

Affected Programs: BadgerCare Plus, Medicaid, SeniorCare

To: Blood Banks, Dentists, Federally Qualified Health Centers, Hospital Providers, Nurse Practitioners, Nursing Homes, Pharmacies, Physician Assistants, Physician Clinics, Physicians, Podiatrists, Rural Health Clinics, HMOs and Other Managed Care Programs

Medication Therapy Management Benefit

Effective for dates of service (DOS) on and after September 1, 2012, ForwardHealth will be implementing a Medication Therapy Management (MTM) benefit in conjunction with the Wisconsin Pharmacy Quality Collaborative (WPQC). The MTM benefit consists of intervention-based services and Comprehensive Medication Review and Assessments (CMR/A). To provide CMR/A services, pharmacies are required to be certified through the WPQC. As a result of this implementation, Pharmaceutical Care services are no longer reimbursable.

Effective for dates of service (DOS) on and after September 1, 2012, ForwardHealth will be implementing a Medication Therapy Management (MTM) benefit in conjunction with the Wisconsin Pharmacy Quality Collaborative (WPQC). As a result of this implementation, effective for DOS on and after September 1, 2012, Pharmaceutical Care (PC) services are no longer reimbursable. Claims submitted for PC services on and after September 1, 2012, will be denied with Explanation of Benefit (EOB) code 1502, which states “PC not covered effective 9/01/2012.”

The WPQC is a group of pharmacy providers, health care purchasers, and medical professionals in Wisconsin working together to reduce the cost of prescription medication use and to avoid the medical costs associated with medication nonadherence. The Department of Health Services (DHS) is working in conjunction with the WPQC to develop the ForwardHealth MTM benefit.

Medication Therapy Management is part of a national trend in health care that reimburses pharmacies for value-added services that assist members in managing their medications. Research has shown that MTM programs improve health care outcomes in a cost-effective manner.

The MTM benefit is covered for members enrolled in the BadgerCare Plus Standard Plan, the BadgerCare Plus Benchmark Plan, the BadgerCare Plus Core Plan, the BadgerCare Plus Basic Plan, SeniorCare, Wisconsin Medicaid, Program for All Inclusive Care for the Elderly (PACE), Family Care Partnership, BadgerCare Plus HMOs, SSI HMOs, and FamilyCare care management organizations and is reimbursed fee-for-service. Managed Care Organizations are not responsible for MTM service reimbursement.

The MTM benefit is not covered for members enrolled in the Wisconsin Chronic Disease Program and Wisconsin Well Woman Program.

Prescriber Information

A prescriber may request that a member receive MTM services by sending a referral to the dispensing pharmacy. Prescribers, depending on the service, may receive communications from pharmacies when a pharmacy provides MTM services.

Federally Qualified Health Centers

Services under the MTM benefit are not eligible for an allowable encounter; therefore, federally qualified health centers (FQHCs) are required to be Medicaid enrolled (formerly referred to as Medicaid certified) as a pharmacy provider in order to be reimbursed for services covered under the MTM benefit. When submitting claims for the MTM benefit, FQHCs will be required to provide the unique taxonomy code for the pharmacy. Claims submitted for the MTM benefit with the FQHC taxonomy will be denied.

Federally qualified health centers should continue to submit non-MTM pharmacy claims under their FQHC National Provider Identifier (NPI) and taxonomy code.

Types of Medication Therapy Management Services

The MTM benefit consists of the following types of services:

- Intervention-based services are focused interventions between a pharmacist and member that are typically rendered in a few minutes. All Medicaid-enrolled pharmacies are eligible to provide these services to members.
- Comprehensive Medication Reviews and Assessments (CMR/A) are private consultations between a pharmacist and a member to review the member's drug regimen. A member must be approved by the ForwardHealth program as a high-risk patient. In addition to being Medicaid-enrolled, pharmacies and pharmacists are required to receive certification through the WPQC to conduct CMR/As for members.

Intervention-Based Services

Intervention-based services are voluntary face-to-face member assessments and interventions performed by a pharmacist. These services are provided to the member to optimize the member's response to medications or to manage treatment-related medication interactions or complications for both compound and noncompound drugs. Intervention-based services require prescriber approval before the service is performed, with the exception of

focused adherence, medication device instruction, and in-home medication management.

Intervention-based services may be any of the following types:

- Cost-effectiveness intervention — A cost-effectiveness intervention may be one or more of the following:
 - ✓ Formulary interchange.
 - ✓ Therapeutic interchange.
 - ✓ Tablet splitting opportunity.
 - ✓ Conversion to an over-the-counter product.
 - ✓ Dose consolidation.
- Three-month supply intervention — Dispensing a three-month supply of drugs streamlines the prescription filling process for pharmacy providers and members, encourages the use of generic, maintenance drugs when medically appropriate for a member, and results in savings to ForwardHealth programs. If the pharmacy provider contacts the prescriber to amend the prescription, pharmacies are eligible to receive the reimbursement for this service. If the prescription is already prescribed for a three-month supply, pharmacies will not be eligible to receive the reimbursement. Providers may refer to the Three-Month Supply Drugs data table on the ForwardHealth Portal at www.forwardhealth.wi.gov/ for a list of drugs that may be dispensed in a three-month supply.
- Dose/dosage form/duration change intervention — Provides the opportunity to change the member's dose, dosage form, or duration of therapy based upon manufacturer recommended dose, organ function or age-appropriateness of dose; insufficient or excessive duration or quantity of medication prescribed; sub-optimal dosage form prescribed; drug-drug interaction or drug-food interaction.
- Focused adherence intervention — Consultation with a member regarding a significant lack of adherence in order to enhance the member's understanding of his or her medication regimen. An adherence tool or referral for a CMR/A may be provided if applicable. A focused adherence intervention may address possible drug misadministration, inability to correctly split tablets,

presence of adverse drug reactions, misunderstanding of prescribed instructions, sharing of unauthorized medications, presence of an uncontrolled disease state, prescription of an inappropriate dosage form, concern relating to health literacy or another concern as determined by the pharmacist, and follow-up consultations on focused adherence for a member who has already received a focused adherence intervention. As a reminder, blister and pill card packaging will be reimbursed at the repackaging allowance rate per our policy in the Repackaging topic (topic # 1954) of the Submission chapter of the Claims section of the Pharmacy service area of the Online Handbook on the Portal. Blister and pill card packaging should not be billed as a focused adherence intervention-based service.

- Medication addition intervention — Recommendation of the addition of a medication based on clinical guidelines, indications, adverse drug reaction, contraindication, black box warning or Food and Drug Administration (FDA) safety alert, additive toxicity, drug-drug interaction, drug-food interaction, drug allergy, or other reason as determined by the pharmacist.
- Medication deletion intervention — Recommendation of the deletion of a medication based on clinical guidelines, indications, adverse drug reaction, contraindication, black box warning or FDA safety alert, additive toxicity, drug-drug interaction, drug-food interaction, drug allergy, or other reason as determined by the pharmacist.
- Medication device instruction intervention — Intensive pharmacist consultation lasting more than five minutes on any device associated with a medication and subsequent patient or caregiver demonstration of the device's use. This includes instructing a member to use a new medication device, correcting technique, patient or prescriber request for instruction, or another reason as determined by the pharmacist.
- In-home medication management — Provided for members who, due to a physical or mental health condition, are not able to pick up their medication and do not have family or friends who can pick up the medication on their behalf, and the medication cannot

be mailed to the member's residence, requiring pharmacy staff to travel to the member's home to provide the medication. Examples of medication eligible for this type of intervention include pre-filled syringes, medication that must be refrigerated, or medication that must be stabilized. This intervention may also be used to assist members with device management in the home, such as automated medication dispensing devices. In-home medication management can only be reimbursed in conjunction with a focused adherence, medication device instruction intervention-based service, or a CMR/A. Claims submitted for in-home medication management without a focused adherence intervention, medication device instruction intervention, or a CMR/A will be denied with EOB code 1500, which states "In-home medication management must be performed in conjunction with one of the following: Focused Adherence intervention, Medication Device Instruction intervention, or Comprehensive Medication Review and Assessment."

Three-month supply and in-home medication management are specific interventions only covered by ForwardHealth. Other WPQC participating payers do not include these services at this time.

Reimbursement for MTM intervention-based services requires the pharmacist to meet all basic requirements of federal and state law for dispensing a drug, plus completing specified activities that result in a positive outcome for members and ForwardHealth. Positive outcomes include increasing patient compliance or preventing potential adverse drug reactions. This fee reimburses pharmacists for additional actions they take beyond the standard dispensing and counseling for a prescription drug.

Documentation Requirements for Intervention-Based Services

The following documentation is required for intervention-based services and must be maintained by the pharmacy in the member's file or on the prescription:

- Member information:

- ✓ Member name.
- ✓ Member identification number.
- ✓ Does the member currently reside in a nursing home?
- Prescriber name and NPI.
- Prescription number.
- Date of service for the intervention-based service.
- Member consent for the service, indicated by the member's signature and date.
- Indication of whether or not the prescriber was contacted.
- If yes, the date the prescriber was contacted.
- Indication of the time spent on service (in minutes), include the time spent providing and documenting the service.
- Pharmacist signature and date on the documentation.

Pharmacies are required to document the following information specific to intervention types:

- Cost-effectiveness intervention — Identify the assessment performed, the current therapy, and the recommended therapy. Did the prescriber accept the change?
- Three-month supply intervention — Name of the drug. Did the prescriber accept or decline?
- Dose/dosage form/duration change intervention:
 - ✓ Name of the drug involved.
 - ✓ Dose — The strength was changed from, the strength was changed to, and the reason for the change.
 - ✓ Dosage form — The dosage form of drug was changed from, the dosage form of drug was changed to, and the reason for change.
 - ✓ Duration change — Duration of drug therapy was changed from and the duration to which the drug therapy was changed.
 - ✓ Reason for the change.
 - ✓ Did the prescriber accept the change?
- Focused adherence intervention:
 - ✓ Name of the drug(s) involved.

- ✓ What is the adherence issue (e.g., late or early refill) and the adherence intervention or education provided?
- Medication addition intervention:
 - ✓ Name of the drug added.
 - ✓ Reason for the drug addition?
 - ✓ Did the prescriber accept the addition?
- Medication deletion intervention:
 - ✓ Name of the drug deleted.
 - ✓ Reason for the drug deletion.
 - ✓ Did the prescriber accept the deletion?
- Medication device instruction intervention — Name of drug or device the member was trained to use.
- In-home medication management intervention — Reason for the service.

Pharmacies may use any format to document intervention-based services, but that format must include all of the aforementioned elements. Documentation must be made available to ForwardHealth upon request. Refer to Attachment 1 of this *Update* for an example of acceptable documentation for intervention-based services.

Intervention-Based Service Limitations

Intervention-based services have the following limits:

- Four of the same intervention-based services are reimbursable per member, per rolling year, with the exception of the cost-effectiveness intervention and three-month supply intervention. Claims for intervention-based services exceeding the limit will be denied with EOB code 0485, which states “Quantity Limit Exceeded.”
- The cost-effectiveness intervention does not have a service limitation.
- Three-month supply interventions are limited to one intervention, per drug, per rolling year.
- Cost-effectiveness, dose/dosage form/duration change intervention, medication addition, medication deletion, and three-month supply are the only intervention-based services covered for members residing in nursing homes.

Policy Override to Exceed Intervention-Based Service Limitations

If a member requires more than four of the same intervention-based service per rolling year, pharmacies must contact the Drug Authorization and Policy Override (DAPO) Center to request a policy override. Pharmacies may contact the DAPO Center at (800) 947-9627 from 8:00 a.m. to 5:30 p.m. (Central Standard Time), Monday through Friday, except holidays.

The pharmacy may be granted a policy override to exceed the limit for an intervention-based service if the pharmacy demonstrates that the member has an appropriate medical need. Examples of when an intervention-based service override request may be approved through the DAPO Center include, but are not limited to, the following:

- The member is unable to fill his or her insulin syringes, does not have a caregiver who can fill the syringes, and the insulin is not available in a pen. The pharmacy provides the member with pre-filled syringes under the focused adherence intervention, but the member has met the limit of four times per rolling year for this intervention and requires additional assistance. The pharmacy may request a policy override to exceed the four times per rolling year limit for the focused adherence intervention.
- The pharmacy provider learns that the prescriber has prescribed an excessive quantity of a medication for a child, and the pharmacy provider would like to perform the dose/dosage form/duration change intervention to change the child's dose, but the member has already met his or her limit of four dose/dosage form/duration change intervention services per rolling year for this intervention. The pharmacy provider may request a policy override to exceed the yearly limit in order to provide this service.

When calling the DAPO Center to request an intervention-based service limitation override, pharmacies should have the following information, similar to the documentation requirements, on hand:

- Member information.

- Pharmacy information.
- Service requested.
- Drugs involved.
- Reason for the override request.
- Number of services beyond the yearly limit that are required.

If the DAPO Center denies the policy override, the intervention-based service is considered a noncovered service. Providers may collect payment for the noncovered service from the member if the member accepts responsibility for payment and makes payment arrangements with the provider. Providers are strongly encouraged to obtain a written statement in advance documenting that the member has accepted responsibility for payment of the service.

Providers may bill members up to their usual and customary charge for noncovered services.

Procedure Codes and Modifiers for Intervention-Based Services

Claims submitted for intervention-based services must be submitted with one of the following *Current Procedural Terminology* (CPT) codes:

- 99605 (Medication therapy management service[s] provided by a pharmacist, individual, face-to-face with patient, with assessment and intervention if provided; initial 15 minutes, new patient).
- 99606 (Medication therapy management service[s] provided by a pharmacist, individual, face-to-face with patient with assessment and intervention if provided; initial 15 minutes, established patient).
- 99607 (Medication therapy management service[s] provided by a pharmacist, individual, face-to-face with patient, with assessment and intervention if provided; each additional 15 minutes [list separately in addition to code for primary service]).

Procedure codes submitted for intervention-based services must be submitted with one of the following modifiers:

- U1 (Cost-Effectiveness Intervention).

- U2 (Three-Month Supply Intervention).
- U3 (Dose/Dosage form/Duration Change Intervention).
- U4 (Focused Adherence Intervention).
- U5 (Medication Addition Intervention).
- U6 (Medication Deletion Interventions).
- U7 (Medication Device Instruction Intervention).
- U8 (In-home Medication Management Intervention).

Pharmacies should submit one procedure code and modifier per detail line. Claim details without the appropriate modifier will be denied.

Refer to Attachment 2 for a complete list of intervention-based CPT codes, modifiers, limits, and reimbursement rates. Refer to Attachment 3 for 1500 Health Insurance Claim Form completion instructions for MTM services and Attachment 4 for a sample 1500 Health Insurance Claim Form for intervention-based services.

Claim Submission for Intervention-Based Services

The MTM benefit is covered for members enrolled in the Standard Plan, the Benchmark Plan, the Core Plan, the Basic Plan, SeniorCare, Wisconsin Medicaid, PACE, Family Care Partnership, BadgerCare Plus HMOs, SSI HMOs, and FamilyCare CMOs and is reimbursed fee-for-service. Managed Care Organizations are not responsible for MTM service reimbursement; however, cost-effectiveness, dose/dosage form/duration change, medication addition, medication deletion, and three-month supply intervention-based services are the *only* intervention-based services covered for members residing in a nursing facility.

Claims for intervention-based services must be submitted fee-for-service on a professional claim by the pharmacy. In order to be reimbursed for intervention-based services, the pharmacy provider is required to submit a professional claim using a valid CPT code and modifier via one of the following claims submission methods:

- 837 Health Care Claim: Professional (837P) transaction.
- Provider Electronic Solutions (PES) software.

- Direct Data Entry (DDE) professional claim.
- Paper 1500 Health Insurance Claim Form.

Pharmacies may need to update their systems to accommodate billing professional claims.

As a reminder, ForwardHealth will reduce reimbursement on most claims submitted to ForwardHealth on paper. Most paper claims will be subject to up to a \$1.10 reimbursement reduction per claim.

Quantity on Claims for New and Established Patients for Intervention-Based Services

When submitting claims for intervention-based services for a new patient, pharmacies should indicate CPT code 99605 with the appropriate modifier, with a quantity of 1 for the first 15 minutes. If an intervention-based service lasts longer than 15 minutes, pharmacies should indicate CPT code 99607, with the appropriate modifier on a separate detail, for each additional 15 minutes. Pharmacies should round up to the nearest 15 minutes. For example, if an intervention-based service lasts 21 minutes, pharmacies should round to 30 minutes on the claim. Refer to Attachment 3 for 1500 Health Insurance Claim Form completion instructions and Attachment 4 for a sample 1500 Health Insurance Claim Form for an intervention-based service for a new patient.

When submitting claims for intervention-based services for an established patient, pharmacies should indicate CPT code 99606 with the appropriate modifier and a quantity of 1 for the first 15 minutes. If an intervention-based service lasts longer than 15 minutes, pharmacies should indicate 99607, with the appropriate modifier, for each additional 15 minutes. Pharmacies should round up to the nearest 15 minutes. For example, if an intervention-based service lasts 21 minutes, pharmacies should round to 30 minutes on the claim.

Pharmacies are required to indicate CPT code 99607 on intervention-based service claims that last longer than 15 minutes. Details submitted with 99607 will be allowed and paid at zero dollars since reimbursement for intervention-

based services occur with CPT code 99605 or 99606 and the appropriate modifier. Although 99607 will be reimbursed at zero dollars, pharmacies are required to submit details with the correct quantities to comply with correct coding practices.

Reimbursement for Intervention-Based Services

All intervention-based services, with the exception of in-home medication management and three-month supply, will be reimbursed at \$30 per intervention. In-home medication management and three-month supply intervention will be reimbursed at \$10 per intervention. Refer to Attachment 2 for reimbursement rates.

For SeniorCare members, pharmacies are reimbursed directly for intervention-based services at the Medicaid rate when the member is in, or has reached, the copayment level of participation. When the member has a spenddown or deductible, the pharmacy is reimbursed by the member. As a reminder, the pharmacy provider is required to obtain member consent for the intervention-based service prior to providing the service.

Coordination of Benefits

Commercial health insurance and Medicare Part D plans (PDP) also have MTM programs. If a member is eligible for a commercial health insurance or Medicare Part D MTM program, the pharmacy provider is required to submit the claim to the member's commercial health insurance or PDP before submitting the claim to ForwardHealth.

Refer to Attachment 3 for 1500Health Insurance Claim Form completion instructions, which includes information on documenting other insurance information.

As a reminder, pharmacies are responsible for coordination of benefits. ForwardHealth is the payer of last resort.

Comprehensive Medication Review and Assessment

The CMR/A services are voluntary medication reviews for members performed by a pharmacist. Comprehensive medication reviews and assessments may include one or more of the following analytical, consultative, educational, and monitoring services, provided by a pharmacist to help members get the best results from medications through enhancing consumer understanding of medication therapy, increasing adherence to medications, controlling costs, and preventing drug complications, conflicts, and interactions.

An initial face-to-face CMR/A identifies, resolves, and prevents medication-related problems, including adverse drug events or can include performing medication reconciliation for a member discharged from a hospital or long term care setting.

A follow-up CMR/A monitors and evaluates the member's response to therapy, including safety and effectiveness of target medications.

Certification Requirements for Providing Comprehensive Medication Review and Assessments

To perform and be reimbursed for CMR/As, the pharmacists and the pharmacy at which the pharmacist is performing the CMR/A are required to be certified by an approved MTM program. Currently, the only approved MTM certification program is conducted by the WPQC. The Pharmacy Society of Wisconsin (PSW) manages the WPQC training and certification process, and has established rates for WPQC certification. For more information about the certification process, providers should visit PSW's Web site at pswi.org/wpqc/.

Note: A separate WPQC certification is not required to perform and receive reimbursement for intervention-based services.

Conducting a Comprehensive Medication Review and Assessment

The CMR/A services may include the following value-added professional services provided by a pharmacist:

- Obtaining the necessary assessments of the member's health status.
- Formulating a medication treatment plan for the member.
- Providing an updated personal medication record and medication action plan to the member following each CMR/A visit.
- Providing information, support services, and resources designed to enhance member adherence with the member's therapeutic regimens.
- Providing verbal education and training designed to enhance the member understanding and appropriate use of the member's medication.
- Documenting the care delivered and communication of essential information to the member's primary care providers.
- Referring an appropriate health care provider, if necessary.
- Coordinating and integrating medication management services within the broader health care system.
- Notifying appropriate prescribers of each comprehensive care review and assessment service provided and sending a copy of the personal medication record and medication action plan. If authorizations to change specific medications are needed, the specific prescriber will be notified.

Qualifying Criteria

A CMR/A service may be provided to a member who has a high risk of experiencing medical complications due to his or her drug regimen. A high-risk member meets one of the following criteria:

- A member who takes four or more prescription medications to treat or prevent two or more chronic conditions, one of which must be hypertension, asthma, chronic kidney disease, congestive heart failure, dyslipidemia, Chronic Obstructive Pulmonary Disease (COPD), or depression.

- The member has diabetes.
- The member requires coordination of care due to multiple prescribers.
- The member has been discharged from the hospital or long term care setting within the past 14 days.
- The member has health literacy issues as determined by the pharmacist.
- The member has been referred for MTM services by the prescriber.

Note: Members residing in a nursing home are not eligible for CMR/As.

If the member meets at least one of the aforementioned criteria, the pharmacy provider must call the DAPO Center to request approval to provide CMR/A services. The CMR/A approval covers the initial and up to three follow-up CMR/As. More information about obtaining approval to provide CMR/A services is in the Comprehensive Medication Review and Assessment Approval Process section of this *Update*.

Comprehensive Medication Review and Assessment Process

The following is a step-by-step process for providing a CMR/A:

- The pharmacist identifies an opportunity or receives a prescriber referral to perform a CMR/A.
- The pharmacy contacts the member about the CMR/A opportunity and the member accepts services.
- The pharmacy calls the DAPO Center to request CMR/A approval.
- If approved, the pharmacist schedules an appointment with the member to perform the CMR/A.
- The pharmacist performs the CMR/A, which may include the following:
 - ✓ Meeting with the member.
 - ✓ Consultation with the prescriber.
 - ✓ Documentation of the intervention.
- Pharmacy provider submits professional claim for the CMR/A.

Documentation Requirements for Comprehensive Medication Reviews and Assessments

The following documentation is required for CMR/A services and must be maintained by the pharmacy in the member's file or on the prescription:

- Member information.
 - ✓ Member name.
 - ✓ ForwardHealth number.
 - ✓ Is the member in a nursing home?
- Pharmacist name and NPI.
- Pharmacy name and NPI.
- Description of the need for the CMR/A.
- Indication if the member has other insurance. If so, indicate whether or not the member is enrolled in the other insurance's MTM program.
- Indication of how the member meets the criteria to receive a CMR/A:
- Date of the CMR/A.
- Member consent for the CMR/A, indicated by the member's signature and date.
- Indication that DAPO approval was received for the CMR/A.
- Indication if this was the initial assessment or a follow-up assessment.
- Description of what was discussed in the CMR/A.
- Face-to-face start and end time of the CMR/A.
- Total time spent providing the CMR/A.
- Pharmacist signature and date on the documentation.

Pharmacies may use any format to document CMR/As, but that format must include all of the aforementioned elements. Documentation must be made available to ForwardHealth upon request. Refer to Attachment 5 for an example of acceptable documentation for comprehensive medication review and assessment documentation.

Comprehensive Medication Review and Assessment Approval Process

Pharmacies must call the DAPO Center to request approval to perform the CMR/A. Pharmacies may contact the DAPO Center at (800) 947-9627 from 8:00 a.m. to 5:30 p.m.

(Central Standard Time), Monday through Friday, except holidays.

When calling the DAPO Center for approval to perform the CMR/A, the following information, similar to the documentation requirements, must be provided:

- Member information.
- Pharmacy and pharmacist information.
- Reason for CMR/A.
- Whether or not the member is enrolled in Medicare Part D.
- Member's qualifying criteria.
- Whether or not member consent was obtained.

Generally DAPO Center staff will approve the CMR/A request by the end of the call based on the information provided by the caller. The pharmacy then must schedule, perform, and submit the claim for the CMR/A within 60 days following the approval. If the CMR/A is not provided within 60 days of approval, a new approval may be granted for a new pharmacy. The CMR/A approval is for the initial CMR/A and the three follow-up CMR/As.

If a pharmacy calls the DAPO Center to request CMR/A approval and the information provided does not qualify, the pharmacy will be informed that the request is not approved.

Limitations for Comprehensive Medication Review and Assessments

In most cases, a CMR/A is limited to one initial assessment and three follow-up assessments per rolling year.

Policy Override to Exceed Comprehensive Medication Review and Assessment Limitations

If a member requires more than the one initial and three follow-up CMR/As per rolling year (for example, a member is discharged from the hospital, released from long term care, or has moved), pharmacies must contact the DAPO Center to request a policy override. Pharmacies may contact the DAPO Center at (800) 947-9627 from 8:00 a.m. to 5:30 p.m. (Central Standard Time), Monday through Friday, except holidays.

Intervention-Based Services That Occur During a Comprehensive Medication Review and Assessment

If an intervention-based service is completed during the CMR/A, pharmacies should not bill and will not be reimbursed for the intervention-based service in addition to the CMR/A. Additionally, the Focused Adherence Intervention or Medication Device Instruction Intervention will not be reimbursed on the same DOS as a CMR/A. Claims submitted for the Focused Adherence Intervention or Medication Device Instruction submitted on the same DOS as a CMR/A will be denied with EOB code 1501, which states “Focused Adherence or Medication Device Instruction Intervention are not allowed on the same date of service as a Comprehensive Medication Review and Assessment.”

In-Home Medication Management and Comprehensive Medication Review and Assessment

If the pharmacist must conduct a CMR/A in the member’s home because the member is unable to visit the pharmacy, the pharmacy may be reimbursed for an in-home medication management intervention in conjunction with a CMR/A.

Procedure Codes and Modifiers

Claims submitted for CMR/As must be submitted with at least one of the following CPT codes:

- 99605 (Medication therapy management service[s] provided by a pharmacist, individual, face-to-face with patient, with assessment and intervention if provided; initial 15 minutes, new patient.)
- 99606 (Medication therapy management service[s] provided by a pharmacist, individual, face-to-face with patient with assessment and intervention if provided; initial 15 minutes, established patient.)
- 99607 (Medication therapy management service[s] provided by a pharmacist, individual, face-to-face with patient, with assessment and intervention if provided; each additional 15 minutes [List separately in addition to code for primary service]).

Procedure codes submitted for CMR/As must be submitted with one of the following modifiers:

- UA (The initial assessment of a member who is at high risk of experiencing medical complications due to his or her drug regimen).
- UB (Follow-up assessment of a member who is experiencing medical complications due to his or her drug regimen and has already received an initial assessment by the pharmacy. The follow-up assessment will not be reimbursed unless the initial assessment has been reimbursed).

Pharmacists should submit one procedure code and modifier per detail line. Claim details without the appropriate modifier will be denied.

Claim Submission for Comprehensive Medication Review and Assessments

Claims for CMR/As must be submitted fee-for-service on a professional claim. In order to be reimbursed for a CMR/A, the pharmacy provider is required to submit a professional claim using a valid CPT code and modifier via one of the following claims submission methods:

- 837 Health Care Claim: Professional transaction.
- Provider Electronic Solutions software.
- Direct Data Entry on the Portal.
- Paper 1500 claim form.

Pharmacies may wish to update their systems to accommodate billing professional claims.

As a reminder, ForwardHealth will reduce reimbursement on most claims submitted to ForwardHealth on paper. Most paper claims will be subject to up to a \$1.10 reimbursement reduction per claim.

Quantity on Claims for Initial and Follow-up Comprehensive Medication and Reviews and Assessments

When submitting claims for an initial CMR/A, pharmacies should indicate CPT code 99605 with the modifier UA, with a quantity of 1 for the first 15 minutes. If the initial CMR/A

lasts longer than 15 minutes, pharmacies should in addition indicate CPT code 99607, with modifier UA, for each additional 15 minutes. Pharmacies should round up to the nearest 15 minutes. For example, if a CMR/A lasts 21 minutes, pharmacies should round to 30 minutes on the claim.

When submitting claims for a follow-up CMR/A, pharmacies should indicate CPT code 99606 with modifier UB, with a quantity of 1 for the first 15 minutes. If a follow-up CMR/A lasts longer than 15 minutes, pharmacies should indicate CPT code 99607, with modifier UB, for each additional 15 minutes. Pharmacies should round up to the nearest 15 minutes. Refer to Attachment 6 for a sample 1500 claim form for comprehensive medication review and assessments.

Pharmacies are required to indicate CPT code 99607 on CMR/A claims that last longer than 15 minutes. Details submitted with 99607 will be allowed and paid at zero dollars since reimbursement for CMR/As occur with CPT code 99605 or 99606 and the appropriate modifier. Although 99607 will be reimbursed at zero dollars, pharmacies are required to submit details with the correct quantities to comply with correct coding practices.

Reimbursement for Comprehensive Medication Review and Assessments

Pharmacies will be reimbursed at \$75.00 for the initial CMR/A and \$35.00 for follow-up CMR/A. Refer to Attachment 2 for a complete list of comprehensive medication review and assessment CPT codes, modifiers, limits, and reimbursement rates.

For SeniorCare members, pharmacies are reimbursed directly for CMR/As at the Medicaid rate when the member is in, or has reached, the copayment level of participation. When the member has a spenddown or deductible, the pharmacy is reimbursed by the member. As a reminder, the pharmacy provider is required to obtain member consent for the CMR/A prior to providing the service.

Coordination of Benefits

Commercial health insurance and Medicare PDP also have MTM programs. If a member is eligible for a commercial health insurance or Medicare Part D MTM program, the pharmacy provider is required to submit the claim to the member's commercial health insurance or PDP before submitting the claim to ForwardHealth.

Pharmacies are responsible for coordination of benefits. ForwardHealth is the payer of last resort.

Place of Service Codes

The following place of service codes are allowed for intervention-based and CMR/A services:

- 01 (Pharmacy).
- 05 (Indian Health Service Free-standing Facility).
- 06 (Indian Health Service Provider-based Facility).
- 07 (Tribal 638 Free-standing Facility).
- 08 (Tribal 638 Provider-based Facility).
- 11 (Office).
- 12 (Home).
- 13 (Assisted Living Facility).
- 14 (Group Home).
- 16 (Temporary Lodging).
- 17 (Walk-in Retail Health Clinic).
- 31 (Skilled Nursing Facility).
- 32 (Nursing Facility).
- 49 (Independent Clinic).
- 50 (Federally Qualified Health Center).
- 54 (Intermediate Care Facility/Mentally Retarded).
- 56 (Psychiatric Residential Treatment Center).
- 57 (Non-residential Substance Abuse Treatment Facility).
- 71 (Public Health Clinic).
- 72 (Rural Health Clinic).

Note: Place of service codes 31, 32, and 54 are only allowed for cost-effectiveness, dose/dosage form/duration change, medication addition, medication deletion, and three-month supply intervention-based services.

Claim Submission Options

837 Health Care Claim: Professional Transaction

Electronic claims for MTM services must be submitted using the 837P transaction. Electronic claims for MTM services submitted using any transaction other than the 837P will be denied.

Pharmacies should refer to the 837P transaction companion guide posted on the Trading Partner area of the Portal for instructions for submitting 837P transactions.

Provider Electronic Solutions Software

The Division of Health Care Access and Accountability offers electronic billing software at no cost to providers. The PES software allows providers to submit electronic claims using an 837 transaction. Providers may download PES software from the ForwardHealth Portal. For assistance installing and using PES software, pharmacies may call the Electronic Data Interchange Helpdesk.

Direct Data Entry of Professional Claims on the Portal

Providers can submit the following claims to ForwardHealth via DDE on the Portal:

- Professional claims.
- Institutional claims.
- Dental claims.
- Compound drug claims.
- Noncompound drug claims.

Direct data entry is an online application that allows providers to submit claims directly to ForwardHealth. When submitting claims via DDE, required fields are indicated with an asterisk next to the field. If a required field is left blank, the claim will not be submitted and a message will appear prompting the provider to complete the specific required field(s). Portal help is available for each online application screen. In addition, search functions accompany certain fields so providers do not need to look up information in secondary resources.

On professional claim forms, providers may search for and select the following:

- Procedure codes.
- Modifiers.
- Diagnosis codes.
- Place of service codes.

1500 Health Insurance Claim Form

Paper claims for MTM services must be submitted using the 1500 Health Insurance Claim Form (dated 08/05).

ForwardHealth denies claims for professional services submitted on any other claim form.

Pharmacies should use the 1500 Health Insurance Claim Form completion instructions for MTM services as shown in Attachment 3 when submitting claims for MTM services.

As a reminder, ForwardHealth will reduce reimbursement on most claims submitted to ForwardHealth on paper. Most paper claims will be subject to a reimbursement reduction of up to \$1.10 per claim.

Terms of Reimbursement

The Pharmacy Terms of Reimbursement has been revised, effective for DOS on and after September 1, 2012. Refer to Attachment 7 for the revised Pharmacy Terms of Reimbursement, F-01518 (09/12), which describes how ForwardHealth will reimburse pharmacies for services rendered. The conditions outlined in the terms of reimbursement will automatically take effect; pharmacies do not need to re-enroll (formerly recertify) with Wisconsin Medicaid.

Webcast Training

A recorded Webcast training session on professional claim submission for MTM services will be available on the ForwardHealth Trainings page of the ForwardHealth Portal for on-demand viewing in September 2012. Providers do not need to register to view the Webcast session.

More Information on the Wisconsin Pharmacy Quality Collaborative

The WPQC is a group of pharmacy providers, health care purchasers, and medical professionals working together to improve the quality and reduce the cost of prescription medication use. The WPQC's goals are to improve medication use by targeted patients, reduce prescription drug costs for participants and health plans, reduce overall health care costs, enhance patient participation in his or her own care, and retool community pharmacies to serve as health care access points.

For more information, visit the WPQC Web site at www.pswi.org/displaycommon.cfm?an=1&subarticlenbr=38.

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 August 23, 2012, and information contained in this *Update* was incorporated into the Online Handbook on October 23, 2012.

ATTACHMENT 1

Intervention-Based Service Documentation Example

(A copy of the “Intervention-Based Service Documentation Example” is located on the following pages.)

INTERVENTION-BASED SERVICE DOCUMENTATION EXAMPLE

SECTION I — MEMBER INFORMATION

Name — Member (Last, First, Middle Initial)

Ima M. Ember

Member Identification Number
0123456789

Is the member currently residing in a nursing home?
 Yes No

SECTION II — PRESCRIPTION INFORMATION

Prescriber Name
Dr. John Smith

Prescriber National Provider Identifier
0222222220

RX Number
0000000001

Intervention-Based Date of Service
September 2, 2012

Was member consent obtained? Yes No

Was the prescriber contacted? Yes No

If yes, date the prescriber was contacted: September 15, 2012

SECTION III — INTERVENTION-BASED SERVICE PERFORMED (CHECK ONE)

Cost-Effectiveness

Agent Switched from Nexium 40mg to pantoprazole 40mg.

Did the prescriber accept the changes? Yes No

Three-Month Supply (Limited to One Override, Per Drug, Per Rolling Year)

Name of Drug: _____

Did the prescriber accept the changes? Yes No

Dose/Dosage Form/ Duration Change

Drug Involved _____

Dosage strength changed from _____ to _____.

Dosage form of drug changed from _____ to _____.

Duration of drug therapy changed from _____ to _____.

Reason for Change _____

Did the prescriber accept the changes Yes No

Focused Adherence

Drug(s) Involved _____

Adherence Issue _____

Adherence Intervention / Education Provided _____

Medication Addition

Name of Drug Added _____

Reason Drug Was Added _____.

Did the prescriber accept the changes? Yes No

Medication Deletion

Name of Drug Deleted _____

Reason Drug Was Deleted _____.

Did the prescriber accept the changes? Yes No

Medication Device Instructions

Dosage Form or Device Member Was Trained to Use _____.

In-Home Medication Management

Reason for Service _____.

Total Time Spent on Service (In Minutes)

15 minutes

SIGNATURE — Pharmacist

John Doe

Date Signed

9/16/2012

ATTACHMENT 2

Intervention-Based Procedure Codes and Modifiers

Current Procedural Terminology Code	Description
99605	Medication therapy management service(s) provided by a pharmacist, individual, face-to-face with patient, with assessment and intervention if provided; initial 15 minutes, new patient
99606	initial 15 minutes, established patient
99607	each additional 15 minutes (List separately in addition to code for primary service)

Type of Intervention	Description	Modifier	CPT Code for New Patient	CPT Code for Established Patient	Reimbursement Rate	Payable for nursing home residents?	Limit
Cost-Effectiveness	Formulary interchange, therapeutic interchange, conversion to an over-the-counter product; tablet splitting opportunity; dose consolidation.	U1	99605 for first 15 minutes; 99607 for each additional 15 minutes	99606 for first 15 minutes; 99607 for each additional 15 minutes	\$30	Yes	Unlimited
Three-Month Supply	Switching from one-month supply to three-month supply.	U2	99605 for first 15 minutes; 99607 for each additional 15 minutes	99606 for first 15 minutes; 99607 for each additional 15 minutes	\$10	Yes	1/ drug/ rolling year

Type of Intervention	Description	Modifier	CPT Code for New Patient	CPT Code for Established Patient	Reimbursement Rate	Payable for nursing home residents?	Limit
Dose/Dosage Form/Duration Change Intervention	Opportunity to change patient's dose, dosage form, or duration of therapy based on manufacturer recommended dose, organ function or age-appropriateness of dose; insufficient or excessive duration or quantity of medication prescribed; sub-optimal dosage form prescribed; drug-drug interaction or drug-food interaction.	U3	99605 for first 15 minutes; 99607 for each additional 15 minutes	99606 for first 15 minutes; 99607 for each additional 15 minutes	\$30	Yes	4/member/rolling year
Focused Adherence Intervention	Consultation with a patient regarding a significant lack of adherence in order to enhance the patient's understanding of his or her medication regimen.	U4	99605 for first 15 minutes; 99607 for each additional 15 minutes	99606 for first 15 minutes; 99607 for each additional 15 minutes	\$30	No	4/member/rolling year
Medication Additions Intervention	Adding a drug based on clinical concerns	U5	99605 for first 15 minutes; 99607 for each additional 15 minutes	99606 for first 15 minutes; 99607 for each additional 15 minutes	\$30	Yes	4/member/rolling year
Medication Deletions Interventions	Deletion of a drug based on clinical concerns	U6	99605 for first 15 minutes; 99607 for each additional 15 minutes	99606 for first 15 minutes; 99607 for each additional 15 minutes	\$30	Yes	4/member/rolling year

Type of Intervention	Description	Modifier	CPT Code for New Patient	CPT Code for Established Patient	Reimbursement Rate	Payable for nursing home residents?	Limit
Medication Device Instruction Intervention	Intensive pharmacist consultation lasting more than five minutes on any device associated with a medication and subsequent patient or caregiver demonstration of the device's use	U7	99605 for first 15 minutes; 99607 for each additional 15 minutes	99606 for first 15 minutes; 99607 for each additional 15 minutes	\$30	No	4/member/rolling year
In-Home Medication Management	Provided to assist members who, due to a physical or mental health condition, are not able to pick up their medication and do not have family members or friends who can pick up medication, or require device management. In-home medication management can only be reimbursed in conjunction with a focused adherence or medication device instruction, intervention-based service, or CMR/A.	U8	99605 for first 15 minutes; 99607 for each additional 15 minutes	99606 for first 15 minutes; 99607 for each additional 15 minutes	\$10	No	4/member/rolling year

Comprehensive Medication Review and Assessment Procedure Codes and Modifiers

Type of Comprehensive Medication Review and Assessment	Description	Modifier	CPT Code for New Patient	CPT Code for Established Patient	Reimbursement	Payable for nursing home residents?	Limit
CMR/A — Initial Assessment	This is an initial assessment of a member who is at a high risk of experiencing medical complications due to his drug regimen.	UA	99605 for first 15 minutes; 99607 for each additional 15 minutes	99606 for first 15 minutes; 99607 for each additional 15 minutes	\$75	No	1/member / rolling year
CMR/A — Follow-Up Assessment	This is a follow-up assessment of a member who is at a high risk of experiencing medical complications due to the drug regimen and has already received an initial assessment by the pharmacy.	UB	N/A	99606 for first 15 minutes; 99607 for each additional 15 minutes	\$35	No	3/member / rolling year

ATTACHMENT 3

1500 Health Insurance Claim Form

Completion Instructions for the Medication Therapy Management Services

Use the following claim form completion instructions, not the claim form's printed descriptions, to avoid denial or inaccurate claim payment. Complete all required elements as appropriate. Be advised that every code used, even if it is entered in a non-required element, is required to be a valid code. Do not include attachments unless instructed to do so.

Members enrolled in BadgerCare Plus or Medicaid receive a ForwardHealth identification card and members enrolled in SeniorCare receive a SeniorCare identification card. Always verify a member's enrollment before providing nonemergency services to determine if there are any limitations on covered services and to obtain the correct spelling of the member's name.

When submitting a claim with multiple pages, providers are required to indicate page numbers using the format "Page X of X" in the upper right corner of the claim form.

Submit completed paper claims to the following address:

ForwardHealth
Claims and Adjustments
313 Blettner Blvd
Madison WI 53784

Element 1 — Medicare, Medicaid, TRICARE CHAMPUS, CHAMPVA, Group Health Plan, FECA, Blk Lung, Other

Enter "X" in the Medicaid check box.

Element 1a — Insured's ID Number

Enter the member identification number. Do not enter any other numbers or letters. Use the ForwardHealth or SeniorCare card or Wisconsin's Enrollment Verification System (EVS) to obtain the correct member ID.

Element 2 — Patient's Name

Enter the member's last name, first name, and middle initial. Use the EVS to obtain the correct spelling of the member's name. If the name or spelling of the name on the ForwardHealth or SeniorCare card and the EVS do not match, use the spelling from the EVS.

Element 3 — Patient's Birth Date, Sex

Enter the member's birth date in MMDDYY format (e.g., February 3, 1955, would be 020355) or in MMDDCCYY format (e.g., February 3, 1955, would be 02031955). Specify whether the member is male or female by placing an "X" in the appropriate box.

Element 4 — Insured's Name

Data is required in this element for Optical Character Recognition (OCR) processing. Any information populated by a provider's computer software is acceptable data for this element (e.g., "Same"). If computer software does not automatically complete this element, enter information such as the member's last name, first name, and middle initial.

Element 5 — Patient's Address

Enter the complete address of the member's place of residence, if known.

Element 6 — Patient Relationship to Insured (not required)

Element 7 — Insured's Address (not required)

Element 8 — Patient Status (not required)

Element 9 — Other Insured's Name

Commercial health insurance must be billed prior to submitting claims to ForwardHealth, unless the service does not require commercial health insurance billing as determined by ForwardHealth.

If the EVS indicates that the member has dental ("DEN") insurance only, is enrolled in a Medicare Advantage Plan only, or has no commercial health insurance, leave Element 9 blank.

If the EVS indicates that the member has any other commercial health insurance, and the service requires other insurance billing, one of the following three Other Insurance (OI) explanation codes must be indicated in the first box of Element 9. If submitting a multiple-page claim, providers are required to indicate OI explanation codes on the first page of the claim.

The description is not required, nor is the policyholder, plan name, group number, etc. (Elements 9a, 9b, 9c, and 9d are not required.)

Code	Description
O-I-P	PAID in part or in full by commercial health insurance or commercial HMO. In Element 29 of this claim form, indicate the amount paid by commercial health insurance to the provider or to the insured.
O-I-D	DENIED by commercial health insurance or commercial HMO following submission of a correct and complete claim, or payment was applied towards the coinsurance and deductible. Do not use this code unless the claim was actually billed to the commercial health insurer.
O-I-Y	YES, the member has commercial health insurance or commercial HMO coverage, but it was not billed for reasons including, but not limited to, the following: <ul style="list-style-type: none">• The member denied coverage or will not cooperate.• The provider knows the service in question is not covered by the carrier.• The member's commercial health insurance failed to respond to initial and follow-up claims.• Benefits are not assignable or cannot get assignment.

- | |
|---|
| <ul style="list-style-type: none"> • Benefits are exhausted. |
|---|

Note: The provider may not use OI-D or OI-Y if the member is covered by a commercial HMO and the HMO denied payment because an otherwise covered service was not rendered by a designated provider. Services covered by a commercial HMO are not reimbursable by ForwardHealth except for the copayment and deductible amounts. Providers who receive a capitation payment from the commercial HMO may not bill ForwardHealth for services that are included in the capitation payment.

Element 9a — Other Insured's Policy or Group Number (not required)

Element 9b — Other Insured's Date of Birth, Sex (not required)

Element 9c — Employer's Name or School Name (not required)

Element 9d — Insurance Plan Name or Program Name (not required)

Element 10a-10c — Is Patient's Condition Related to: (not required)

Element 10d — Reserved for Local Use (not required)

Element 11 — Insured's Policy Group or FECA Number

If an Explanation of Medicare Benefits (EOMB) indicates that the member is enrolled in a Medicare Advantage Plan and the claim is being billed as a crossover, enter "MMC" in the upper right corner of the claim, indicating that the other insurance is a Medicare Advantage Plan and the claim should be processed as a crossover claim.

Use the first box of this element only. (Elements 11a, 11b, 11c, and 11d are not required.) Element 11 should be left blank when one or more of the following statements are true:

- Medicare never covers the procedure in any circumstance.
- ForwardHealth indicates the member does not have any Medicare coverage, including a Medicare Advantage Plan, for the service provided. For example, the service is covered by Medicare Part A, but the member does not have Medicare Part A.
- ForwardHealth indicates that the provider is not Medicare-enrolled.
- Medicare has allowed the charges. In this case, attach the EOMB, but do not indicate on the claim form the amount Medicare paid.

If none of the previous statements are true, a Medicare disclaimer code is necessary. If submitting a multiple-page claim, indicate Medicare disclaimer codes on the first page of the claim. The following Medicare disclaimer codes may be used when appropriate.

Code	Description
M-7	Medicare disallowed or denied payment. This code applies when Medicare denies the claim for reasons related to policy (not billing errors), or the member's lifetime benefit, spell of illness, or yearly allotment of available benefits is exhausted. <i>For Medicare Part A, use M-7 in the following instances (all three criteria must be met):</i>

	<ul style="list-style-type: none"> • The provider is identified in ForwardHealth files as certified for Medicare Part A. • The member is eligible for Medicare Part A. • The service is covered by Medicare Part A but is denied by Medicare Part A due to frequency limitations, diagnosis restrictions, or exhausted benefits. <p><i>For Medicare Part B, use M-7 in the following instances (all three criteria must be met):</i></p> <ul style="list-style-type: none"> • The provider is identified in ForwardHealth files as certified for Medicare Part B. • The member is eligible for Medicare Part B. • The service is covered by Medicare Part B but is denied by Medicare Part B due to frequency limitations, diagnosis restrictions, or exhausted benefits.
M-8	<p>Noncovered Medicare service. This code may be used when Medicare was not billed because the service is not covered in this circumstance.</p> <p><i>For Medicare Part A, use M-8 in the following instances (all three criteria must be met):</i></p> <p>The provider is identified in ForwardHealth files as certified for Medicare Part A.</p> <p>The member is eligible for Medicare Part A.</p> <p>The service is usually covered by Medicare Part A but not in this circumstance (e.g., member's diagnosis).</p> <p><i>For Medicare Part B, use M-8 in the following instances (all three criteria must be met):</i></p> <p>The provider is identified in ForwardHealth files as certified for Medicare Part B.</p> <p>The member is eligible for Medicare Part B.</p> <p>The service is usually covered by Medicare Part B but not in this circumstance (e.g., member's diagnosis).</p>

Element 11 a — Insured's Date of Birth, Sex (not required)

Element 11b — Employer's Name or School Name (not required)

Element 11c — Insurance Plan Name or Program Name (not required)

Element 11d — Is There Another Health Benefit Plan? (not required)

Element 12 — Patient's or Authorized Person's Signature (not required)

Element 13 — Insured's or Authorized Person's Signature (not required)

Element 14 — Date of Current Illness, Injury, or Pregnancy (not required)

Element 15 — If Patient Has Had Same or Similar Illness (not required)

Element 16 — Dates Patient Unable to Work in Current Occupation (not required)

Element 17 — Name of Referring Provider or Other Source (required for evaluation & management [E&M] consultations and laboratory and radiology services only) (not required)

Element 17a (not required)

Element 17b — NPI (required for Medication Therapy Management benefit)

Enter the NPI of the prescribing provider that was contacted.

Element 18 — Hospitalization Dates Related to Current Services (not required)

Element 19 — Reserved for Local Use (not required)

If a provider bills an unlisted (or not otherwise classified) procedure code, a description of the procedure must be indicated in this element. If there is no more specific code available, the provider is required to submit the appropriate documentation, which could include a PA request, to justify use of the unlisted procedure code and to describe the procedure or service rendered.

Element 20 — Outside Lab? \$Charges (not required)

Element 21 — Diagnosis or Nature of Illness or Injury (not required)

Enter a valid *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis code for each symptom or condition related to the services provided. The required use of valid diagnosis codes includes the use of the most specific diagnosis codes. List the primary diagnosis first. Etiology ("E") and manifestation ("M") codes may not be used as a primary diagnosis. The diagnosis description is not required.

ForwardHealth accepts up to eight diagnosis codes. To enter more than four diagnosis codes:

- Enter the fifth diagnosis code in the space *between* the first and third diagnosis codes.
- Enter the sixth diagnosis code in the space *between* the second and fourth diagnosis codes.
- Enter the seventh diagnosis code in the space to the right of the third diagnosis code.
- Enter the eighth diagnosis code in the space to the right of the fourth diagnosis code.

When entering fifth, sixth, seventh, and eighth diagnosis codes, do not number the diagnosis codes (e.g., do not include a "5." before the fifth diagnosis code).

Family Planning Services

Indicate the appropriate ICD-9-CM diagnosis code from the V25 series for services and supplies that are only contraceptive management related.

Element 22 — Medicaid Resubmission (not required)

Element 23 — Prior Authorization Number (not required)

Element 24

The six service lines in Element 24 have been divided horizontally. Enter service information in the bottom, unshaded area of the six service lines. The horizontal division of each service line is not intended to allow the billing of 12 lines of service.

Element 24A-24G (shaded area)

These instructions apply to claims submitted for provider-administered drugs. National Drug Codes (NDCs) must be indicated in the shaded area of Elements 24A-24G. Providers may indicate up to two NDCs per completed service line. Each NDC must be accompanied by an NDC qualifier, unit qualifier, and units. To indicate an NDC, providers should do the following:

- Indicate the NDC qualifier "N4," followed by the 11-digit NDC, with no space in between.
- Indicate one space between the NDC and the unit qualifier.
- Indicate one unit qualifier (F2 [International unit], GR [Gram], ME [Milligram], ML [Milliliter], or UN [Unit]), followed by the NDC units, with no space in between. The NDC units should be recorded with an implied decimal three digits from the left; for example, to indicate a unit of "1," "1000" would be entered after the unit qualifier.
- If indicating two NDCs in a service line, separate the two "sets" of NDC data by three spaces.
- When submitting more than one NDC on a detail, providers are required to use Healthcare Common Procedure Coding System (HCPCS) service code J3490.

For example, two NDCs indicated in the shaded area of Elements 24A-24G would look like:

N412345678912 GR123678 N498765432198 UN67000

Element 24A — Date(s) of Service

Enter to and from dates of service (DOS) in MMDDYY or MMDDCCYY format. If the service was provided on only one DOS, enter the date under "From." Leave "To" blank or re-enter the "From" date.

If the service was provided on consecutive days, those dates may be indicated as a range of dates by entering the first date as the "From" DOS and the last date as the "To" DOS in MMDDYY or MMDDCCYY format.

A range of dates may be indicated only if the POS, the procedure code (and modifiers, if applicable), the charge, the units, and the rendering provider were identical for each DOS within the range.

Element 24B — Place of Service

Enter the appropriate two-digit place of service (POS) code for each item used or service performed.

Element 24C — EMG (not required)

Enter a "Y" for each procedure performed as an emergency. If the procedure was not an emergency, leave this element blank.

Element 24D — Procedures, Services, or Supplies

Enter the single most appropriate five-character procedure code. ForwardHealth denies claims received without an appropriate procedure code.

Modifiers

Enter the appropriate (up to four per procedure code) modifier(s) in the "Modifier" column of Element 24D.

Element 24E — Diagnosis Pointer

Enter the number(s) that corresponds to the appropriate ICD-9-CM diagnosis code(s) listed in Element 21. Up to four diagnosis pointers per detail may be indicated. Valid diagnosis pointers, digits 1 through 8, should not be separated by commas or spaces.

Element 24F — \$ Charges

Enter the total charge for each line item.

Enter the dollar amount right justified in the dollar area of the field. Do not use commas when reporting dollar amounts. Dollar signs should not be entered. Enter "00" in the cents area if the amount is a whole number.

Providers are to bill ForwardHealth their usual and customary charge. The usual and customary charge is the provider's charge for providing the same service to persons not entitled to ForwardHealth benefits.

Element 24G — Days or Units

Enter the number of days or units. Only include a decimal when billing fractions (e.g., 1.50).

Element 24H — EPSDT/Family Plan (not required)

Enter a "Y" for each family planning procedure. If family planning does not apply, leave this element blank.

Note: Providers should not use this element to indicate that a service is a result of a HealthCheck referral.

Element 24I — ID Qual (not required)

If the rendering provider's NPI is different from the billing provider number in Element 33a, enter a qualifier of "ZZ," indicating provider taxonomy, in the shaded area of the detail line.

Element 24J — Rendering Provider ID. # (not required)

If the rendering provider's NPI is different from the billing provider number in Element 33a, enter the rendering provider's 10-digit taxonomy code in the shaded area of this element and enter the rendering provider's NPI in the white area provided for the NPI.

Element 25 — Federal Tax ID Number (not required)

Element 26 — Patient's Account No. (not required)

Optional — Providers may enter up to 14 characters of the patient's internal office account number. This number will appear on the Remittance Advice (RA) and/or the 835 Health Care Claim Payment/Advice (835) transaction.

Element 27 — Accept Assignment? (not required)

Element 28 — Total Charge

Enter the total charges for this claim. If submitting a multiple-page claim, enter the total charge for the claim (i.e., the sum of all details from all pages of the claim) only on the last page of the claim.

Enter the dollar amount right justified in the dollar area of the field. Do not use commas when reporting dollar amounts. Dollar signs should not be entered. Enter "00" in the cents area if the amount is a whole number.

Element 29 — Amount Paid

Enter the actual amount paid by commercial health insurance. If submitting a multiple-page claim, indicate the amount paid by commercial health insurance only on the first page of the claim.

Enter the dollar amount right justified in the dollar area of the field. Do not use commas when reporting dollar amounts. Dollar signs should not be entered. Enter "00" in the cents area if the amount is a whole number.

If a dollar amount indicated in Element 29 is greater than zero, "OI-P" must be indicated in Element 9. If the commercial health insurance denied the claim, enter "000." Do not enter Medicare-paid amounts in this field.

Element 30 — Balance Due

Enter the balance due as determined by subtracting the amount paid in Element 29 from the amount in Element 28. If submitting a multiple-page claim, enter the balance due for the claim (i.e., the sum of all details from all pages of the claim minus the amount paid by commercial insurance) only on the last page of the claim.

Enter the dollar amount right justified in the dollar area of the field. Do not use commas when reporting dollar amounts. Dollar signs should not be entered. Enter "00" in the cents area if the amount is a whole number.

Element 31 — Signature of Physician or Supplier, Including Degrees or Credentials

The provider or authorized representative must sign in Element 31. The month, day, and year the form is signed must also be entered in MMDDYY or MMDDCCYY format.

Note: The signature may be a computer-printed or typed name and date or a signature stamp with the date.

Element 32 — Service Facility Location Information (not required)

Element 32a — NPI (not required)

Element 32b (not required)

Element 33 — Billing Provider Info & Ph #

Enter the name of the provider submitting the claim and the practice location address. The minimum requirement is the provider's name, street, city, state, and ZIP+4 code. Do not enter a Post Office Box or a ZIP+4 code associated with a PO Box. The practice location address entered must correspond with the NPI listed in Element 33a and match the practice location address on the provider's file maintained by ForwardHealth.

Element 33a — NPI

Enter the NPI of the billing provider.

Element 33b

Enter qualifier "ZZ" followed by the appropriate 10-digit provider taxonomy code on file with ForwardHealth. Do not include a space between the qualifier ("ZZ") and the provider taxonomy code.

Note: Providers should use qualifier "PXC" when submitting an electronic claim using the 837 Health Care Claim: Professional (837P) transaction. For further instructions, refer to the companion guide for the 837P transaction.

ATTACHMENT 4

Sample 1500 Health Insurance Claim Form for Intervention-Based Services

(The "Sample 1500 Health Insurance Claim Form for Intervention-Based Services" is located on the following pages.)

Sample 1500 Health Insurance Claim Form For Intervention-based Services

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

<input type="checkbox"/> PICA										PICA <input type="checkbox"/>	
1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK/LUNG <input type="checkbox"/> OTHER <input type="checkbox"/> (Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID#) (SSN or ID) (SSN) (ID)										1a. INSURED'S I.D. NUMBER (For Program in Item 1) 1234567890	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) MEMBER, IM A					3. PATIENT'S BIRTH DATE MM DD YY M <input checked="" type="checkbox"/> F <input type="checkbox"/> MM DD YY			4. INSURED'S NAME (Last Name, First Name, Middle Initial) SAME			
5. PATIENT'S ADDRESS (No., Street) 609 WILLOW ST					6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>			7. INSURED'S ADDRESS (No., Street)			
CITY ANYTOWN			STATE WI		8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>			CITY		STATE	
ZIP CODE 55555		TELEPHONE (Include Area Code) (444) 444-4444			Employed <input type="checkbox"/> Full-Time <input type="checkbox"/> Student <input type="checkbox"/> Part-Time <input type="checkbox"/>			ZIP CODE		TELEPHONE (Include Area Code) ()	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)					10. IS PATIENT'S CONDITION RELATED TO:			11. INSURED'S POLICY GROUP OR FECA NUMBER			
a. OTHER INSURED'S POLICY OR GROUP NUMBER					a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO			a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>			
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>					b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input type="checkbox"/> NO			b. EMPLOYER'S NAME OR SCHOOL NAME			
c. EMPLOYER'S NAME OR SCHOOL NAME					c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO			c. INSURANCE PLAN NAME OR PROGRAM NAME			
d. INSURANCE PLAN NAME OR PROGRAM NAME					10d. RESERVED FOR LOCAL USE			d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i>			
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.	
SIGNED _____ DATE _____										SIGNED _____	
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY			15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY			16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY					
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE IM A PROVIDER					17a. NPI 0111111110		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY				
19. RESERVED FOR LOCAL USE					20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.				
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. 250 . 01					23. PRIOR AUTHORIZATION NUMBER		24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. ICD-9-CM Family Plan I. ID. QUAL J. RENDERING PROVIDER ID. #				
1	9 15 12		01	99605		U1	1	XX XX	1	NPI	
2	9 15 12		01	99607		U1	1	XX XX	1	NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	
25. FEDERAL TAX I.D. NUMBER SSN EIN					26. PATIENT'S ACCOUNT NO. 1234JED		27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ XX XX	29. AMOUNT PAID \$	30. BALANCE DUE \$ XX XX
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) <i>J.M. Provider</i> SIGNED _____ DATE 09302012					32. SERVICE FACILITY LOCATION INFORMATION a. NPI		33. BILLING PROVIDER INFO & PH # () I.M. PROVIDER 1 W WILLIAMS ST ANYTOWN WI 55555-1234 a. 0222222220 b. ZZ123456789X				

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

CARRIER
PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION

ATTACHMENT 5

Comprehensive Medication Review and Assessment Documentation Example

(A copy of the “Comprehensive Medication Review and Assessment Documentation Example” is located on the following pages.)

COMPREHENSIVE MEDICATION REVIEW AND ASSESSMENT DOCUMENTATION EXAMPLE

SECTION I — MEMBER INFORMATION

Name — Member (Last, First, Middle Initial)

Ima M. Ember

Member Identification Number

0123456789

Is the member currently residing in a nursing home?

Yes

No

SECTION II — PHARMACY INFORMATION

Pharmacist Name Jane Doe

Pharmacist NPI 0333333330

Pharmacy Name: Doe Pharmacy

Pharmacy NPI 0222222222

SECTION III — COMPREHENSIVE MEDICATION REVIEW AND ASSESSMENT

Describe the need for the CMR/A: Member is taking 5 different medications for Hypertension and Dyslipidemia; adherence is questionable

Does the member have other insurance?

Yes No

Is the member covered by the other insurance MTM Services?

Yes No

The patient meets the following criteria (check all that apply):

Take four or more prescription medications to treat or prevent two or more chronic conditions. Chronic conditions include at least one of the following:

Hypertension

Asthma

Chronic Kidney Disease

Congestive Heart Failure

Dyslipidemia

COPD

Depression

Have Diabetes

Coordination of care issue identified due to multiple prescribers

Discharge from the hospital or long term care setting within the past 14 days

Experience health literacy issues as determined by the pharmacist

Prescriber referral

Other referral

Date of CMR/A

10/15/2012

Member consent obtained? Yes

No

SIGNATURE — Member

Im A. Member

Date Signed

9/1/2012

Override Approved? Yes

No

SECTION II — SERVICE PERFORMED

Type of Service

 Initial Assessment Date 10/15/2012 Follow-Up Assessment (1) Date _____ (2) Date _____ (3) Date _____

Describe what was discussed in the CMR/A. The dosing Schedule and reasons for taking each medication was discussed with the member.
Barriers to adherence were also discussed, and the member has agreed to use a pill reminder.

Start Time 1:00 p.m.	End Time 1:45 p.m.	Total Time Spent on Service (In Minutes) 45 minutes
SIGNATURE — Pharmacist Jane Doe		Date Signed 10/15/2012

ATTACHMENT 6

Sample 1500 Health Insurance Claim Form for Comprehensive Medication Reviews and Assessments

(A copy of the "Sample 1500 Health Insurance Claim Form for Comprehensive Medication Reviews and Assessments" is located on the following pages.)

ATTACHMENT 7

Pharmacy Terms of Reimbursement

(A copy of the "Pharmacy Terms of Reimbursement" is located on the following pages.)



FORWARDHEALTH

PROVIDER SERVICES
313 BLETTNER BLVD
MADISON WI 53784

Scott Walker
Governor

Dennis G. Smith
Secretary

State of Wisconsin

Department of Health Services

Telephone: 800-947-9627
TTY: 711 or 800-947-3529

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PHARMACY TERMS OF REIMBURSEMENT

The Department of Health Services (DHS) will establish maximum allowable fees for all covered pharmaceutical items, disposable medical supplies (DMS), and Medication Therapy Management (MTM) services provided to Wisconsin Medicaid members eligible on the date of service. Maximum allowable fees may be adjusted to reflect reimbursement limits or limits on the availability of federal funding as specified in federal law (42 CFR s. 447.512).

All covered legend and over-the-counter drugs will be reimbursed at the lower of the Estimated Acquisition Cost (EAC) of the drug, plus a dispensing fee, or the provider's usual and customary charge.

The EAC of legend drugs, over-the-counter drugs, and diabetic supplies will be determined based on the following.

The DHS' best estimate of prices currently and generally paid for pharmaceuticals. Individual drug cost estimates will be based on either state Maximum Allowed Cost (state MAC), the expanded Maximum Allowed Cost (expanded MAC), or published wholesale acquisition cost.

Drug costs will be calculated based on the package size from which the prescription was dispensed, as indicated by the National Drug Code. The only exceptions are those drugs for which quantity minimums are specified by federal regulations and those drugs listed on the Wisconsin state MAC list.

The maximum allowable dispensing fee shall be based on allowed pharmacy overhead costs and determined by various factors, including data from previous cost of dispensing surveys, the Wisconsin state legislature's Medicaid budgetary constraints, and other relevant economic limitations.

The maximum allowable fees for DMS and MTM services shall be established upon a review of various factors. These factors include a review of usual and customary charges submitted to Wisconsin Medicaid; cost, payment, and charge information from companies that provide DMS and MTM services; Medicaid payment rates from other states; and the current Medicare fee schedule. Other factors taken into consideration include the Wisconsin state legislature's Medicaid budget constraints, limits on the availability of federal funding as specified in federal law, and other relevant economic and reimbursement limitations. Maximum allowable fees may be adjusted periodically.

Providers are required to bill their usual and customary charges for pharmaceutical items and for DMS and MTM services provided. The usual and customary charge is the amount charged by the provider for the same service when provided to non-Medicaid patients. Covered services shall be reimbursed at the lower of the provider's usual and customary charge or the maximum allowable fee established by the DHS. For providers using a sliding fee scale for specific services, the usual and customary charge is the median of the individual provider's charge for the service when provided to non-Medicaid patients.

Wisconsin Medicaid reimbursement, less appropriate copayments and payments by other insurers, will be considered to be payment in full.

The DHS will adjust payments made to providers to reflect the amounts of any allowable copayments that the providers are required to collect pursuant to ch. 49, Wis. Stats.

Payments for deductible and coinsurance payable on an assigned Medicare claim shall be made in accordance with s. 49.46(2)(c), Wis. Stats.

In accordance with federal regulations contained in 42 CFR 447.205, the DHS will provide public notice in advance of the effective date of any significant proposed change in its methods and standards for setting maximum allowable fees for services.

F-01518 (09/12)