version D.0 standards, ForwardHealth has developed a new payer sheet, which replaces the ForwardHealth Companion Document to HIPAA Implementation Guide: NCPDP V5.1. Providers may refer to the ForwardHealth Payer Sheet: National Council for Prescription Drug Programs (NCPDP) Version D.0 on the Portal for more information about NCPDP version D.0 transactions. The payer sheet provides ForwardHealth-specific information that should be used with the national HIPAA Implementation Guides.

Data Dictionary and External Code Lists

ForwardHealth follows the NCPDP July 2007 Data Dictionary and the September 2010 External Code List. ForwardHealth will notify providers if new versions of the data dictionary or external code list will be supported. Providers should *not* begin using other versions of the data dictionary or external code list on transactions exchanged with ForwardHealth until ForwardHealth announces the adoption and effective date of the new versions.

Providers should note that as a result of the use of the external code list, other payer reject codes for billing errors and syntactical errors may be modified.

For More Information

Providers may refer to the following *Updates* for more information about NCPDP version D.0 implementation:

- The September 2011 *Update* (2011-59), titled "Effective Dates for the Implementation of HIPAA Version 5010

Standard and the NCPDP Telecommunication Standard Version D.0."

- The August 2011 *Update* (2011-49), titled "Changes to Prior Authorization for Drugs and Diabetic Supplies Resulting from Implementation of the National Council for Prescription Drug Programs Telecommunication Standard Version D.0."

Providers may refer to the HIPAA Version 5010 and NCPDP Version D.0 Electronic Transaction Standards page of the Portal for the most current information about version 5010 and version D.0 implementations.

Background on HIPAA Accredited Standards Committee X12 Version 5010 and National Council for Prescription Drug Programs Version D.0

Effective January 1, 2012, changes to HIPAA and NCPDP standards will impact electronic, paper, PES, and Portal transactions exchanged with ForwardHealth. All covered entities (e.g., health plans, health care clearinghouses, and health care providers) will be required to begin using the new Accredited Standards Committee (ASC) X12 version 5010 and NCPDP version D.0 standards.

Refer to the HIPAA ASC X12 Version 5010 and NCPDP Version D.0 Implementation Page on the Portal for more information.

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 (MCO). Medicaid and BadgerCare Plus HMOs must provide at least the same benefits as those provided under fee-for-service.

Members who are enrolled in the Wisconsin Chronic Disease Program only are not enrolled in MCOs.

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/*.

P-1250

This *Update* was issued on 9/23/11 and information contained in this *Update* was incorporated into the Online Handbook on 12/16/11.

ATTACHMENT 1
Noncompound Drug Claim Completion Instructions

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

NONCOMPOUND DRUG CLAIM COMPLETION INSTRUCTIONS

ForwardHealth requires certain information to authorize and pay for medical services provided to eligible Wisconsin Medicaid, BadgerCare Plus, SeniorCare, and Wisconsin Chronic Disease Program (WCDP) members.

Members of ForwardHealth are required to give providers full, correct, and truthful information for the submission of correct and complete claims for reimbursement. This information should include, but is not limited to, information concerning enrollment status, accurate name, address, and member identification number (DHS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about ForwardHealth applicants and members is confidential and is used for purposes directly related to ForwardHealth administration such as determining eligibility of the applicant, processing prior authorization requests, or processing provider claims for reimbursement.

The Noncompound Drug Claim form, F-13072, is used by ForwardHealth and is mandatory when submitting paper claims for noncompound drugs. Failure to supply the information requested by the form may result in denial of 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. For Elements 15, 17, 19, 21, 23, and 26, refer to the ForwardHealth Payer Sheet: National Council for Prescription Drug Programs (NCPDP) Version D.0, P-00272, on the ForwardHealth Portal for tables and accepted values.

ForwardHealth members receive an identification card upon being determined eligible. Always verify a member’s enrollment before providing nonemergency services by using Wisconsin’s Enrollment Verification System (EVS) to determine if there are any limitations on covered services.

For questions regarding these instructions, providers may contact Provider Services at (800) 947-9627.

Note: Submit claims for non-drug items, such as clozapine management services, disposable medical supplies, durable medical equipment, and enteral nutrition products, on the 1500 Health Insurance Claim Form or the 837 Health Care Claim: Professional transaction using nationally recognized five-digit procedure codes.

For Medicaid, BadgerCare Plus, and SeniorCare members, return the form to the following address:

ForwardHealth
Claims and Adjustments
6406 Bridge Rd
Madison WI 53784-0002

For WCDP members, return the form to the following address:

Wisconsin Chronic Disease Program
PO Box 6410
Madison WI 53716-0410

SECTION I — PROVIDER INFORMATION

Element 1 — Name — Provider
Enter the name of the billing provider.

Element 2 — National Provider Identifier
Enter the National Provider Identifier (NPI) of the billing provider.

Element 3 — Address — Provider
Enter the address, including the street, city, state, and ZIP+4 code of the billing provider.

SECTION II — MEMBER INFORMATION

Element 4 — Member Identification Number
Enter the member ID. Do not enter any other numbers or letters.

Element 5 — Name — Member
Enter the member's name from the member's ForwardHealth identification card. Use the EVS to obtain the correct spelling of the member's name. If the name or spelling of the name on the ForwardHealth card and the EVS do not match, use the spelling from the EVS.

Element 6 — Date of Birth — Member
Enter the member's date of birth in MM/DD/CCYY format (e.g., July 14, 1953, would be 07/14/1953).

Element 7 — Sex — Member
Enter "0" for unspecified, "1" for male, or "2" for female.

Element 8 — Copay Exempt
Indicate whether or not a nursing facility member enrolled in the BadgerCare Plus Standard Plan or Wisconsin Medicaid is exempt from copayment for drugs on the date of discharge from a nursing facility.

SECTION III — CLAIM INFORMATION

Element 9 — Prescriber Number
Enter a valid NPI for the prescriber.

Element 10 — Date Prescribed
Enter the date shown on the prescription in MM/DD/CCYY format.

Element 11 — Date Filled
Enter the date that the prescription was filled or refilled in MM/DD/CCYY format.

Element 12 — Refill
Enter the refill indicator. The first two digits of the refill indicator is 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 non-refillable 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 the ForwardHealth-assigned 11-digit procedure code for the item being billed. (Use the NDC indicated on the product.)

Element 14 — Days' Supply
Enter the days' supply of medication that has been dispensed for the member. This must be a whole number greater than zero (e.g., if a prescription is expected to last for five days, enter "5").

Element 15 — Quantity
Enter the metric decimal quantity in the specified unit of measure according to the ForwardHealth Drug File. Quantities billed should be rounded to two decimal places (i.e., nearest hundredth).

Element 16 — Prescription Number
Enter the prescription number. Each drug billed must have a unique prescription number.

Element 17 — Drug Description (Optional)

Element 18 — Special Packaging Indicator
Enter a value of "4" (custom packaging) or "5" (multi-drug compliance packaging) to indicate that repackaging has occurred for non-unit dose drugs. Any other valid value indicated in this field will not be used to determine reimbursement for repackaging.

Element 19 — Dispense As Written
Enter the appropriate one-digit NCPDP Dispense As Written (DAW) code. Refer to the payer sheet for a list of DAW codes.

Element 20 — Place of Service
Enter the appropriate place of service code designating where the requested item would be provided/performed/dispensed.

Element 21 — Diagnosis Code
This element is required when billing for a drug for which ForwardHealth requires a diagnosis or when billing for Pharmaceutical Care (PC) services. If the diagnosis of the drug is different from 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 22 — Level of Effort
This element is required when billing for PC services. Refer to the Pharmacy page of the ForwardHealth Online Handbook for PC information. Enter the NCPDP code that corresponds with the time required to perform the PC service. Refer to the payer sheet for a list of level of effort codes.

Element 23 — Reason for Service
This element is required when billing for Drug Utilization Review (DUR) or PC services. Refer to the Pharmacy page of the ForwardHealth Online Handbook for DUR and PC information and the payer sheet for applicable PC values.

Element 24 — Professional Service
This element is required when billing for DUR or PC services. Refer to the Pharmacy page of the ForwardHealth Online Handbook for DUR and PC information and the payer sheet for applicable PC values.

Element 25 — Result of Service
This element is required when billing for DUR or PC services. Refer to the Pharmacy page of the ForwardHealth Online Handbook for DUR and PC information and the payer sheet for applicable PC values.

Element 26 — Other Coverage Code
ForwardHealth is usually the payer of last resort for program-covered services. (Refer to the Pharmacy page of the ForwardHealth Online Handbook for more information about Coordination of Benefits.) Prior to submitting a claim to ForwardHealth, providers are required to verify whether a member has other health insurance coverage (e.g., commercial health insurance, HMO, or Medicare).

If a member has Medicare and other insurance coverage, the provider is required to bill both prior to submitting a claim to ForwardHealth. Enter one of the NCPDP other coverage (OC) codes that best describe the member's situation. Refer to the payer sheet for a list of other coverage codes.

Element 27 — Charge
Enter the total charges for this claim.

Element 28 — Other Coverage Amount
When applicable, enter the amount paid by commercial health insurance. This is required when the OC code in Element 26 indicates "2."

Note: Pharmacies may also include the Medicare-paid amount in this field for claims that fail to automatically crossover from Medicare to ForwardHealth within 30 days.

Element 29 — Patient Paid Amount
When applicable for SeniorCare claims, enter the member's out-of-pocket expense due to OC, including Medicare Part B or D and/or commercial health insurance. Do not enter an expected copayment for Wisconsin Medicaid, BadgerCare Plus, SeniorCare, or WCDP.

Element 30 — Net Billed
Enter the balance due by subtracting the OC amount and the patient paid amount from the amount in Element 27.

Element 31 — Certification
The provider is required to read the certification information of the form. By signing and dating Element 32 and Element 33, the provider attests to the certification information in Element 31.

Element 32 — Signature — Pharmacist or Dispensing Physician
The pharmacist or dispensing physician is required to complete and sign this form.

Note: The signature may be computer generated or stamped.

Element 33 — Date Signed
Enter the month, day, and year the form was signed in MM/DD/CCYY format.

ATTACHMENT 2
Noncompound Drug Claim

(A copy of the "Noncompound Drug Claim" is located on the following page.)

DEPARTMENT OF HEALTH SERVICES
Division of Health Care Access and Accountability
F-13072 (09/11)

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

NONCOMPOUND DRUG CLAIM

Instructions: Type or print clearly. Before completing this form, read the Noncompound Drug Claim Completion Instructions, F-13072A.

For questions, contact Provider Services at (800) 947-9627. For ForwardHealth members, return the completed form to: ForwardHealth, Claims and Adjustments, 6406 Bridge Road, Madison, WI 53784-0002.

For Wisconsin Chronic Disease Program members, return form to: ForwardHealth, P.O. Box 6410, Madison, WI 53716-0410.

SECTION I — PROVIDER INFORMATION

1. Name — Provider	2. National Provider Identifier

3. Address — Provider (Street, City, State, ZIP+4 Code)

SECTION II — MEMBER INFORMATION

4. Member Identification Number	5. Name — Member (Last, First, Middle Initial)	6. Date of Birth — Member	7. Sex — Member	8. Copay Exempt

SECTION III — CLAIM INFORMATION

9. Prescriber Number	10. Date Prescribed	11. Date Filled	12. Refill	13. NDC	14.Days' Supply

15. Quantity	16. Prescription Number	17. Drug Description

18. Special Package Indicator	19. Dispense as Written	20. Place of Service	21. Diagnosis Code

22. Level of Effort	23.Reason for Service	24.Professional Service	25. Result of Service

26. Other Coverage Code	27. Charge	28. Other Coverage Amount	29. Patient Paid Amount	30. Net Billed
	$	$	$	$

31. Certification

I certify the services and items for which reimbursement is claimed on this claim form were provided to the previously named member 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 ForwardHealth.

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.

32. SIGNATURE — Pharmacist or Dispensing Physician	33. Date Signed

F-13072

ATTACHMENT 3
Compound Drug Claim Completion Instructions

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

COMPOUND DRUG CLAIM COMPLETION INSTRUCTIONS

ForwardHealth requires certain information to authorize and pay for medical services provided to eligible Wisconsin Medicaid, BadgerCare Plus, and SeniorCare members.

Members of ForwardHealth are required to give providers full, correct, and truthful information for the submission of correct and complete claims for reimbursement. This information should include, but is not limited to, information concerning enrollment status, accurate name, address, and member identification number (DHS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about ForwardHealth applicants and members is confidential and is used for purposes directly related to ForwardHealth administration such as determining eligibility of the applicant, processing prior authorization requests, or processing provider claims for reimbursement.

The Compound Drug Claim form is used by ForwardHealth and is mandatory when submitting paper claims for compound drugs. Failure to supply the information requested by the form may result in denial of 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. For Elements 15, 17, and 18, refer to the ForwardHealth Payer Sheet: National Council for Prescription Drug Programs (NCPDP) Version D.0 on the ForwardHealth Portal for tables and accepted values.

ForwardHealth members receive a ForwardHealth identification card upon being determined eligible. Always verify a member's enrollment before providing nonemergency services by using Wisconsin's Enrollment Verification System (EVS) to determine if there are any limitations on covered services.

For questions regarding these instructions, providers may contact Provider Services at (800) 947-9627.

Note: Submit claims for non-drug items, such as clozapine management services, disposable medical supplies, durable medical equipment, and enteral nutrition products, on the 1500 Health Insurance Claim Form or the 837 Health Care Claim: Professional transaction using nationally recognized five-digit procedure codes.

Return the completed form to the following address:

ForwardHealth
Claims and Adjustments
6406 Bridge Rd
Madison WI 53784-0002

SECTION I — PROVIDER INFORMATION

Element 1 — Name — Provider
Enter the name of the billing provider.

Element 2 — National Provider Identifier
Enter the National Provider Identifier (NPI) of the billing provider.

Element 3 — Address — Provider
Enter the address, including the street, city, state, and ZIP+4 code of the billing provider.

SECTION II — MEMBER INFORMATION

Element 4 — Member Identification Number
Enter the member ID. Do not enter any other numbers or letters.

Element 5 — Name — Member
Enter the member's name from the member's ForwardHealth identification card. Use the EVS to obtain the correct spelling of the member's name. If the name or spelling of the name on the ForwardHealth card and the EVS do not match, use the spelling from the EVS.

Element 6 — Date of Birth — Member
Enter the member's date of birth in MM/DD/CCYY format (e.g., July 14, 1953, would be 07/14/1953).

Element 7 — Sex — Member
Enter “0” for unspecified, “1” for male, or “2” for female.

Element 8 — Copay Exempt
Indicate whether or not a nursing facility member enrolled in the BadgerCare Plus Standard Plan or Wisconsin Medicaid is exempt from copayment for drugs on the date of discharge from a nursing facility.

SECTION III — CLAIM INFORMATION

Element 9 — Prescriber Number
Enter a valid NPI for the prescriber.

Element 10 — Date Prescribed
Enter the date shown on the prescription in MM/DD/CCYY format.

Element 11 — Date Filled
Enter the date that the prescription was filled or refilled in MM/DD/CCYY format.

Element 12 — Refill
Enter the refill indicator. The first two digits of the refill indicator is 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 non-refillable 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 days’ supply of medication that has been prescribed for the member. This must be a whole number greater than zero (e.g., if a prescription is expected to last for five days, enter “5”).

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 — Place of Service
Enter the appropriate place of service code designating where the requested item would be provided/performed/dispensed.

Element 17 — Diagnosis Code
This element is required when billing for any drug within the compound in which ForwardHealth 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 Pharmacy page of the ForwardHealth Online Handbook for more information about covered services and reimbursement.

Element 18 — Level of Effort
Enter the NCPDP level of effort code that corresponds with the time required to prepare the compound. Refer to the payer sheet for a list of level of effort codes.

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 — Other Coverage Code
ForwardHealth is usually the payer of last resort for program-covered services. Prior to submitting a claim to ForwardHealth, providers are required to verify whether a member has other health insurance coverage (e.g., commercial health insurance, HMO, or Medicare).

If a member has Medicare and other insurance coverage, the provider is required to bill both prior to submitting a claim to ForwardHealth. Enter one of the NCPDP other coverage codes that best describe the member's situation. Refer to the payer sheet for a list of other coverage codes.

Element 20 — Charge
Enter the total charges for this claim.

Element 21 — Other Coverage Amount
When applicable, enter the amount paid by commercial health insurance. This is required when the other coverage code indicated in Element 19 is "2."

Note: Pharmacies may also include the Medicare-paid amount in this field for claims that fail to automatically crossover from Medicare to ForwardHealth within 30 days.

Element 22 — Patient Paid Amount
When applicable on SeniorCare claims, enter the member's out-of-pocket expense due to other coverage, including Medicare Part B or D and/or commercial health insurance. Do not enter a member's expected copayment for Wisconsin Medicaid, BadgerCare Plus, or SeniorCare.

Element 23 — Net Billed
Enter the balance due by subtracting the other coverage amount and the patient paid amount from the amount in Element 20.

Element 24 — Certification
The provider is required to read the certification information of the form. By signing and dating Element 25 and Element 26, the provider attests to the certification information in Element 24.

Element 25 — Signature — Pharmacist or Dispensing Physician
The pharmacist or dispensing physician is required to complete and sign this form.

Note: The signature may be computer generated or stamped.

Element 26 — Date Signed
Enter the month, day, and year the form was signed in MM/DD/CCYY format.

ATTACHMENT 4
Compound Drug Claim

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

DEPARTMENT OF HEALTH SERVICES
Division of Health Care Access and Accountability
F-13073 (09/11)

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

COMPOUND DRUG CLAIM

Instructions: Type or print clearly. Before completing this form, read the Compound Drug Claim Completion Instructions, F-13073A. Return the completed form to: ForwardHealth, Claims and Adjustments, 6406 Bridge Road, Madison, WI 53784-0002.

SECTION I — PROVIDER INFORMATION

1. Name — Provider	2. National Provider Identifier

3. Address — Provider (Street, City, State, ZIP+4 Code)

SECTION II — MEMBER INFORMATION

4. Member Identification Number	5. Name — Member (Last, First, Middle Initial)	6. Date of Birth — Member	7. Sex — Member	8. Copay Exempt

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. Place of Service	17. Diagnosis Code	18. Level of Effort

SECTION IV — COMPOUND INGREDIENTS

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

19. Other Coverage Code	20. Charge	21. Other Coverage Amount	22. Patient Paid Amount	23. Net Billed
	$	$	$	$

24. Certification

I certify that the services and items for which reimbursement is claimed on this claim form were provided to the previously named member 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 ForwardHealth.

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.

25. **SIGNATURE** — Pharmacist or Dispensing Physician	26. Date Signed