Pharmacy

SeniorCare

wisconsin **Medicaid**
and BadgerCare
Information for Providers
Department of Health and Family Services

DIVISION OF HEALTH CARE FINANCING

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Department of Health and Family Services

M E M O R A N D U M

DATE: March 20, 2003

TO: All Pharmacies, Dispensing Physicians, HMOs, and Blood Banks

FROM: Mark B. Moody, Administrator
               Division of Health Care Financing

SUBJECT   Updated Medicaid Pharmacy Handbook

I.   Updated Pharmacy Handbook

Attached is a copy of the updated Wisconsin Medicaid Pharmacy Handbook. The
Pharmacy Data Tables section is updated and has changes to the following tables:

- Appendix 1 – Numeric Listing of Manufacturers that have signed Rebate
  Agreements.
- Appendix 2 – Less than Effective/Identical, Related or Similar Drugs.
- Appendix 3 – Legend Drug Maximum Allowed Cost (MAC) List.
- Appendix 4 – Over-the-Counter Maximum Allowed Cost List.
- Appendix 6 – Wisconsin Medicaid Noncovered Drugs – Manufacturer
  Rebates Refused.

II.   All-Provider Handbook Included

CD-ROM copies of the updated Wisconsin Medicaid Pharmacy Handbook include the
All-Provider Handbook and the Disposable Medical Supply Handbook.

III. SeniorCare Information

CD-ROM copies of this updated Wisconsin Medicaid Pharmacy Handbook includes a
new SeniorCare section. Additional information including the link for looking up
SeniorCare covered drugs can be found at www.dhfs.state.wi.us/seniorcare/index.htm.

IV.   Prior Authorization Required for Brand name Anti-Hyperlipidemic Drugs
         Beginning April 15, 2003.

Effective for dates of service on and after April 15, 2003, brand name Antihyperlipidemic
drugs (Statins) require prior authorization (PA). PA will be available through the STAT
PA system. The criteria for determining whether or not PA will be granted include:

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♦ Any recipient currently on an effective brand name Statin will be granted prior authorization to continue on that Statin drug.

♦ Any recipient who requires >35 percent LDL reduction, has impaired renal function, or is at high risk for drug interactions will be granted prior authorization to start on the brand name Statin drugs.

♦ Only recipients new to Statin drugs will be required to try Lovastatin first.

Attachment 1 is an optional worksheet with additional information.

V.   Prior Authorization Required for Brand name Proton Pump Inhibitor (PPI) Drugs Beginning May 7, 2003.

Effective for dates of service on and after May 7, 2003, brand name Proton Pump Inhibitor (PPI) Drugs will require prior authorization (PA). PA will be available through the STAT PA system. All PPI drugs, including generic omeprazole, continue to be diagnosis restricted. PA for brand name PPIs will only be granted when a patient has tried and failed or had an adverse reaction to generic omeprazole. Attachment 2 is an optional worksheet with additional information.

VI.   Drug Addition Request/Correction Form Revised
The Drug Addition Request/Correction Form is revised to include the pharmacist's signature certifying that the price listed on the invoice reflects actual costs net of rebates or any other discounts received from the drug wholesaler or any other entity. Attachment 3 is a copy of the new form for your use. This completed form plus a copy of your invoice must be received to process your request.

VII.   Over the Counter Claritin Covered
Wisconsin Medicaid covers over-the-counter (OTC) Claritin (loratadine) and Alavert OTC Claritin and Alavert are billable through the point-of-sale system. As with all covered OTC products in Medicaid, loratadine requires a prescription. As new generic loratadine products become available, they will be added to the Wisconsin Medicaid covered drug list.

Since SeniorCare does not cover OTCs, SeniorCare does not cover OTC Claritin.

VIII.   Additional Copies of Publications

All Wisconsin Medicaid and BadgerCare Updates, as well as the Pharmacy Handbook and the All-Provider Handbook and the DMS handbook, can be downloaded from the Medicaid L.C. Web site at *www.dhfs.state.wi.us/medicaid/*. Additional copies of the handbook may be downloaded from the CD-ROM.

Pharmacies will automatically receive a CD-ROM quarterly, unless they notify pharmacy Provider Services that they want only a paper copy. Pharmacies may receive either a CD-ROM or a paper copy, but not both.

If you would like to receive only paper copies of pharmacy materials, please call Provider Services at (800) 947-9627 or (608) 221-9883.

If you have questions about the information in this handbook, please call Provider Services.

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Enclosures

STAT-PA Drug Worksheet:
Brand Name Cholesterol Lowering Drugs (Statins)

This worksheet is to be used by pharmacists or dispensing physicians only!
(NOT REQUIRED FOR PRESCRIBING PHYSICIANS)

Generic cholesterol lowering drugs (statins) have NO RESTRICTIONS as to either diagnosis codes or prior authorization (PA). As with all innovator drugs, prescribers must write "Brand Medically Necessary" on all hard copies of the prescriptions and on each new nursing facility order sheet.

REMINDER: *The Specialized Transmission Approval Technology — PA (STAT-PA) Drug Worksheet is* *optional*. *This form is not required, but is provided as a guideline only to access STAT-PA or as provider documentation. The STAT-PA system will ask for the following items in the order listed below:*

Provider Number: _____

Recipient Medicaid Identification Number: _____

Recipient Name: _____

National Drug Code (NDC)/Procedure Code of Product Requested: _____

Type of Service: __D__ Prescriber's Drug Enforcement Administration (DEA) Number: _____

Diagnosis Code: _____ (Use the recipient's *International Classification of Diseases, Ninth Revision, Clinical Modification* [ICD-9-CM] diagnosis code. The decimal is not necessary.)

Place of Service: _____

Date of Service: _____ (The date of service may be up to 31 days in the future, or up to four days in the past.)

Days' Supply Requested: _____

STAT-PA Request Checklist
ALL information must be checked within each category in order to be processed electronically.

A. Is the patient currently stabilized on an effective brand name statin?
    1. If yes, approve PA request for up to 365 days.
    2. If no, then ask:
B. Does this recipient require >35 percent LDL reduction, have impaired renal function, or have a high risk for drug interactions?
    1. If yes, approve PA request for up to 365 days.
    2. If no, then ask:
C. Has the recipient tried and failed or had an adverse drug reaction to a generic statin?
    1. If yes, approve PA request for up to 365 days.
    2. If no, return the PA with the following message: "Your prior authorization request requires additional
       information. Please submit your request on paper with complete clinical documentation."

OVER

ATTACHMENT 1

As the pharmacist, you have learned of this diagnosis or reason for use when:

_____   a.   The patient has informed you through patient consultation. In most cases, it is possible to learn the necessary information from the patient.

_____   b.   The physician wrote the diagnosis or reason for use on this form or on a prior prescription order for this drug.

_____   **c.**   **The physician or personnel in the physician's office informed you by telephone, either now or on a previous occasion.**

Assigned Prior Authorization Number: _____

Grant Date: _____   Expiration Date: _____

Number of Days Approved: _____

This is a New Prior Authorization Request: _____

This is a Renewed Prior Authorization Request: _____

Diagnosis Code Description
Choose the most appropriate ICD-9-CM diagnosis. If the diagnosis is not a Food and Drug Administration-approved diagnosis for a particular drug, you must submit the PA request on a paper PA Request Form.

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STAT-PA Drug Worksheet:
Brand Name Proton Pump Inhibitor Drugs (PPIs)

This worksheet is to be used by pharmacists or dispensing physicians only!
(NOT REQUIRED FOR PRESCRIBING PHYSICIANS)

Generic proton pump inhibitor (PPIs) drugs have NO RESTRICTIONS as to prior authorization (PA). PPI drugs continue to be diagnosis restricted. As with all innovator drugs, prescribers must write "Brand Medically Necessary" on all hard copies of the prescriptions and on each new nursing facility order sheet.

REMINDER: *The Specialized Transmission Approval Technology — PA (STAT-PA) Drug Worksheet is* <u>*optional*</u>. *This form is not required, but is provided as a guideline only to access STAT-PA or as provider documentation. The STAT-PA system will ask for the following items in the order listed below:*

Provider Number: _____

Recipient Medicaid Identification Number: _____

Recipient Name: _____

National Drug Code (NDC)/Procedure Code of Product Requested: _____

Type of Service: __D__ Prescriber's Drug Enforcement Administration (DEA) Number: _____

Diagnosis Code: _____ (Use the recipient's *International Classification of Diseases, Ninth Revision, Clinical Modification* [ICD-9-CM] diagnosis code. The decimal is not necessary**.) The diagnosis code must be one of the PPI approved codes. ***

Place of Service: _____

Date of Service: _____ (The date of service may be up to 31 days in the future, or up to four days in the past.)

Days' Supply Requested:

STAT-PA Request Checklist
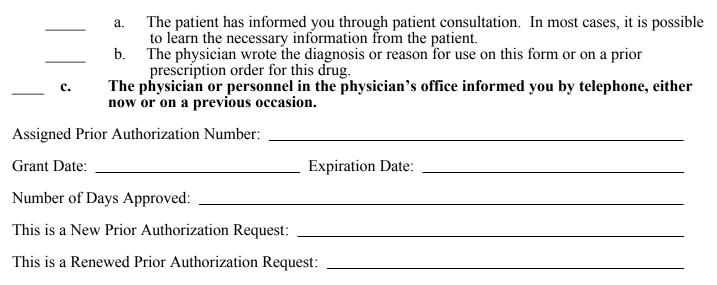<u>ALL</u> information must be checked within each category in order to be processed electronically.

A. Has the recipient tried and failed or had an adverse drug reaction to a generic PPI?
   a. If yes, approve PA request for up to 365 days.
   b. If no, return the PA with the following message: "Your prior authorization request requires additional information. Please submit your request on paper with complete clinical documentation."

* Valid NDCs are:

E9356	NSAID-induced gastric ulcer, NSAID-induced duodenal ulcer
04186	H. Pylori infectrion
2515	Zollinger-Ellison syndrome
53019	Erosive esophagitis
53081	Gastroesophageal reflux
5368	Gastric hypersecretory condition

OVER

ATTACHMENT 2

As the pharmacist, you have learned of this diagnosis or reason for use when:

      _____   a.   The patient has informed you through patient consultation. In most cases, it is possible to learn the necessary information from the patient.

      _____   b.   The physician wrote the diagnosis or reason for use on this form or on a prior prescription order for this drug.

   ____   **c.**   **The physician or personnel in the physician's office informed you by telephone, either now or on a previous occasion.**

Assigned Prior Authorization Number: _____

Grant Date: _____   Expiration Date: _____

Number of Days Approved: _____

This is a New Prior Authorization Request: _____

This is a Renewed Prior Authorization Request: _____

Diagnosis Code Description
Choose the most appropriate ICD-9-CM diagnosis. If the diagnosis is not a Food and Drug Administration-approved diagnosis for a particular drug, you must submit the PA request on a paper PA Request Form.

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Wisconsin Medicaid Drug Addition/Correction Request Form

This form must be used to request the addition of National Drug Code (NDC) billing codes for unlisted over-the-counter (OTC) drugs. Providers must 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   **FAX NUMBER:** (608) 266-1096
Division of Health Care Financing
P.O. Box 309
Madison, WI 53701-0309

Provider Name: _____   Prov ID No: _____
Street/Mail Address: _____   Tel No.: _____
City, State, ZIP: _____

NEW DRUG ADDITIONS

NDC (11 digit number)	Drug Name	Pkg Size	AWP	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

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 prices increase which is not reflected on Wisconsin Medicaid price file).

_____

_____

I certify that the price listed on the invoice reflects my actual net costs after rebates or any other discounts received from my drug wholesaler or any other entity.

Pharmacist Signature: **Date:**

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

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*P*harmacy Quick-Reference Page

Pharmacy Point-of-Sale (POS) Correspondents

For questions regarding Medicaid and SeniorCare 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 SeniorCare and Medicaid Web Sites

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

- Pharmacy handbook, data tables, and *Wisconsin Medicaid and BadgerCare Updates* online and available for viewing and downloading.
- Pharmacy POS information.
- SeniorCare Drug Inquiry Search Tool.

Fax Number for Prior Authorization (PA)

Paper PA requests may be submitted by fax.

(608) 221-8616

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 participant eligibility.

Service	Information Available	Telephone Number	Hours
Automated Voice Response (AVR) System (Computerized voice response to provider inquiries.)	Checkwrite Information Claim Status Prior Authorization Status Participant 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	Participant 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 Information Claim Status Prior Authorization Status Provider Certification Participant 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 Information Claim Status Prior Authorization Status Participant Eligibility*	Call (608) 221-4746 for more information.	7:00 a.m. - 6:00 p.m. (M-F)
SeniorCare Customer Service Hotline (Participants or persons calling on behalf of participants only.)	Participant Eligibility Medicaid-Certified Providers General SeniorCare Information	(800) 657-2038	7:30 a.m. - 5:00 p.m. (M-F)

*Please use the information exactly as it appears on the participant's identification card or EVS to complete the patient information section on claims and other documentation. Participant 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

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Preface

The Wisconsin Medicaid, BadgerCare, and SeniorCare 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 Wisconsin Medicaid, BadgerCare, and SeniorCare.

Wisconsin Medicaid, BadgerCare, and SeniorCare 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, BadgerCare, and SeniorCare.

Verifying Eligibility

Wisconsin Medicaid providers should always verify a participant's eligibility before providing services, both to determine eligibility for the current date and to determine any limitations to the participant'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.
- SeniorCare.

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, BadgerCare, and SeniorCare

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

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 430-498 — Public Health.

Wisconsin Law and Regulation

- Law: Wisconsin Statutes: Sections 49.43-49.499 and 49.665.
- Regulation: Wisconsin Administrative Code, Chapters HFS 101-108.

Wisconsin SeniorCare Law and Regulation

- Law: Wisconsin Statutes: Section 49.688.
- Regulation: Wisconsin Administrative Code, Emergency Rule Chapter HFS 109.

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, BadgerCare, and SeniorCare are available at the following Web sites:

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

Medicaid Fiscal Agent

The DHFS contracts with a fiscal agent, which is currently EDS.

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Participant Information

General Information About Wisconsin SeniorCare

Individuals enrolled in Wisconsin SeniorCare are called participants.

Wisconsin SeniorCare is a prescription drug assistance program for Wisconsin residents who are 65 years of age or older who meet eligibility criteria.

Wisconsin SeniorCare is modeled after Wisconsin Medicaid in terms of drug coverage and reimbursement, although there are a few differences. Refer to Appendix 1 of this section for a comparison between Wisconsin SeniorCare and Wisconsin Medicaid policies.

Pharmacies, dispensing physicians, blood banks, and Federally Qualified Health Centers do not need to be separately certified to provide services to SeniorCare participants. Providers who are currently Wisconsin Medicaid certified are required to both:

*   Participate in Wisconsin SeniorCare.
*   Submit SeniorCare claims during all levels of participation when a SeniorCare participant presents his or her card and a prescription is filled.

Individuals enrolled in Wisconsin SeniorCare are called participants. When a participant receives a prescription, the pharmacist will know that a participant is eligible for Wisconsin SeniorCare by a SeniorCare card that the participant should show the pharmacist each time a prescription is filled. The participant may have an out-of-pocket expense depending on his or her level of participation. The policies detailed in this handbook section apply to all levels of SeniorCare participation, unless stated otherwise.

Providers may obtain information from Wisconsin SeniorCare about the following:

*   The participant's out-of-pocket expense requirements.
*   SeniorCare reimbursement for the prescription.

Providers who have questions about Wisconsin SeniorCare may contact the resources listed on the Pharmacy Quick Reference Page and Important Telephone Numbers table in the front of this handbook section.

Participant Eligibility

To be eligible to participate in Wisconsin SeniorCare, an applicant must:

*   Be a Wisconsin resident.
*   Be a U.S. citizen or a qualifying immigrant.
*   Be 65 years of age or older.
*   Provide a Social Security number or apply for one.
*   Submit a $20 annual enrollment fee per person.

Individuals with prescription drug coverage under commercial health plans are eligible to enroll in Wisconsin SeniorCare.

Seniors who are Wisconsin Medicaid or BadgerCare recipients are not eligible for Wisconsin SeniorCare, except for the following:

*   Qualified Medicare Beneficiaries.
*   Qualifying Individuals (QI-1 or QI-2).
*   Specified Low Income Medicare Beneficiaries.
*   Recipients receiving tuberculosis-related services.
*   Recipients with an unmet Medicaid deductible.

Participant Application

Seniors apply for Wisconsin SeniorCare for a 12-month benefit period. If eligible, their SeniorCare benefits are effective on the first day of the month following the month in which eligibility criteria are met. All SeniorCare participants must reapply after 12 months.

Applications are available from the following sources:

- Local Offices on Aging, Senior Centers, or Aging Resource Centers.
- The SeniorCare Web site at *www.dhfs.state.wi.us/seniorcare/*.
- The SeniorCare Customer Service Hotline at (800) 657-2038.

Applications may be submitted by the applicant or his or her authorized representative, legal guardian, or financial power of attorney.

Wisconsin SeniorCare will notify participants before their eligibility period expires. To reapply, the participant must complete and submit the preprinted review form that is sent to each participant and pay another $20 enrollment fee. Eligibility will be redetermined for a new 12-month period within 30 days after a complete review form is received. Participants may contact the SeniorCare Customer Service Hotline at (800) 657-2038 for more information.

Eligibility Verification

Providers should always verify a participant's eligibility before providing services, both to determine eligibility for the current date and to determine any limitations to the participant's coverage.

Identification Cards

Each participant in Wisconsin SeniorCare receives a prescription benefits card, modeled after National Council for Prescription Drug Programs standards for identification cards. Participants have been instructed to present their card each time they get a prescription filled.

The SeniorCare card is different from the Medicaid Forward card. Refer to Appendix 2 of this section for an example of a SeniorCare card.

SeniorCare participants may also have a Forward card and may receive other benefits as described under "Participant Eligibility" earlier in this chapter. For more information on Wisconsin Medicaid benefit categories, refer to the Medicaid All-Provider Handbook. When filling a prescription, the provider should verify the participants' Medicaid and SeniorCare eligibility to determine which benefit the individual is eligible for before providing services.

The Eligibility Verification System

Pharmacies using real-time Point-of-Sale (POS) online processing systems have eligibility verification as part of the claims processing system.

Pharmacies and other providers not using real-time online claims processing should verify SeniorCare eligibility by using the Wisconsin Medicaid Eligibility Verification System (EVS). When using the EVS to verify a participant's eligibility, providers will encounter different eligibility status responses that have been established for Wisconsin SeniorCare. Refer to Appendix 3 of this section for a list of these responses.

The EVS can be accessed in a number of ways. The different EVS access methods include:

- Automated Voice Response (AVR). The AVR is available 24 hours a day, seven days a week. To access the AVR, call (800) 947-3544 or (608) 221-4247. The AVR system will prompt providers for participant information, and the AVR message will inform providers if a participant is eligible for Wisconsin SeniorCare. Refer to Appendix 3 of this section for a list of AVR system responses that providers receive when a participant is eligible for Wisconsin SeniorCare.

Pharmacies and other providers not using real-time online claims processing should verify SeniorCare eligibility by using the Wisconsin Medicaid Eligibility Verification System (EVS).

- Personal computer software. If the participant is eligible for Wisconsin SeniorCare, one of the following messages will be displayed:
  1. "Eligible for SeniorCare. Call Provider Services (800) 947-9627."
  2. "Eligible for multiple programs. Call 800-947-9627."

  Providers should call Provider Services for a more detailed explanation of services covered for the participant.
- Direct Information Access Line with Updates for Providers (Dial-Up). The Dial-Up system is available from 7:00 a.m. until 6:00 p.m. If the participant is eligible for Wisconsin SeniorCare, the system will display the participant's medical status and description. Refer to Appendix 3 of this section for a list of SeniorCare medical status codes and descriptions.
- Provider Services. Call (800) 947-9627 or (608) 221-9883. Correspondents are available Monday and Wednesday through Friday from 8:30 a.m. until 6:00 p.m. and on Tuesday from 9:30 a.m. to 6:00 p.m.

Wisconsin SeniorCare will inform the pharmacy of the amount to charge the participant during all levels of participation through the real-time POS claim response and the Remittance and Status (R/S) Report.

Obtaining Information About Participant Out-of-Pocket Expenses

Wisconsin SeniorCare has three levels of program participation based on the income of the participant. Each level has different out-of-pocket expense requirements:

- Level 1 (copayment).
- Level 2 (deductible).
- Level 3 (spenddown).

Wisconsin SeniorCare will inform the pharmacy of the amount to charge the participant during all levels of participation through the real-time POS claim response and the Remittance and Status (R/S) Report. The pharmacy should never charge the participant more than the amount indicated by Wisconsin SeniorCare, according to s. 49.688(5)(a), Wis. Stats. If a SeniorCare participant pays an amount greater than the SeniorCare claim response during any level of participation, the provider must refund the difference to the participant.

Level 1

A participant is required to pay a copayment in each of the following situations:

- Upon applying for SeniorCare, the participant meets the income limits for Level 1 (copayment).
- Subsequent to applying for SeniorCare, the participant meets the Wisconsin SeniorCare spenddown and/or deductible requirements.

Copayment amounts are the following:

- A $5 copayment on each generic prescription drug, generic insulin, and compound drug.
- A $15 copayment for each brand-name prescription drug and insulin.

Wisconsin SeniorCare uses First Data Bank to determine brand-name and generic drugs for copayment determination.

There is no limit on the total amount of copayments a participant may be required to pay during his or her SeniorCare eligibility. Unlike Wisconsin Medicaid, Wisconsin SeniorCare does not make exemptions for copayment.

When a participant is required to pay a copayment, pharmacies will collect the copayment from the participant and Wisconsin SeniorCare will reimburse the remainder of the prescription cost up to the SeniorCare rate.

The copayment may be paid at the time the drug is dispensed. If the participant does not pay the copayment, the pharmacist can choose not to dispense the drug.

Level 2

A participant is required to pay a $500 deductible in each of the following situations:

- Upon applying for SeniorCare, the participant meets the income limits for Level 2 (deductible).
- Subsequent to applying for SeniorCare, the participant meets the Wisconsin SeniorCare spenddown requirement.

Until a participant meets the required deductible, pharmacies may charge the participant no more than the SeniorCare rate, which equals the Medicaid reimbursement rate plus 5%, plus the applicable Medicaid dispensing fee.

Providers may obtain deductible information for a specific participant through the following sources:

- The real-time POS system.
- The R/S Report.
- Provider Services at (800) 947-9627 or (608) 221-9883.

Dollars applied toward the deductible are not carried over into the next benefit period. After the participant meets the deductible amount, he or she will then be able to purchase drugs at the copayment amounts.

Level 3

Under SeniorCare income requirements, participants are required to pay a spenddown equal to the amount their income exceeds 240% of the federal poverty level. For households in which only one individual is eligible for Wisconsin SeniorCare, the participant's spenddown amount is based on the individual's income. If the individual is married and living with his or her spouse, however, SeniorCare eligibility is based on the income of both spouses.

If both spouses are eligible for Wisconsin SeniorCare, the spenddown amount is based on the total of both participants' incomes.

SeniorCare-covered drugs for either participant will be applied to satisfy the spenddown amount. For example, a spenddown of $1,200 has been determined for the couple. One spouse could pay $700 for prescription drugs and the other could pay $500 to meet the total spenddown amount of $1,200. Once the spenddown is satisfied, each spouse will be required to satisfy a $500 deductible.

Participants eligible at Level 3 pay the retail price for drugs while meeting this spenddown. Until participants meet their required spenddown, pharmacies may charge participants no more than their usual and customary/retail rate.

Providers may obtain spenddown information for a specific participant through the following sources:

- The real-time POS system.
- The R/S Report.
- Provider Services at (800) 947-9627 or (608) 221-9883.

Dollars applied toward spenddown are not carried over into the next benefit period. After the participant meets the spenddown amount, he or she then must meet the $500 deductible. Once the deductible is met, he or she may purchase drugs at the copayment amounts.

Participant Payment for Noncovered Drugs

A participant may obtain drugs that are not covered under SeniorCare or drugs for which prior authorization (PA) was denied. For information about PA, refer to "Prior Authorization and Diagnosis-Restricted Drugs" in the Reimbursement chapter. In these instances, the participant is responsible for payment only if the provider informs the participant of the following *prior* to providing the drug:

- Wisconsin SeniorCare does not cover the drug.
- The participant will be responsible for the cost.

Under SeniorCare income requirements, participants are required to pay a spenddown equal to the amount their income exceeds 240% of the federal poverty level.

Covered Services

Covered Drugs

Wisconsin SeniorCare covers the following when provided by a Wisconsin Medicaid-certified pharmacy:

- Prescription legend drugs for which there is a signed drug rebate agreement with the manufacturer.
- Over-the-counter (OTC) insulin.
- Compound drugs with at least two ingredients, at least one of which Wisconsin SeniorCare covers.
- Brand-name innovator drugs identified as "brand medically necessary" on the prescription and the "dispense as written" indicator on the drug claim.

Based on the prescription and the drug dispensed, Wisconsin SeniorCare will cover up to a 100-day supply. Refer to the Covered Services section of the Pharmacy Handbook for a list of legend drugs that providers may dispense in the quantity prescribed, up to a 100-day supply.

Coverage of Emergency Drugs

Wisconsin SeniorCare will cover drugs provided by noncertified, in-state providers only if the drug(s) is provided in an emergency situation. Emergency services are those services which are necessary to prevent death or serious impairment of the health of the individual. The emergency situation must be sufficiently documented on the claim. Refer to the Provider Certification section of the Medicaid All-Provider Handbook for more information.

Coverage of Drugs Provided Out-of-State

Participants should arrange with their pharmacy to obtain necessary prescriptions before traveling outside Wisconsin.

Wisconsin SeniorCare will cover drugs provided by noncertified, out-of-state providers in either of the following situations:

- Prior authorization (PA) is obtained from Wisconsin SeniorCare *before* the service is provided.
- The drug(s) is provided in an emergency situation arising from an accident or sudden illness.

Refer to the Provider Certification section of the Wisconsin Medicaid All-Provider Handbook for more information.

Prescription Drug Search Tool

The Wisconsin SeniorCare Web site at *www.dhfs.state.wi.us/seniorcare/* includes a search tool for prescription drugs covered by Wisconsin SeniorCare. Wisconsin Medicaid-certified pharmacies and other health care providers can use the search tool to help identify and calculate ingredient rates of drugs covered by Wisconsin SeniorCare.

The information provided through the search tool does not guarantee SeniorCare coverage or payment. As with Wisconsin Medicaid, the following requirements must also be met before reimbursement is made:

- Provider certification.
- Participant eligibility.
- Participant spenddown and deductible.
- Medical necessity.
- All other state and federal requirements.

Wisconsin SeniorCare will periodically update the information on the search tool. Providers should refer to the revision date if they call Provider Services with questions about the information received from the search tool.

Information Included in the Search Tool

For each National Drug Code (NDC) and label name listed in the search tool, the following information is available:

- Age restrictions associated with the NDC.
- Copayment amount (brand, generic, compound, or not applicable).
- Diagnosis code restrictions. Refer to the Prior Authorization section of the Pharmacy Handbook for a list of drugs whose coverage is restricted and for a valid list of diagnosis codes.
- Effective date of the listed ingredient rate.
- Indicator for whether the NDC can only be billed as a compound drug ingredient.
- Maximum days' supply permitted in one dispensing (34 or 100 days).
- Medicare coverage of the prescription.
- The package size used to derive a unit price. It is the usual labeled quantity from which the pharmacist dispenses, such as 100 tablets, 1,000 capsules, or 20-ml vials.
- The reimbursement methodology applicable to the prescription. Refer to "Provider Payment Rates" in the Reimbursement chapter of this section for definitions of Wisconsin SeniorCare reimbursement methodologies.
- Unit of measurement, or drug form, that indicates the basic drug measurement unit for performing price calculations. Valid values are for each (tablets, kits, etc.), milliliters (liquids), or grams (solids).
- Wisconsin Medicaid PA requirements. Refer to the Prior Authorization section of the Pharmacy Handbook for a list of drugs that require PA.

Instructions for Using the Search Tool

Refer to the following instructions for use of the search tool on the SeniorCare Web site:

1. From the Wisconsin SeniorCare home page at *www.dhfs.state.wi.us/seniorcare/* click on "Information for Providers" in the menu on the left of the screen.

2. Click on the link to the covered drug search tool.
3. Identify the drug for which the provider wants to search by entering the 11-digit NDC or the drug label name into the appropriate box. For a list of NDCs by labeler code, enter a minimum of five digits for the NDC followed by an asterisk (*). For a list of NDCs with similar names, enter a minimum of five characters in the label name.
4. Select the criteria by which the provider wishes to sort the results: NDC, brand/generic, or label name.
5. After entering all applicable information, click on the "Search" button.
6. Users may receive one of three types of responses:
   - If SeniorCare covers the prescription drug, the user will receive a list of drugs based on the search criteria.
   - If the search returns results in excess of 100 items, the user will be prompted to start a new search with more detailed information.
   - If Wisconsin SeniorCare does not cover the prescription drug, the user will receive a message that "The Label Name '[Label Name]' cannot be found. This may indicate that the Label Name is not covered, invalid, or has been terminated."
7. For details about a particular drug, click on the applicable NDC of the drugs listed on the search results.
8. It is recommended that the provider keep a copy of the Drug Information Web page for future reference.

Noncovered Services

Wisconsin SeniorCare does not cover the following:

- A drug for a specific participant for which PA has been requested and denied.
- Brand-name innovator drugs without "brand medically necessary" handwritten by the prescriber on the prescription.

It is recommended that the provider keep a copy of the Drug Information Web page for future reference.

Covered Services

- 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.)
- Common medicine chest items such as antiseptics and Band-Aids®.
- Cosmetics.
- Disposable Medical Supplies (e.g., insulin supplies).
- Drugs identified by the Centers for Medicare and Medicaid Services (CMS) as less-than-effective or identical, related, or similar.
- Drugs included in the Wisconsin Negative Formulary.
- Durable Medical Equipment.

- Items that are in the inventory of a nursing facility.
- Medicare coinsurance and deductible.
- Over-the-counter drugs other than insulin.
- "Patent" medicines.
- Personal care items.
- Personal hygiene items.
- Prefill allowance.
- Prescriptions administered in a physician's office.
- Prescription legend drugs for which there is not a rebate agreement with the manufacturer.
- Refills of schedule II drugs. (Partial fills are acceptable if they comply with Board of Pharmacy regulations.)
- Refills beyond those described under "Refill Policy" in the Covered Services and Reimbursement section of the Wisconsin Medicaid Pharmacy Handbook.
- Uneconomically small package sizes.

Covered Services

Covered Services

*R*eimbursement

Provider Certification

Wisconsin Medicaid-certified pharmacies, dispensing physicians, blood banks, and Federally Qualified Health Centers do not need to be separately certified to provide services to SeniorCare participants. These providers are required to participate in Wisconsin SeniorCare and to submit SeniorCare claims during all levels of participation when a SeniorCare participant presents his or her card and a prescription is filled.

Provider Payment Rates

*S*tate law limits what pharmacies may charge SeniorCare participants for covered drugs. Wisconsin SeniorCare payment rates are based on the Wisconsin Medicaid payment rate plus 5%, plus the applicable Medicaid dispensing fee. Regardless of the participant's level of participation, pharmacies should always submit their usual and customary/retail rate.

Wisconsin SeniorCare's two payment rates are:

- Average Wholesale Price (AWP) of a National Drug Code (NDC) minus 11.25%, plus 5%, (AWP – 11.25% + 5%) plus the applicable Medicaid dispensing fee.
- Maximum Allowable Cost (MAC) for the NDC plus 5%, plus the applicable Medicaid dispensing fee. Refer to the Pharmacy Data Tables section of the Pharmacy Handbook for a list of MAC drugs.

Drug Utilization Review and Pharmaceutical Care

SeniorCare policy is modeled after Wisconsin Medicaid with a few differences. Refer to Appendix 1 of this section for a comparison

between Wisconsin SeniorCare and Wisconsin Medicaid policies.

Prospective and Retrospective Drug Utilization Review

Wisconsin SeniorCare uses both prospective and retrospective Drug Utilization Review (DUR).

Prospective DUR is applied to all SeniorCare real-time Point-of-Sale (POS) claims submitted to Wisconsin SeniorCare. Real-time claims for nursing home participants are reviewed but do not require a response from the pharmacy.

The following types of claims are excluded from prospective DUR:

- Paper claims.
- Electronic Media Claims (EMC).

Retrospective DUR and Participant Lock-In are applied to all SeniorCare claims.

Refer to the Drug Utilization Review and Pharmaceutical Care section of the Pharmacy Handbook for details about prospective and retrospective DUR.

Pharmaceutical Care

Wisconsin SeniorCare allows the same Pharmaceutical Care (PC) codes as Wisconsin Medicaid for all levels of SeniorCare participation with the same limitations on occurrences per calendar year.

Wisconsin SeniorCare reimburses pharmacies directly for PC at the Wisconsin Medicaid rate when the participant is in, or has reached, the copayment level of participation.

While the participant has a spenddown or deductible, the pharmacy must obtain participant consent for PC services prior to providing them.

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*S*tate law limits what pharmacies may charge SeniorCare participants for covered drugs. Wisconsin SeniorCare payment rates are based on the Wisconsin Medicaid payment rate plus 5%, plus the applicable Medicaid dispensing fee.

Reimbursement

Refer to the Drug Utilization Review and Pharmaceutical Care section of the Wisconsin Medicaid Pharmacy Handbook for more information about PC services.

Prior Authorization and Diagnosis-Restricted Drugs

For certain drugs, Wisconsin SeniorCare requires prior authorization (PA) or specific diagnosis codes for the pharmacy to receive reimbursement, regardless of the level of participation. Prior authorization requirements for Wisconsin SeniorCare are modeled after Wisconsin Medicaid requirements. Refer to the Prior Authorization section of the Wisconsin Medicaid Pharmacy Handbook for details about PA procedures.

Wisconsin SeniorCare uses the Wisconsin Medicaid list of drugs for both PA and diagnosis restrictions. Refer to the Prior Authorization section of the Pharmacy Handbook for this information.

As with PA requests submitted to Wisconsin Medicaid, pharmacies may submit PA requests in the following ways:

- Wisconsin Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) requests.
- Paper PA requests submitted by fax to (608) 221-8616.
- Paper PA requests submitted by mail to:

    Wisconsin SeniorCare
    Prior Authorization
    Ste 88
    6406 Bridge Rd
    Madison WI 53784-0088

For paper requests, Wisconsin SeniorCare requires completion of the same forms as Wisconsin Medicaid in order to request PA:

- Prior Authorization Request Form (PA/RF).
- Prior Authorization Drug Attachment (PA/DGA) for prescription drugs.

Claims Submission

Claims submission procedures for Wisconsin SeniorCare are modeled after Wisconsin Medicaid and differ primarily in real-time POS submissions as described on the next page. However, pharmacies are required to submit separate claims for Wisconsin Medicaid services and Wisconsin SeniorCare services.

Pharmacies are required under HFS 109.51(5), Wis. Admin. Code, to submit claims to Wisconsin SeniorCare for SeniorCare participants at all levels of participation. Wisconsin SeniorCare will not accept receipts or claims submitted by SeniorCare participants for reimbursement.

Methods of Claims Submission

Pharmacies may submit claims to Wisconsin SeniorCare in one of three ways:

- The POS electronic claims management system.
- Electronic Media Claims.
- Paper claims using Wisconsin Medicaid and SeniorCare claim forms (Compound Drug, Non-Compound Drug, and the Adjustment Request Form) and mailed to:

    Wisconsin SeniorCare
    Claims and Adjustments
    6406 Bridge Road
    Madison WI 53784-0002

Refer to the Claims Submission section of the Wisconsin Medicaid Pharmacy Handbook for details about each form of claims submission.

For certain drugs, Wisconsin SeniorCare requires prior authorization (PA) or specific diagnosis codes for the pharmacy to receive reimbursement, regardless of the level of participation.

Field Names May Vary

When submitting real-time POS, electronic, or paper claims to Wisconsin SeniorCare, providers may notice that names of fields on the claim form may vary for the following reasons:

- Depending on the form of submission, the "Other Insurance Amount" and "Patient Paid Amount" have different field names. Refer to the Changes in Field Names by Form of Submission table on this page.
- For real-time claims submission, the "Patient Paid Amount" field may be labeled differently depending on the provider's system (e.g., copayment, spenddown, or patient price).

Enhanced Point-of-Sale System for SeniorCare Claims Submission

Real-time POS claims submission provides the most accurate information about SeniorCare participant eligibility, drug coverage, and reimbursement determination. To allow for SeniorCare claims processing, POS has been enhanced to provide pharmacies the following information using National Council for Prescription Drug Programs (NCPDP) standard fields:

- The amount to be collected from participants.
- Participant copayment amount.
- Participant deductible amount for the prescription and remaining deductible for the benefit period.
- Participant spenddown amount for the prescription and remaining spenddown for the benefit period.

If the pharmacy is unable to obtain this information by POS, the pharmacy should contact its software vendor.

Appendix 4 of this section contains the NCPDP fields that Wisconsin SeniorCare uses to collect and adjudicate SeniorCare POS claims in addition to fields used by Wisconsin Medicaid. This appendix also details participant information that is provided in response to a real-time claim.

Refer to Appendix 5 of this section for examples of real-time claim responses.

Obtaining Information for Paper and Electronic Media Claims

Pharmacies that submit EMC and paper claims to Wisconsin SeniorCare may receive spenddown and deductible information for each participant from the following sources:

- Provider Services at (800) 947-9627 or (608) 221-9883.
- The Remittance and Status (R/S) Report.

Reversals and Adjustments

Claims submitted real-time through POS may be reversed within 90 days of the claim paid date. Providers are required to use the paper Adjustment Request Form for the following types of claims:

- Electronic Media Claims.
- Paper claims.
- Real-time claims after 90 days.

Changes in Field Names by Form of Submission		
Form of Submission	"Other Insurance Amount" Field	"Patient Paid Amount" Field
Real-time	Field 431	Field 433
EMC	OI-PAID	PAT-PAID
Paper	Element 30 — OC Amount	Element 31 — Patient Paid

Refer to the Claims Submission section of the Pharmacy Handbook for details about reversals and adjustments and a copy of the Adjustment Request Form.

As a result of claim reversals or adjustments:

• Participants may change levels of participation (e.g., from deductible to spenddown) as a result of claim reversals or adjustments.
• Wisconsin SeniorCare will reapply spenddown and/or deductible as applicable.

Coordination of Benefits

Wisconsin SeniorCare is the payer of last resort except when the participant is also eligible for the Wisconsin Chronic Disease Program.

For participants with other insurance, Wisconsin SeniorCare requires pharmacies to bill primary insurance before submitting a claim to Wisconsin SeniorCare. After obtaining a response from the participant's primary insurance, the pharmacy may submit a claim to Wisconsin SeniorCare for the remainder of the covered drug charges, including reporting any out-of-pocket expenses (coinsurance, deductible, copayment) determined by the primary insurance. Using this information, Wisconsin SeniorCare will coordinate with the primary insurance to determine the SeniorCare out-of-pocket expense.

Pharmacies should submit claims for drugs paid by primary insurance separately from those not covered by primary insurance for the same SeniorCare participant.

Information Available to Pharmacies

Due to coordination of benefits, Wisconsin SeniorCare may indicate that the pharmacy collect from the participant an amount different than the amount indicated by primary

insurance. Pharmacies may obtain this information by:

• The POS system. Refer to Appendix 4 of this section for the definition and description of the standard NCPDP fields that will be used for SeniorCare POS claims submission and response.
• The R/S Report.

Indicating Other Insurance Payments on a Claim

When submitting claims to Wisconsin SeniorCare to coordinate benefits with other coverage, whether the other coverage is an insurance or discount card or plan, the following fields must be used to provide the outcome of billing other coverage:

• The NCPDP other coverage code in the "Other Coverage" field. Refer to the Claims Submission section of the Pharmacy Handbook for a crosswalk between the NCPDP other coverage code and the Wisconsin Medicaid other insurance indicator.
• The amount paid by other insurance in the "Other Payor Amount" field.
• The amount of the participant's other coverage cost sharing out-of-pocket expense (i.e., copayment, deductible, coinsurance) in the "Patient Paid Amount" field.

Depending on the provider's system and form of submission, these fields may have different names. For example, the "Patient Paid Amount" may be labeled differently depending on the provider's system (e.g., copayment, spenddown, or patient price). Depending on the form of submission, the "Other Insurance Amount" and "Patient Paid Amount" also have different field names.

If the provider fails to indicate or provide the "Patient Paid Amount" field with the participant's out-of-pocket expense after the other coverage determination is made, coordination of benefits will be based solely on the amount present in the "Other Payor

Due to coordination of benefits, Wisconsin SeniorCare may indicate that the pharmacy collect from the participant an amount different than the amount indicated by primary insurance.

*F*or those
pharmacies
honoring
prescription
discount cards or
plans, the
discounted amount
should be provided
in the "Patient Paid
Amount" field.

Amount" field. The participant's out-of-pocket expense is determined using the primary insurance copayment or deductible and is indicated in the "Patient Paid Amount" field.

Refer to the following appendices of this section for claim examples:

• Appendix 6 for examples of coordination of benefits claims by type of insurance.
• Appendix 7 for real-time claim response examples for coordination of benefits claims.

Private Insurance

Wisconsin SeniorCare monitors the same private insurance carriers as Wisconsin Medicaid. Refer to the Claims Submission section of the Pharmacy Handbook for a current list of insurance carriers. For those insurance carriers that Wisconsin SeniorCare

and Wisconsin Medicaid monitor, providers must indicate the private insurance determination on each claims submission. If this information is not provided, the claim will be denied.

Discount Cards and Plans

Wisconsin SeniorCare does not mandate or require pharmacies to honor discount cards or plans, nor are these kept on file with Wisconsin SeniorCare as other coverage.

For those pharmacies honoring prescription discount cards or plans, the discounted amount should be provided in the "Patient Paid Amount" field. For example, if the pharmacy honors a discount card that provides a 10% discount and the usual and customary/retail rate is $100, enter $90 in the "Patient Paid Amount" field. Refer to the example in Appendix 6 of this section.

Reimbursement

ARCHIVAL USE ONLY
Refer to the Online Handbook
for current policy

*A*ppendix

ARCHIVAL USE ONLY
Refer to the Online Handbook
for current policy

Appendix

Appendix 1

Comparison of Wisconsin SeniorCare and Wisconsin Medicaid Policies

The table below compares Wisconsin Medicaid and Wisconsin SeniorCare policies.

Policy	Same as Wisconsin Medicaid	Comment
Provider help desk	Yes	
Claims submission methods	Yes	
Compound dispensing	Yes	
34 and 100 days' supply	Yes	
Prospective Drug Utilization Review (DUR)	Yes	
Dispensing fee	Yes	
Retrospective DUR	Yes	
Lock-In	Yes	
Remittance and Status (R/S) Report	Yes	Medicaid and SeniorCare claims will appear on the same weekly R/S Report.
Eligibility verification	Yes	
Participant customer service	No	(800) 657-2038.
Prior authorization (PA)	No	Drugs without a manufacturer rebate agreement are not covered and cannot be obtained with a PA.
Pharmaceutical Care (PC)	No	Must have participant's prior consent during deductible and spenddown levels of participation to receive and be charged for PC service. SeniorCare will reimburse PC services during copayment period, same as Wisconsin Medicaid.
Copayment	No	$5 on each generic prescription drug, generic insulin, and compound drug. $15 for each brand-name prescription drug and insulin.
Copayment exemptions	No	Medicaid exemptions do not apply to Wisconsin SeniorCare.
Covered drugs	No	Legend drugs and over-the-counter insulin with a signed manufacturer rebate agreement.

Appendix

Policy	Same as Wisconsin Medicaid	Comment
Drug reimbursement rate	No	• Level 1 (copayment) — Wisconsin SeniorCare reimburses pharmacies up to the SeniorCare rate. • Level 2 (deductible) — participant pays up to the SeniorCare rate (Medicaid ingredient rate plus 5%, plus the Medicaid dispensing fee). • Level 3 (spenddown) — participant pays up to retail price.
Identification cards	No	SeniorCare card. Refer to Appendix 2 of this section for an example.
Age restriction	No	Participants must be 65 years of age or older.
Managed care	No	SeniorCare participants will not be enrolled in Medicaid managed care programs.
Coordination of benefits	No	Pharmacies are required to submit any out-of-pocket expenses the participant incurs in the "Patient Paid Amount" field and any other insurance payments in the "Other Payor Amount" field.

Appendix

Appendix 2

Sample SeniorCare Card

Below is an example of the SeniorCare card that participants will receive.

Front

SENIORCARE
Prescription Drugs for Wisconsin Seniors

RxBIN   610499
Issuer (80840)

ID   1234567890

Name   IMA PARTICIPANT

Back

Participants:
• Show this card each time you get your prescription drugs.
• For customer service, call 1-800-657-2038.

Pharmacists:
Submit claims electronically or send paper claims to:

Claims and Adjustments Unit
6406 Bridge Rd.
Madison, WI 53784-0002

Provider Services: 1-800-947-9627

Appendix

Appendix

Appendix 3

Medical Status Descriptions and Automatic Voice Response System Responses

Pharmacies and other providers not using real-time Point-of-Sale online claims processing should verify a participant's SeniorCare eligibility by using the Wisconsin Medicaid Eligibility Verification System (EVS), which can be accessed in a number of ways. The table below lists SeniorCare eligibility messages available through the following means of accessing EVS:

- Direct Information Access Line with Updates for Providers, which displays the participant's medical status and description.
- Automated Voice Response, which sends providers the following responses when a participant is eligible for SeniorCare.

Medical Status Code	Medical Status Description	Automatic Voice Response
SS	SeniorCare spenddown	For this period, the participant is eligible for SeniorCare. SeniorCare only covers prescription drugs. For spenddown, deductible, or copay status, press "0" for a correspondent, or press "1" to continue.
SD or SE	SeniorCare deductible	For this period, the participant is eligible for SeniorCare. SeniorCare only covers prescription drugs. For deductible or copay status, press "0" for a correspondent, or press "1" to continue.
SC	SeniorCare copayment	For this period, the participant is eligible for SeniorCare. SeniorCare only covers prescription drugs.
SF	SeniorCare deductible/ Medicare Premium Assistance	For this period, the participant is eligible for SeniorCare and QMB*. SeniorCare only covers prescription drugs. The patient is also eligible for payment of coinsurance and deductible for all services covered by Medicare. For more information on covered services, SeniorCare deductible or copay status, press "0" for a correspondent, or press "1" to continue.
SG	SeniorCare copayment/ Medicare Premium Assistance	For this period, the participant is eligible for SeniorCare and QMB*. SeniorCare only covers prescription drugs. The patient is also eligible for payment of coinsurance and deductible for all services covered by Medicare. For more information on covered services, press "0" for a correspondent, or press "1" to continue.
SH	SeniorCare deductible/ Tuberculosis (TB)-related/Medicare Premium Assistance	For this period, the participant is eligible for SeniorCare, TB-related Medicaid, and QMB*. SeniorCare only covers prescription drugs. The patient is also eligible for TB-related services and payment of coinsurance and deductible for all services covered by Medicare. For more information on covered services, SeniorCare deductible, or copay status, press "0" for a correspondent, or press "1" to continue.

*QMB is Qualified Medicare Beneficiary.

Medical Status Code	Medical Status Description	Automatic Voice Response
SJ	SeniorCare copayment/ TB-related/Medicare Premium Assistance	For this period, the participant is eligible for SeniorCare, TB-related Medicaid, and QMB*. SeniorCare only covers prescription drugs. The patient is also eligible for TB-related services and payment of coinsurance and deductible for all services covered by Medicare. For more information on covered services, press "0" for a correspondent, or press "1" to continue.
TS	SeniorCare deductible/ TB-related	For this period, the participant is eligible for SeniorCare and TB-related Medicaid. SeniorCare only covers prescription drugs. Tuberculosis-related lab, X-ray, and outpatient services are also covered for this participant. No inpatient services are payable. For deductible or copay status, press "0" for a correspondent, or press "1" to continue. To repeat the eligibility information for this recipient, press "8." To inquire on another recipient's eligibility, press "1." To return to the main menu, press "9." If you would like assistance from a correspondent, press "0."
ST	SeniorCare copayment/ TB-related	For this period, the participant is eligible for SeniorCare and TB-related Medicaid. SeniorCare only covers prescription drugs. Tuberculosis-related lab, X-ray, and outpatient services are also covered for this participant. No inpatient services are payable. To repeat the eligibility information for this recipient, press "8." To inquire on another recipient's eligibility, press "1." To return to the main menu, press "9." If you would like assistance from a correspondent, press "0."

*QMB is Qualified Medicare Beneficiary.

Appendix 4

National Council for Prescription Drug Programs Fields

The tables below list the National Council for Prescription Drug Programs (NCPDP) fields that Wisconsin SeniorCare uses to collect and provide information for adjudicating SeniorCare Point-of-Sale claims in addition to the fields used for Wisconsin Medicaid. All format modifications for SeniorCare claims will also apply to Wisconsin Medicaid claims.

SeniorCare-Related Claims Submission Format Changes	
NCPDP Field 433-DX Patient Paid Amount (Optional)	
NCPDP definition	Amount received from a patient for the prescription dispensed.
SeniorCare format changes	SeniorCare requires pharmacies to enter the participant's out-of-pocket expenses for the prescription dispensed (i.e., copayments/coinsurance related to the primary billing or the amount paid by the participant less the discount related to a pharmacy discount card).

SeniorCare-Related Claim Response Format Changes	
NCPDP Field 504 Message (Required)	
NCPDP definition	Free form text.
SeniorCare format changes	SeniorCare formats this field to display the total amount the participant has yet to pay before satisfying his or her spenddown and the total amount the participant has yet to pay before satisfying his or her deductible.
NCPDP Field 505 Patient Pay Amount (Required)	
NCPDP definition	Amount to be collected from the patient.
SeniorCare format changes	SeniorCare provides the total amount of copayment, spenddown, and/or deductible for which the participant is liable for the prescription. This is the amount to be collected by the pharmacy, regardless of copayment/coinsurance indicated by the primary insurance.
NCPDP Field 513-FD Remaining Deductible (Optional)	
NCPDP definition	The amount in dollars not met by the patient/family in the deductible plan.
SeniorCare format changes	SeniorCare provides the total amount the participant has yet to pay for prescription drugs before his or her spenddown and deductible amounts have been satisfied for his or her current eligibility period.
NCPDP Field 517-FH Amount Applied to Periodic Deductible (Optional)	
NCPDP definition	Amount to be collected from a patient that is applied to a periodic deductible.
SeniorCare format changes	SeniorCare provides the total amount from the claim that has been applied to the participant's annual spenddown and deductible.
NCPDP Field 518-FI Amount of Copayment/Coinsurance (Optional)	
NCPDP definition	Amount to be collected from a patient that is due to a per prescription copayment/coinsurance.
SeniorCare format changes	SeniorCare provides the total amount of copayment for which the participant is liable.

Appendix

Appendix 5

Real-Time Claim Response Examples

The examples in this appendix indicate how certain Wisconsin SeniorCare claims would appear in a real-time Point-of-Sale claim response. In all of these examples, the following are constants:

- The usual and customary charge for each prescription drug is $125. (The compound drug example includes ingredients totalling $125.)
- The SeniorCare rate for each prescription drug is $87.
- A brand-name drug is dispensed.
- For the example with compound drugs, the level of service/dispensing fee is $9.
- The compound copayment is always $5.
- The amounts indicated in fields 513 and 517 are a total of spenddown plus deductible, not just deductible.

	Example 1: Single Prescription, Non-Compound Claim with Spenddown						
	Field 509	Field 505	Field 513	Field 517	Field 518	Field 504	
	Total Amount Paid (by SeniorCare)	Patient Pay Amount*	Remaining Deductible Amount	Amount Applied to Periodic Deductible	Copay Amount	Remaining Spenddown	Remaining Deductible
Prescription 1	$0	$125	$575	$125	$0	$75	$500

*This amount represents the participant's out-of-pocket liability for spenddown.

	Example 2: Single Prescription, Non-Compound Claim with Deductible						
	Field 509	Field 505	Field 513	Field 517	Field 518	Field 504	
	Total Amount Paid (by SeniorCare)	Patient Pay Amount*	Remaining Deductible Amount	Amount Applied to Periodic Deductible	Copay Amount	Remaining Spenddown	Remaining Deductible
Prescription 1	$0	$87	$413	$87	$0	$0	$413

*This amount represents the participant's out-of-pocket liability for deductible.

	Example 3: Single Prescription, Non-Compound Claim with Copayment						
	Field 509	Field 505	Field 513	Field 517	Field 518	Field 504	
	Total Amount Paid (by SeniorCare)	Patient Pay Amount*	Remaining Deductible Amount	Amount Applied to Periodic Deductible	Copay Amount	Remaining Spenddown	Remaining Deductible
Prescription 1	$72	$15	$0	$0	$15	$0	$0

*This amount represents the participant's out-of-pocket liability for copayment.

Example 4: Multiple Prescriptions, Non-Compound Claim with Spenddown and Deductible

	Field 509	Field 505	Field 513	Field 517	Field 518	Field 504	
	Total Amount Paid (by SeniorCare)	Patient Pay Amount*	Remaining Deductible Amount	Amount Applied to Periodic Deductible	Copay Amount	Remaining Spenddown	Remaining Deductible
Prescription 1	$0	$125	$575	$125	$0	$75	$500
Prescription 2	$0	$125	$450	$125	$0	$0	$450
Prescription 3	$0	$87	$363	$87	$0	$0	$363

*This amount represents the participant's out-of-pocket liability for spenddown and deductible.

Example 5: Multiple Prescriptions, Non-Compound Claim with Deductible

	Field 509	Field 505	Field 513	Field 517	Field 518	Field 504	
	Total Amount Paid (by SeniorCare)	Patient Pay Amount*	Remaining Deductible Amount	Amount Applied to Periodic Deductible	Copay Amount	Remaining Spenddown	Remaining Deductible
Prescription 1	$0	$87	$13	$87	$0	$0	$13
Prescription 2	$74	$13	$0	$13	$0	$0	$0
Prescription 3	$72	$15	$0	$0	$15	$0	$0

*This amount represents the participant's out-of-pocket liability for deductible and copayment.

Example 6: Compound Drug Claim with Copayment

	Field 509	Field 505	Field 513	Field 517	Field 518	Field 504	
	Total Amount Paid (by SeniorCare)	Patient Pay Amount*	Remaining Deductible Amount	Amount Applied to Periodic Deductible	Copay Amount	Remaining Spenddown	Remaining Deductible
Level of service/ dispensing fee	$4	$5	$0	$0	$5	$0	$0
Ingredient 1	$12	$0	$0	$0	$0	$0	$0
Ingredient 2	$6	$0	$0	$0	$0	$0	$0
Ingredient 3	$35	$0	$0	$0	$0	$0	$0
Ingredient 4	$25	$0	$0	$0	$0	$0	$0

*This amount represents the participant's out-of-pocket liability for copayment.

Appendix

Appendix 6

Coordination of Benefits Claim Examples

The following table provides examples to assist pharmacies that submit real-time through the Point-of-Sale system. In all of these examples, the usual and customary charge is $125.

Other Coverage Plan Type		Other Insurance Determination	"Other Coverage" Field	Amount to Be Entered in "Other Payor Amount" Field	Amount to Be Entered in "Patient Paid Amount" Field*
Example 1	Deductible plan	Other insurance applied $100 to deductible, paid $25.	2	$25	$100
Example 2	Coinsurance plan (80/20)	Other insurance plan rate is $100, plan pays $80, coinsurance is $20.	2	$80	$20
Example 3	Copayment plan	Other insurance plan rate is $75, plan pays $70, copayment is $5.	2	$70	$5
Example 4	Discount card	A discount of $25 is provided. This is an automatic discount. A claim is *not* filed with a discount card.	1	$0	$100
Example 5	100% copayment plan	No payment made, plan discounts the price of the drug to $95.	4	$0	$95
Example 6	Miscellaneous plan	Other insurance pays $95, coinsurance/copayment is $30.	2	$95	$30
Example 7	Insurance plan and a discount card	Other insurance denies the claim. A discount card is also presented giving a $10 discount.	0	$0	$115
Example 8	Miscellaneous plan	Other insurance denies the claim, no payment made.	0	$0	$0

Note: If the provider fails to indicate or provide the "Patient Paid Amount" field with the participant's out-of-pocket expense after the other coverage determination is made, coordination of benefits will be based solely on the amount present in the "Other Payor Amount" field. The participant's out-of-pocket expense is determined from the primary insurance copayment or deductible and is indicated in the "Patient Paid Amount" field.

For a listing of "Other Coverage" field codes and their descriptions, refer to the Coordination of Benefits section of the Pharmacy Handbook.

*For real-time claims submission, the "Patient Paid Amount" field may be labeled differently depending on the provider's system (e.g., copay, spenddown, or patient price).

Appendix

Appendix

Appendix 7

Real-Time Claim Response Examples for Coordination of Benefits Claims

The examples in this appendix indicate how certain SeniorCare claims would appear in a real-time Point-of-Sale (POS) claim response. In all of these examples, the following are constants:

- The usual and customary charge for each prescription drug is $125.
- The SeniorCare rate for each prescription drug is $87.
- A brand-name drug is dispensed.
- The amounts indicated in fields 513 and 517 are a total of spenddown plus deductible, not just deductible.

Example 1: Single Prescription, Non-Compound Claim with Spenddown							
	Field 509	Field 505	Field 513	Field 517	Field 518	Field 504	
	Total Amount Paid (by SeniorCare)	Patient Pay Amount*	Remaining Deductible Amount	Amount Applied to Periodic Deductible	Copay Amount	Remaining Spenddown	Remaining Deductible
Prescription 1	$0	$100	$575	$100	$0	$75	$500

*This amount represents the participant's out-of-pocket liability left by other insurance which was applied to spenddown.

Example 2: Single Prescription, Non-Compound Claim with Deductible							
	Field 509	Field 505	Field 513	Field 517	Field 518	Field 504	
	Total Amount Paid (by SeniorCare)	Patient Pay Amount*	Remaining Deductible Amount	Amount Applied to Periodic Deductible	Copay Amount	Remaining Spenddown	Remaining Deductible
Prescription 1	$0	$7	$493	$7	$0	$0	$493

*This amount represents the participant's responsibility. This is the lesser of the participant's out-of-pocket expense left by other insurance and the SeniorCare rate minus the actual insurance payment.

Example 3: Single Prescription, Non-Compound Claim with Copayment							
	Field 509	Field 505	Field 513	Field 517	Field 518	Field 504	
	Total Amount Paid (by SeniorCare)	Patient Pay Amount*	Remaining Deductible Amount	Amount Applied to Periodic Deductible	Copay Amount	Remaining Spenddown	Remaining Deductible
Prescription 1	$0	$5	$0	$0	$5	$0	$0

*This amount represents the participant's responsibility. This is the lesser of the participant's out-of-pocket expense left by other insurance and the SeniorCare rate minus the actual insurance payment.

Appendix

Example 4: Single Prescription, Non-Compound Claim with Copayment						
	Field 509	Field 505	Field 513	Field 517	Field 518	Field 504	
	Total Amount Paid (by SeniorCare)	Patient Pay Amount*	Remaining Deductible Amount	Amount Applied to Periodic Deductible	Copay Amount	Remaining Spenddown	Remaining Deductible
Prescription 1	$72	$15	$0	$0	$15	$0	$0

*This amount represents the participant's liability for copayment.

Example 5: Single Prescription, Non-Compound Claim with Deductible						
	Field 509	Field 505	Field 513	Field 517	Field 518	Field 504	
	Total Amount Paid (by SeniorCare)	Patient Pay Amount*	Remaining Deductible Amount	Amount Applied to Periodic Deductible	Copay Amount	Remaining Spenddown	Remaining Deductible
Prescription 1	$0	$87	$413	$87	$0	$0	$413

*This amount represents the participant's liability for deductible. Wisconsin SeniorCare will apply the SeniorCare allowed amount or the participant's out-of-pocket expense left by the primary plan, whichever is less.

Example 6: Single Prescription, Non-Compound Claim with Copayment						
	Field 509	Field 505	Field 513	Field 517	Field 518	Field 504	
	Total Amount Paid (by SeniorCare)	Patient Pay Amount*	Remaining Deductible Amount	Amount Applied to Periodic Deductible	Copay Amount	Remaining Spenddown	Remaining Deductible
Prescription 1	$0	$0	$0	$0	$0	$0	$0

*This amount represents the participant's responsibility. This is the lessor of the participant's out-of-pocket expense left by other insurance and the SeniorCare rate minus the actual insurance payment. In this example, the primary insurance plan paid in excess of the SeniorCare rate; therefore, the claim is considered paid in full. There is no participant liability.

Appendix

Example 7: Single Prescription, Non-Compound Claim with Deductible						
	Field 509	Field 505	Field 513	Field 517	Field 518	Field 504	
	Total Amount Paid (by SeniorCare)	Patient Pay Amount*	Remaining Deductible Amount	Amount Applied to Periodic Deductible	Copay Amount	Remaining Spenddown	Remaining Deductible
Prescription 1	$0	$87	$413	$87	$0	$0	$413

*This amount represents the participant's liability for deductible. Wisconsin SeniorCare will apply the SeniorCare allowed amount or the participant's out-of-pocket expense left by his or her primary plan, whichever is less.

Example 8: Single Prescription, Non-Compound Claim with Spenddown						
	Field 509	Field 505	Field 513	Field 517	Field 518	Field 504	
	Total Amount Paid (by SeniorCare)	Patient Pay Amount*	Remaining Deductible Amount	Amount Applied to Periodic Deductible	Copay Amount	Remaining Spenddown	Remaining Deductible
Prescription 1	$0	$125	$510	$125	$0	$10	$500

*This amount represents the participant's out-of-pocket liability which was applied to spenddown.

Appendix

Appendix

Glossary of Common Terms

Adjustment

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

Allowed claim

A 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.

Brand medically necessary

Phrase that must appear in the prescriber's own handwriting on the face of each new prescription order for Wisconsin SeniorCare to reimburse an innovator drug at an amount greater than the Medicaid maximum allowable cost (MAC) because the prescription is "medically necessary" for that recipient as documented in the recipient's medical record.

CMS

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

Compound Drug

A prescription drug prepared by a pharmacist using at least two ingredients containing at least one of which Wisconsin SeniorCare covers.

Copayment

A SeniorCare level of participation during which the participant is responsible for paying $5 for each generic prescription drug, generic insulin, and compound drug and $15 for each brand-name prescription drug and insulin.

Deductible

A SeniorCare level of participation during which the participant is responsible for paying $500 in out-of-pocket expenses for his or her prescription drugs.

DHCF

Division of Health Care Financing. The DHCF administers Wisconsin Medicaid and SeniorCare 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 Centers for Medicare and Medicaid Services (CMS), formerly HCFA, and the U.S. Department of Health and Human Services (DHHS) assurances that the program is administered in conformity with federal law and CMS policy.

DHFS

Department of Health and Family Services. The DHFS administers Wisconsin Medicaid and SeniorCare. 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.

Glossary

Dual entitlee

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

DUR

Drug Utilization Review. There are two components of DUR, prospective and retrospective. Prospective DUR is a system within the Pharmacy Point-of-Sale (POS) system that assists pharmacy providers in screening selected drug categories for clinically important potential drug therapy problems before the prescription is dispensed to the recipient. Retrospective DUR screens after the prescription has been dispensed to the recipient through drug profiling and peer grouping.

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.

EOB

Explanation of Benefits. Appears on the provider's Remittance and Status (R/S) Report and notifies the Medicaid-certified provider of the status or action taken on a claim.

EVS

Eligibility Verification System. Wisconsin Medicaid and SeniorCare encourage 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 Medicaid fiscal agent (EDS) is under contract with the Department of Health and Family Services (DHFS) to certify providers, process and pay claims, answer provider and recipient questions, issue identification cards to recipients, publish information for providers and recipients, and maintain the Wisconsin Medicaid and SeniorCare Web sites.

HCFA

Health Care Financing Administration. *Please see the definition under CMS.*

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).

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.

Glossary

Medically necessary

According to HFS 101.03(96m), Wis. Admin. Code, a 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; and

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.

OC

Other Coverage. A National Council for Prescription Drug Programs (NCPDP) value entered into the OC field in a claim that indicates the recipient has other insurance, such as commercial health insurance or Medicare.

OTC

Over-the-counter. Drugs that can be obtained without a prescription. Wisconsin SeniorCare covers only OTC insulin.

PA

Prior authorization. The electronic or written authorization issued by Wisconsin Medicaid and SeniorCare to a provider prior to the provision of a service.

Participant

An individual enrolled in Wisconsin SeniorCare.

Payee

Party to whom checks are made payable. The payee's address is used as the mailing address for checks and Remittance and Status (R/S) Reports.

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

Place of service. A two-digit code which identifies the place where the service was performed.

POS

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

QMB Only

Qualified Medicare Beneficiary under the Medicare Catastrophic Health Act. These recipients are only eligible for the payment of the coinsurance and the deductible for Medicare-allowed claims.

Real-time processing

Immediate electronic online claims transaction allowing for an electronic pay or deny response within seconds of submitting the claim.

Glossary

Real-time response

Information returned to a provider for a real-time claim indicating claim payment or denial.

Retail rate

The provider's charge for providing the same service to a private-pay patient.

R/S Report

Remittance and Status Report. A statement generated by the Medicaid fiscal agent to inform the provider regarding the processing of the provider's claims.

SeniorCare

SeniorCare is a prescription drug assistance program for Wisconsin residents who are 65 years of age or older who meet the eligibility criteria. The program is designed to help seniors with their prescription drug costs.

Wisconsin SeniorCare participants are eligible only for prescription drug benefits and over-the-counter insulin. Wisconsin Medicaid-certified pharmacies are required by law to participate in Wisconsin SeniorCare.

Spenddown

A SeniorCare level of participation during which the participant is required to pay for his or her prescription drugs an amount equal to the amount the income exceeds 240% of the federal poverty level. For households in which only one individual is eligible for Wisconsin SeniorCare, the participant's spenddown amount is based on his or her income. If both spouses are eligible for Wisconsin SeniorCare, the spenddown amount is based on the total of both participants' incomes.

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 or fax for certain drugs.

Usual and customary charge

The amount charged by the provider for the same service when provided to private-pay patients.

*I*ndex

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