Pharmacy

Covered Services and Reimbursement

ARCHIVAL USE ONLY
Refer to the Online Handbook for current policy

wisconsin Medicaid and BadgerCare
Wisconsin Medicaid and BadgerCare Information for Providers

Department of Health and Family Services

Pharmacy Quick-Reference Page

Pharmacy Point-of-Sale (POS) Correspondents

For questions regarding Medicaid policies and billing, please call:
(800) 947-9627 or (608) 221-9883; select "2" when prompted.

Hours available: 8:30 a.m. to 6:00 p.m. Monday, Wednesday, Thursday, and Friday.
9:30 a.m. to 6:00 p.m. Tuesday.
Not available on weekends or holidays.

Clearinghouse, Switch, or Value-Added Network (VAN) Vendors

For transmission problems, call your switch, VAN, or clearinghouse vendor:

- Healtheon/WebMD switching services: (800) 433-4893.
- Envoy switching services: (800) 333-6869.
- National Data Corporation switching services: (800) 388-2316.
- QS1 Data Systems switching services: (864) 503-9455 ext. 7837.

Electronic Media Claims (EMC) Help Desk

For any questions regarding EMC (tape, modem, and interactive software), please call:
(608) 221-4746 Ext. 3037 or 3041.

Hours available: 8:30 a.m. to 4:30 p.m. Monday through Friday.
Not available on weekends or holidays.

Wisconsin Medicaid Web Site

www.dhfs.state.wi.us/medicaid/

- Pharmacy handbook, replacement pages, and *Wisconsin Medicaid and BadgerCare Updates* on-line and available for viewing and downloading.
- Pharmacy POS information.

Fax Number for Prior Authorization (PA)

(608) 221-8616

Paper PA requests may be submitted by fax.

Specialized Transmission Approval Technology — PA (STAT-PA) System Numbers

For PCs:
(800) 947-4947
(608) 221-1233
Available from 8:00 a.m. to 11:45 p.m., seven days a week.

For touch-tone telephones:
(800) 947-1197
(608) 221-2096
Available from 8:00 a.m. to 11:45 p.m., seven days a week.

For the Help Desk:
(800) 947-1197
(608) 221-2096
Available from 8:00 a.m. to 6:00 p.m., Monday through Friday, excluding holidays.

Important Telephone Numbers

Wisconsin Medicaid's Eligibility Verification System (EVS) is available through the following resources to verify checkwrite information, claim status, prior authorization status, provider certification, and/or recipient eligibility.

Service	Information available	Telephone number	Hours
Automated Voice Response (AVR) System (Computerized voice response to provider inquiries.)	Checkwrite Info. Claim Status Prior Authorization Status Recipient Eligibility*	(800) 947-3544 (608) 221-4247 (Madison area)	24 hours a day/ 7 days a week
Personal Computer Software and Magnetic Stripe Card Readers	Recipient Eligibility*	Refer to Provider Resources section of the All-Provider Handbook for a list of commercial eligibility verification vendors.	24 hours a day/ 7 days a week
Provider Services (Correspondents assist with questions.)	Checkwrite Info. Claim Status Prior Authorization Status Provider Certification Recipient Eligibility*	(800) 947-9627 (608) 221-9883	Policy/Billing and Eligibility: 8:30 a.m. - 4:30 p.m. (M, W-F) 9:30 a.m. - 4:30 p.m. (T) Pharmacy/DUR: 8:30 a.m. - 6:00 p.m. (M, W-F) 9:30 a.m. - 6:00 p.m. (T)
Direct Information Access Line with Updates for Providers (Dial-Up) (Software communications package and modem.)	Checkwrite Info. Claim Status Prior Authorization Status Recipient Eligibility*	Call (608) 221-4746 for more information.	7:00 a.m. - 6:00 p.m. (M-F)
Recipient Services (Recipients or persons calling on behalf of recipients only.)	Recipient Eligibility Medicaid-Certified Providers General Medicaid Information	(800) 362-3002 (608) 221-5720	7:30 a.m. - 5:00 p.m. (M-F)

*Please use the information exactly as it appears on the recipient's identification card or EVS to complete the patient information section on claims and other documentation. Recipient eligibility information available through EVS includes:

- Dates of eligibility.
- Medicaid managed care program name and telephone number.
- Privately purchased managed care or other commercial health insurance coverage.
- Medicare coverage.
- Lock-In Program status.
- Limited benefit information.

Table of Contents

Preface

The Wisconsin Medicaid and BadgerCare Pharmacy Handbook is issued to pharmacy providers who are Wisconsin Medicaid certified. It contains information that applies to *fee-for-service* Medicaid providers. The Medicaid information in the handbook applies to both Medicaid and BadgerCare.

Wisconsin Medicaid and BadgerCare are administered by the Department of Health and Family Services (DHFS). Within the DHFS, the Division of Health Care Financing (DHCF) is directly responsible for managing Wisconsin Medicaid and BadgerCare. BadgerCare extends Medicaid coverage to uninsured children and parents with incomes at or below 185% (as of January 2001) of the federal poverty level and who meet other program requirements. BadgerCare recipients receive the same health benefits as Wisconsin Medicaid recipients and their health care is administered through the same delivery system.

Medicaid and BadgerCare recipients enrolled in state-contracted HMOs are entitled to at least the same benefits as fee-for-service recipients; however, HMOs may establish their own requirements regarding prior authorization, billing, etc. If you are an HMO network provider, contact your managed care organization regarding its requirements. Information contained in this and other Medicaid publications is used by the DHCF to resolve disputes regarding covered benefits that cannot be handled internally by HMOs under managed care arrangements.

Verifying Eligibility

Wisconsin Medicaid providers should always verify a recipient's eligibility before providing services, both to determine eligibility for the current date and to discover any limitations to the recipient's coverage. Wisconsin Medicaid's Eligibility Verification System (EVS) provides eligibility information that providers can access a number of ways.

Refer to the Important Telephone Numbers page at the beginning of this section for detailed information on the methods of verifying eligibility. If you are billing a pharmacy claim through real-time Point-of-Sale (POS), eligibility verification is part of the claims submission process.

Handbook Organization

The Pharmacy Handbook consists of the following sections:

- Claims Submission.
- Covered Services and Reimbursement.
- Drug Utilization Review and Pharmaceutical Care.
- Pharmacy Data Tables.
- Prior Authorization.

In addition to the Pharmacy Handbook, each Medicaid-certified provider is issued a copy of the All-Provider Handbook. The All-Provider Handbook includes the following subjects:

- Claims Submission.
- Coordination of Benefits.
- Covered and Noncovered Services.
- Prior Authorization.
- Provider Certification.
- Provider Resources.
- Provider Rights and Responsibilities.
- Recipient Rights and Responsibilities.

Legal Framework of Wisconsin Medicaid and BadgerCare

The following laws and regulations provide the legal framework for Wisconsin Medicaid and BadgerCare:

Federal Law and Regulation

- Law: United States Social Security Act; Title XIX (42 US Code ss. 1396 and following) and Title XXI.
- Regulation: Title 42 CFR Parts 430-456 — Public Health.

Wisconsin Law and Regulation

- Law: Wisconsin Statutes: Sections 49.43-49.497 and 49.665.
- Regulation: Wisconsin Administrative Code, Chapters HFS 101-108.

Handbooks and *Wisconsin Medicaid and BadgerCare Updates* further interpret and implement these laws and regulations.

Handbooks and *Updates*, maximum allowable fee schedules, helpful telephone numbers and addresses, and much more information about Wisconsin Medicaid and BadgerCare are available at the following Web sites:

www.dhfs.state.wi.us/medicaid
www.dhfs.state.wi.us/badgercare

Medicaid Fiscal Agent

The DHFS contracts with a fiscal agent, which is currently EDS, to provide health claims processing, communications, and other related services.

General Information

Scope of Service

The policies in the Pharmacy Handbook govern services provided within the scope of the profession's practice as defined in the Wisconsin Statutes and the Wisconsin Administrative Code.

For Wisconsin Medicaid certification for dispensing pharmaceuticals, the provider must be currently licensed by the Wisconsin Department of Regulation and Licensing.

Provider Certification

For Wisconsin Medicaid certification for dispensing pharmaceuticals, the provider must currently be licensed by the Wisconsin Department of Regulation and Licensing in one or both of the following ways:

- As a pharmacy, currently meeting all requirements in chapters 450 and 961, Wis. Stats., chapters Phar 1 through 14 and chapters CSB 1 and 2, Wis. Admin. Code.
- As a physician, currently licensed to practice medicine and surgery according to sections 448.05 and 448.07, Wis. Stats., and chapters Med 1, 2, 3, 4, 5, and 14, Wis. Admin. Code.

For general information on applying for Wisconsin Medicaid certification, please refer to the Provider Certification section of the All-Provider Handbook.

Pharmacies

Pharmacies may dispense disposable medical supplies (DMS) and durable medical equipment (DME) in addition to drugs without separate certification. Refer to the DME Handbook as well as the DME and DMS Indices for all DME and DMS covered services, prior authorization (PA) guidelines, and billing instructions. In addition to receiving publications for pharmacy services, Medicaid-certified pharmacy providers automatically receive all publications regarding DME and DMS services.

Pharmacies that change ownership or locations are required to notify Wisconsin Medicaid's Provider Maintenance Unit of all changes, including a new license number. (Refer to the Provider Certification section of the All-Provider Handbook for further information on change of address and status.) When pharmacies have multiple locations, *each* location with a unique license number must have its own Medicaid certification and provider number.

Dispensing Physicians

Dispensing physicians, as part of their usual and customary professional services, may dispense drug products to their patients.

Dispensing physicians must comply with all the related limitations and service requirements in this handbook.

Clarifying the Terms "Dispensing Physician," "Pharmacist," and "Pharmacy Provider"

- *Dispensing physician* is a physician who dispenses medication to patients and bills Wisconsin Medicaid. These medications must be dispensed according to pharmacy dispensing rules. This does not include giving "samples."
- *Pharmacist* is an individual licensed as such under ch. 450, Wis. Stats. Wisconsin Medicaid does not certify individual pharmacists.
- *Pharmacy Provider* is any Wisconsin Medicaid-certified pharmacy or dispensing physician billing Wisconsin Medicaid for pharmacy services.

Pharmacy Providers

Detailed information about the responsibilities as a Medicaid-certified provider can be found in the Provider Rights and Responsibilities section of the All-Provider Handbook. Refer to that section for information about the following:

- Fair treatment of the recipient.
- Recipient requests for noncovered services.
- Services rendered to a recipient during periods of retroactive eligibility.
- Grounds for provider sanctions.
- Additional state and federal requirements.

Recipient Information

Medicaid Identification Cards

Wisconsin Medicaid recipients receive a Medicaid ID card upon initial enrollment into Wisconsin Medicaid.

Medicaid ID cards may be in any of the following formats:

- Blue plastic Forward cards.
- Green temporary paper cards.
- Beige Presumptive Eligibility paper cards.

The Forward card is a plastic magnetic stripe identification card that enables providers to verify eligibility.

When green temporary paper cards or beige presumptive eligibility paper cards are presented, providers should accept these cards for the dates on the cards that indicate when the recipient is eligible. Wisconsin Medicaid encourages providers to keep photocopies of paper cards.

Eligibility Verification

Possession of a Medicaid ID card does not guarantee eligibility. Wisconsin Medicaid providers should *always* verify a recipient's eligibility before providing services, both to determine eligibility for the current date and to discover any limitations to the recipient's coverage. Keep in mind when verifying eligibility with the temporary card or the presumptive eligibility card that eligibility may not be on file right away; the information should be accessible within 7-10 days.

Refer to the Claims Submission section of this handbook for information on eligibility verification and the claims submission process.

Special Recipient Programs

Wisconsin Medicaid Managed Care Program Coverage

Wisconsin Medicaid fee-for-service denies claims submitted for services covered by a recipient's Medicaid-contracted managed care program.

Refer to the Wisconsin Medicaid Managed Care Guide's provider section for additional information regarding managed care program noncovered services, emergency services, and hospitalizations.

Recipient Lock-In Program

If Wisconsin Medicaid determines that a recipient is abusing use of the Medicaid ID card or benefits, Wisconsin Medicaid may restrict the recipient's access to services by assigning the recipient to the Recipient Lock-In Program.

Wisconsin Medicaid only reimburses designated health care providers in lock-in situations; it may reimburse other providers if the services were provided during an emergency or with a referral from the designated health care provider. Refer to the Recipient Rights and Responsibilities section of the All-Provider Handbook for more information about restricted benefit categories and other eligibility issues, such as lock-in status.

Wisconsin Medicaid providers should *always* verify a recipient's eligibility before providing services, both to determine eligibility for the current date and to discover any limitations to the recipient's coverage.

Providers are required to notify the Division of Health Care Financing (DHCF) regarding suspected cases of recipient misuse or abuse of Wisconsin Medicaid benefits. Notification may be made by telephoning or by writing to:

Division of Health Care Financing
Bureau of Health Care Program Integrity
P.O. Box 309
Madison, WI 53701-0309

Telephone: (800) 947-9627
(608) 221-9883

Wisconsin Medicaid automatically deducts applicable copayment amounts from Medicaid payments.

Refer to the Drug Utilization Review and Pharmaceutical Care section of this handbook for further information on the Recipient Lock-In Program.

Hospice

As defined in HFS 101.03(75m), Wis. Admin. Code, a hospice is a licensed public agency, a private organization, or a subdivision of either that primarily provides palliative care to persons experiencing the last stages of terminal illness and that provides supportive care for the family and other individuals caring for the terminally ill persons.

Hospice recipients usually receive care from one hospice and one physician. Their prescriptions may be filled at any Medicaid-certified pharmacy.

Hospices are required to pay for medications *directly* related to the terminal illness, such as narcotics for pain management. Pharmacies should bill these medications directly to the hospice. Medications not directly related to the terminal illness (such as blood pressure medications) should be billed as you would bill other drugs to Wisconsin Medicaid. Refer to the Claims Submission section of this handbook for more information on claims submission processes.

Spenddown

Occasionally an individual with significant medical bills meets all Wisconsin Medicaid requirements except those pertaining to income. These individuals are required to "spenddown" their income to meet Wisconsin Medicaid's financial requirements.

The certifying agency calculates the individual's Medicaid spenddown (or deductible) amount, tracks all medical costs the individual incurs, and determines when the medical costs have satisfied the spenddown amount. (A medical service does not have to be *paid* by the individual to be considered as payment toward satisfying the spenddown amount.)

For more information on spenddown, refer to the Recipient Rights and Responsibilities section of the All-Provider Handbook.

Copayments

Except as noted under "Copayment Exemptions," recipients are responsible for paying part of the costs involved in obtaining pharmacy services, DMS, and DME. Most legend and over-the-counter (OTC) drugs are subject to a recipient copayment amount. Wisconsin Medicaid automatically deducts applicable copayment amounts from Medicaid payments. Pharmacies should not reduce the billed amount of a claim by the amount of recipient copayments or record any dollar amount in the "Patient Paid" field for real-time claims submission.

The Medicaid copayment amount for legend drugs is $1.00 for each new or refilled prescription, up to a maximum copayment amount of $5.00 per recipient, per provider, per calendar month. The Medicaid copayment amount for OTC drugs (excluding iron supplements for pregnant or lactating women) is $0.50 for each new or refilled prescription.

For OTC drugs, DMS, and DME, there is no limitation on the total amount of copayment a recipient may be required to pay in a calendar month.

For DME and DMS, including enteral nutrition products, Wisconsin Medicaid bases copayments for each procedure code on its maximum allowable fee. The copayment amount for urine and blood glucose test strips remains $0.50.

Copayment Exemptions

Copayment exemptions include the following:

- Emergency services.
- Family planning services and related supplies.
- Services provided to nursing facility residents.
- Services provided to recipients under 18 years of age.
- Services provided to pregnant women if the services are pregnancy-related.
- Services provided to enrollees of a Medicaid HMO or special managed care program.
- Pharmaceutical Care dispensing fee.

All providers who perform services that require recipient copayment must make a reasonable attempt to collect that copayment from the recipient. However, providers may not deny services to a recipient for failing to make a copayment.

Copayments: Prescriptions, Disposable Medical Supplies, and Durable Medical Equipment

Prescriptions

• Over-the-counter drugs, each prescription (no monthly limit):	$0.50
• All legend drugs, each new and refilled prescription:	$1.00

Legend drugs, no more than $5.00 per month, per recipient, at each pharmacy.

Disposable Medical Supplies and Durable Medical Equipment

• Based on maximum allowable fees:	
√ Up to $10.00	$0.50
√ From $10.01 to $25.00	$1.00
√ From $25.01 to $50.00	$2.00
√ Over $50.00	$3.00
• Urine or blood test strips (per date of service):	$0.50

All providers who perform services that require recipient copayment must make a reasonable attempt to collect that copayment from the recipient. However, providers may not deny services to a recipient for failing to make a copayment.

Covered Drugs and Services

Wisconsin Medicaid covers most legend drugs and a limited number of over-the-counter (OTC) drugs.

Wisconsin Medicaid will cover only the legend drug products of manufacturers who have signed an annual rebate agreement with the federal Health Care Financing Administration.

Legend Drugs

As defined under HFS 101.03(94), Wis. Admin. Code, a legend drug is any drug that requires a prescription under federal code 21 USC 353(b). Legend drugs are covered by Wisconsin Medicaid when:

- The drug is approved by the Food and Drug Administration (FDA) and is not on the Negative Formulary List.
- The manufacturer has signed the federal rebate agreement for the drug.
- The manufacturer has reported the drug information to First DataBank.

Some drugs covered by Wisconsin Medicaid may require prior authorization (PA), and others require an appropriate diagnosis code for reimbursement. Refer to Appendices 2 and 3 of this section for lists of Wisconsin Medicaid covered drugs, including PA and diagnosis-restricted drugs. Also refer to the Prior Authorization section of this handbook for more information on PA.

Drug Rebate Agreement

Wisconsin Medicaid uses an open formulary for legend drug products with few restrictions. According to the federal Omnibus Budget Reconciliation Act of 1990 (OBRA '90), pharmaceutical manufacturers who choose to participate in state Medicaid programs must sign an annual rebate agreement with the federal Health Care Financing Administration (HCFA). Wisconsin Medicaid will cover only the legend drug products of manufacturers who have signed this rebate agreement. Non-participating manufacturers have the option of signing a rebate agreement that is effective the following quarter.

Manufacturer rebates are based on Medicaid claims data showing the quantity of each National Drug Code (NDC) dispensed to Medicaid recipients. Manufacturers may dispute the payment of drug rebates because they believe the utilization data reported to them is inaccurate. To resolve disputes, Wisconsin Medicaid verifies utilization data by having individual providers check the accuracy of claims information they submitted.

Refer to the Pharmacy Data Tables section of this handbook for a list of manufacturers with current rebate agreements and a list of noncovered NDCs and the reasons that manufacturers will not pay rebates on these NDCs.

Additional Coverage of Legend Drugs

Wisconsin Medicaid may cover certain legend drugs through the paper PA process even though their manufacturers did not sign rebate agreements. Refer to the Prior Authorization section of this handbook for special instructions to be followed when requesting PA for these drugs.

New National Drug Codes

Wisconsin Medicaid automatically adds an NDC of a new legend drug to the Medicaid drug file if it meets Medicaid guidelines and is produced by a manufacturer participating in the drug rebate program.

Noncovered Legend Drugs

Noncovered legend drugs include the following:

- *Rebate Refused:* the manufacturer has refused to sign a rebate agreement with HCFA.
- *Wisconsin Negative Formulary:* Wisconsin Medicaid has determined that the drug has little therapeutic value, is not medically necessary, or is not cost-effective.
- *Negative Drug List:* drugs listed include the following:
  - √ Less-than-effective (LTE) drugs as defined by the FDA.
  - √ Experimental or other drugs that have no medically-accepted indications.

Refer to Appendix 6 of this section for a full list of noncovered legend drugs.

Over-the-Counter Drugs

Wisconsin Medicaid covers the *generic* products of specific categories of OTC drugs from manufacturers who have signed rebate agreements with HCFA (as required by OBRA '90). In addition, Wisconsin Medicaid covers *all* brands of insulin, ophthalmic lubricants, and contraceptive products. All OTC drugs require legal prescriptions in order to be covered by Wisconsin Medicaid.

As per s. 49.46(2)(b)(6)(i), Wis. Stats., Wisconsin Medicaid covers the following classes of OTC drugs:

- Aspirin, acetaminophen, and ibuprofen (however, combination products including those that contain caffeine or buffering agents are not covered).
- Antacids.
- Antibiotic ointments.
- Contraceptive products.
- Cough syrup with codeine.*
- Cough syrup with dextromethorphan.*
- Cough syrup, plain expectorant.*
- Diphenhydramine.
- Hydrocortisone creams.
- Insulin.
- Iron supplements for pregnant women (and for a 60-day period beyond the end of pregnancy).
- Lice-control products.
- Meclizine.
- Ophthalmic lubricants.
- Pseudoephedrine.
- Therapeutic electrolyte replacement solutions.
- Topical antifungals.
- Vaginal antifungals.

**Note:* Wisconsin Medicaid limits coverage of cough syrups to products that treat only coughs and does not include multiple ingredient cough/cold combination products.

Refer to Appendix 2 of this section for more information on Medicaid-covered and noncovered OTC drugs. To request an addition of an NDC to the list of covered OTCs, complete Appendix 1 of this section.

Compound Drugs

Wisconsin Medicaid covers a particular compound drug only when the compound drug prescription:

- Contains more than one ingredient.
- Contains at least one Medicaid-covered drug.
- Does not contain any drug listed on the Medicaid LTE Drug List, or any equivalent or similar drug.
- Does not result in drug combinations that FDA considers LTE. For example, a topical compound drug is considered LTE if it combines any two of the following: a steroid, an antibiotic, or an antifungal agent.

Wisconsin Medicaid does not cover a compound drug prescription intended for a therapeutic use if the FDA does not approve the therapeutic use of the combination.

Wisconsin Medicaid covers the *generic* products of specific categories of over-the-counter drugs from manufacturers who have signed rebate agreements with HCFA.

Clozapine Management

Clozapine (Clozaril) is an antipsychotic drug that is indicated for the management of severely ill schizophrenic patients who fail to respond adequately to standard antipsychotic treatment. Food and Drug Administration regulations require that clozapine be made available only when there is a system in place to monitor white blood cell counts.

Conditions For Coverage of Clozapine Management

Wisconsin Medicaid provides reimbursement for clozapine management services if specific requirements are met. Clozapine management is a specialized care management service that may be required to ensure the safety of recipients who are using clozapine. Wisconsin Medicaid may separately reimburse physicians and pharmacies for clozapine management services when all of the conditions listed in Appendix 4 of this section are met.

Home intravenous (IV) injections and total parenteral nutrition (TPN) solution, including lipids, are covered and reimbursed as compounds.

Home Infusion

Home intravenous (IV) injections and total parenteral nutrition (TPN) solution, including lipids, are covered and reimbursed as compounds. Supplies and equipment, such as infusion pumps associated with the IV, may be separately reimbursable. Refer to the Claims Submission section of this handbook for TPN claims submission instructions. Also refer to the Durable Medical Equipment Index and the Disposable Medical Supplies Index for limitations and PA requirements for supplies and equipment.

HealthCheck "Other Services"

As a result of the Omnibus Budget Reconciliation Act of 1989 (OBRA`89), Wisconsin Medicaid considers requests for coverage of medically necessary pharmacy services that are not specifically listed as covered services, or that are listed under "Noncovered Services" in the Pharmaceutical Procedures chapter of this section, when all of the following conditions are met:

- The recipient is under 21 years of age.
- The provider verifies that a comprehensive HealthCheck screening has been performed within the previous 365 days.
- The service is allowed under the Social Security Act as a "medical service."
- The service is medically necessary and reasonable to correct or improve a condition or defect.
- The service is noncovered under the current Medicaid State Plan.
- A service covered by Wisconsin Medicaid is not appropriate to treat the identified condition.

All requests for HealthCheck "Other Services" require PA, except for those drug categories listed under "Covered Drugs - Over-the-Counter Drugs (HealthCheck "Other Services")" in Appendix 2 of this section. In addition, the drug categories listed in the Wisconsin Medicaid HealthCheck "Other Services" Drug List are covered without PA if the pharmacy documents that the recipient received a comprehensive HealthCheck screening within one year prior to the date on the prescription.

Refer to the Pharmacy Data Tables section of this handbook for the HealthCheck "Other Services" drug list. Also refer to the Prior Authorization section for information on requesting PA for HealthCheck "Other Services."

Pharmaceutical Procedures

Prescribing Providers

The prescriber must write the prescription or the pharmacist must take the prescription verbally or electronically from the prescriber.

Wisconsin Medicaid covers *medically necessary* legend drugs and certain over-the-counter (OTC) drugs identified in the Medicaid Drug File. Only certain licensed health professionals may prescribe legend drugs and OTC drugs according to HFS 107.10(1), Wis. Admin. Code. The professional must be authorized by Wisconsin Statutes or Wisconsin Administrative Code to prescribe legend and/or OTC drugs.

Prescribers may only prescribe items that are within their scope of practice. The following categories of licensed health professionals may prescribe covered legend drugs and OTC drugs:

- Dentist.
- Doctor of Medicine.
- Doctor of Osteopathy.
- Advanced Practice Nurse Prescriber.
- Optometrist.
- Physician assistant.
- Podiatrist.

Prescription Requirements

Except as otherwise provided in federal or state law, either the prescriber must write the prescription or the pharmacist must take the prescription verbally or electronically from the prescriber. The prescription must include the following:

- The name, strength, and quantity of the drug or item prescribed.
- The date of issue of the prescription.
- The prescriber's name and address.
- The recipient's name and address.
- The prescriber's signature (if the prescriber writes the prescription).
- The directions for use of the prescribed drug or item.

If the pharmacist takes the prescription verbally from the prescriber, the pharmacist must generate a hard copy. Medicaid prescription orders are valid for no more than one year from the date of the prescription, except for controlled substances and prescriber-limited refills which are valid for periods of less than one year.

"Brand Medically Necessary" Requirements For Innovator Drugs

Wisconsin Medicaid reimburses providers for an innovator drug at an amount greater than the Medicaid maximum allowed cost (MAC) only if the prescriber certifies that the innovator drug is "medically necessary" for that recipient and documents the reason in the recipient's medical record. An "innovator" drug is the brand-name product of the patented drug on the MAC List.

The phrase "brand medically necessary" must appear in the prescriber's own handwriting on the face of each new prescription order. It must also appear on each new nursing facility order.

A typed certification, a signature stamp, or a certification handwritten by someone other than the prescriber does not satisfy the requirement. Blanket authorization for an individual recipient, drug, or prescriber is not acceptable documentation.

For claims submission information on "brand medically necessary" drugs, refer to the Claims Submission section of this handbook.

Informing Prescribers About "Brand Medically Necessary" Requirements

When a prescriber telephones a prescription order to a pharmacy and indicates a medical need for the innovator drug, the pharmacy must inform the prescriber that a handwritten certification is necessary to meet Wisconsin Medicaid's requirements. Pharmacy providers

must have this documentation available before submitting claims to Wisconsin Medicaid. The prescriber may fax the information to the pharmacy.

Retention and Maintenance of Prescription Records

Providers must retain hard copies of prescription orders for five years from the date of service, according to HFS 105.02(4) and 105.02(7), Wis. Admin. Code, and s. 450.11(2), Wis. Stats. (statutory requirements for the Pharmacy Examining Board). In addition, prescription orders transmitted electronically may be filed and preserved in electronic format, per s. 961.38(2), Wis. Stats. If the pharmacist takes the prescription verbally from the prescriber, the pharmacist must generate a hard copy.

Maximum Days' Supply

According to HFS 107.10(3)(e), Wis. Admin. Code, providers must dispense the following legend drugs in the quantity prescribed, up to a 100-day supply:

- Digoxin, digitoxin, digitalis.
- Hydrochlorothiazide and chlorothiazide.
- Prenatal vitamins.
- Fluoride.
- Levothyroxine, liothyronine, thyroid extract.
- Phenobarbital.
- Phenytoin.
- Oral contraceptives.

Providers must dispense all other legend drugs in the quantity prescribed, not to exceed a 34-day supply. This policy includes refills.

Refill Policy

According to HFS 107.10(3), Wis. Admin. Code, Wisconsin Medicaid limits refills in the following ways:

- Schedule II drug prescriptions may not be refilled.
- Schedule III, IV, and V drug prescriptions are limited to the original dispensing plus five refills, if authorized by the prescriber, or six months from the date on the prescription, whichever comes first.
- All non-scheduled legend drugs are limited to the original dispensing plus 11 refills, if authorized by the prescriber, or 12 months from the date on the original prescription, whichever comes first.

Unused Medications of Nursing Facility Residents

Return and Reuse of Medications by Pharmacies

Phar 7.04, Wis. Admin. Code, specifies that a health care facility may return certain drugs, medicines, or personal hygiene items to the dispensing pharmacy if the medication is in its original container and the pharmacist determines that the contents are unadulterated and uncontaminated. Under federal law, controlled substances may not be returned to the pharmacy.

Pharmacy providers that accept returned Medicaid-covered medications from nursing facilities may assure facility and pharmacy compliance with these regulations by taking the following steps:

- Verify that the nursing facility maintains complete records of all discontinued medications, whether or not they are returned to the pharmacy.
- Verify that the pharmacy's records of returned medications are properly maintained.
- Establish criteria for pharmacy staff to determine drugs acceptable for reuse by the pharmacy.
- Identify and destroy medications unacceptable for reuse.

Pharmacies are required to refund Medicaid payment to Wisconsin Medicaid for drug prescriptions that cost over $5 and are

Providers must retain hard copies of prescription orders for five years from the date of service.

acceptable for reuse. Pharmacies may not accept returned medications from nursing facilities unless they credit all reusable medications.

Refund For Returned, Reusable Medications

A refund must be made on any item returned that is over $5 per prescription.

A refund must be made on any item returned that is over $5 per prescription. Wisconsin Medicaid allows a pharmacy to retain 20% of the net amount identified as the total cost of reusable units of each drug returned to cover the pharmacy's administrative costs. Wisconsin Medicaid does not consider dispensing fees part of the total cost and, therefore, the dispensing fees need not be returned.

For claims that were submitted real-time, providers may refund Wisconsin Medicaid by reversing the original claim within 90 days of the submission. A new claim with the adjusted quantity should then be submitted. After 90 days, a paper adjustment must be used to change the quantity on an allowed claim. (Refer to the Claims Submission section of this handbook for the Adjustment Request Form.)

Pharmacies choosing not to reverse or adjust the original claim must refund Wisconsin Medicaid by check. If this option is chosen, the pharmacy must remit a check to Wisconsin Medicaid for funds representing these reusable drugs no more than once per month or no less than once every three months. Providers remitting a check for returned, reusable medications must maintain a record of the transaction.

Make checks payable to "Department of Health and Family Services." Write "Returned Drugs" on the check. Also, please include your provider number and the dates (MM/DD/YYYY) referenced by the check. Send checks to:

Wisconsin Medicaid
Cash Unit
6406 Bridge Rd.
Madison, WI 53784-0004

Destruction of Medications by Nursing Facilities

Unless otherwise ordered by a physician, the nursing facility must destroy a recipient's medication not returned to the pharmacy for credit within 72 hours of the following circumstances:

- A physician's order discontinuing the medication's use.
- The recipient's discharge from the nursing facility.
- The recipient's death.
- The medication's expiration date.

A nursing facility may not retain a recipient's medication for more than 30 days unless the prescriber orders in writing, every 30 days, that the facility must retain the medication. HFS 132.65(6)(c), Wis. Admin. Code, defines the procedural and record keeping requirements that nursing facilities must follow for recipients' unused medications.

Repackaging and Relabeling Medications For Recipients

Pharmacy providers dispensing medications using recipient "compliance aid" packaging (e.g., Pill Minder, blister packaging) must relabel unused quantities when the drug regimen is changed. Providers must not discard unused medications that the recipient still needs. Relabeling and repackaging of medication for reuse by the patient is permitted through Phar 7.04, Wis. Admin. Code.

Noncovered Services

Under HFS 107.10(4), Wis. Admin. Code, Wisconsin Medicaid does not cover the following pharmacy services and items:

- Claims from pharmacy providers for reimbursement for drugs, disposable medical supplies (DMS), and durable medical equipment (DME) included in the nursing facility daily rate for nursing facility recipients. (Refer to the DME and DMS Indices for a list of DMS and DME included in the nursing facility daily rate.)

- Refills of schedule II drugs. (Partial fills are acceptable if they comply with Board of Pharmacy regulations.)
- Refills beyond those described under "Refill Policy" of this chapter.
- Personal care items.
- Cosmetics.
- Common medicine chest items such as antiseptics and Band-Aids™.
- Personal hygiene items.
- "Patent" medicines.
- Uneconomically small package sizes.
- Items that are in the inventory of a nursing facility.
- Drugs produced by manufacturers who have not signed a rebate agreement.*
- A drug service for a specific recipient for which prior authorization has been requested and denied.
- Drugs included in the Wisconsin Negative Formulary.
- Drugs identified by the Health Care Financing Administration as less-than-effective (LTE), or identical, related, or similar.
- Brand-name OTC analgesics, antacids, cough syrups, and iron supplements.

**Note:* See the Prior Authorization section of this handbook for exceptions to the rebate agreement requirement.

Unacceptable Practices

Based on the claims submission requirements in HFS 106.03(3), Wis. Admin. Code, and the definition of covered services in HFS 107.10, Wis. Admin. Code, the following are examples of unacceptable and, in some cases, fraudulent practices:

- Billing Wisconsin Medicaid for a quantity of a legend drug that is greater than the quantity prescribed.
- Billing Wisconsin Medicaid for a higher-priced drug when a lower-priced drug was prescribed and dispensed to the recipient.
- Dispensing a brand-name drug, billing for the generic, and then charging the recipient for the difference.
- Billing for a drug quantity greater than the quantity dispensed to the recipient (prescription shorting).
- Charging a drug price greater than the price usually charged to the general public.
- Billing for a legend or OTC drug without a prescription.
- Submitting a claim with a National Drug Code (NDC) other than the NDC on the package from which the drug was dispensed.
- Providing unit-dose carts and recipient drug regimen review without charge. Lease arrangements for carts and other services must reflect fair market value.
- Dispensing a smaller quantity than was prescribed in order to collect more than one professional dispensing fee (prescription splitting).
- Dispensing and billing a medication of lesser strength than prescribed to obtain more than one dispensing fee.
- Billing more than once per month for maintenance drugs for nursing facility recipients. A maintenance drug is a drug ordered on a regular, ongoing, scheduled basis. This limitation does not apply to treatment medications (e.g., topical preparations) or drugs ordered with a stop date of less than 30 days.

Wisconsin Medicaid may suspend or terminate a provider's Medicaid certification for violations of these or other restrictions that constitute fraud or billing abuses. Refer to HFS 106.06 and 106.08, Wis. Admin. Code, for information on provider sanctions.

Wisconsin Medicaid may suspend or terminate a provider's Medicaid certification for violations of these or other restrictions that constitute fraud or billing abuses.

Reimbursement

Providers are required to charge Wisconsin Medicaid their *usual and customary charge*, meaning the provider's charge for providing the same service to a private-pay patient.

The Department of Health and Family Services (DHFS) determines maximum reimbursement rates for all covered over-the-counter (OTC) and legend pharmaceutical items. Maximum reimbursement rates may be adjusted to reflect market rates, reimbursement limits, or limits on the availability of federal funding as specified in federal law (42 CFR 447.331).

Providers are required to charge Wisconsin Medicaid their *usual and customary charge*, meaning the provider's charge for providing the same service to a private-pay patient.

Ingredient Cost Reimbursement

Legend Drugs

Some covered legend drugs are reimbursed at either the drug's Average Wholesale Price (AWP) minus 10% plus a dispensing fee, or the provider's usual and customary charge, whichever is less. Other legend drugs are reimbursed at either the drug's price on the Medicaid Maximum Allowed Cost (MAC) List plus a dispensing fee or the provider's usual and customary charge, whichever is less.

Refer to the Pharmacy Data Tables section of this handbook for the Legend Drug MAC List and the OTC Drug MAC List.

Wisconsin Medicaid reimburses providers for an innovator drug at the same rate that it reimburses for the generic equivalent of the drug if it is on the MAC List, unless the "Brand Medically Necessary" prescription requirements are met. This policy is required by HFS 107.10, Wis. Admin. Code, and by the Omnibus Budget Reconciliation Act of 1990 (OBRA `90) revisions to Title XIX of the Social Security Act.

Over-the-Counter Drugs

The estimated acquisition cost for covered OTC drugs is determined by applying a 10% discount to the AWP as listed by First DataBank, except for MAC drugs.

Refer to the Covered Drugs chapter and Appendix 5 of this section for information on Medicaid coverage of OTC drugs. To request an addition of National Drug Codes for unlisted OTCs, complete Appendix 1 of this section.

Dispensing Fee Reimbursement

Wisconsin Medicaid reimburses different dispensing fees depending on the service provided. These fees include the following:

- Traditional dispensing fee.
- Unit dose dispensing fee.
- Repackaging allowance with either a traditional or unit dose dispensing fee.
- Compound drug dispensing fee.
- Pharmaceutical Care (PC) dispensing fee.

Refer to Appendix 7 of this section for the pharmacy dispensing fee schedule.

Traditional Dispensing Fee

A traditional dispensing fee is usually paid once per recipient, per service, per month, per provider, dependent on the physician's prescription. Refer to the Pharmaceutical Procedures chapter of this section for a list of unacceptable practices.

Unit Dose Dispensing Fee

Wisconsin Medicaid reimburses providers a unit dose dispensing fee when a qualified unit dose dispensing system is used. The drugs may be packaged into unit doses by the manufacturer or by the provider. As per HFS 132.65(7), Wis. Admin. Code, a qualified unit dose dispensing system must:

- Contain not more than one dose, although the dose may consist of two capsules if ordered by the physician. Most topical products and oral liquids do not meet the requirement of unit dose packaging.
- Be sealed and labeled with the drug name, strength, lot or control number, and expiration date, when applicable.
- Be delivered in a quantity consisting of no more than a 96-hour supply of medication delivered at any one time.

Multiple dose "blister packs" or "punch cards" are not unit dose packaging and, therefore, are not reimbursable for unit dose dispensing.

Dispensing Fee Limitation for Unit Dose

The unit dose dispensing fee is limited to one dispensing fee per calendar month, per legend drug, per recipient. Reimbursement is limited to only those pharmaceuticals actually used by the recipient.

Repackaging Allowance

Wisconsin Medicaid may pay a repackaging allowance with either a traditional dispensing fee or a unit dose dispensing fee. Wisconsin Medicaid reimburses providers an additional amount per unit (repackaging allowance) in the following two situations:

Situation One: When the provider repackages a drug into unit dose packages. Drugs packaged by a manufacturer do not qualify for the repackaging allowance.

Situation Two: When the provider repackages a drug into a compliance aid system such as "punch cards," "pill minders," or "pill boxes." Wisconsin Medicaid pays the additional amount only for package systems that meet all federal and state requirements for the packaging, labeling, and dispensing of drugs.

Compound Drug Dispensing Fee

Wisconsin Medicaid reimburses providers for the pharmacist's compounding time. Compounding time is indicated in the level of service field. Refer to the Claims Submission section of this handbook for detailed information on billing for the compound drug dispensing fee.

Pharmaceutical Care Dispensing Fee

Providers may receive an enhanced PC dispensing fee if they perform certain additional, documented services. These services must go beyond the basic activities required by federal and state standards for recordkeeping, profiles, prospective Drug Utilization Review, and counseling when dispensing and must result in a positive outcome for both the recipient and for Wisconsin Medicaid. Examples of these services include increasing patient compliance or preventing potential adverse drug reactions.

Reimbursement is based on the following:

- The reason for intervention.
- The action taken by the pharmacist.
- The result of that action.
- The time spent by the pharmacist performing the activity (exclusive of the documentation time).

Please refer to the Drug Utilization Review and Pharmaceutical Care section of this handbook for more information on PC and the PC dispensing fee.

Wisconsin Medicaid may pay a repackaging allowance with either a traditional dispensing fee or a unit dose dispensing fee.

Appendix

ARCHIVAL USE ONLY
Refer to the Online Handbook
for current policy

Appendix 1
Wisconsin Medicaid Drug Addition/Correction Request Form (for photocopying)

See reverse side of this page for the Wisconsin Medicaid Drug Addition/Correction Request Form.

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Wisconsin Medicaid Drug Addition/Correction Request Form

This form may be used to request the addition of National Drug Code (NDC) billing codes for unlisted over-the-counter (OTC) drugs. Providers may use this form to notify Wisconsin Medicaid of pricing errors contained in the drug index. Pharmacies *must send/fax a copy of an invoice* to substantiate any price change in the Maximum Allowed Cost (MAC) list. New NDCs are automatically added to the Wisconsin Medicaid drug file subject to Wisconsin Medicaid limitations if the manufacturer has signed a drug rebate agreement with the Health Care Financing Administration. This form is to be used by Wisconsin Medicaid-certified providers only.

MAIL TO: Drug Price File
Division of Health Care Financing
P.O. Box 309
Madison, WI 53701-0309

FAX NUMBER: (608) 267-3380

Provider Name: _____ Prov ID No: _____

Street/Mail Address: _____ Tel No.: _____

City, State, ZIP: _____ Contact Person: _____

NEW DRUG ADDITIONS

Code (Internal Use Only)	NDC (11-digit number)	Drug Name	Pkg Size	AWP (Avg Wholesale Price)	Disp Date	Rx/ OTC?

A — Added to Index as Requested; B — Already in Index; C — Less-Than-Effective (LTE) Drug (non-covered); D — Not Eligible for Coverage

PRICE UPDATE/CORRECTION

Code (Internal Use Only)	NDC (11-digit number)	Drug Name	Pkg Size	Currently Allowed	Correct Price	Eff Date

Describe reason for drug price update request (e.g., no generic available at MAC price, manufacturer price increase which is not reflected on Wisconsin Medicaid price file).

_____

_____

Attach a copy of the invoice to verify any requests for price change.

Appendix 2
Wisconsin Medicaid Covered Drugs

Covered Drugs — Legend Drugs

Wisconsin Medicaid uses an open formulary for legend drugs with few restrictions. Restrictions include drugs which require prior authorization (PA), diagnosis-restricted drugs, noncovered manufacturer drugs, less-than-effective (LTE) drugs, and negative formulary drugs.

Covered Drugs — Over-the-Counter Drugs

General over-the-counter (OTC) categories are:

- Analgesics — Oral/ Rectal.[1]
- Antacids.
- Antibiotic Ointments.
- Antifungals-Topical.
- Antifungals-Vaginal.
- Bismuth Subsalicylate.
- Capsaicin.
- Contraceptive Supplies.
- Cough Syrups.[2]
- Diphenhydramine.
- Ferrous Gluconate/ Sulfate for pregnant women (and for a 60-day period beyond the end of the pregnancy).
- Hydrocortisone Products — Topical.
- Insulin.
- Lice Control Products.
- Meclizine.
- Ophthalmic Lubricants.
- Pinworm Treatment Products.
- Pseudoephedrine.
- Pyridoxine Tablets.
- Therapeutic Oral Electrolyte Replacement Solutions.

Note: Coverage is limited to generic drugs for most covered OTC drugs [excluding the OTC product categories of insulin, ophthalmic lubricants, and contraceptive supplies]. Some products in these categories are not covered because the manufacturer did not sign a rebate agreement. Examples of noncovered brand name products include Advil, Ascriptin, Clear Tears, Ecotrin, Lyteers, Maalox, Mylanta, Neo Tears, Riopan, Robitussin, Rolaids, Titralac, and Tylenol.

[1] Limited to single entity aspirin, acetaminophen, ibuprofen products only. These analgesics are in the daily rate for nursing facility recipients.

[2] Covered "cough syrups" are limited to products for treatment of coughs only. Covered products include those containing a single component (terpin hydrate or guaifenesin), a single cough suppressant (codeine or dextromethorphan), or a combination of an expectorant and cough suppressant. Multiple ingredient cough/cold combination products are noncovered.

Covered Drugs — Over-the-Counter Drugs (HealthCheck "Other Services")

Effective with dates of service beginning January 1, 1994, the following drug categories are covered through HealthCheck "Other Services" without PA but with verification that a comprehensive HealthCheck screen occurred within the last 365 days. HealthCheck is a preventive health care program for children under the age of 21. Refer to the HealthCheck "Other Services" Drug List in the **Pharmacy Data Tables section** of this handbook for a full list of covered drugs.

- Anti-Diarrheals.
- Iron Supplements.
- Lactase Products.
- Laxatives.
- Multivitamins.
- Topical Protectants.

Covered Non-Rebated Drugs — Prior Authorization Required

These drugs require PA because the manufacturer did not sign a rebate agreement. Prescribers are requested to provide a statement regarding the nature of the medical need for these specific brand drugs, as well as a statement which asserts that failure to cover the drug will result in costs to Wisconsin Medicaid which exceed the cost of the drug. This list may change if the manufacturer signs a rebate agreement. Generic equivalents of these drugs are not included in this requirement and may be billed without PA if the generic manufacturer has signed a rebate agreement.

- Dalmane.
- Libritabs.
- Librium.
- Melanex.
- Menrium.
- Quarzan.
- Rimso 50.
- Valium.

Appendix 2
continued

Covered Rebated Drug Categories — Prior Authorization Required

These drug categories are produced by manufacturers who have signed rebate agreements but PA is required to determine medical necessity. Diagnosis and information regarding the medical requirements for these drug categories must be provided on the PA request.*

Paper PA Submission

• Enteral Nutritional Products.	• Fertility Enhancement Drugs (when used to treat conditions other than infertility).	• Human Growth Hormone.	• Treatment for Kaposi's Sarcoma Lesions.
• Unlisted/Investigational Drugs.		• Impotence Treatment Drugs (when used for a condition other than impotence).	

Specialized Transmission Approval Technology-Prior Authorization (STAT-PA)

• Brand name histamine 2 antagonists.	• Proton-Pump Inhibitors (when requested for use outside of approved diagnosis ranges).	• Alpha-1-Proteinase Inhibitor.	• Certain ACE Inhibitors: √ Accupril. √ Altace. √ Lotensin. √ Monopril. √ Prinivil. √ Zestril.
• Weight Loss Agents.	• C-III and C-IV Stimulants (excludes Mazindol).	• Brand name non-steroidal anti-inflammatory drugs (NSAIDs).	

Covered Rebated Drugs — Diagnosis-Restricted Drugs

Reimbursement for these drugs and drug categories is restricted by a valid diagnosis code. See **Appendix 3** of this section for a list of acceptable diagnosis codes for each drug. These drugs require PA when prescribed for a diagnosis outside the approved diagnosis ranges. Submit paper PA requests for diagnosis-restricted drugs when prescribed for a diagnosis outside the approved diagnosis ranges. Prior authorization for proton-pump inhibitors outside the approved diagnosis may be obtained through STAT-PA or paper PA requests*.

• Alglucerase. • Anti-H. Pylori Treatment. • Cerezyme. • Colony Stimulating Factors.	• Epoetin Alfa. • Interferon Alpha (all groups). • Interferon Beta 1a (Avonex).	• Interferon Beta 1b (Betaseron). • Legend Smoking Cessation Products (OTC products not covered).	• Mupirocin. • Muromonab and other monclonal antibodies. • Prenatal vitamins. • Proton-pump inhibitors.

**Note:* Prior authorization requests can either be mailed to Wisconsin Medicaid or sent via fax. Use the address and fax number below:

Wisconsin Medicaid
Prior Authorization Unit
Suite 88
6406 Bridge Road
Madison, WI 53784-0088
Fax: (608) 221-8616

Refer to the Prior Authorization section of this handbook for further information on PA requests.

Appendix 3
Diagnosis Code Table For Diagnosis-Restricted Drugs and Drug Categories

For uses outside of the following diagnoses, prior authorization (PA) is required. Submission of peer-reviewed medical literature to support the proven efficacy of the requested use of the drug is required for PA outside of the diagnosis restriction. Refer to the Prior Authorization section of this handbook for further information on diagnosis-restricted drugs.

Drug Name or Category	Brand Name	Diagnosis Code	Disease Description
Proton-Pump Inhibitors	Aciphex, Nexium, Prevacid, Prilosec, Protonix	E9356 04186 2515 53019 53081 5368	Non-steroidal anti-inflammatory drug (NSAID)-induced gastric ulcer NSAID-induced duodenal ulcer H. Pylori infection Zollinger-Ellison syndrome Erosive esophagitis Gastroesophageal reflux Gastric hypersecretory conditions
Misoprostol	Cytotec	E9356	NSAID-induced gastric ulcer NSAID-induced duodenal ulcer
Lansoprazole/ Antibiotic	Prevpac	04186	H. Pylori infection
Ranitidine/ Bismuth	Tritec	04186	H. Pylori infection
Alglucerase, Imiglucerase	Ceredase, Cerezyme	2727	Gaucher's Disease
Epoetin	Epogen, Procrit	042 585 2399	Anemia from acquired immune deficiency syndrome (AIDS) Renal failure Malignancy
Interferon Alfa 2A	Roferon-A	07054 1729 1760-1769 2024 2028 2030 2051 2337 2339	Chronic hepatitis C w/o hepatic coma Malignant melanoma Kaposi's sarcoma Hairy cell leukemia Non-Hodgkin's lymphoma Multiple myeloma Chronic myelocytic leukemia Bladder carcinoma Renal cell carcinoma
Interferon Alfa 2B	Intron A PEG-Intron	07811 1729 1760-1769 2024 2028 2030 2337 2339	Condylomata acuminata Malignant melanoma Kaposi's sarcoma Hairy cell leukemia Non-Hodgkin's lymphoma Multiple myeloma Bladder carcinoma Renal cell carcinoma

OVER

Drug Name or Category	Brand Name	Diagnosis Code	Disease Description
Interferon Alfa N3	Alferon N	07811	Condylomata acuminata
Interferon Gamma 1B	Actimmune	2881	Chronic granulomatous disease
Interferon Alfacon 1	Infergen	07054	Chronic hepatitis C w/o hepatic coma
Interferon Alfa 2B/ Ribavirin	Rebitron	07054	Chronic hepatitis C w/o hepatic coma
Interferon Beta 1A	Avonex	340	Multiple sclerosis
Interferon Beta 1B	Betaseron	340	Multiple sclerosis
Filgrastim	Neupogen	2880	Agranulocytosis/Neutropenia
Sargramostim	Leukine	205	Myeloid leukemia
Mupirocin	Bactroban 2%	684	Impetigo
Muromonab CD3	Orthoclone OKT-3	9968	Organ transplant rejection
Bupropion	Zyban	3051	Nicotine dependence treatment
Nicotine	Nicotine	3051	Nicotine dependence treatment
Legend Prenatal Vitamins		V22-V229 V23-V239 V241	Normal pregnancy Supervision of high-risk pregnancy Lactating mother

Appendix 4
Clozapine Management Services

Conditions for Clozapine Management

Pharmacies may be separately reimbursed for clozapine management services when all of the following conditions are met:

- A physician prescribes the clozapine management services in writing if any of the components of clozapine management are provided by individuals who are not under the direct, on-site supervision of a physician. Although separate prescriptions are not required for clozapine tablets and clozapine management, the clozapine management service must be identified as a separately prescribed service from the drug itself.
- The recipient is currently taking or has taken clozapine tablets within the past four weeks.
- The recipient resides in a community-based setting (excludes hospitals and nursing facilities).
- The physician or qualified staff person has provided the components of clozapine management as described below.

Clozapine is appropriate for recipients with an *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) code diagnosis between 295.10 and 295.95 and who have a documented history of failure of at least two psychotropic drugs. Lithium Carbonate may not be one of the two failed drugs. Reasons for the failure may include:

- No improvement in functioning level.
- Continuation of positive symptoms (hallucinations or delusions).
- Severe side effects.
- Tardive dyskinesia/dystonia.

Components of Clozapine Management

The following components are part of the clozapine management service (regardless of which of the three clozapine management procedure codes is billed) and must be provided, as needed, by the physician or by a qualified professional under the general supervision of the physician:

1. Ensure that the recipient has the required weekly or biweekly white blood count testing. Recipients must have a blood sample drawn for white blood cell count testing before initiation of treatment with clozapine and must have subsequent white blood cell counts done weekly for the first six months of clozapine therapy.

   If a recipient has been on clozapine therapy for six months of continuous treatment and if the weekly white blood cell counts remain stable (greater than or equal to 3,000/mm^3) during the period, the frequency of white blood cell count monitoring may be reduced to once every two weeks. For these recipients, further weekly white blood cell counts require justification of medical necessity. *Recipients who have their clozapine dispensed every week but have their blood drawn for white blood cell counts every two weeks qualify for biweekly, not weekly, clozapine management services.*

   For recipients who have a break in therapy, white blood cell counts must be taken at a frequency in accordance with the rules set forth in the "black box" warning of the manufacturer's package insert.

   The provider may draw the blood or transport the recipient to a clinic, hospital, or laboratory to have the blood drawn, if necessary. The provider may travel to the recipient's residence or other places in the community where the recipient is available to perform this service, if necessary. The provider's transportation to and from the recipient's home or other community location to carry out any of the required services listed here is considered part of the capitated weekly or biweekly payment for clozapine management and is not separately reimbursable. The blood test is separately reimbursable for a Medicaid-certified laboratory.

2. Obtain the blood test results in a timely fashion.
3. Ensure that abnormal blood test results are reported in a timely fashion to the provider dispensing the recipient's clozapine.
4. Ensure that the recipient receives medications as scheduled and that the recipient stops taking medication when a blood test is abnormal, if this decision is made, and receives any physician-prescribed follow-up care to ensure that the recipient's physical and mental well-being is maintained.
5. Make arrangements for the transition and coordination of the use of clozapine tablets and clozapine management services between different care locations.
6. Monitor the recipient's mental status according to the care plan. The physician is responsible for ensuring that all individuals having direct contact with the recipient in providing clozapine management services have sufficient training and education. These individuals must be able to recognize the signs and symptoms of mental illness and side effects from drugs used to treat mental illness and to recognize when changes in the recipient's level of functioning need to be reported to a physician or registered nurse.
7. Keep records as described below.

Recordkeeping Requirements for Clozapine Management

The provider must have a unique record for each recipient for whom clozapine management is being provided. This record may be a part of a larger record which is also used for other services if the provider is also providing other services to the recipient. However, the clozapine management records must be clearly identified as such and must contain the following:

- A face sheet identifying the recipient including the following information:
  - √ Recipient's Medicaid identification number.
  - √ Recipient's name.
  - √ Recipient's current address.
  - √ Name, address, and telephone number of the primary medical provider (if different than the prescribing physician).
  - √ Name, address, and telephone number of the dispensing provider from whom the recipient is receiving clozapine.
  - √ Address and telephone number of other locations at which the recipient may be receiving a blood draw and at which the recipient may be located on a regular basis.

- A care plan indicating the manner in which the provider ensures that the covered services are provided (e.g., plan indicates where and when blood will be drawn, whether the recipient will pick up medications at the pharmacy or whether they will be delivered by the provider). The plan should also specify signs or symptoms that might be associated with medical conditions resulting from side effects of the drug or related to the recipient's mental illness which should be reported to a qualified medical professional.

  The plan should indicate the health care professionals to whom oversight of the clozapine management services has been delegated and indicate how often they will be seeing the recipient. The plan should be reviewed every six months during the first year of clozapine use. Reviews may be reduced to once per year after the first year of use if the recipient is stable, as documented in the record.

- Copies of physician's prescriptions for clozapine and clozapine management.

- Copies of laboratory results of white blood cell counts.

- Signed and dated notes documenting all clozapine management services. Indicate date of all blood draws as well as who performed the blood draws. If the provider had to travel to provide services, indicate the travel time. Document services provided to ensure that the recipient received medically necessary care following an abnormal white blood cell count.

Physicians and pharmacies providing clozapine management services must be extremely careful not to double bill Wisconsin Medicaid for services. This may happen when the physician provides clozapine management services as well as other Medicaid-allowable physician services during the same encounter. In these cases, the physician must document the amount of time that was spent on the other physician service separate from the time spent on clozapine management. Regular psychiatric medication management is not considered a part of the clozapine management services and may be billed separately.

Noncovered Clozapine Management Services

Wisconsin Medicaid does not cover the following as clozapine management services:

- Clozapine management for a recipient not receiving clozapine, except for the first four weeks after discontinuation of the drug.
- Clozapine management for recipients residing in a nursing facility or hospital on the date of service.
- Care coordination, medical services, or provider transportation not related to the recipient's use of clozapine.

Related Services That are Reimbursed Separately from Clozapine Management

White Blood Cell Count - The white blood cell count must be performed and billed by a Medicaid-certified laboratory to receive Wisconsin Medicaid reimbursement.

Recipient Transportation - Recipient transportation to a physician's office or pharmacy is reimbursed in accordance with HFS 107.23, Wis. Admin. Code. Such transportation, when provided by a specialized medical vehicle, is not covered unless the recipient has a disability. Recipient transportation by common carrier must be approved and paid for by the county agency responsible for Medicaid transportation services.

Billing for Clozapine Management

Refer to the Claims Submission section of this handbook for information on billing for clozapine management.

Appendix 5
Wisconsin Medicaid Coverage of Over-the-Counter Medications

Some over-the-counter (OTC) drugs are covered for Wisconsin Medicaid eligible recipients. Additional OTCs may be covered for children under 21 years of age through HealthCheck "Other Services." All OTCs require a legal prescription for Wisconsin Medicaid reimbursement.

When presented with a legal prescription for an OTC, pharmacists should do the following:

- Submit the National Drug Code (NDC) through the Point-of-Sale (POS) system.
- If the NDC reports as payable, do the following:
  - √ Dispense the medication.
  - √ Transmit the claim.

If the OTC is covered through HealthCheck "Other Services," pharmacists must ensure there is verification the child received a comprehensive HealthCheck exam within the last 365 days. The recipient must have verification of the HealthCheck exam. This may be a completed HealthCheck card, verification of the date of the HealthCheck exam written on the prescription, or any document with the date of the HealthCheck exam and the provider's signature.

If the NDC for the medication dispensed is *not* covered by Wisconsin Medicaid and the medication is for a child who has had a HealthCheck exam:

- Complete prior authorization (PA) forms. Be sure to do all the following:
  - √ Include a copy of the HealthCheck verification.
  - √ Include a completed section B of the Prior Authorization Drug Attachment (PA/DGA) or a copy of the prescription order.
  - √ Write the words "HealthCheck Other Services" across the top of the PA Request Form (PA/RF).
  - √ Mail the form to Wisconsin Medicaid at the following address:

    Wisconsin Medicaid
    Prior Authorization
    Suite 88
    6406 Bridge Road
    Madison, WI 53784-0088

    Fax number: (608) 221-8616
- If PA is approved, do all of the following:
  - √ Dispense the medication.
  - √ Submit the HCFA 1500 claim form using the procedure code assigned on the PA/RF.

Appendix 6
Wisconsin Medicaid Noncovered Drugs

Noncovered Drugs — No Manufacturer Rebate Agreement

Manufacturers of the following drugs have chosen not to participate in Wisconsin Medicaid. This is not a complete list of noncovered drugs. This list may change if manufacturers sign rebate agreements. Wisconsin Medicaid does not cover or grant prior authorization (PA) for these drugs. Wisconsin Medicaid may cover the generic alternatives for these drugs if the manufacturer of the generic drugs signed a rebate agreement. The noncovered drugs include:

- Asthmanephrine.
- Bichloracetic Acid.
- Clear Tears.
- Drysol.
- Duolube.
- Eppy N Ophth Solution.
- Eppy Sol Ophth.
- Karidium.
- Karigel.
- Lyteers.
- Moisture Drops.
- Monoject Insulin Jel.
- Nafrinse.
- Neo-Tears.
- Tinver Lotion.
- Xerac AC.
- Yodoxin.

Noncovered Drugs — FDA Less-Than-Effective Drugs

Wisconsin Medicaid does not cover or grant PA for less-than-effective (LTE) drugs nor for any generic alternatives identified by the Food and Drug Administration (FDA) as identical, related, or similar to these drugs. Refer to the **Pharmacy Data Tables section** of this handbook for a complete list of LTE drugs.

Noncovered Drugs — Wisconsin Negative Formulary

Prior authorization will not be granted for these drugs.

- Alginate.
- Eflornithine (Vaniqa) Topical.
- Gaviscon.
- Minoxidil Topical.
- Non-Rebated Drugs Ineligible for Prior Authorization.
- Progesterone for premenstrual syndrome (PMS).
- Legend Multi-Vitamins (Non-prenatal) — excludes HealthCheck.
- Finasteride (Propecia).

Fertility Enhancement Drugs (when used to treat infertility):

- Chorionic Gonadotropin.
- Clomiphene.
- Crinone.
- Gonadorelin.
- Menotropins.
- Urofollitropin.

Impotence Treatment Drugs:

- Alprostadil Intracavernosal (Caverject, Edex).
- Phentolamine Intracavernosal (Regitine).
- Sildenafil (Viagra).
- Urethral Suppository (MUSE).
- Yohimbine.

- Any drug determined to be experimental in nature or not proven as an effective treatment for the condition for which it is prescribed (See HFS 107.035, Wis. Admin. Code).

Appendix 7
Wisconsin Medicaid
Maximum Allowed Pharmacy Dispensing Fee Schedule[1]

Per-Prescription Drug Payment Reduction (Effective 07/01/95)	$0.50/prescription dispensed
Traditional Dispensing Fee (Effective 07/01/98)	$4.88
Unit Dose Dispensing Fee[2] (Effective 07/01/98)	$6.94
Dispensing Allowance for Re-Packaging (Effective 04/01/97)	$0.015/unit
Injectible Syringe Prefill Allowance (88888-0000-07)	$1.20/unit

Note: One unit is one syringe.

Estimated Acquisition Cost (EAC) Calculation (Effective 07/01/90)

Legend Drugs and Covered Over-the-Counter (OTC) Drugs — Average Wholesale Price (AWP) minus 10% or Maximum Allowed Cost (MAC)

Compound Drug, Time Allowance

Level	Time	Fee
11	0-5 minutes	$ 9.45
12	6-15 minutes	$14.68
13	16-30 minutes	$22.16
14	31-60 minutes	$22.16
15	61+ minutes	$22.16

1 Providers must bill Wisconsin Medicaid at an amount not in excess of the usual and customary charge billed to non-Medicaid recipients for the same service.

2 Unit dose fee is only available for qualified unit dose systems.

Glossary of Common Terms

Adjustment
A modified or changed claim that was originally paid or allowed, at least in part, by Wisconsin Medicaid.

Allowed status
A Medicaid or Medicare claim that has at least one service that is reimbursable.

BadgerCare
BadgerCare extends Medicaid coverage through a Medicaid expansion under Titles XIX and XXI to uninsured children and parents with incomes at or below 185% of the federal poverty level and who meet other program requirements. The goal of BadgerCare is to fill the gap between Medicaid and private insurance without supplanting or "crowding out" private insurance.

BadgerCare benefits are identical to the benefits and services covered by Wisconsin Medicaid, and recipients' health care is administered through the same delivery system.

CPT
Current Procedural Terminology. A listing of descriptive terms and codes for reporting medical, surgical, therapeutic, and diagnostic procedures. These codes are developed, updated, and published annually by the American Medical Association and adopted for billing purposes by the Health Care Financing Administration (HCFA) and Wisconsin Medicaid.

Compound Drug
A prescription drug prepared by a pharmacist using at least two ingredients.

Crossover claim
A Medicare-allowed claim for a dual entitlee sent to Wisconsin Medicaid for possible additional payment of the Medicare coinsurance and deductible.

Daily nursing facility rate
The amount that a nursing facility is reimbursed for providing each day of routine health care services to a recipient who is a patient in the home.

Days' Supply
The estimated days' supply of tablets, capsules, fluids cc's, etc. that has been prescribed for the recipient. Days' supply is not the duration of treatment, but the expected number of days the drug will be used.

Dispensing Physician
A physician who dispenses medication to patients and bills Medicaid.

DHCF
Division of Health Care Financing. The DHCF administers Wisconsin Medicaid for the Department of Health and Family Services (DHFS) under statutory provisions, administrative rules, and the state's Medicaid plan. The state's Medicaid plan is a comprehensive description of the state's Medicaid program that provides the Health Care Financing Administration (HCFA) and the U.S. Department of Health and Human Services (DHHS), assurances that the program is administered in conformity with federal law and HCFA policy.

DHFS
Wisconsin Department of Health and Family Services. The DHFS administers the Wisconsin Medicaid program. Its primary mission is to foster healthy, self-reliant individuals and families by promoting independence and community responsibility; strengthening families; encouraging healthy behaviors; protecting vulnerable children, adults, and families; preventing individual and social problems; and providing services of value to taxpayers.

DHHS
Department of Health and Human Services. The United States government's principal agency for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves.

The DHHS includes more than 300 programs, covering a wide spectrum of activities, including overseeing Medicare and Medicaid; medical and social science research; preventing outbreak of infectious disease; assuring food and drug safety; and providing financial assistance for low-income families.

DOS

Date of service. The calendar date on which a specific medical service is performed.

Dual entitlee

A recipient who is eligible for both Medicaid and Medicare, either Medicare Part A, Part B, or both.

EMC

Electronic Media Claims. Method of claims submission through a personal computer or mainframe system. Claims can be mailed on tape or transmitted via telephone and modem.

Emergency services

Those services which are necessary to prevent death or serious impairment of the health of the individual. (For the Medicaid managed care definition of emergency, refer to the Managed Care Guide or the Medicaid managed care contract.)

EOB

Explanation of Benefits. Appears on the provider's Remittance and Status (R/S) Report and informs Medicaid providers of the status of or action taken on their claims.

EVS

Eligibility Verification System. Wisconsin Medicaid encourages all providers to verify eligibility before rendering services, both to determine eligibility for the current date and to discover any limitations to a recipient's coverage. Providers may access recipient eligibility information through the following methods:

- Automated Voice Response (AVR) system.
- Magnetic stripe card readers.
- Personal computer software.
- Provider Services (telephone correspondents).
- Direct Information Access Line with Updates for Providers (Dial-Up).

Fee-for-service

The traditional health care payment system under which physicians and other providers receive a payment for each unit of service provided rather than a capitation payment for each recipient.

Fiscal agent

The Department of Health and Family Services (DHFS) contracts with Electronic Data Systems (EDS) to provide health claims processing services for Wisconsin Medicaid, including provider certification, claims payment, provider services, and recipient services. The fiscal agent also issues identification cards to recipients, publishes information for providers and recipients, and maintains the Wisconsin Medicaid Web site.

HCFA

Health Care Financing Administration. An agency housed within the U.S. Department of Health and Human Services (DHHS), HCFA administers Medicare, Medicaid, related quality assurance programs, and other programs.

HCPCS

HCFA Common Procedure Coding System. A listing of services, procedures, and supplies offered by physicians and other providers. HCPCS includes *Current Procedural Terminology* (CPT) codes, national alphanumeric codes, and local alphanumeric codes. The national codes are developed by the Health Care Financing Administration (HCFA) to supplement CPT codes.

HealthCheck

Program which provides Medicaid-eligible children under age 21 with regular health screenings.

ICD-9-CM

International Classification of Diseases, Ninth Revision, Clinical Modification. Nomenclature for medical diagnoses required for billing. Available through the American Hospital Association.

Innovator

Brand name of the original patented drug of those listed on the Maximum Allowed Cost (MAC) list.

Legend Drug

Any drug that requires a prescription under federal code 21 USC 353(b).

LOS

Level of Service. Field required when billing PC services or compound drugs indicating the time associated with the service provided.

Maximum allowable fee schedule

A listing of all procedure codes allowed by Wisconsin Medicaid for a provider type and Wisconsin Medicaid's maximum allowable fee for each procedure code.

Medicaid

Medicaid is a joint federal/state program established in 1965 under Title XIX of the Social Security Act to pay for medical services for people with disabilities, people 65 years and older, children and their caretakers, and pregnant women who meet the program's financial requirements.

The purpose of Medicaid is to provide reimbursement for and assure the availability of appropriate medical care to persons who meet the criteria for Medicaid. Medicaid is also known as the Medical Assistance Program, Title XIX, or T19.

Medically necessary

According to HFS 101.03(96m), Wis. Admin. Code, a Medicaid service that is:

a) Required to prevent, identify or treat a recipient's illness, injury or disability; and
b) Meets the following standards:
   1. Is consistent with the recipient's symptoms or with prevention, diagnosis or treatment of the recipient's illness, injury or disability.
   2. Is provided consistent with standards of acceptable quality of care applicable to type of service, the type of provider and the setting in which the service is provided.
   3. Is appropriate with regard to generally accepted standards of medical practice.
   4. Is not medically contraindicated with regard to the recipient's diagnoses, the recipient's symptoms or other medically necessary services being provided to the recipient.
   5. Is of proven medical value or usefulness and, consistent with s. HFS 107.035, is not experimental in nature.
   6. Is not duplicative with respect to other services being provided to the recipient.
   7. Is not solely for the convenience of the recipient, the recipient's family or a provider.
   8. With respect to prior authorization of a service and to other prospective coverage determinations made by the department, is cost-effective compared to an alternative medically necessary service which is reasonably accessible to the recipient.
   9. Is the most appropriate supply or level of service that can safely and effectively be provided to the recipient.

NCPDP

National Council for Prescription Drug Programs. This entity governs the telecommunication formats used to submit prescription claims electronically.

NDC

National Drug Code. An 11-digit code assigned to each drug. The first five numbers indicate the labeler code (Health Care Financing Administration [HCFA]-assigned), the next four numbers indicate the drug and strength (labeler assigned), and the remaining two numbers indicate the package size (labeler assigned).

OBRA

Omnibus Budget Reconciliation Act. Federal legislation that defines Medicaid drug coverage requirements and drug rebate rules.

OTC

Over-the-counter. Drugs that non-Medicaid recipients can obtain without a prescription.

PA

Prior authorization. The electronic or written authorization issued by the Department of Health and Family Services (DHFS) to a provider prior to the provision of a service.

PC

Pharmaceutical Care. An enhanced dispensing fee paid to providers for specified activities which result in a positive outcome. Some outcomes include increasing patient compliance or preventing potential adverse drug reactions.

POS

Point-of-Sale. A system that enables Medicaid providers to submit electronic pharmacy claims in an on-line, real-time environment.

R/S Report

Remittance and Status Report. A statement generated by the Medicaid fiscal agent to inform providers regarding the processing of their claims.

STAT-PA

Specialized Transmission Approval Technology — Prior Authorization. An electronic PA system that allows Medicaid-certified pharmacy providers to request and receive PA electronically rather than by mail for certain drugs.

Switch transmissions

System that routes real-time transmissions from a pharmacy to the processor. Also called Clearinghouse or Value-Added Network (VAN) system.

TOS

Type of service. A single-digit code which identifies the general category of a procedure code.

UD

Unit Dose Dispensing Fee. Reimbursement to providers when a qualified unit dose dispensing system is used. The drugs may be packaged into unit doses by the labeler or the provider.

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