Pharmacy

Claims Submission

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.

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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 Billing Information

Submission Options

The pharmacy system verifies recipient eligibility and monitors Medicaid pharmacy policy.

Within the pharmacy system, providers may choose from the following claims submission options:

- Real-time.
- Paper.
- Electronic Media Claims (EMC).

Providers are required to submit claims for Medicaid managed care enrollees to the recipient's managed care organization.

Real-Time Claims Submission

Wisconsin Medicaid uses a voluntary pharmacy Point-of-Sale (POS) electronic claims management system for Medicaid fee-for-service recipients. The POS system enables Medicaid providers to submit electronic pharmacy claims for legend and over-the-counter drugs in an on-line, real-time environment.

The pharmacy system verifies recipient eligibility and monitors Medicaid pharmacy policy. Within seconds of submitting a real-time claim, these processes are completed and the provider receives an electronic response indicating payment or denial.

Wisconsin Medicaid uses the National Council for Prescription Drug Programs (NCPDP) telecommunication standard format versions 3.2 variable, 3C, and 4.0 variable (as of September 1999). Using these formats, providers are able to:

- Initiate new claims and reverse and resubmit previously paid real-time claims.
- Submit individual claims or a batch of claims for the same recipient within one electronic transmission.
- Submit claims for Pharmaceutical Care (PC).
- Submit claims for compound drugs.

Pharmacy providers who use real-time claims submission are required to submit electronic transactions for pharmacy services to Wisconsin Medicaid via an approved switch vendor. Refer to the Pharmacy Quick Reference page at the beginning of this section for switch vendor contact information. Refer to Appendix 1 of this section for real-time claims submission instructions and Appendix 2 of this section for information about the response to real-time claims submission.

Paper Claims Submission

Providers have the option of submitting paper claim forms for pharmacy services. Paper claims are processed through the pharmacy system but do not furnish real-time claim responses to the provider. Providers who use paper claims receive claim status on a Remittance and Status (R/S) Report. Medicaid uses two paper claim forms: one for non-compound drugs and one for compound drugs. Both forms accommodate NCPDP standards. Sample claim forms and completion instructions are in Appendices 3, 4, 5, and 6 of this section.

Medicaid Pharmacy Claim System Submission Options

Paper Claim Form	POS real-time electronic billing through software company	EMC (tape or modem)

To order paper claim forms, (form 1141 for non-compound drugs and form 1142 for compound drugs), call Provider Services at (800) 947-9627 or (608) 221-9883, or write to the following address:

Wisconsin Medicaid
Form Reorder
6406 Bridge Road
Madison, WI 53784-0003

Remember to indicate the number of forms needed. Submit completed paper claim forms for payment to the following address:

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

Electronic Media Claims Submission

Providers may also submit claims using EMC. These claims are processed through the pharmacy system but do not furnish real-time claim responses to the provider. Providers who use EMC receive claim status on their R/S Reports. Providers who contract with an EMC vendor are responsible for the data submitted to their vendor.

Compound drugs and PC cannot be billed through EMC. Providers should submit these claims using a different claims submission option.

Unlike real-time and paper claims submissions, which use NCPDP values, EMC claims require the use of Wisconsin Medicaid values. Refer to Appendix 7 of this section for EMC submission instructions.

For additional information about EMC, contact the Wisconsin Medicaid EMC unit at (608) 221-4746.

Eligibility Verification

The pharmacy system verifies recipient eligibility for real-time claims. For paper and EMC, providers can obtain eligibility information from Wisconsin Medicaid's Eligibility Verification System (EVS) through one or more of the following methods:

- Wisconsin Medicaid's Automated Voice Response system.
- Commercial magnetic stripe card readers.
- Commercial personal computer software and Internet access.
- Wisconsin Medicaid's Provider Services (Telephone correspondents).
- Wisconsin Medicaid's Direct Information Access Line with Updates for Providers (Dial-Up).

Refer to Appendix 8 of this section for further EVS information.

Coordination of Benefits

Wisconsin Medicaid is the payer of last resort for most Medicaid-covered services. Pharmacies are required to bill private HMOs, certain commercial health insurance, or Medicare prior to billing Medicaid fee-for-service. For specific carriers, Wisconsin Medicaid denies claims where a recipient's commercial health insurance policy covers drugs. Refer to Appendix 9 of this section for the list of carriers.

Providers have several methods for determining commercial health insurance coverage. Real-time claims submission includes review of recipient eligibility and commercial health insurance coverage. The real-time rejection response includes health insurance information to assist in claims submission to the insurance plan when recipient eligibility indicates other insurance coverage. Providers may need to contact their software vendor to get access to this field.

Compound drugs and PC cannot be billed through EMC. Providers should submit these claims using a different claims submission option.

Medicaid fee-for-service covers charges for recipients enrolled in a managed care program that does not include drug coverage.

Refer to Appendix 2 of this section for real-time response information. To determine if a claim was denied due to other commercial health insurance coverage, refer to Appendix 11 of this section.

Providers cannot bill Medicaid recipients for copayments required by commercial health insurance carriers. A pharmacy should bill Wisconsin Medicaid for the insurance copayment instead of billing the recipient after commercial health insurance has reimbursed the pharmacy for the bill. Medicaid recipients are responsible only for the Medicaid copayments if applicable.

If a commercial managed care program or Wisconsin Physician Service/Health Maintenance Plan is billed and pays on the claim, the provider must submit a paper or real-time claim to Wisconsin Medicaid indicating "2" ("P" for EMC) and the commercial insurer's paid amount in the other payer amount field.

When commercial insurance is not billed for an appropriate reason, indicate "4" ("Y" for EMC) in the other coverage field, unless the commercial insurance was billed and denied the claim.

Refer to Appendix 1 of this section for real-time other coverage code information. To determine the appropriate indicator for EMC claims, refer to Appendix 12 of this section.

When a pharmacy is not contracted with the recipient's commercial HMO, Wisconsin Medicaid cannot be billed for the service. Recipients should be redirected to a contracted provider of the commercial HMO in accordance with HFS 106.03(7)(k), Wis. Admin. Code.

Note: If a recipient is enrolled in a Medicaid managed care program, providers should submit claims to the Medicaid managed care program. Medicaid fee-for-service covers charges for recipients enrolled in a managed care program that does not include drug coverage. Refer to Appendix 10 of this section for a list of Medicaid managed care programs.

Preparing Claims

Claims Submission Deadline

If it has been more than 90 days since the date of process, or if the original claim was submitted on paper or EMC, the provider may *only* submit an Adjustment Request Form to change the claim.

All claims for services provided to eligible Medicaid recipients must be received by Wisconsin Medicaid within 365 days of the date of service. This policy pertains to all initial claims submissions, resubmissions, and adjustment requests.

Refer to the Claims Submission section of the All-Provider Handbook for exceptions to the claims submission deadline and requirements for submission to Late Billing Appeals.

Procedure Codes

Pharmacies must use the 11-digit National Drug Code (NDC) on the package or the Medicaid-assigned 11-digit procedure code for all drugs dispensed when submitting pharmacy claims.

Billed Amounts

Providers must bill Wisconsin Medicaid their usual and customary charge for services provided. The usual and customary charge is the amount charged by the provider for the same service when provided to private-pay patients. Providers may not discriminate against Medicaid recipients by charging a higher fee for the service than is charged to a private-pay patient.

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.

Adjustments and Claim Reversals

In Wisconsin Medicaid, only paid claims can be adjusted. When adjusting pharmacy claims, use the same indicators, either National Council for Prescription Drug Programs (NCPDP) or Wisconsin Medicaid, as used in the original transmission of the claim. For example, if adjusting electronic media claims (EMC), use Wisconsin Medicaid values. If adjusting paper claims, use NCPDP values.

Paid claims submitted real-time may be reversed through real-time for up to 90 days after the date of process using NCPDP transaction code "11." If it has been more than 90 days, or if the original claim was submitted on paper or EMC, the provider may *only* submit an Adjustment Request Form to change the claim. The paper Adjustment Request Form and instructions can be found in Appendices 13 and 14 of this section.

When a claim reversal to a paid real-time claim is performed, Wisconsin Medicaid erases the original claim. If the claim reversal is submitted during the same week as the original real-time claim, neither the original claim nor the reversal will appear on the provider's Remittance and Status (R/S) Report. If the real-time claim is reversed after midnight on Friday (the real-time deadline), the reversal will appear on the R/S Report.

Claim adjustments must be filed within 365 days of the date of service. To generate an adjustment for paper, EMC, or real-time claims more than 90 days old, you will need to submit the paper Adjustment Request Form.

To ensure rapid and accurate processing, attach a corrected paper claim form when submitting a paper adjustment.

Drug Enforcement Administration Number

All claims submitted by pharmacies and dispensing physicians for prescribed legend drugs and over-the-counter drugs must identify a prescriber using the prescriber's Drug Enforcement Administration (DEA) number when it is known.

Providers must make a reasonable effort to obtain and use a prescriber's current DEA number. Providers can only obtain DEA numbers from prescribers, as Wisconsin Medicaid cannot release this information.

Wisconsin Medicaid realizes that some prescribers do not have a DEA number and that some DEA numbers are not readily available to providers. Nevertheless, Wisconsin Medicaid requests that providers give careful attention to the coding and verification of DEA numbers. Wisconsin Medicaid uses DEA numbers to allow direct communication with prescribers regarding potential drug-use problems or "drug shopping" activities by certain Medicaid recipients. The success of these efforts rests on the cooperation of providers to supply valid DEA numbers.

"Default" Drug Enforcement Administration Numbers

If the provider is unable to obtain a prescriber's current DEA number after a reasonable effort, the provider may use the appropriate default DEA number:

- XX5555555 — Prescriber's DEA number cannot be obtained.
- XX9999991 — Prescriber does not have a DEA number.

These default DEA numbers may *not* be used when submitting claims for a controlled substance. State and federal regulations require that prescriptions not be filled for controlled substances if the DEA number is not known or not provided for verification.

Providers who regularly and systematically use default DEA numbers may be audited. If claims are submitted through a computer software company, the provider should review this policy with the software company to ensure that a default DEA number* is not being automatically indicated on claims submitted to Wisconsin Medicaid.

**Note:* When a default DEA number is used on a claim, the following explanation of benefits message will be indicated on the R/S report: *Default prescribing physician number was indicated. Valid numbers are important for DUR purposes. Please obtain a valid number for future use.*

Prescriptions Written By Therapeutic Pharmaceutical Agents-Certified Optometrists

Wisconsin Medicaid reimburses for prescription orders written by optometrists with a Therapeutic Pharmaceutical Agent (TPA) certificate. However, not every TPA-certified optometrist has a DEA number since it is required only for prescribers that prescribe Schedule III, IV, or V narcotic analgesics as listed in Ch. RL 10.01(10), Wis. Admin. Code.

Optometrists are encouraged to indicate either their DEA number or their eight-digit Medicaid provider number on the prescription order for a Medicaid recipient. Contact the prescribing optometrist for one of these two numbers if the number is missing from the prescription order.

If the prescribing optometrist does not have a DEA number, but has a Medicaid provider number, indicate "OD" followed by the first seven digits of the prescriber's eight-digit Medicaid provider number in the DEA number field.

If the prescribing optometrist has neither a DEA number nor a Medicaid provider number, indicate XX9999991 in the DEA number field.

Providers must make a reasonable effort to obtain and use a prescriber's current DEA number.

Prescriptions Written By Advanced Practice Nurse Prescribers

Chapter N8, Wis. Admin. Code, authorizes the certification of qualified advanced practice nurses as advanced practice nurse prescribers to issue prescription orders with certain limitations.

Wisconsin Medicaid monitors pharmacy claims for accuracy.

Advanced practice nurse prescribers are encouraged to write their DEA registration number on all prescription orders for Medicaid recipients.

Accuracy in Pharmacy Claims Submission

Wisconsin Medicaid monitors pharmacy claims for accuracy. Fields monitored may include:

- Unit dose.
- Days supply.
- Prescription number.
- Quantity.
- Amount billed.
- Dispensed as written.
- Brand medically necessary.

A post-pay review of these fields may result in an audit by Wisconsin Medicaid.

Special Billing Circumstances

Billing For Compound Drugs

All of the ingredients of a compound must be billed as one compound drug.

Providers are required to submit claims for compound drugs using the compound drug paper claim form or through real-time Point-of-Sale (POS) using National Council for Prescription Drug Programs' (NCPDP) format version 4.0 variable. Compound drugs are billed using a National Drug Code (NDC) for each component. Injectibles (intravenous [IV], intramuscular [IM], subcutaneous, total parenteral nutrition [TPN] solution, and lipids) with more than one component should be billed as compound drugs.

The following conditions must be met in order to receive payment for a compound drug claim:

- Compound drugs must have at least two components.
- Claims must include at least one drug covered by Medicaid.
- The claim must not include a drug that is listed on the less-than-effective (LTE) list.
- The compounded prescription must not result in a drug combination that the Food and Drug Administration considers LTE.
- If one component of the compound drug requires prior authorization (PA), the compound drug requires PA.
- If one component of the compound drug has a diagnosis restriction, the compound drug has the same restriction.
- If a compound drug has one noncovered component, payment for that component will be denied, but the rest of the components will be covered, assuming the other conditions are met.

Note: National Drug Codes of bulk chemicals are on file for reimbursement where there is a signed rebate agreement and are billable only as part of a compound drug.

Compound Drug Preparation Time

Providers should indicate time spent preparing the compound drug on the claim. Wisconsin Medicaid notes the time indicated and, as a result, is better able to price the compound drug when an unusual amount of time is required to prepare the compound drug.

Providers must indicate the time (in minutes) to compound the prescription by using a level of service (LOS) code. The maximum amount of time that Wisconsin Medicaid will reimburse is 30 minutes (LOS code 13). Providers may indicate LOS codes 14 and 15 to indicate that compounding the drug took more than 30 minutes, but they will only be reimbursed for up to 30 minutes. In calculating LOS, do not include non-professional staff time, set-up time, or clean-up time in the total.

The usual and customary charge should include both the dispensing reimbursement and the cost of the drug ingredients. Refer to the Covered Services and Reimbursement section of this handbook for further reimbursement information.

Billing Compound Drug Ingredients

All of the ingredients of a compound must be billed as one compound drug. Individual items of a compound may not be billed separately with an accompanying dispensing fee for each ingredient. The quantity field should be the total number of units being dispensed. This number is *not* the total number of units for each individual ingredient.

When submitting real-time claims, enter NCPDP compound drug indicator "2" in the compound drug indicator field. This alerts the pharmacy system that the following NDCs comprise a single compound drug.

For claims submission instructions for a compound drug, refer to Appendices 1 and 5 of this section.

Billing Options When Compound Drug Ingredients Are Not on File

If one or more of the ingredients in the compound drug are not present on the drug file, the provider has three billing options:

Option one: On the non-compound drug claim form, use "dummy" NDC 00990-0000-00 for the entire compound. The non-compound drug claim must be submitted through Special Handling to have the "dummy" NDC manually priced. The NDC of each Medicaid-covered drug, plus its name, strength, and quantity used in compounding must be indicated. All other ingredients used to compound the prescription must also be identified by name, strength, quantity used, and manufacturer.

Option two: Choose not to bill the ingredient(s) not on file. The provider should submit the remaining ingredients real-time on the compound drug claim form using the previously defined billing instructions for these media.

Option three: On the compound drug claim form, use "dummy" NDC 88888-8888-88 for the ingredient(s) not on file. Note that this NDC requires PA prior to dispensing. Once a PA is obtained, a compound drug claim can be submitted through Special Handling to have the "dummy" NDC manually priced.

Billing For Total Parenteral Nutrition and Lipids

Total parenteral nutrition (TPN) solution and TPN lipids are reimbursed by using NDCs for each item used to prepare and administer the TPN. These NDCs may be billed by using the compound drug paper claim form or through real-time by using NCPDP format version 4.0 variable. Providers who submit claims using electronic media claims (EMC) are required to bill TPN drugs on the compound drug paper claim form.

If a chemical used in the TPN does not have an NDC, the claim must be submitted on a compound drug paper claim form with documentation for consultant review through pharmacy Special Handling, using "dummy" NDC 00990-0000-00. When requesting Special Handling, the provider is required to submit the paper claim form with the Special Handling request.

Refer to "Special Handling" later in this chapter for further Special Handling information and to Appendix 15 of this section for the Special Handling Request Form.

Providers should submit claims for disposable medical supplies (DMS) and durable medical equipment (DME) associated with TPNs separately. Use the HCFA 1500 claim form to bill for DMS and DME. For more information about submitting claims for DMS or DME, refer to the DMS Index and the DME Handbook and Index.

When requesting Special Handling, the provider is required to submit the paper claim form with the Special Handling request.

Billing For Prefilled Syringes

Syringes filled by the pharmacist are billed:

- Using the NDC.
- Using the Prefill Allowance Procedure Code (88888-0000-07).

Syringes for injections that contain more than one ingredient must be billed as a compound drug. Note the following exceptions:

- The syringe may be billed separately using a DMS code on a HCFA 1500 claim form.
- The prefill syringe allowance is for injection drugs only and may not be billed for oral medications administered by syringe.

The exact metric quantity of each liquid ingredient must be billed per ingredient (e.g., if 7 ml of normal saline is used, do not bill for an entire 1000 ml bag).

One unit is one syringe. Refer to the Covered Services and Reimbursement section of this handbook for Maximum Fee Schedule reimbursement on this and other procedures.

Syringes prefilled by the manufacturer should be billed with the NDC *only*.

For recipients who have weekly white blood cell counts, clozapine management may only be billed one time per week, regardless of the number of services provided during that week.

Billing For Clozapine Management

Providers must bill clozapine management services on the national HCFA 1500 claim form, either electronically or on paper. For recipients who have weekly white blood cell counts, clozapine management may only be billed one time per week, regardless of the number of services provided during that week.

For recipients who have white blood cell counts taken every other week, clozapine management may be billed only once every two weeks. The allowable procedure code, type of service code, and place of service codes may be billed using only one of the codes found in Appendix 16 of this section.

HCFA 1500 claim form completion instructions and a sample HCFA 1500 claim form for clozapine management can be found in Appendices 17 and 18 of this section.

Although related to clozapine management, Wisconsin Medicaid reimburses white blood cell count services *separately* from clozapine management. The white blood cell count must be performed and billed by a Medicaid-certified provider to be reimbursed by Wisconsin Medicaid.

Billing For Pharmaceutical Care Dispensing Fee

Pharmaceutical Care (PC) services can be billed through real-time POS or by using the non-compound drug claim form using PC codes in the three fields shared with Drug Utilization Review (DUR) and LOS. Pharmaceutical Care is not billable for compound drugs. The usual and customary charge should include both the Medicaid-covered PC service and drug cost. Refer to the Drug Utilization Review and Pharmaceutical Care section of this handbook for further PC information.

Billing For Diagnosis-Restricted Drugs

Some drugs do not require PA when billed with certain valid diagnoses. Reimbursement for these drugs is restricted by an acceptable and valid *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis code. Refer to the Covered Services and Reimbursement section of this handbook for a list of these drug categories and the corresponding brand names, diagnosis codes, and disease descriptions.

If a provider uses an unacceptable or invalid diagnosis code, he or she will receive a message that a paper PA request is required. This will be a real-time message if billing via real-time. If the provider bills through EMC or on paper, the message will appear in the provider's R/S Report.

Claims using diagnosis codes are monitored by Division of Health Care Financing (DHCF) auditors. The provider is expected to have reasonable, readily retrievable documentation to verify the accuracy of the diagnosis for the original prescription. This documentation must

show the diagnosis was provided by the prescription, someone in the prescriber's office, or by the recipient. The diagnosis should be reasonably comprehensive, not just the single word definition of the ICD-9-CM code.

Maximum Allowed Cost Override

The maximum allowed cost (MAC) override enables a provider to receive higher reimbursement for an "innovator" drug by overriding the pricing limits indicated on the MAC List. An innovator drug is the brand name of the original, patented drug of those drugs listed on the MAC List.

Use the MAC override when all three conditions are present:

- The drug being billed is listed on the Medicaid MAC List.
- The prescriber indicates "Brand Medically Necessary" in his or her own handwriting on the prescription.
- The drug being billed is the innovator drug, as indicated on the MAC List.

The MAC override policy applies only to legend drugs, not to the over-the-counter (OTC) drugs indicated on the Medicaid MAC OTC List. Since Wisconsin Medicaid does not cover innovator OTCs, it is never appropriate to indicate the MAC override indicator for OTCs.

Unit Dose Dispensing

Only providers with a unit dose system may bill for a unit dose fee. The reimbursement for unit dose services is limited to pharmaceuticals the recipient used or consumed during the preceding month. Submit a claim only after the medication is completely consumed or utilization is determined for that month.

Refer to Appendix 12 of this section for a chart identifying the specific conditions for each of the unit dose indicators used in Element 16 of the non-compound drug claim form.

Services Provided to Medicaid Nursing Facility Recipients

Unit Dose Dispensing for Nursing Facility Recipients

Identical unit dose drugs ordered for two or more separate intervals during the billing period, or for multiple, simultaneous dosing schedules, must be totaled and billed as a single unit dose service at the end of the billing period.

A billing period need not be from the first day of a calendar month to the last day of that month. For example, a billing period could be from June 15 through July 14, and the provider submits the bill on July 15. The date on the claim form, however, must be the last date of service (e.g., July 14).

When a drug is added to the list of drugs requiring PA, and the effective date of PA falls in the middle of a billing period, the claim must include the PA number and must be submitted with two detail lines. The first detail line must be for the time period that the drug was not on the PA list. The second detail line must be for the time period that the drug was on the PA list, after the provider has obtained an approved PA.

> *Example:* A provider's billing period is from June 15 through July 14. The provider submits a claim with two detail lines. The first detail line has June 30 as the date of service, which is the last date of service before the drug was on the Medicaid PA list. The second detail line has July 14 as the last date of service in this billing period after the drug was on Wisconsin Medicaid PA list (and has an approved PA).

The MAC override policy applies only to legend drugs, not to the over-the-counter (OTC) drugs indicated on the Medicaid MAC OTC List.

Two claims must be submitted when there are two PA numbers for the same drug within the same billing period.

Two claims must be submitted when there are two PA numbers for the same drug within the same billing period. Only one PA number can be on a claim. In other words, two claims must be submitted when:

- One PA expires for a drug.
- A subsequent approved PA for the same drug begins during the same billing period.

  Example: A provider's billing period is from September 15 to October 14. The approved PA expires on September 28. The subsequent approved PA begins on September 29. The first claim is for dates of service through September 28. The second claim is for dates of service beginning on September 29 through October 14.

Purchasing Items for Nursing Facility Recipients

There are three ways in which pharmacy items can be purchased for Medicaid recipients residing in a nursing facility. Pharmacies and nursing facilities are responsible for using the correct method to bill Wisconsin Medicaid:

Method One: Medicaid Pharmacy Claim. Prescribed Medicaid-covered legend drugs, and certain OTC products (except OTCs included in the nursing facility daily rate) must be billed to Wisconsin Medicaid using an appropriate claims submission method.

Method Two: Nursing Facility Daily Rate. Under Section 5.100 of the Nursing Home Methods of Implementation, personal care and other hygiene products, dietary supplies, and incontinence supplies are included in the nursing facility daily rate. Do not bill these items separately to Wisconsin Medicaid, to the nursing facility recipient, or to the recipient's family.

Refer to Appendix 19 of this section for a list of the types of products that are classified as personal care products included in the nursing facility daily rate.

Method Three: Patient's Personal Needs Account. If a recipient has been informed that Wisconsin Medicaid does not cover the particular pharmacy item, but the recipient chooses to purchase the item anyway, the recipient is liable for payment. This type of pharmacy item includes:

- Medicaid noncovered legend drugs, including:
  - √ Less-than-effective drugs.
  - √ Negative formulary drugs.
  - √ Drugs for which the pharmacy has been denied PA for the specific recipient.
- Sundry items such as cough drops, cigarettes, candy, and alcoholic beverages.

Refer to Appendix 20 of this section for a partial list of pharmacy items that may be reimbursed from the recipient's personal needs account.

Special Handling Requests

The Special Handling Request Form must accompany any paper claims submitted by a pharmacy provider that requires "Special Handling" and cannot be processed as normal claims. The form must be completed as indicated. Only one Special Handling form is required for each set of similar problem claims.

A sample Special Handling Request Form can be found in Appendix 15 of this section. Providers can also prepare their own form to request Special Handling, but that form should include all the elements in the sample Special Handling Request Form.

Examples of Special Handling claims requiring a completed copy of the Special Handling form include:

- Compound drugs having at least one ingredient whose NDC is not a payable NDC on the Medicaid Drug File.
- Two claims for the same recipient, same strength of drug filled on the same day. The second claim will be denied if processed through normal processing channels because of a duplicate audit.
- A claim that qualifies for "late billing" as in retroactive eligibility instances.
- Any other unusual circumstance where there is a legitimate reason for the state pharmacist consultant to override an existing computer edit or audit.
- A claim from a pharmacy that has filled a prescription for a lock-in recipient when that pharmacy is not the designated lock-in pharmacy.

A fiscal agent pharmacist consultant reviews claims for compound drugs. The state pharmacist consultant reviews all other claims.

The following Wisconsin Medicaid-assigned codes must be billed through the pharmacy system by using a paper drug claim form and attaching a completed Special Handling Request Form:

Proc. Code	Description
92000100012*	Condoms
88888888888†	Drugs not on file

**Note:* This can be billed on *any* medium.
†*Note:* This local code always requires PA.

Submit completed Special Handling Request Forms and accompanying claim(s) to the following address:

Wisconsin Medicaid
Pharmacy Special Handling Unit
Suite 20
6406 Bridge Road
Madison, WI 53784-0020

Good Faith Billing Procedures

A Good Faith claim is a claim that has been denied with an eligibility-related explanation of benefits code, even though the provider verified that the recipient was Medicaid-eligible for the dates of service billed. Good Faith billing policy states that providers should include a photocopy of the paper ID card as documentation that they verified a recipient's eligibility.

Good Faith billing policy with Forward ID cards require providers to submit *one* of the following along with a legible copy of the claim and a legible, printed copy of the real-time denial screen (or R/S Report for paper and EMC claims) showing one of the eligibility-related rejection codes listed:

- A photocopy of one of the following:
  - √ Beige presumptive eligibility ID card.
  - √ Green temporary ID card.
  - √ Paper ID card for services provided before the recipient received a Forward card.
- A photocopy of the response received through eligibility verification services provided from a commercial eligibility verification vendor.
- The transaction log number received from Automated Voice Response (AVR) or response received from a commercial eligibility verification vendor*.

**Note:* Pharmacy providers who submit real-time claims should only send a copy of the recipient eligibility information the provider received at the time of service.

Good Faith billing policy states that providers should include a photocopy of the paper ID card as documentation that they verified a recipient's eligibility.

Appendix

Appendix 1
Real-Time Claims Submission Instructions

Wisconsin Medicaid requires providers to use National Council for Prescription Drug Programs (NCPDP) values for real-time pharmacy claims submission. Point-of-Sale (POS) accepts NCPDP transaction formats 3.2 variable, 3C, and 4.0 variable. (Version 4.0 is required for compound claims submissions).

To avoid denial or inaccurate claim payment, use the following real-time claim instructions. Enter all required data in the appropriate fields. All fields are required unless "optional" or "not required" is indicated. Additionally, some fields that are required may also have specific Medicaid billing requirements that are different from other payers' requirements.

Fields marked with an asterisk (*): For additional questions regarding these fields, the provider may find it helpful to contact their software provider. Depending on the software, these fields may be formatted to look differently, or possibly the provider does not see these fields at all. For example, the Compound Code field: the provider may have different screens for compound and non-compound drugs, and depending on which screen is used, the software may autoplug the value.

Transaction Code*

Enter the appropriate transaction.

Code	NCPDP Description
01	Billing 1 prescription.
02	Billing 2 prescriptions.
03	Billing 3 prescriptions.
04	Billing 4 prescriptions.
11	Reversal.

Pharmacy Number*

Enter the billing provider's eight-digit Medicaid provider number.

Cardholder ID Number

Enter the recipient's 10-digit Medicaid identification (ID) number exactly as it appears on the current Medicaid identification card.

Patient First Name

Enter the recipient's first name from the recipient's Medicaid ID card. Use the Eligibility Verification System (EVS) to obtain the correct spelling of the recipient's name. If the name or spelling of the name on the Medicaid ID card and the EVS do not match, use the spelling from the EVS.

Patient Last Name

Enter the recipient's last name from the recipient's Medicaid ID card. Use the EVS to obtain the correct spelling of the recipient's name. If the name or spelling of the name on the Medicaid ID card and the EVS do not match, use the spelling from the EVS.

Compound Code*

This code is used to indicate whether a prescription is a compound drug.

Note: If submitting a compound claim and the compound indicator does not indicate compound, the claim will be processed as a non-compound claim with a single detail.

Code	NCPDP Description
0	Not specified.
1	Not a compound.
2	Compound.

Appendix

Other Coverage Code

Wisconsin Medicaid is usually the payer of last resort for Medicaid-covered services (refer to the Coordination of Benefits section of the All-Provider Handbook for more information). Prior to submitting a claim to Wisconsin Medicaid, providers must verify whether a recipient has other health coverage (e.g., commercial insurance, HMO, or Medicare). Claims for recipients who have other commercial health coverage must be billed to the other health insurance carrier prior to submitting to Medicaid.

Enter the appropriate other coverage code in the other coverage field:

Code	NCPDP Description	Wisconsin Medicaid Description
0	Not specified.	A correct and complete claim was submitted to and denied by the recipient's commercial health insurance. The claim was denied because the recipient's benefits were exhausted, the services are not covered, the deductible was reached, etc., or the payment was applied towards the recipient's coinsurance and deductible.
1	No other coverage identified.	The recipient has no other health coverage (e.g., commercial health insurance).
2	Other coverage exists — payment collected.	The claim was paid in part by the recipient's commercial health insurance or HMO. The amount paid by the health insurance carrier or the insured must be indicated on the claim.
3	Other coverage exists — this claim not covered.	The recipient has only Medicare coverage, and Medicare denied the claim because the recipient's benefits are exhausted or the service is not a covered Medicare benefit. Do not use this other coverage code when the recipient is covered by Medicare and commercial health insurance or private HMO.
4	Other coverage exists — payment not collected.	The recipient has other commercial health insurance coverage. However, the health insurance carrier was not billed for reasons including, but not limited to, the following: • The recipient denies coverage or will not cooperate. • The provider knows the service in question is not covered by the carrier. • The health insurance carrier fails to respond to initial and follow-up claims. • The benefits are not assignable or cannot get an assignment. • The provider does not contract with the recipient's commercial health insurance plan. • Services would be applied to a deductible amount.

Appendix 1
continued

Code	NCPDP Description	Wisconsin Medicaid Description
4 (continued)	Other coverage exists — payment not collected.	• Insurance plan requires paper claim forms for billing. • Insurance plan maintains a short billing deadline that cannot be met. • Insurance plan is a 100% discount plan. • Total billed amount is less than $10.00. • Other billing problems exist.
5	Managed care plan denial.	The recipient has commercial HMO or health maintenance plan (HMP) health insurance coverage. However, the HMO does not cover the service, or the billed amount does not exceed the coinsurance or deductible amount. The recipient resides outside the commercial HMO service area. Do NOT use this indicator if the HMO or HMP denied payment because a designated provider did not provide an otherwise covered service.
7	Other coverage exists — not in effect at time of service.	The recipient is not Medicare eligible at the time of service.

Customer Location

Enter the appropriate two-digit place of service codes for each drug or supply billed.

Code	NCPDP Description
00	Not specified.
01	Home (IV-IM Services Only).
07	Skilled care facility.
08	Sub-acute care facility.
10	Outpatient (Doctor's Office).

Date Filled/Date of Service*

Enter the date that the prescription was filled or refilled in MM/DD/YY or MM/DD/YYYY format.

Note: When billing unit dose services, the last date of service in the billing period must be entered.

Prescription Number

Enter the prescription number. Each legend and over-the-counter (OTC) drug billed must have a unique prescription number.

New/Refill Code

Enter the appropriate NCPDP code that indicates the number of refills for this prescription.

Code	NCPDP Description
00	New prescription.
01	1st refill of prior prescription.
02	2nd refill of prior prescription.
03	3rd refill of prior prescription.
04	4th refill of prior prescription.
05	5th refill of prior prescription.
06	6th refill of prior prescription.
07	7th refill of prior prescription.
08	8th refill of prior prescription.
09	9th refill of prior prescription.
10-99	10th-99th refill of prior prescription.

Metric Quantity (used for compound drug submission only)

Enter the total quantity of the entire compound.

Days Supply

Enter the estimated days supply of tablets, capsules, fluid cc's, etc., that has been prescribed for the recipient. This must be a whole number greater than zero (e.g., if a prescription is expected to be used for five days, enter "5").

Note: Days supply is not the duration of the treatment, but the expected number of days the drug will be used.

NDC

Enter the 11-digit National Drug Code (NDC) or Medicaid-assigned 11-digit procedure code for the item being billed. (Use the NDC indicated on the product).

Dispense As Written/Product Selection Code Other Coverage Code

If the legend drug dispensed is listed in the Wisconsin Medicaid Drug File as the innovator with a state maximum allowable cost (MAC), and the prescribing physician indicated "Brand Medically Necessary" on the prescription, enter "1" in this field, otherwise indicate a "0".

Code	NCPDP Description
0	No product selection indicated.
1	Substitution not allowed by prescriber.

Ingredient Cost

Enter the ingredient cost in this field.

Prescriber ID

Enter the nine-character Drug Enforcement Agency (DEA) number of the prescribing provider. This number must be two alpha characters followed by seven numeric characters. If the DEA number cannot be obtained, use one of the following default codes:

XX5555555 — Prescriber's DEA number cannot be obtained.
XX9999991 — Prescriber does not have a DEA number.

These codes must *not* be used for prescriptions for controlled substances.

Date Prescription Written

Enter the date shown on the prescription using YYYYMMDD format.

Level of Service

This field is required when billing for Pharmaceutical Care (PC) services and for compound drugs. When billing for PC, the level of service must be billed with all three Drug Utilization Review (DUR) fields. The following are the valid values to be indicated:

Code	Description
11	0 through 5 minutes.
12	6 through 15 minutes.
13	16 through 30 minutes.
14	31 through 60 minutes.
15	61 + minutes.

Diagnosis Code (optional)

This field must be completed when billing for a drug that requires a diagnosis code or when billing for PC services. If the diagnosis of the drug is different from that of the PC services, enter the diagnosis code of the drug from the *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) coding structure. Enter all digits of the diagnosis code, including the preceding zeros.

Unit Dose Indicator

Enter one of the following single-numeric indicators when billing for unit dose for non-compound drugs. A unit dose indicator is required when billing for PC services.

Code	NCPDP Description	Wisconsin Medicaid Description
0	Not specified.	Use for traditional dispensing fee with no repackaging allowance. No unit dose dispensed. To be used when billing non-dispensing PC services.
1	No unit dose.	Use for dispenser-repackaged unit dose drugs for which you are entitled to only the **traditional** dispensing fee. Providers are reimbursed an additional unit dose repackaging fee, but not the higher unit dose dispensing fee.
2	Manufacturer unit dose.	Unit dose for manufacturer-prepackaged unit dose drugs for which you are entitled to the unit dose dispensing fee. Providers are reimbursed the higher unit dose dispensing fee, but not the repackaging allowance. To be used when billing non-dispensing PC services.
3	Pharmacy unit dose.	Use for dispenser-repackaged unit dose drugs for which you are also entitled to the unit dose dispensing fee. Providers are reimbursed an additional unit dose repackaging fee and the higher dispensing fee.

Usual and Customary

Enter the total charge for each line item. The charge should represent your usual and customary fee.

Other Payer Amount (optional)

When applicable, enter the amount paid by other commercial insurance. Required when "Other Coverage Code" indicates "2" (other coverage exists — payment collected).

Note: This element is not used for the Medicare paid amount.

Patient Paid Amount (optional)

When applicable, enter the recipient spenddown amount in this field. *Do not* enter a recipient's Medicaid copayment in this field. Wisconsin Medicaid automatically deducts the applicable Medicaid copayment amount from the claim.

Metric Decimal Quantity

Enter the metric decimal quantity in the specified unit of measure according to the Wisconsin Medicaid Drug File. This field allows three decimal places.

Prior Authorization Number (optional)*

If prior authorization (PA) has been obtained, enter the seven-digit number in this field, preceded by a "1."

DUR Conflict/Reason for Service Code (optional)

This field is required when billing for DUR or PC services. Refer to the Drug Utilization Review and Pharmaceutical Care section of this handbook for applicable field values and further information on DUR and PC.

DUR Intervention Code/Action (optional)

This field is required when billing for DUR or PC services.

DUR Outcome Code/Result (optional)

This field is required when billing for DUR or PC services.

Compound Ingredient Component Counter (compound claims only)*

A count of each ingredient in the mixture submitted. The compound ingredient counter number is incremented for each ingredient submitted. (For example, the first ingredient will be 01, second will be 02, etc.)

NDC (compound drug claims only)

Enter the NDC that identifies the compound ingredient.

Compound Ingredient Metric Decimal Quantity (compound claims only)

Enter the quantity of the product included in the compound in metric decimal format (e.g., 99999.999).

Compound Ingredient Drug Cost (compound claims only)

Enter the ingredient cost for the metric decimal quantity of the product included in the compound indicated in field 448-ED.

Bin Number

Always use value 610499.

Version/Release Number

This number identifies the NCPDP format being sent:

- 32 = Version 3.2.
- 3C = Version 3C.
- 40 = Version 4.0.

Processor Control Number

This is a vendor code number assigned by Wisconsin Medicaid to identify the software used in the claims submission.

Appendix 2
Real-Time Claim Response

The response screen includes three different fields of information: the header response field, the required free form text field, and the optional free form text field (verify that the latter is turned on by your software vendor).

Header Response Field

The header response field displays the following information:

- The status of each claim, indicated as one of the following:
  - √ Paid.
  - √ Rejected.
  - √ Duplicate National Council for Prescription Drug Programs (NCPDP) transaction.
- Amount paid (if applicable).
- Reject count (if claim denied).
- Reject codes. (Refer to **Appendix 11** of this section for a list of NCPDP reject codes and messages.
- Authorization number (to be used when corresponding with Provider Services).
- Patient pay (includes copayment deduction and recipient spenddown amount).

Required Free Form Text Field

The required free form text field displays up to six Medicaid Explanation of Benefits (EOB) codes. See **Appendix 11** of this section for the corresponding message for each EOB code.

Optional Free Form Text Field

The optional free form text field displays the following information:

- Duplicate internal control number (ICN), including date of duplicate claim in YYYYMMDD format.
- Managed care program (MCP) codes. (Refer to **Appendix 10** of this section for a list of MCP carriers.)
  - √ MCP code.
  - √ MCP telephone number.
  - √ MCP provider specialty.
- Third Party Liability (TPL) Also known as commercial or other insurance. (Refer to **Appendix 9** of this section for a list of commercial HMO and other insurance carrier codes that are monitored for drugs.)
  - √ TPL Carrier Code.
  - √ TPL Relationship Code.
  - √ TPL Policy Number.
  - √ TPL Group Number.
  - √ TPL Policy Start Date.
  - √ TPL Policy End Date.
- Other insurance relationship code (see box at left).
- Lock-In.
  - √ Lock-in period start date.
  - √ Lock-in period end date.
  - √ Lock-in coverage type.

Relationship Code	Relationship
1	Self
2	Spouse
3	Child
4	Stepchild
5	Other

Appendix

Appendix 3
Wisconsin Medicaid Non-Compound Drug Claim Form Completion Instructions

To avoid denial or inaccurate claim payment, use the following claim form completion instructions. Enter all required data on the claim form in the appropriate element. Do not include attachments unless instructed to do so. All elements are required unless "optional" or "not required" is indicated.

Wisconsin Medicaid only reimburses providers for drugs listed in the Wisconsin Medicaid Drug File. Submit disposable medical supply items on a HCFA 1500 claim form using HCFA Common Procedure Coding System (HCPCS) codes.

Element 1 — Provider Name and Address
Enter the name (exactly as indicated on the provider's notification of certification letter), address, city, state, and ZIP code of the billing provider.

Element 2 — Provider Number
Enter the billing provider's eight-digit Medicaid provider number.

Element 3 — Medicaid Number
Enter the recipient's 10-digit Medicaid identification (ID) number exactly as it appears on the current Medicaid identification card.

Element 4 — Last Name
Enter the recipient's last name from the recipient's Medicaid ID card. Use the Eligibility Verification System (EVS) to obtain the correct spelling of the recipient's name. If the name or spelling of the name on the Medicaid ID card and the EVS do not match, use the spelling from the EVS.

Element 5 — First Name
Enter the recipient's first name from the recipient's Medicaid ID card. Use the EVS to obtain the correct spelling of the recipient's name. If the name or spelling of the name on the Medicaid ID card and the EVS do not match, use the spelling from the EVS.

Element 6 — Sex
Enter "0" for unspecified, "1" for male, and "2" for female.

Element 7 — Date of Birth
Enter the recipient's date of birth in MM/DD/YY format (e.g., February 4, 1977, would be 02/04/77) or in MM/DD/YYYY format (e.g., July 15, 1953, would be 07/15/1953).

Element 8 — Prescriber Number
Enter the nine-character Drug Enforcement Agency (DEA) number of the prescribing provider. This number must be two alpha characters followed by seven numeric characters. If the DEA number cannot be obtained, use one of the following default codes:

XX5555555 — Prescriber's DEA number cannot be obtained.
XX9999991 — Prescriber does not have a DEA number.

These codes must *not* be used for prescriptions for controlled substances.

Element 9 — Date Prescribed
Enter the date shown on the prescription in MM/DD/YY or MM/DD/YYYY format.

Element 10 — Date Filled

Enter the date that the prescription was filled or refilled in MM/DD/YY or MM/DD/YYYY format.

Note: When billing unit dose services, the last date of service (DOS) in the billing period must be entered.

Element 11 — Refill

Enter the refill indicator. The two digits of the refill indicator is the refill being billed. This must be "00" if the date prescribed equals the date filled. The second element is the total refills allowed (e.g., the second refill of a six refill prescription would be "02/06"). A non-refillable prescription would be "00/00." Enter "99" in the second element if the prescription indicates an unlimited number of refills.

Element 12 — NDC

Enter the 11-digit National Drug Code (NDC) or Medicaid-assigned 11-digit procedure code for the item being billed. (Use the NDC indicated on the product).

Element 13 — Days Supply

Enter the estimated days supply of tablets, capsules, fluid cc's, etc., that has been prescribed for the recipient. This must be a whole number greater than zero (e.g., if a prescription is expected to last for five days, enter "5").

Note: Days supply is not the duration of treatment, but the expected number of days the drug will be used.

Element 14 — Quantity

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

Element 15 — Charge

Enter the total charge for each line item. The charge should represent your usual and customary fee.

Element 16 — UD

Enter one of the following single-numeric indicators when billing for unit dose (UD) drugs and for non-unit dose drugs.

Note: This is a required field for ALL pharmacy claims.

Indicator	Description
0	Use for traditional dispensing fee with no repackaging allowance. No unit dose dispensed.
1	Use for dispenser-repackaged unit dose drugs for which you are entitled to only the traditional dispensing fee. Providers are reimbursed an additional unit dose repackaging fee, but not the higher unit dose dispensing fee.
2	Use for manufacturer-prepackaged unit dose drugs for which you are entitled to the unit dose dispensing fee. Providers are reimbursed the higher unit dose dispensing fee, but not the repackaging allowance.
3	Use for dispenser-repackaged unit dose drugs for which you are also entitled to the unit dose dispensing fee. Providers are reimbursed an additional unit dose repackaging fee *and* the higher dispensing fee.

Element 17 — Prescription Number

Enter the prescription number. Each legend and over-the-counter drug billed must have a unique prescription number.

Element 18 — MAC

If the legend drug dispensed is listed in the Wisconsin Medicaid Drug File as the innovator with a state maximum allowed cost (MAC), and the prescribing physician indicated "Brand Medically Necessary" on the prescription, enter "1" in this element, otherwise indicate a "0."

Element 19 — Drug Description (optional)

Element 20 — Place of Service

Enter the appropriate two-digit place of service codes for each drug or supply billed.

Code	Description
00	Pharmacy.
01	Home (IV-IM Services Only).
07	Skilled Care Facility.
08	Sub-Acute Care Facility.
10	Outpatient (Doctor's Office).

Element 21 — Diagnosis Code

This field must be completed when billing for a drug that requires a diagnosis or when billing for Pharmaceutical Care (PC) services. If the diagnosis of the drug is different than that of the PC services, enter the diagnosis code of the drug from the *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) coding structure. Enter all digits of the diagnosis code, including the preceding zeroes.

Element 22 — Level of Service

This field is required when billing for PC services. The following are the valid values to be indicated:

Code	Description
11	0 through 5 minutes.
12	6 through 15 minutes.
13	16 through 30 minutes.
14	31 through 60 minutes.
15	61+ minutes.

Element 23 — DUR Conflict/Reason (Reason)

This field is required when billing for Drug Utilization Review (DUR) or PC services. Refer to the Drug Utilization Review and Pharmaceutical Care section of this handbook for DUR and PC information and applicable PC values.

Element 24 — DUR Intervention (Action)

This field is required when billing for DUR or PC services. Refer to the Drug Utilization Review and Pharmaceutical Care section of this handbook for DUR and PC information and applicable PC values.

Element 25 — DUR Outcome (Result)

This field is required when billing for DUR or PC services. Refer to the Drug Utilization Review and Pharmaceutical Care section of this handbook for DUR and PC information and applicable PC values.

Element 26 — Certification (Pharmacist's or Dispensing Physician's Signature and Date)

The provider or the authorized representative must sign in Element 26. The month, day, and year the form is signed must also be entered in MM/DD/YY format (e.g., April 4, 2000, would be 04/04/00) or in MM/DD/YYYY format (e.g., November 15, 2000, would be 11/15/2000).

Note: The signature may be computer generated or stamped.

Element 27 — Prior Authorization Number

If prior authorization (PA) has been obtained, enter the seven-digit number in Element 27. Do not attach a copy of the PA to the claim. Services authorized under multiple PAs must be billed on separate claims.

Element 28 — OC

Wisconsin Medicaid is usually the payer of last resort for Medicaid-covered services (refer to the Coordination of Benefits section of the All-Provider Handbook for more information). Prior to submitting a claim to Wisconsin Medicaid, providers must verify whether a recipient has other health coverage (e.g., commercial insurance, HMO, or Medicare). Claims for recipients who have other health coverage must be billed to the other health insurance carrier prior to submitting to Medicaid.

If a recipient has Medicare and other insurance coverage, the provider is required to bill both when submitting a claim to Wisconsin Medicaid. When submitting the claim, enter the other coverage (OC) code for the other insurance in Element 28. Do not enter the Medicare OC code.

If a recipient is covered by Medicare and Medicaid only, enter "3" or "7" in Element 28.

Indicate one of the following OC codes that corresponds to the other coverage disclaimer:

OC Code	Other Coverage Disclaimer
0	A correct and complete claim was submitted to and denied by the recipient's commercial health insurance. The claim was denied because the recipient's benefits were exhausted, the services are not covered, the deductible was reached, etc., *or* the payment was applied towards the recipient's coinsurance and deductible.
1	The recipient has no other health coverage (e.g., commercial health insurance).
2	The claim was paid in part by the recipient's commercial health insurance or HMO. The amount paid by the health insurance carrier or the insured must be indicated on the claim.
3	The recipient has only Medicare coverage, and Medicare denied the claim because the recipient's benefits are exhausted or the service is not a covered Medicare benefit. Do not use this OC code when the recipient is covered by Medicare and commercial health insurance or private HMO.
4	The recipient has other commercial health insurance coverage, however, the health insurance carrier was not billed for reasons including, but not limited to: • The recipient denies coverage or will not cooperate. • The provider knows the service in question is not covered by the carrier. • The health insurance carrier fails to respond to initial and follow-up claim. • The benefits are not assignable or cannot get an assignment. • The provider does not contract with the recipient's commercial health insurance plan. • Services would be applied to a deductible amount. • Insurance plan requires paper claim forms for billing. • Insurance plan maintains a short billing deadline that cannot be met. • Insurance plan is a 100% discount plan. • Total billed amount is less than $10.00. • Other billing problems exist.

5	The recipient has commercial HMO or Health Maintenance Plan (HMP) health insurance coverage; however, the HMO does not cover the service, or the billed amount does not exceed the coinsurance or deductible amount. The recipient resides outside the commercial HMO service area. **Do not** use this indicator if the HMO or HMP denied payment because a designated provider did not render an otherwise covered service.
7	The recipient is not Medicare eligible at the time of service. Do not use this OC code when the recipient is covered by Medicare and commercial health insurance or private HMO.

Element 29 — Total Charges
Enter the total charges for this claim.

Element 30 — O.C. Amount
When applicable, enter the amount paid by other commercial insurance. Required when "OC" indicates "2" (other coverage exists — payment collected).

Note: This element is not used for the Medicare paid amount.

Element 31 — Patient Paid
When applicable, enter the recipient spenddown amount in this field. **Do not enter a recipient's Medicaid copayment in this field.** Wisconsin Medicaid automatically deducts the applicable Medicaid copayment amount from the claim.

Element 32 — Net Billed
Enter the balance due by subtracting any other commercial insurance amount and recipient spenddown from the amount in Element 29.

Appendix 4

Sample Non-Compound Drug Claim Form

Form 98–1141 (8/98). Replaces 482–020
Authorized under HFS 106.03 (1), Wis. Admin. Code

Return to:

EDS
6406 Bridge Road
Madison, WI 53784–0002

ICN (DO NOT WRITE IN THIS SPACE)

1. PROVIDER NAME AND ADDRESS	2. PROVIDER NUMBER	Wisconsin Medicaid NON–COMPOUND DRUG CLAIM FORM
I.M. Provider 1 West Williams Anytown, WI 55555	12345678	

RECIPIENT INFORMATION

3. MEDICAID NUMBER	4. LAST NAME	5. FIRST NAME	6. SEX	7. DATE OF BIRTH
1234567890	Recipient	Ima	2	08/28/72

CLAIM INFORMATION

	8. PRESCRIBER NUMBER	9. DATE PRESCRIBED	10. DATE FILLED	11. REFILL	12. NDC	13. DAYS SUPPLY	14. QUANTITY	15. CHARGE
1	AS7654321	12/20/00	12/20/00	00 00	00168 0199 15	30	15	$XX.XX
2	AS1234567	11/20/00	12/20/00	00 00	00781 1232 13	30	60	$XX.XX
3								$
4								$

	16. UD	17. PRESCRIPTION NUMBER	18. MAC	19. DRUG DESCRIPTION	20. POS
1	0	3942877	0	Timolol 0.25% eye drops	08
2	1	1279433	0	Enalapril 10 mg tablet	08
3					
4					

	21. DIAGNOSIS CODE	22. LEVEL OF SERVICE	23. DUR CONF./REASON	24. DUR INTERVENTION	25. DUR OUTCOME
1	V72.0	13	EX	MO	1C
2					
3					
4					

26. CERTIFICATION

I certify the services and items for which reimbursement is claimed on this claim form were provided to the above named recipient pursuant to the prescription of a licensed physician, podiatrist, or dentist. Charges on this claim form do not exceed my (our) usual and customary charge for the same services or items when provided to persons not entitled to receive benefits under Wisconsin Medicaid.
I understand that any payment made in satisfaction of this claim will be derived from federal and state funds and that any false claims, statements or documents, or concealment of a material fact may be subject to prosecution under applicable federal or state law.

PHARMACIST'S OR DISPENSING PHYSICIAN'S SIGNATURE I.M. Provider DATE 01/01/01

27. PRIOR AUTHORIZATION NUMBER

28. O.C. 2

30. O.C. AMOUNT $XX.XX

31. PATIENT PAID $

32. NET BILLED $XX.XX

PLACE OF SERVICE (POS)	DESCRIPTION
00	PHARMACY
01	HOME (IV–IM SERVICES ONLY)
07	SKILLED CARE FACILITY
08	SUB-ACUTE CARE FACILITY
10	OUTPATIENT (DOCTOR'S OFFICE)

Appendix

Appendix 5
Wisconsin Medicaid Compound Drug Claim Form Completion Instructions

To avoid denial or inaccurate claim payment, use the following claim form completion instructions. Enter all required data on the claim form in the appropriate element. Do not include attachments unless instructed to do so. All elements are required unless "optional" or "not required" is indicated.

Wisconsin Medicaid only reimburses providers for drugs listed in the Wisconsin Medicaid Drug File. Submit disposable medical supply items on a HCFA 1500 claim form using HCFA Common Procedure Coding System (HCPCS) codes.

Element 1 — Provider Name and Address
Enter the name (exactly as indicated on the provider's notification of certification letter), address, city, state, and ZIP code of the billing provider.

Element 2 — Provider Number
Enter the billing provider's eight-digit Medicaid provider number.

Element 3 — Medicaid Number
Enter the recipient's 10-digit Medicaid identification (ID) number exactly as it appears on the current Medicaid identification card.

Element 4 — Last Name
Enter the recipient's last name from the recipient's Medicaid ID card. Use the Eligibility Verification System (EVS) to obtain the correct spelling of the recipient's name. If the name or spelling of the name on the Medicaid ID card and the EVS do not match, use the spelling from the EVS.

Element 5 — First Name
Enter the recipient's last name from the recipient's Medicaid ID card. Use the EVS to obtain the correct spelling of the recipient's name. If the name or spelling of the name on the Medicaid ID card and the EVS do not match, use the spelling from the EVS.

Element 6 — Sex
Enter "0" for unspecified, "1" for male, and "2" for female.

Element 7 — Date of Birth
Enter the recipient's date of birth in MM/DD/YY format (e.g., May 20, 1980, would be 5/20/80) or in MM/DD/YYYY format (e.g., July 14, 1953, would be 07/14/1953).

Element 8 — Prescriber Number
Enter the nine-character Drug Enforcement Agency (DEA) number of the prescribing provider. This number must be two alpha characters followed by seven numeric characters. If the DEA number cannot be obtained, use one of the following default codes:

XX5555555 — Prescriber's DEA number cannot be obtained.
XX9999991 — Prescriber does not have a DEA number.

Element 9 — Date Prescribed
Enter the date shown on the prescription in MM/DD/YY or in MM/DD/YYYY format.

Element 10 — Date Filled

Enter the date that the prescription was filled or refilled in MM/DD/YY or MM/DD/YYYY format.

Element 11 — Refill

Enter the refill indicator. The first two digits of the refill indicator is the refill being billed. This must be "00" if the date prescribed equals the date filled. The second element is the total refills allowed (e.g., the second refill of a six refill prescription would be "02/06.") A non-refillable prescription would be "00/00." Enter "99" in the second element if the prescription indicates an unlimited number of refills.

Element 12 — Days Supply

Enter the estimated days supply of tablets, capsules, fluid cc's, etc. that has been prescribed for the recipient. This must be a whole number greater than zero (e.g., if a prescription is expected to last for five days, enter "5").

Note: Days supply is not the duration of treatment, but the expected number of days the drug will be used.

Element 13 — Quantity

Enter the metric decimal quantity reflecting total number of compounded units dispensed. Quantities billed should be whole numbers.

Note: This quantity may not always equal the total of the compound ingredient metric decimal quantity.

Element 14 — Prescription Number

Enter the prescription number for the entire compound.

Element 15 — Place of Service

Enter the appropriate two-digit place of service code for each drug billed.

Code	Description
00	Pharmacy.
01	Home (IV-IM Services Only).
07	Skilled Care Facility.
08	Sub-Acute Care Facility.
10	Outpatient (Doctor's Office).

Element 16 — Diagnosis Code

This field is required when any drug within the compound requires a diagnosis. Enter a diagnosis code from the *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) coding structure in this element. Refer to the Covered Services and Reimbursement section of this handbook for more information.

Element 17 — Level of Service

Enter the code from the list below that corresponds with the time required to prepare the compound.

Code	Description
11	0 through 5 minutes.
12	6 through 15 minutes.
13	16 through 30 minutes.

Compound Ingredients
Indicate up to 24 compound ingredients using the following guidelines:

Ingredient NDC	Indicate the 11-digit National Drug Code (NDC) for the item being billed. (Use the NDC indicated on the product).
Metric Decimal Quantity	Indicate the exact fractional metric quantity for the component ingredient used in the compound. Quantity billed should be rounded to two decimal places (i.e., nearest hundredth).
Ingredient Cost	Indicate the cost for the component ingredient used in the compound. The charge should represent your usual and customary fee for the compound component.

Element 18 — Certification (Pharmacist's or Dispensing Physician's Signature and Date)

The provider or the authorized representative must sign in Element 18. The month, day, and year the form is signed must also be entered in MM/DD/YY format (e.g., June 7, 2000, would be 06/07/00) or in MM/DD/YYYY format (e.g., August 8, 2000, would be 08/08/2000).

Note: The signature may be computer generated or stamped.

Element 19 — Prior Authorization Number

This field is required when any drug within the compound requires prior authorization (PA). Enter the seven-digit number from the approved PA form in element 19. Do not attach a copy of the PA to the claim. Services authorized under multiple PAs must be billed on separate claims.

Element 20 — OC

Wisconsin Medicaid is usually the payer of last resort for Medicaid-covered services. Claims for recipients who have commercial health insurance must be billed to the other health insurance carrier prior to submitting to Medicaid.

If a recipient has Medicare and other commercial insurance coverage, the provider is required to bill both before submitting a claim to Wisconsin Medicaid. When submitting the claim, enter the other coverage (OC) code for the other insurance in Element 20. Do not enter the Medicare OC code.

If a recipient is covered by Medicare and Medicaid only, enter "3" in Element 20.

Indicate one of the following OC codes that corresponds to the other coverage disclaimer:

OC Code	Other Coverage Disclaimer
0	A correct and complete claim was submitted to and denied by the recipient's commercial health insurance. The claim was denied because the recipient's benefits were exhausted, the services are not covered, the deductible was reached, etc., *or* the payment was applied towards the recipient's coinsurance and deductible.
1	The recipient has no other health coverage (e.g., commercial health insurance).
2	The claim was paid in part by the recipient's commercial health insurance or HMO. The amount paid by the health insurance carrier or the insured must be indicated on the claim.

OC Code	Other Coverage Disclaimer
3	The recipient has only Medicare coverage, and Medicare denied the claim because the recipient's benefits are exhausted or the service is not a covered Medicare benefit. Do not use this OC code when the recipient is covered by Medicare and commercial health insurance or private HMO.
4	The recipient has other commercial health insurance coverage, however, the health insurance carrier was not billed for reasons including, but not limited to: • The recipient denies coverage or will not cooperate. • The provider knows the service in question is not covered by the carrier. • The health insurance carrier fails to respond to initial and follow-up claim. • The benefits are not assignable or cannot get an assignment. • The provider does not contract with the recipient's commercial health insurance plan. • Services would be applied to a deductible amount. • Insurance plan requires paper claim forms for billing. • Insurance plan maintains a short billing deadline that cannot be met. • Insurance plan is a 100% discount plan. • Total billed amount is less than $10.00. • Other billing problems exist.
5	The recipient has HMO or Health Maintenance Plan (HMP) health insurance coverage; however, the HMO does not cover the service, the billed amount does not exceed the coinsurance or deductible amount, or the recipient resides outside the commercial HMO service area. Do not use this indicator if the HMO or HMP denied payment because a designated provider did not render an otherwise covered service.
7	The recipient is not Medicare eligible at the time of service. Do not use this OC code when the recipient is covered by Medicare and commercial health insurance or private HMO.

Element 21 — Total Charges
Enter the total charges for this claim.

Element 22 — O.C. Amount
Enter the amount paid by commercial health insurance. Required when "OC Code" indicates "2" (other coverage exists — payment collected).

Note: This element is not used for the Medicare paid amount.

Element 23 — Patient Paid
When applicable, enter the recipient spenddown amount in this field. **Do not enter a recipient's Medicaid copayment in this field.** Wisconsin Medicaid automatically deducts the applicable Medicaid copayment amount from the claim.

Element 24 — Net Billed
Enter the balance due by subtracting any other insurance amount and recipient spenddown from the amount in Element 21.

Appendix 6
Sample Compound Drug Claim Form

Form 98–1142 (8/98)
Authorized under HFS 106.03 (1), Wis. Admin. Code

Return to:

EDS
6406 Bridge Road
Madison, WI 53784–0002

ICN (DO NOT WRITE IN THIS SPACE)

1. PROVIDER NAME AND ADDRESS
I.M. Provider
1 West Williams
Anytown, WI 55555

2. PROVIDER NUMBER
12345678

Wisconsin Medicaid

COMPOUND DRUG CLAIM FORM

RECIPIENT INFORMATION

3. MEDICAID NUMBER	4. LAST NAME	5. FIRST NAME	6. SEX	7. DATE OF BIRTH
1234567890	Recipient	Ima	2	08/28/72

CLAIM INFORMATION

8. PRESCRIBER	9. DATE PRESCRIBED	10. DATE FILLED	11. REFILL	12. DAYS SUPPLY	13. QUANTITY
AB1111111	01/01/01	01/01/01	00 00	14	210

14. PRESCRIPTION	15. POS	16. DIAGNOSIS CODE	17. LEVEL OF SERVICE
1234567	00		12

COMPOUND INGREDIENTS

	INGREDIENT NDC	METRIC DECIMAL QUANTITY	INGREDIENT COST		INGREDIENT NDC	METRIC DECIMAL QUANTITY	INGREDIENT COST
1.	00469 0469 61	100	$X.XX	13.			$
2.	03976 9042 10	10	$X.XX	14.			$
3.	00469 8600 60	50	$X.XX	15.			$
4.	00469 1187 25	30	$X.XX	16.			$
5.	00517 7210 25	10	$X.XX	17.			$
6.	00186 1199 35	10	$X.XX	18.			$
7.			$	19.			$
8.			$	20.			$
9.			$	21.			$
10.			$	22.			$
11.			$	23.			$
12.			$	24.			$

18. CERTIFICATION
I certify the services and items for which reimbursement is claimed on this claim form were provided to the above named recipient pursuant to the prescription of a licensed physician, podiatrist, or dentist. Charges on this claim form do not exceed my (our) usual and customary charge for the same services or items when provided to persons not entitled to receive benefits under Wisconsin Medicaid.
I understand that any payment made in satisfaction of this claim will be derived from federal and state funds and that any false claims, statements or documents, or concealment of a material fact may be subject to prosecution under applicable federal or state law.

PHARMACIST'S OR DISPENSING PHYSICIAN'S
SIGNATURE I.M. Provider DATE 01/01/01

19. PRIOR AUTHORIZATION NUMBER

20. O.C. 1

PLACE OF SERVICE (POS)	DESCRIPTION
00	PHARMACY
01	HOME (IV–IM SERVICES ONLY)
07	SKILLED CARE FACILITY
08	SUB-ACUTE CARE FACILITY
10	OUTPATIENT (DOCTOR'S

21. TOTAL CHARGES $XX.XX
22. O.C. AMOUNT
23. PATIENT PAID
24. NET BILLED $XX.XX

Appendix

Appendix 7
Electronic Media Claims Submission Instructions

Fields marked with an asterisk (*): This information does not appear or it autoplugs on the software.

Claim Header Record 1

REC-ID (Record Identifier)*
This is a one-byte numeric field. Enter the constant character of "1."

CT (Claim Type)
This is a two-byte numeric field. Enter the constant characters "10."

BP-NBR (Billing Provider Number)
Enter your eight-digit provider number assigned by Wisconsin Medicaid.

MID (Medicaid Identification Number)
Enter the recipient's Medicaid identification number as it appears on the current Medicaid identification card.

L-NAME (Last Name)
Enter up to 12 characters of the recipient's last name from the recipient's Medicaid identification card. Use the Eligibility Verification System (EVS) to obtain the correct spelling of the recipient's name. If the name or spelling of the name on the Medicaid ID card and the EVS do not match, use the spelling from the EVS.

F-NAME (First Name)
Enter the first two characters of the recipient's first name.

FP-NBR (Facility Provider Number)
Leave this field blank.

OI-IND (Other Insurance Indicator)
Enter one of the following codes:

Code	Description
P	Paid in part by commercial insurance, HMO, or Health Maintenance Plan (HMP).
D	Denied by commercial insurance (benefits exhausted, not covered, deductible reached, etc.).
Y	Yes, card indicated other coverage but was not billed for reasons.
H	HMO or HMP does not cover this service or the billed amount does not exceed the coinsurance or deductible amount.
Blank	No other insurance coverage.

Note: If indicator is "P," amount of commercial insurance payment must be entered in "Other Insurance Paid."

MSC (Medicare Status Code)
Enter one of the following codes that best reflect the Medicare status of the recipient.

Code	Description
6	Non-Medicare Eligible Recipient.
7	Medicare Benefits Denied/Rejected.
Blank	Patient has no Medicare.

Note: Required field, if previously processed by Medicare and denied or if recipient is Medicare eligible but service is not a benefit.

PCN (Patient Control Number)
Enter up to 12 characters in this field as desired. These characters will be printed in the Medical Record field on the Remittance and Status Report.

PA-NBR (Prior Authorization Number)
Enter the seven-digit prior authorization (PA) number from the approved PA form. Services authorized under multiple PAs must be billed on separate claims. If the procedure(s) does not require PA, leave the space blank.

DIAG (Diagnosis Code)
When submitting a diagnosis-restricted drug, enter the applicable five-digit diagnosis code from the *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) coding structure in this field. If not submitting a claim for a diagnosis-restricted drug, this field may be left blank. Enter all digits of the diagnosis code, including preceding zeros, without any decimal, that is applicable to the diagnosis-restricted drug. Multiple diagnosis-restricted drugs **cannot** be submitted on the same claim.

Claim Detail Record 3

REC-ID (Record Identifier)*
This is a one-byte numeric field. Enter the constant character "3."

CT (Claim Type)*
This is a two-byte numeric field. Enter the constant characters "10." (10 is for pharmacy claims.)

PRESCRIBER (Prescribing Physician)
Enter the nine-digit Drug Enforcement Administration (DEA) number of the prescribing provider. This number must be two alpha characters followed by seven numeric characters. If the DEA number is not available, enter one of the following default DEA numbers:

XX5555555 — Prescriber's DEA cannot be obtained.
XX9999991 — Prescriber does not have a DEA number.

RX-DT (Prescription Date)
Enter the date shown on the prescription using YYYYMMDD format.

FILL-DT (Fill Date)
Enter the date that the prescription was filled or refilled in YYYYMMDD format.

Note: When billing for unit dose services, the last date of service in the billing period must be entered.

RF (Refill Indicator)
Enter a one-digit code indicating the number of refills for this prescription.

Code	Description
0	New prescription.
1	1st refill of prior prescription.
2	2nd refill of prior prescription.
3	3rd refill of prior prescription.
4	4th refill of prior prescription.
5	5th refill of prior prescription.
6	6th refill of prior prescription.
7	7th refill of prior prescription.
8	8th refill of prior prescription.
9	9th-11th refill of prior prescription.

NDC (National Drug Code)
Enter the 11-digit NDC code or Medicaid-assigned 11-digit procedure code for the item being billed (use the NDC indicated on the product).

DAYS (Days Supply)
Enter the estimated days supply of the tablets, capsules, fluid cc's, etc., that has been prescribed for the recipient. This must be a whole number greater than zero (e.g., if a prescription is expected to be used for five days, enter "5").

Note: Days supply is not the duration of the treatment, but the expected number of days the drug will be used.

QTY (Quantity Dispensed)
Enter the quantity in specified unit of measure according to the Wisconsin Medicaid Drug/Medical Supply Index.

Note: Two decimal places are assumed (e.g., a quantity of "1" should be entered as "100," a unit of "1 ¼" should be entered as "125," a unit of "1 ½" should be entered as "150"). Do not enter the decimal.

CHARGE (Detail Billed)
Enter the billed amount for each detail procedure including professional fees.

Note: Two decimal places are assumed (e.g., $10.00 is keyed as 1000).

UD (Unit Dose Indicator)
Enter the appropriate unit dose indicator.

U	Unit dose dispensing fee with no repackaging allowance.
B	Unit dose dispensing fee with repackaging allowance.
D	Traditional dispensing fee with repackaging allowance.
Blank	Traditional dispensing fee with no repackaging allowance.

RX-NBR (Prescription Number)
Enter up to eight characters of the prescription number. Each legend and over-the-counter drug must have a unique prescription number.

MAC (Maximum Allowed Cost)
If the legend drug dispensed is listed in the Wisconsin Medicaid Drug File as the innovator with a state MAC and the prescribing physician indicated "Brand Medically Necessary" on the prescription, enter "N," otherwise leave this field blank.

POS (Place of Service)
Enter the appropriate single-digit place of service code.

Code	Description
0	Pharmacy.
3	Doctor's office.
4	Home (IV-IM services only).
7	Nursing facility/extended care facility.
8	Skilled nursing facility.

Appendix 8
Eligibility Verification System Quick-Reference Guide

Provider Services

(800) 947-9627 or (608) 221-9883

Provider Services Hours

Hours for recipient eligibility information and all other Provider Services inquiries (except pharmacy) are:

- 8:30 a.m. to 4:30 p.m. Mondays, Wednesdays, Thursdays, and Fridays.
- 9:30 a.m. to 4:30 p.m. on Tuesdays.

Hours for policy/billing information relating to pharmacy services are:

- 8:30 a.m. to 6:00 p.m. Mondays, Wednesdays, Thursdays, and Fridays.
- 9:30 a.m. to 6:00 p.m. on Tuesdays.

Magnetic Stripe Card Readers

Eligibility access available 24 hours a day, seven days a week

- The readers look and work similarly to credit card terminals and may be purchased through commercial eligibility verification vendors. (Refer to the Provider Resources section of the All-Provider Handbook for a list of these vendors.)
- Using the magnetic stripe on the back of the Forward card to access current Medicaid eligibility information, the readers enable providers to print a hard copy of the recipient's eligibility information for their records.

Direct Information Access Line with Updates for Providers (Dial-Up)

Eligibility access available Monday through Friday, 7:00 a.m. to 6:00 p.m., except holidays

Offers information through your personal computer or "dumb terminal" with the use of a software communications package and telephone modem. The package can be purchased through the fiscal agent.

To receive fee information and a provider agreement for Dial-Up, call Wisconsin Medicaid or write to:

Wisconsin Medicaid
Dial-Up
6406 Bridge Road
Madison, WI 53784-0009
(608) 221-4746

Automated Voice Response System

(800) WIS-ELIG (947-3544) or (608) 221-4247
Available 24 hours a day, seven days a week

The Automated Voice Response (AVR) system is a computerized service that allows providers with touch-tone telephones direct access to eligibility information for the current benefit month and previous 365 days. It also allows providers to access provider Checkwrite information, claim status information, and prior authorization (PA) status information. Providers are able to make up to **eight inquiries** per call.

Providers should wait at least 15 business days from the date of submission to verify PA and claim status information.

The AVR system features:

- Easy-to-follow prompts.
- Toll-free telephone lines.
- Option to press "0" to transfer to Provider Services.

er Software

24 hours a day, seven days a week

r current computer system and, using a modem, can access the gnetic stripe card readers.

copy of the recipient's eligibility information for your records.

Some eligibility verification vendors also provide access to the EVS through the Internet. Providers can print a hard copy of a recipient's eligibility information through this method also. Refer to the Provider Resources section of the All-Provider Handbook for a list of commercial eligibility verification vendors.

Appendix

Appendix 9
Private HMO and Commercial Insurance Carrier Codes

Private HMO Carrier Codes

A83	PruCare HMO	Matteson	IL
B20	Heritage National Health Plan	Moline	IL
B37	MetLife Health Care Network	Maitland	FL
B70	Butterworth HMO	Grand Rapids	MI
B72	First Plan HMO	Two Harbors	MN
E29	Q Care	Madison	WI
H25	Health Partners HMO	Minneapolis	MN
H54	PruCare HMO	Houston	TX
I18	Valley Health Plan	Eau Claire	WI
J31	Medical Associates HMO	Dubuque	IA
K63	Heritage National Health Plan	Rockford	IL
M14	DeanCare HMO	Madison	WI
M31	HMO of Wisconsin	Sauk City	WI
M98	PrimeCare	Milwaukee	WI
Q63	Humana, Inc.	Louisville	KY
Q75	Mayo Clinic Health Plan	Rochester	MN
Q85	HMO Chicago	Chicago	IL
R84	Clinicare	Rockford	IL
R95	Physicians Plus HMO	Madison	WI
U17	HMO Illinois	Chicago	IL
U34	FHP of Illinois	Colorado Springs	CO
W03	Atrium Health Plan	St. Paul	MN
W65	Health Reach HMO	Madison	WI
X80	Family Health Plan	Bloomington	MN
Y46	Network Health Plan	Menasha	WI
Y59	Met Life HMO	Maitland	FL
Z05	United Health of Wisconsin	Appleton	WI
Z72	Wisconsin Health Fund	Milwaukee	WI
Z73	Unity Health Plan	Sauk City	WI
063	Employers Health Plan HMO	Green Bay	WI
09I	Rockford Health Plans	Rockford	IL
090	Compcare	Milwaukee	WI
091	Security Health Plan	Marshfield	WI
092	Group Health Coop SC Wisconsin	Madison	WI
093	Group Health Coop Eau Claire	Eau Claire	WI
109	Family Health Plan Coop	Milwaukee	WI
11K	Coordinated Care	Milwaukee	WI
24K	Greater LaCrosse Health Plan	LaCrosse	WI
33B	Keystone Health Plan	Camp Hill	PA
36I	Compass Health Care HMO	Rosemont,	IL
56G	Gunderson Lutheran Health Plan	La Crosse	WI
57F	MercyCare Insurance Co.	Janesville	WI
60B	Humana Health Plan	Chicago	IL
712	Blue Plus	St. Paul	MN
80C	Managed Health Services	Milwaukee	WI
84A	Medica Choice HMO	Duluth	MN

Commercial Health Insurance Carrier Codes

C81	Cigna HealthCare	Atlanta	GA
F03	AARP Health Care Options	Philadelphia	PA
G14	Great West Life & Annuity	Rosemont	IL
J48	Cigna	Bourbonnais	IL
J60	Midwest Security	Green Bay	WI
K36	Cigna HealthCare	Des Moines	IA
L82	Aetna Pharmacy Mgt Claim Support	Minneapolis	MN
M73	Provantage	Brookfield	WI
M82	Caremark Prescription Service	San Antonio	TX
Z27	Employers Health Insurance Co.	Green Bay	WI
029	Mutual of Omaha	Omaha	NE
039	Fortis Health	Milwaukee	WI
046	WPS/Provantage	Brookfield	WI
085	Blue Cross & Blue Shield of Wisconsin	Milwaukee	WI
287	Unicare	Boston	MA
385	PCS	Phoenix	AZ
403	PCS	Phoenix	AZ
810	Express Scripts Value Rx	Minneapolis	MN
962	Cigna HealthCare	Bristol	CT
12B	United HealthCare Insurance Company	Duluth	MN
23I	PrimeCare/DPS	International Falls	MN
28E	Paid Prescriptions	Parsippany	NJ
28I	Superior Health Services	Woodruff	WI
37K	Unity Health Plan non-HMO Community Network	Sauk City	WI
38H	Cigna Rx Prime	Hartford	CT
38K	Unity Health Plans non-HMO UW Health Network	Sauk City	WI
46C	Wausau/DPS	International Falls	MN
51D	United HealthCare	Newnan	GA
56J	Wellpoint	Woodland Hills	CA
64H	Provantage/AMS	Brookfield	WI
65I	Community Health Plan of Wisconsin	Milwaukee	WI
70G	Provantage Blue Cross Blue Shield	Brookfield	WI
74D	Time Insurance/DPS	International Falls	MN
75I	Atrium Point of Service	St. Paul	MN

Appendix 10
Medicaid Managed Care HMOs/Programs List

When providers submit real-time claims, a managed care code is identified in the optional free form text field when the recipient is in a Medicaid HMO or special managed care program. The following lists identify each HMO/managed care program's code, name, and telephone number. If you are not part of their provider network, contact the managed care program prior to providing services to an enrollee.

Managed Care HMO Name	Telephone Number	Managed Care Code
Atrium Health Plan	(888) 203-7771 (715) 552-4310	04
Dean Health Plan	(800) 279-1301 (608) 828-1301	03
Greater La Crosse Health Plan	(800) 545-8499 (608) 791-7848	05
Group Health Cooperative of Eau Claire	(888) 203-7770 (715) 552-4300	17
Group Health Cooperative of South Central Wisconsin	(608) 251-3356	02
Managed Health Services	(800) 222-9831 (414) 345-4628	22
MercyCare Health Plans	(800) 895-2421	11
Network Health Plan	(800) 222-9831 (414) 345-4628	12
Security Health Plan	(800) 791-3044	01
Touchpoint Health Plan (formerly United Health of Wisconsin)	(800) 757-1950 (920) 831-1950	15
UnitedHealthCare (PrimeCare)	(800) 879-0071 x.4310 (414) 443-4130	13
Unity Health Plans	(800) 362-3310	21
Valley Health Plan	(800) 472-5411 x.1974 or x.1284	34

HMO Coverage Codes

Certain HMOs cover dental and chiropractic services. One of the following codes will be indicated for real-time claims:

186 Dental and chiropractic services covered.
187 Chiropractic services covered.
188 Dental services covered.
189 Neither chiropractic nor dental services covered.

Special Managed Care Program Name	Telephone Number	Managed Care Code
Children Come First	(608) 250-6634, ext. 106	64
Community Care Organization	(414) 385-6600	65
Community Health Partnership	(715) 838-2900	67
Community Living Alliance	(608) 242-8335	63
Elder Care Options	(608) 240-0020	69
Independent Care	(414) 223-4847	66
Wraparound Milwaukee	(414) 257-7611	62

Appendix 11

National Council For Prescription Drug Programs Reject Codes/Messages and Wisconsin Medicaid Edit/Audit Codes/Messages

NCPDP: National Council for Prescription Drug Programs.
M/I: Missing/invalid.

NCPDP Reject Code	NCPDP Message/Explanation	Additional Information
01	M/I Bin	Provider should contact software vendor.
02	M/I Version Number	Provider should contact software vendor.
03	M/I Transaction Code	Provider should contact software vendor.
04	M/I Processor Control Number	Provider should contact software vendor.
05	M/I Pharmacy Number	Provider should contact software vendor.
15	M/I Date Filled/Date of Service	Provider should check date submitted. If valid, provider should contact software vendor.
16	M/I Prescription Number	Provider should check prescription (Rx) number submitted. If numeric, provider should contact software vendor.
18	M/I Metric Quantity	Provider should check metric quantity submitted. If numeric, provider should contact software vendor.
19	M/I Days Supply	Provider should check days supply submitted. If numeric, provider should contact software vendor.
20	M/I Compound Code	Provider should contact software vendor.
21	M/I NDC Number	Provider should check National Drug Code (NDC) number submitted. If within range 99900000000-99998999999 or 90000000011-90000000015, instruct provider to not submit Pharmaceutical Care (PC) or compound drug NDC.
28	M/I Date Prescription Written	Provider should check date submitted. If valid, provider should contact software vendor.
30	M/I PA Code and Number	Provider should contact software vendor.
32	M/I Level of Service	Provider should check level of service (LOS). If valid value, provider should contact software vendor.
83	Duplicate Paid/Captured Claim	Provider should check date of service (DOS) and Rx number. If same as another paid claim, provider should resubmit claim with different Rx number.
84	Claim Has Not Been Paid/Captured	Claim denied due to Wisconsin Medicaid edit or audit.
85	Claim Not Processed	Detail not processed because of another detail on claim. No corrective action necessary on this detail at this time. Resubmit.

Appendix 11
continued

NCPDP Reject Code	NCPDP Message/Explanation	Additional Information
88	DUR Reject Error	
93	Planned Unavailable	
99	Host Processing Error	
DQ	M/I Usual and Customary	Provider should check usual and customary charge. If numeric, provider should contact software vendor.
DV	M/I Other Payer Amount	Provider should check other payer amount. If numeric, provider should contact software vendor.
DW	M/I Basis of Days Supply Determination	Provider should check other payer amount. If numeric, provider should contact software vendor.
DX	M/I Patient Paid Amount	Provider should check other payer amount. If numeric, provider should contact software vendor.
NN	Transaction Rejected at Switch or Intermediary	Provider should check other payer amount. If numeric, provider should contact software vendor.
E4	DUR Conflict/Reason for Service Code	If provider is submitting Drug Utilization Review (DUR) code on compound claim, instruct provider that professional services are not billable on compound claim.
E5	DUR Intervention/Professional Service Code	If provider is submitting DUR code on compound claim, instruct provider that professional services are not billable on compound claim.
E6	DUR Outcome/Result of Service Code	If provider is submitting DUR code on compound claim, instruct provider that professional services are not billable on compound claim.
E7	M/I Metric Decimal Quantity	Provider should check metric decimal quantity. If numeric, provider should contact software vendor.
EC	M/I Compound Ingredient Component Counter Number	Provider should contact software vendor.
ED	M/I Compound Ingredient Metric Decimal Quantity	Provider should check compound ingredient metric decimal quantity. If numeric, provider should contact software vendor.
M5	Requires Manual Claim (Wisconsin Medicaid POS = Unable to be reversed real-time)	Provider should verify that the pharmacy number, date filled/DOS, and prescription number are correct and resubmit. If valid, submit adjustment request on paper.
EE	M/I Compound Ingredient Drug Cost	Provider should check compound ingredient drug cost. If numeric, provider should contact software vendor.
M5	Error Overflow (Wisconsin Medicaid POS = Unable to display additional error messages. Contact Provider Services)	

Appendix 11
continued

Explanation of Benefits (EOB) Message #	Edit/Audit EOB Message Description
005	Charges paid at reduced rate based upon your usual and customary pricing profile.
006	Amount paid reduced by amount of other insurance payment.
009	Recipient name missing. Please correct and resubmit.
010	Recipient is eligible for Medicare. Please bill Medicare first. Indicate Medicare disclaimer on claim if Medicare denied or attach the Explanation of Medicare Benefits if Medicare paid.
012	Service paid at the maximum amount allowed by Wisconsin Medicaid reimbursement policies.
014	A discrepancy was noted between the other insurance indicator, and the amount paid on your claim.
020	Claim reduced due to recipient spenddown.
024	Provider certification has been suspended by the Department of Health and Family Services (DHFS).
025	Provider certification has been cancelled by the DHFS.
029	Wisconsin Medicaid number does not match recipient's last name.
050	Payment reduced by recipient copayment.
060	*International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis code is missing or invalid.
074	No electronic media claims agreement form on file. Please contact Wisconsin Medicaid.
084	Claim denied due to missing or invalid provider signature and/or billing date.
095	Generic substitute invalid. Please correct and resubmit.
100	Claim previously/partially paid on (internal control number) on remittance advice (RA) date (DDMMYY). Adjust paid claim.
114	Schedule 3/4/5 drugs are limited to the original dispensing plus five refills or six months.
116	Procedure or drug code not a benefit on DOS.
137	This claim paid at per diem rate.
146	Non-scheduled legend drugs are limited to the original dispensing plus 11 refills or 12 months.
153	Claim denied due to missing and/or incorrect total billed amount.
158	Quantity billed is missing or exceeds the maximum allowed per DOS.
171	Denied. Claim/adjustment received after 12 months from DOS indicated on claim/ adjustment.
172	Recipient's Wisconsin Medicaid number not eligible for DOS.
177	Denied. Procedure not payable for place of service or invalid place of service code submitted. Resubmit with correct place of service code for procedure provided.

Appendix 11
continued

EOB Message #	Edit/Audit EOB Message Description
183	Provider not authorized to perform procedure code and/or type of service code.
184	Procedure billed does not correspond with Wisconsin Medicaid age criteria guidelines.
185	Procedure billed is not appropriate to recipient's sex.
201	Performing provider not certified by Wisconsin Medicaid/prescribing Drug Enforcement Agency (DEA) number invalid for NDC billed.
203	Estimated days supply missing or incorrect.
221	No charge was submitted for this procedure.
224	Quantity billed is missing or incorrect.
228	Medicare Part B deducted charges.
240	Prescription number is missing or incorrect.
242	Prescription date is missing, invalid, after DOS, or exceeds one year. Please correct and resubmit.
247	Procedure code/NDC is invalid, obsolete, or not billable to Wisconsin Medicaid, or this procedure/type of service combination is invalid. Resubmit with valid Wisconsin Medicaid codes for the DOS.
277	Services billed are included in the nursing facility rate structure.
278	Denied. Recipient eligibility file indicates other insurance. Submit to other insurance carrier.
281	Recipient's Wisconsin Medicaid identification number is incorrect. Please verify and correct the Wisconsin Medicaid number and resubmit claim.
287	Claim denied. Recipient is enrolled in a Medicaid HMO or other managed care program.
289	Services performed by out-of-state providers are limited to those prior authorized or emergency in nature.
310	Traditional professional dispensing fee reimbursement policy applied.
322	Service(s) denied/cutback. The maximum prior authorized service limitation or frequency allowance has been exceeded.
324	EDS Federal has recouped payment for service(s) per provider request.
361	No more than two dispensing fees per month per prescription shall be paid.
369	The indicated legend drug shall be dispensed in amounts not to exceed 34-days supply.
376	The indicated legend drug shall be dispensed in amounts not to exceed a 100-days supply.
388	Incorrect or invalid type of service/NDC/procedure code/accommodation code or ancillary code billed.
398	Prior authorization (PA) number submitted is missing or incorrect.
399	Date of service must fall between the PA grant date and expiration date.

Appendix 11
continued

EOB Message #	Edit/Audit EOB Message Description
400	Performing provider on the claim must be the same as the performing provider who received PA for this service.
424	Billing provider name/number is missing, mismatched, or unidentifiable. Indicate one billing provider name/number in the appropriate element.
425	Performing/prescribing provider number/DEA number is missing or unidentifiable. Please indicate separately on each detail.
426	Claim denied. Payment is limited to one unit dose service per calendar month, per legend drug, per recipient.
469	Claim is being processed through Special Handling. No action on your part is required. Please disregard additional messages for this claim.
477	Billing provider indicated on claim not allowable as a billing provider. A clinic, facility, or supervising provider must be the billing provider.
498	Pharmaceutical Care code must be billed with a valid LOS.
509	Claim denied. Please verify the units and dollars billed. If correct, refer to Pharmacy Handbook for special billing instructions.
510	Denied. Prior authorization/diagnosis is required for a payment of this service. A valid PA number/diagnosis is required and/or the type of service/procedure must match the approved PA.
511	National Drug Code is only billable as a compound drug.
595	One service allowed per day. This procedure is denied as a duplicate.
614	Wisconsin Medicaid number does not match recipient's first name.
618	Claim denied. Unit dose indicator billed is invalid with NDC billed.
619	Claim denied. Do not indicate "no substitute" on the claim when the NDC billed is for a generic drug.
630	A valid LOS is required for billing compound drugs or PC.
631	Recipient locked-in to a pharmacy provider or enrolled in a hospice. Contact recipient's hospice for a payment of services or resubmit with documentation of unrelated nature of care.
643	Billing provider not certified for the DOS.
683	Qualified Medicare Beneficiary Only recipient is allowable only for coinsurance and deductible on a Medicare crossover claim.
698	Recipient not eligible for Medicaid benefits.
751	Denied. No substitution indicator invalid for drugs not on the current Wisconsin Maximum Allowed Cost (MAC) list.
843	All three DUR fields must indicate a valid value for prospective DUR. A valid LOS is also required for PC reimbursement.
846	Denied. This procedure code is not valid in the pharmacy Point-of-Sale (POS) system. Please resubmit on the HCFA 1500 using the correct HCFA Common Procedure Coding System (HCPCS) procedure code.

Appendix 11
continued

EOB Message #	Edit/Audit EOB Message Description
852	Denied. Quantity must be a whole number for this NDC. Correct and resubmit.
853	Fill date is missing, incorrect, or contains future date.
877	The quantity allowed was reduced to a multiple of the product's packaging size.
887	Default prescribing physician number XX5555555 was indicated. Valid numbers are important for DUR purposes. Please obtain a valid number for future use.
888	Default prescribing physician number XX9999991 was indicated. Valid numbers are important for DUR purposes. Please verify that physician has no DEA number.
907	Our records indicate you have billed more than one unit dose dispensing fee for this calendar month. Reimbursement for this detail does not include unit dose dispensing fee.
916	Pharmaceutical Care codes are billable on non-compound drug claims only.
920	Denied. A discrepancy exists between the other coverage (OC) indicator submitted and the OC information on the file for the recipient. Please verify and resubmit.
922	Duplicate component billed on same compound claim.
935	Invalid billing of procedure code.
957	Other coverage indicator is missing or invalid. Please correct and resubmit.
960	Denied. These supplies/items are included in the purchase of the durable medical equipment item billed on the same DOS.
976	Resubmit on paper for special handling.
979	Pharmaceutical Care code must be billed with a payable drug detail.
994	Compound drugs require a minimum of two components with at least one payable Medicaid covered drug.
996	Denied, limitation exceeded.

Appendix 12
Wisconsin Medicaid/National Council For Prescription Drug Programs Crosswalks

The following tables list National Council for Prescription Drug Programs (NCPDP) values and the equivalent Wisconsin Medicaid values. Use the NCPDP values for real-time and paper claims. Use Wisconsin Medicaid values for electronic media claims (EMC) and when submitting prior authorization requests.

Crosswalk One
Other Coverage Code (NCPDP)/Other Insurance Indicator (Wisconsin Medicaid)

NCPDP Code	NCPDP Description	Wisconsin Medicaid Code	Wisconsin Medicaid Description
0	Not specified.	D	Denied by commercial insurance (benefits exhausted, not covered, deductible reached, etc.)
1	No other coverage identified.	Blank	No other insurance coverage.
2	Other coverage exists — payment collected.	P	Paid in part by commercial insurance or HMO.
3	Other coverage exists — this claim not covered.	7	Medicare benefits denied/rejected.
4	Other coverage exists — payment not collected.	Y	Yes, recipient has other coverage but was not billed for reasons.
5*	Managed care plan denial.	H	Commercial HMO or health maintenance plan does not cover this service or billed amount does not exceed the coinsurance or deductible amount.
7*	Other coverage exists — not in effect at time of service.	6	Non-Medicare eligible recipient.

*Effective with NCPDP version 3.3 and higher.

Appendix

Crosswalk Two
Customer Location (NCPDP)/Place of Service (Wisconsin Medicaid)

NCPDP Code	NCPDP Description	Wisconsin Medicaid Code	Wisconsin Medicaid Description
00	Not specified.	0	Pharmacy.
01	Home.	4	Home (IV-IM services only).*
07	Skilled care facility.	8	Skilled nursing facility.
08	Sub-acute care facility.	7	Nursing home extended care facility.
10	Outpatient.	3	Doctor's office.

**Note:* Most National Drug Codes (NDCs) do not allow this option.

Crosswalk Three
New/Refill Code (NCPDP)/Refill (Wisconsin Medicaid)

NCPDP Code	NCPDP Description	Wisconsin Medicaid Code	Wisconsin Medicaid Description
00	New prescription.	0	New prescription.
01	Number of refills.	1	1 refill.
02	Number of refills.	2	2 refills.
03	Number of refills.	3	3 refills.
04	Number of refills.	4	4 refills.
05	Number of refills.	5	5 refills.
06	Number of refills.	6	6 refills.
07	Number of refills.	7	7 refills.
08	Number of refills.	8	8 refills.
09	Number of refills.	9	9-99 refills.
10-99	Number of refills.	9	9-11 refills.

Crosswalk Four
Dispense As Written/Product Selection (NCPDP)/Maximum Allowed Cost (MAC) Waiver Code (Wisconsin Medicaid)

NCPDP Code	NCPDP Description	Wisconsin Medicaid Code	Wisconsin Medicaid Description
0	No product selection indicated.	Blank	Not specified.
1	Substitution not allowed by prescriber.	N	No substitute.

Crosswalk Five
Unit Dose Indicator (NCPDP)/Unit Dose (Wisconsin Medicaid)

NCPDP Code	NCPDP Description	Wisconsin Medicaid Code	Wisconsin Medicaid Description
0	Not specified.	Blank	Traditional dispensing fee with no repackaging allowance.
1	Not unit dose.	D	Traditional dispensing fee with repackaging allowance.
2	Manufacturer unit dose.	U	Unit dose dispensing fee with no repackaging allowance.
3	Pharmacy unit dose.	B	Unit dose dispensing fee with repackaging allowance.

Appendix 13
Adjustment Request Form Completion Instructions

The Adjustment Request Form is used to request an adjustment of an allowed claim (a paid or partially paid claim). Providers may request an adjustment when claim information needs to be changed. After the changes are made to the original claim, the adjusted claim is processed as other claims.

Providers cannot adjust a totally denied claim. A claim that was totally denied must be resubmitted through normal channels after the additional information has been supplied or the necessary correction has been made to the claim.

Questions about adjustments and other procedures or policies may be directed to Provider Services at (800) 947-9627 or (608) 221-9883.

The Adjustment Request Form is reviewed by Wisconsin Medicaid based on the information provided. Providers may photocopy the Adjustment Request Form in **Appendix 14** of this section for their own use. Be as specific as possible when describing how the original claim is to be changed. Complete the adjustment request as follows:

Step 1: Enter the following information from your Remittance and Status Report:

Element 1: Provider name.
Element 2: Wisconsin Medicaid provider number to which the claim was paid (eight digits).
Element 3: Date of the Remittance and Status (R/S) Report showing the paid claim you are adjusting.
Element 4: Claim number of the paid/allowed claim (15 digits). (When adjusting a previously adjusted claim, use the claim number assigned to the most recently processed claim/adjustment.)
Element 5: Complete name of the Wisconsin Medicaid recipient for whom payment was received (Last, First, MI).
Element 6: Recipient's Wisconsin Medicaid identification number (10 digits).

Step 2: Add a detail(s).

If submitting an adjustment to add a detail(s) to a paid/allowed claim, enter the complete information you are requesting to be added to the claim in Elements 7 through 15.

Correct a detail(s).

If submitting an adjustment to correct a detail(s) on a paid/allowed claim, enter the information from the R/S Report in Elements 7 through 15. Enter the correct information in the comment area.

Step 3: Indicate reason for adjustment.

Element 16: Check one of the following boxes indicating your reason for submitting the adjustment:

- *Recoup entire Medicaid payment.* This would include claims billed in error or completely paid by another insurance carrier.
- *Other insurance payment.* Enter the amount paid by the other insurance carrier.
- *Copayment deducted in error.* Indicate if the recipient was a nursing facility resident on the date of service, or the correct number of covered service days, or if an emergency service was provided.
- *Medicare reconsideration.* Attach both the original and the new Explanation of Medicare Benefits (EOMB). (If the claim was paid as a straight Wisconsin Medicaid claim, submit an adjustment to recoup that claim, then submit a new day claim with the EOMBs attached.)
- *Correct detail.* Use the R/S Report to complete Elements 7 through 15 with information about the claim to be adjusted. Enter the correct information in the comment area.
- *Other/comments.* Add any clarifying information not included above. If there are extenuating circumstances, complications, or new procedures, indicate "For Consultant Review" and attach a history and physical, operative report, or anesthesia report.

Step 4: Enter the following:

*Element 17. Authorized signature.
*Element 18. Date of signature. Use either the MM/DD/YY format or the MM/DD/YYYY format.
Element 19. Indicate if a corrected claim form is attached. Although this is optional, Medicaid encourages providers to attach a corrected claim form when adding additional details or information to allow adjustments to be processed more quickly and accurately.

*If the date or signature is missing on the Adjustment Request Form, the adjustment request will be denied.

Appendix 14
Adjustment Request Form (for photocopying)

See reverse side of this page for the Adjustment Request Form.

[This page was intentionally left blank.]

Adjustment Request Form

1. PROVIDER NAME _____

2. PROVIDER NUMBER | | | | | | | | |

DO NOT WRITE IN THIS SPACE

3. R&S DATE _____ 5. RECIPIENT NAME _____

4. CLAIM NUMBER | | | | | | | | | | | | | | |

6. RECIPIENT NUMBER | | | | | | | | | |

☐ ADD NEW DETAIL(S) TO PREVIOUSLY PAID/ALLOWED CLAIM: (in 7–15, enter information to be added)

☐ CORRECT DETAIL ON PREVIOUSLY PAID/ALLOWED CLAIM: (in 7–15, enter information as it appears on R&S Report)

7. DATE(S) OF SERVICE FROM	TO	8. POS	9. TOS	10. PROCEDURE/ NDC/REVENUE CODE	MOD	MOD	11. BILLED AMT	12. UNIT QTY	13. EPSDT FAM PLAN	14. EMG	15. PERFORMING PROVIDER

16. REASON FOR ADJUSTMENT

☐ RECOUP ENTIRE MEDICAID PAYMENT

☐ OTHER INSURANCE PAYMENT $_____ (OI–P)

☐ COPAY DEDUCTED IN ERROR: ☐ RECIPIENT IN NURSING FACILITY ☐ COVERED DAYS_____ ☐ EMERGENCY

☐ MEDICARE RECONSIDERATION (EOMB's ATTACHED)

☐ CORRECT DETAIL (In 7–15, enter information as it appears on R&S Report. Enter correct information in comment area.)

☐ OTHER/COMMENTS:

17. SIGNATURE

18. DATE

MAIL TO: EDS
6406 BRIDGE ROAD
MADISON, WI 53784–0002

19. ☐ CLAIM FORM ATTACHED (optional)

Appendix 15
Wisconsin Medicaid Pharmacy Special Handling Request Form (for photocopying)

See reverse side of this page for the Wisconsin Medicaid Pharmacy Special Handling Request Form.

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Wisconsin Medicaid Pharmacy Special Handling Request

Reason for Request:

☐ **Original Claim Denied** **Date of Denial:**_____
Authorization/Internal Control Number:_____
Explanation of Benefits (EOB)
Number: _____ **EOB Description:**_____

☐ **NDC Not on Medicaid File**
NDC:_____ **Description:**_____

☐ **Pharmacy Consultant Review**
Explanation of Review Needed:_____
_____
_____

Narrative:_____
_____
_____
_____
_____
_____

NOTE: Please provide supporting documentation when available (e.g., Remittance and Status Report, manufacturer- and/or peer-reviewed literature).

Provider Number:_____ **Phone Number:** _____

Provider Signature:_____ **Date:** _____

Submit paper claim and form to: **Wisconsin Medicaid**
Pharmacy Special Handling Unit
Suite 20
6406 Bridge Road
Madison, WI 53784-0020

Appendix 16
Clozapine Management Codes

	Procedure Code	Type of Service	Place of Service
Clozapine Management — No face-to-face contact between client and clozapine management provider. Client may need a telephone reminder to assure the blood draw is done, but the client is able to get to the blood draw site.	W8902	1	0, 2, 3
Clozapine Management — Clozapine management provider does the blood draw at his or her office or at a site where multiple clients come.	W8903	1	0, 2, 3, 4
Clozapine Management — Clozapine management provider must go to a client's home or elsewhere to find client and draw blood (only one client per site).	W8904	1	0, 4

Allowable Place of Service Codes For Clozapine Management

Code	Description
0	Pharmacy
2	Outpatient Hospital
3	Doctor's Office
4	Home

Appendix 17
Completion Instructions For the HCFA 1500 Claim Form For Clozapine Management Services

Use these claim form instructions to complete claims for clozapine management services. Enter all required data on the claim form in the appropriate element. Include attachments only when requested. All elements are required unless "not required" is specified.

Note: Medicaid providers should ***always*** verify recipient eligibility before rendering services.

Element 1 – Program Block/Claim Sort Indicator
Enter claim sort indicator "P" in the Medicaid check box. Claims submitted without this indicator are denied.

Element 1a – Insured's I.D. Number
Enter the recipient's 10-digit Medicaid identification (ID) number exactly how it appears on the current Medicaid identification card.

Element 2 – Patient's Name
Enter the recipient's last name, first name, and middle initial from the Medicaid ID card. Use the Eligibility Verification System (EVS) to obtain the correct spelling of the recipient's name. If the name or spelling of the name on the Medicaid ID card and the EVS do not match, use the spelling from the EVS.

Element 3 – Patient's Birth Date, Patient's Sex
Enter the recipient's birth date in MM/DD/YY format (e.g., February 3, 1955, would be 02/03/55) or in MM/DD/YYYY format (e.g., February 3, 1955, would be 02/03/1955). Specify if male or female with an "X."

Element 4 – Insured's Name (optional)

Element 5 – Patient's Address
Enter the complete address of the recipient's place of residence.

Element 6 – Patient Relationship to Insured (optional)

Element 7 – Insured's Address (optional)

Element 8 – Patient Status (optional)

Element 9 – Other Insured's Name
Do not enter anything in this element if no health insurance is indicated under "Other Coverage" on the recipient's ID card.

If the recipient's Medicaid ID card indicates private health insurance under "Other Coverage," you must attempt to bill the private health insurance. If you receive payment from the private insurer, indicate the following code in the first box of Element 9.

Code	Description
OI-P	Use the OI-P disclaimer code when the health insurance pays in part. The claim indicates the amount paid by the health insurance company to the provider or the insured.

Leave this element blank if the other insurer denies payment.

Element 10 – Is Patient's Condition Related to (optional)

Element 11 – Insured's Policy, Group or FECA Number
Leave this element blank.

Elements 12 and 13 – Authorized Person's Signature
(Not required since the provider automatically accepts assignment through Medicaid certification.)

Element 14 – Date of Current Illness, Injury, or Pregnancy (optional)

Element 15 – If Patient Has Had Same or Similar Illness (optional)

Element 16 – Dates Patient Unable to Work in Current Occupation (optional)

Element 17 – Name of Referring Physician or Other Source
Enter the referring or prescribing physician's name.

Element 17a – I.D. Number of Referring Physician
Enter the referring or prescribing provider's eight-digit Medicaid provider number. If the referring provider is not Medicaid-certified, enter the provider's license number.

Element 18 – Hospitalization Dates Related to Current Services (optional)

Element 19 – Reserved for Local Use (optional)

Element 20 – Outside Lab
If laboratory services are billed, check either "yes" or "no" to indicate whether an outside lab was used.

Element 21 – Diagnosis or Nature of Illness or Injury
The *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis code must be entered for each symptom or condition related to the services provided. Manifestation ("M") codes are not acceptable. List the primary diagnosis first. Etiology ("E") codes may not be used as a primary diagnosis. The diagnosis description is not required.

Element 22 – Medicaid Resubmission (optional)

Element 23 – Prior Authorization (optional)

Element 24a – Date(s) of Service
Enter the month, day, and year for each procedure using the following guidelines:

- When billing for one date of service (DOS), enter the date in MM/DD/YY or MM/DD/YYYY format in the "From" field.
- When billing for two, three, or four dates of service on the same line, enter the first DOS in MM/DD/YY or MM/DD/YYYY format in the "From" field, and subsequent dates of service in the "To" field by listing *only* the date(s) of the month (e.g. DD, DD/DD, or DD/DD/DD).

It is allowable to enter up to four dates of service per line if all of the following apply:

- All dates of service are in the same calendar month.
- All services are billed using the same procedure code and modifier, if applicable.
- All procedures have the same type of service (TOS) code.
- All procedures have the same place of service (POS) code.
- All procedures were performed by the same provider.
- The same diagnosis is applicable for each procedure.
- The charge for each procedure is identical. (Enter the total charge *per detail line* in Element 24f.)
- The number of services performed on each DOS is identical.
- All procedures have the same HealthCheck indicator.
- All procedures have the same emergency indicator.

Element 24b – Place of Service

Enter the appropriate single-digit place of service code for each service.

Numeric	Description
0	Other
2	Outpatient Hospital
3	Office
4	Home

Element 24c – Type of Service Code

Enter TOS "1" here.

Element 24d – Procedures, Services, or Supplies

Enter the appropriate five-character procedure code.

Element 24e – Diagnosis Code

Enter the number (1, 2, 3, or 4) that corresponds to the appropriate diagnosis in Element 21.

Element 24f – Charges

Enter the total charge for each line.

Element 24g – Days or Units

Enter a quantity of one for each calendar week (Sunday through Saturday) of clozapine management for recipients who have weekly white blood counts. Enter a quantity of one for each two-week period (Sunday through Saturday) of clozapine management for recipients who have biweekly white blood counts.

Element 24h – EPSDT/Family Planning

Enter "H" for each procedure that was performed as a result of HealthCheck (EPSDT) referral. If HealthCheck does not apply, leave this element blank.

Element 24i – EMG (optional)

Element 24j – COB (optional)

Element 24k – Reserved for Local Use

Enter the eight-digit Medicaid provider number of the performing provider *for each procedure*. This is different from the billing provider number used in Element 33.

When applicable, enter the word "spenddown" and under it, the spenddown amount on the last detail line of Element 24k directly above Element 30. Refer to the Recipient Rights and Responsibilities section of the All-Provider Handbook for information on recipient spenddown.

Any other information entered in this column may cause claim denial.

Element 25 – Federal Tax ID Number (optional)

Element 26 – Patient's Account No.

Optional — The provider may enter up to 12 characters of the patient's internal office account number. This number will appear on the Remittance and Status (R/S) Report.

Element 27 – Accept Assignment

(Not required, provider automatically accepts assignment through Medicaid certification.)

Element 28 – Total Charge

Enter the total charges for this claim.

Element 29 – Amount Paid

Enter the amount paid by the health insurance. If the other health insurance denied the claim, enter $0.00. (If a dollar amount is indicated in Element 29, "OI-P" must be indicated in Element 9.)

Element 30 – Balance Due

Enter the balance due as determined by subtracting the recipient spenddown amount in Element 24k and the amount paid by health insurance in Element 29 from the amount in Element 28.

Element 31 – Signature of Physician or Supplier

The provider of the authorized representative must sign Element 31. Also enter the month, day, and year the form is signed in MM/DD/YY or MM/DD/YYYY format.

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

Element 32 – Name and Address of Facility Where Services Rendered

If the services were provided to a recipient in a nursing facility (POS "7" or "8"), indicate the nursing facility's eight-digit provider number.

Element 33 – Physician's Suppliers Billing Name, Address, ZIP Code, and Telephone

Enter the Wisconsin Medicaid billing provider's name (exactly as indicated on the provider's notification of certification letter) and address. At the bottom of Element 33, enter the billing provider's eight-digit provider number.

Appendix 18

Sample HCFA 1500 Claim Form For Clozapine Management Services

APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE ☐ (Medicare #) MEDICAID [P] (Medicaid #) CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (VA File #) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 1234567890

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Recipient, Im A.

3. PATIENT'S BIRTH DATE MM DD YY: MM DD YY SEX M [X] F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): 609 Willow St.

6. PATIENT RELATIONSHIP TO INSURED: Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY: Anytown STATE: WI

8. PATIENT STATUS: Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY STATE

ZIP CODE: 55555 TELEPHONE (Include Area Code): (XXX) XXX-XXXX

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): OI-P

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) ☐ YES ☐ NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? ☐ YES ☐ NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: I.M. Prescribing

17a. I.D. NUMBER OF REFERRING PHYSICIAN: 11223344

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 295.70 3. 2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 02	02	00				3	1	W8902		1	XX XX	1.0				
2 02	15	00				3	1	W9803		1	XX XX	1.0				
3																
4																
5																
6																

25. FEDERAL TAX I.D. NUMBER SSN EIN ☐ ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO

28. TOTAL CHARGE $ XXX XX

29. AMOUNT PAID $ XX XX

30. BALANCE DUE $ XXX XX

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED I.M. Authorized DATE MM/DD/YY

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

I.M. Billing
1 W. Williams
Anytown, WI 55555 87654321

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) **PLEASE PRINT OR TYPE** FORM HCFA-1500 (12-90) FORM OWCP-1500 FORM RRB-1500

CARRIER — PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION

Appendix

Appendix 19

Items Covered by Wisconsin Medicaid in the Nursing Facility Daily Rate

The following is a partial list of items that are covered in the nursing facility daily rate under Section 5.100 of the Nursing Home Methods of Implementation. Wisconsin Medicaid retains its authority under s. 49.45(10), Wis. Stats., to amend, modify, or delete items on the list.

Over-the-Counter Drugs

- Acetaminophen.
- Antidiarrheals.
- Aspirin.
- Decubitus treatments.
- Digestive aids.
- Hemorrhoidal products.
- Ibuprofen.
- Laxatives.
- Minerals.
- Noncovered antihistamines.
- Noncovered cough and cold products.
- Noncovered ophthalmic products.
- Noncovered vaginal products.
- Quinine.
- Saliva Substitutes.
- Vitamins.

Dietary Supplies

- Artificial sweeteners.
- Diet supplements (e.g., Metrecal, Ensure, Vivonex, and related/similar products).
- Salt substitutes (e.g., Neocurtasal, etc.).
- Sugar substitutes.

Incontinence Supplies

- Catheters (Foley and Condom), catheter sets, component parts (e.g., tubing, urine collection apparatus, bags, bed bags, etc.).
- Diapers — disposable and reusable (including purchased diaper service).
- Underpads — disposable and reusable.

Personal Comfort Items and Medical Supplies

- Alcohols (e.g., rubbing, antiseptic, swabs).
- Analgesic rubs (e.g., Ben-Gay, Infrarub, Vicks, Vapo-rub, etc.).
- Antiseptics (e.g., Betadine, iodine, mercurochrome, merthiolate, and similar products).
- Baby, comfort, and foot powders.
- Body lotions, skin lubricants, moisturizers, and protectants, including:
  - √ Olive oil.
  - √ Nivea oil/cream/lotion.
  - √ Lubath.
  - √ Alpha-Keri.
  - √ Keri Lot sween cream.
  - √ Aluminum paste.
  - √ Zinc Oxide ointment/paste.
  - √ Neutrogena Lotion.
  - √ Crisco.
  - √ Sunscreens and suntan products.
  - √ A&D ointment.
  - √ Caldescene.
  - √ Desitin.
  - √ Lubriderm.
  - √ Eucerin.
  - √ Aveeno.
  - √ Taloin ointment.
  - √ Diaperene.
  - √ Carrington moisture barrier.
- Cotton-tipped applicators and cotton balls.
- Denture products (e.g., adhesives, cleaning products).
- Deodorants and antiperspirants.
- Disposable tissues (e.g., Kleenex).
- Dressings (e.g., adhesive pads, abdominal pads, gauze pads and rolls, eye pads, sanitary pads, stockinette, Op-site, and related products).

Personal Comfort Items and Medical Supplies (continued)

- Enema administration apparatus.
- Gloves (latex or vinyl).
- Hydrogen peroxide.
- Lemon or glycerin swabs.
- Lubricating jellies (e.g., Vaseline, K-Y jelly).
- Oral hygiene products (e.g., dental floss, toothpaste, toothbrush, Waterpik).
- Phosphate enemas.
- Plastic or adhesive bandages (e.g., Band-aids).
- Shampoos (except specialized shampoos that are legend products, e.g., Selsun).
- Soaps (antiseptic and non-antiseptic).
- Straws (paper, plastic, etc.)
- Syringes and needles (disposable or reusable).
- Tapes (all types).
- Tincture of benzoin.
- Tongue depressors.
- Tracheotomy care sets and suction catheters.
- Tube feeding sets and component parts.

Durable Medical Equipment

Most durable medical equipment (DME) items are covered in the nursing facility daily rate. Refer to the DME Index for items that can be separately billed for nursing facility recipients.

Appendix 20

Partial List of Items Reimbursed From a Nursing Facility Recipient's Personal Needs Account

The following is a list of items that may be paid from a recipient's personal needs account, if the recipient has been informed that the item is not covered by Wisconsin Medicaid. Wisconsin Medicaid retains its authority under s. 49.45(10), Wis. Stats., to amend, modify, or delete items from the list:

- Less-than-effective (LTE) drugs such as Peritrate, Naldecon, Midrin, Tigan Capsule/Suppository, Vioform-HC.
- Wisconsin Negative Formulary drugs (e.g., Gaviscon, Rogaine [Minoxidil topical]). Also, legend vitamin products that are not covered by Wisconsin Medicaid, such as Eldec, Vicon Forte, Poly-Vi-Flor, Tri-Vi-Flor, Cefol, and Larobec.
- Covered products for which prior authorization *has been denied* for the recipient.
- Other items considered to be not medically necessary (e.g., Menthol-based lozenges [such as Hall's Mentho-Lyptus, Vicks Throat Lozenges, Throat Disks], Luden's Cough Drops, lemon drops, hard candy, beer, brandy, wine, and cigarettes).

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.

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

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.

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

Crosswalk
The systematic process of changing a provider submitted value for a specific field on a claim to a value required by the system when they are not the same.

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.

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.

ICN

Internal Control Number. Unique number assigned to a claim for identification purposes.

Innovator

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

LOS

Level of Service. Field required when billing Pharmaceutical Care 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 (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.

OC

Other Coverage. A National Council for Prescription Drug Programs' 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 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.

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

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

Real-time processing
Immediate electronic claim transaction allowing for an electronic pay or deny response within seconds of submitting the claim.

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

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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