Medical Assistance Provider Bulletin

Attention: All Title XIX Certified Pharmacies, Dispensing Physicians, Blood Banks, Personal Care Providers, and Electronic Billing Services

Subject: Claim Submission Limit on Drug Claims

Date: December 20, 1993
Code: MAPB-093-055-H

**Department of Health and Social Services, Division of Health,
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I. *INTRODUCTION*

This Medical Assistance Provider Bulletin (MAPB) is a follow up to MAPB-093-053-H dated October 1, 1993, which described the Wisconsin Medical Assistance Program's (WMAP) implementation of a drug claim submission limit policy.

Please review this information carefully and share it immediately with your billing staff or the billing service that submits your WMAP paper or electronic drug claims. A copy of this MAPB is also being sent to WMAP-certified electronic billing services.

Many providers have expressed concerns about this policy which addresses the volume of drug claims and the manner in which they are submitted. The WMAP wishes to keep the policy easy to understand and implement, by limiting drug claim submissions to one per calendar week (Sunday through Saturday), per recipient, per provider, yet allow efficient billing for providers.

Although the basic drug claim submission limit policy will remain unchanged, the WMAP recognizes the following concerns:

- A calendar week does not always coincide with a provider's billing period (e.g., Friday through Thursday, biweekly, monthly)
- The end of a monthly billing period rarely falls on a Saturday
- Some drugs must be billed to other insurance prior to billing the WMAP, which results in delayed claim submission
- Compounded drugs, which must be billed on paper claims, create a problem if a provider bills electronically and more than compound drugs are dispensed during the week
- There is only room for one prior authorization number on a drug claim.

As a result of these concerns, the WMAP has modified one of the exceptions to the claim submission policy, added another exception, and identified three more situations in which a second claim can be submitted during the calendar week (Sunday through Saturday).

II. *EXEMPTIONS TO THE CLAIM SUBMISSION LIMIT POLICY*

The exemptions to the claim submission limit policy are:

- Each claim which includes one detail for a drug requiring prior authorization. This is a **modification** to a current exemption to the claim submission limit policy.
- Each claim which includes one or more details for compounded drugs. This is an **additional** exemption to the claim submission limit policy.
- Each claim which includes one or more details with a variance ("V-Y") indicator. This is a **current** exemption to the claim submission limit policy and remains unchanged.

Note: If a provider submits a claim that qualifies for an exemption, the provider may submit as many claims per calendar week as the number of exemptions. However, providers are encouraged to combine details on claims, to the extent possible, in order to minimize the number of claims submitted.

III. *ALLOWABLE SITUATIONS FOR A SECOND CLAIM SUBMISSION*

In addition, the WMAP allows a second claim in a calendar week (Sunday through Saturday) in the following five situations:

- If more than six products are dispensed during a calendar week and a provider submits paper claims, then two or more paper claims may be submitted for a calendar week. However, each claim must have all six details completed except for the last claim submitted. This is **current** policy and remains unchanged.

- If more than 25 products are dispensed during a calendar week and a provider submits electronic claims, then two or more electronic claims may be submitted for a calendar week. However, each claim must have all 25 details completed except for the last claim submitted. This is **current** policy and remains unchanged.

- If a pharmacy or vendor's weekly billing cycle is different than Sunday through Saturday, and additional drug products or supplies are dispensed to the same recipient after the end of the provider's billing period, a second claim may be submitted for the additional products. However, providers are encouraged to bill these services with the claim for the next weekly billing period. This is an **additional** situation in which the WMAP allows two claims in a calendar week.

- If a monthly biller needs to bill a second time because a month ends on any day other than Saturday, then a second claim may be submitted for services provided after the end of the providers billing period. However, providers are encouraged to bill these services with the claim for the next monthly billing period. This is an **additional** situation in which the WMAP allows two claims in a calendar week.

- If one or more details on a claim needs to be submitted for other insurance payment prior to submitting to the WMAP, a provider may submit one claim to the WMAP for the services which are not covered by other insurance, and a second claim may be submitted for the calendar week after the other insurance has processed the claim. This is an **additional** situation in which the WMAP allows two claims in a calendar week.

A provider may define their own billing period, as long as the billing period is greater than or equal to **one week** (e.g., monthly). When defining their own billing period, a provider **must** submit no more than one claim per week, per recipient except for the situations listed above.

Note: If a provider submits a claim that qualifies for submission of a second claim in a calendar week, only one claim may be submitted per calendar week in addition to the original claim. Additional details can only be reimbursed by adjusting a previously paid claim. For example, if a provider uses a billing week other than Sunday through Saturday, a second claim may be submitted for the week. However, if services are provided which require billing other insurance, the provider must submit an Adjustment Request Form in order to be reimbursed. A provider may not submit these details as a third claim for that week.

VI. *PROVIDER FOLLOW-UP*

Providers are reminded that an Adjustment Request Form must be submitted to EDS for reimbursement of services not billed on the original claim (except for the situations listed in Section III of this MAPB), or for reimbursement of denied details on a partially paid claim. Claims which are totally denied must be corrected and resubmitted for payment. An Adjustment Request form which is submitted for a totally denied claim is denied. Refer to Appendices 27 and 27a of Part A of the WMAP Provider Handbook for information on submitting an Adjustment Request Form. Refer to Attachment 1 of this MAPB for a sample Adjustment Request Form.