

Web address: <http://health.utah.gov/medicaid>

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Medicaid Information

- S Salt Lake City area, call: (801) 538-6155
- S In Utah, Idaho, Wyoming, Colorado, New Mexico, Arizona and Nevada, call toll-free: 1-800-662-9651
- S From other states, call: (801) 538-6155

Requesting a Medicaid publication?

- Send a Publication Request Form.
- By fax: (801) 536-0476
 - By mail: Division of MHF
Box 143106, Salt Lake City UT 84114-3106

11- 113 Place of Service Module

On December 20, 2010, the Division of Medicaid and Health Financing implemented a prepayment cost-saving editing solution to enhance the current editing within the Medicaid Management Information System (MMIS). The program incorporates correct coding principles, and industry accepted standards and guidelines to identify appropriate coding for provider billing and reimbursement.

On January 1, 2012, Utah Medicaid will be adding an additional module to the existing prepayment editing tool. The new module will affect professional claims that are billed with an invalid place of service. The Place of Service Module will detect when services are billed in an inappropriate setting, and deny the entire line and all units of service on the claim line when this occurs.

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11- 114 HIPAA Version 5010 Implementation

Testing

Utah Health Information Network (UHIN) is offering acceptance testing to its members. Medicaid strongly encourages providers to work with UHIN for initial testing. Contact UHIN at (877) 693-3071 to coordinate 5010 acceptance testing before you commence testing with Medicaid.

Initially, Medicaid will do provider testing with a select group of providers. However, the majority of providers will test in production after UHIN acceptance testing. Watch for posted updates on our website and through our phones for dates when production transactions may be submitted. Providers should transmit 5010 files to the production mailbox: HT000004-001. The Medicaid EDI team can be contacted at (801) 538-6155 or toll-free 1-800-662-9651, options 3 and 5, regarding any testing issues. Once a provider feels their testing is successful, the X12 4010 standard format can be discontinued (this may occur prior to January 1, 2012).

Testing for real-time transactions (270/271, 276/277 & 278, 999) is scheduled for early 2012. We will invite providers and billers who have completed UHIN's acceptance testing to participate with Medicaid testing.

Remittance Advice Updates (835)

Medicaid will provide a 5010 parallel run of the 4010 version for two weeks in November or early December. Providers wanting to test the 835 transaction can download the 5010 parallel file through UHIN Sundance, and review it against the 4010 version. Watch for posted updates on our website and through our phones for dates when the parallel run may be downloaded.

Take note that the allowed amount segment was removed from the 5010 835. Medicaid will continue to report patient responsibility and third party liability (TPL) at the claim level. Call the EDI team if you notice any discrepancies on your 5010 835 parallel run.

Medicaid's recoupment of overpayments will be changing. Currently, claims are held against a credit balance until the claims submitted cover the balance owed. Beginning January 1, 2012, Medicaid will utilize the PLB segment of the 835 to report balance forward and current balance owed. Claims payment information will be released against the forward balance in the 835. Negative amounts in this segment are payments, and positive amounts are take backs.

Gross adjustments or provider-level adjustments/payments are currently reported in the PLB segment. Medicaid will utilize more of the PLB qualifiers to better define the type of lump sum adjustment/payment being made. Please ensure that your reports generated from the 835 capture the PLB adjustments and reasons.

Medicaid will return the service provider NPI in addition to the billing provider NPI of the group practice.

Providers wanting to transition to 5010 format for the 835 prior to January 2012, should e-mail the EDI team the contact name, phone number, provider NPI or payment contract ID, tax ID, and location, in order to receive the 5010 835. Please email the information to: HCF_OS&D@utah.gov.

When transition is complete, it is understood that you do not revert back to the 4010 format.

Medicaid Online (BlueZone)

With the implementation of real-time transactions in early 2012, Medicaid Online (HLRP access through BlueZone) will be eliminated. Providers using Medicaid Online need to check with their system programmers to assure they are able to utilize the 270/271 (eligibility) and 276/277 (claim status) transactions.

Effective January 2012, we will no longer accept applications to access Medicaid Online.

Notifications

To receive Medicaid notices of program changes, announcements of MIBs, 5010 status updates and other information, sign up for the Utah Medicaid Newsletter email list serve at: medicaidops@utah.gov. You may also sign up to receive the UHIN Alerts Newsletter at: <http://www.uhin.org/pages/membership/newsletter-alerts.php> for notification and payer's availability.

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11- 115 Medicaid Point of Sale Conversion / Black-Out Dates

On December 28, 2011, Utah Medicaid will convert its existing pharmacy point of sale system over to a new point of sale system designed by Goold Health Systems. System programmers will require two (2) days for the process of conversion to be complete. No claims will be processed on December 28th and 29th. Consequently, pharmacies will need to utilize their downtime procedure systems to process Medicaid prescriptions during that time. The new system will be brought up for prescription claims processing on December 30, 2011.

Emergency medications requiring a prior authorization must be processed under the 72-hour emergency supply rules. The policy states, "Some medications that require PA may be provided in a medical emergency before authorization is obtained from Medicaid. When a medical emergency occurs, and a medication requiring a PA is required, pharmacy providers may provide up to a 72-hour supply of the medication. When contacted, Medicaid will issue an authorization for the 72-hour supply of the medication on the next business day. All subsequent quantities must meet all PA requirements for the medication. It is the responsibility of the medication prescriber to provide the necessary documentation."

Utah Medicaid recognizes that this represents an unusual inconvenience in downtime. We ask for your patience and indulgence during this conversion process. We sincerely acknowledge your assistance with this endeavor and gratefully recognize all that you do to serve Medicaid patients.

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11- 116 Medicaid New POS NCPDP Standards Conversion

In compliance with new industry requirements, Utah Medicaid has released its new payer sheet standards that correspond with the new National Council for Prescription Drug Processing (NCPDP) D.0 pharmacy prescription adjudication standards that are required to be implemented by January 1, 2012. You can download these new prescription adjudication standards from the HIPAA website at: <http://health.utah.gov/hipaa/guides.htm>.

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11- 117 New National Provider Identifier (NPI) Regulations

In compliance with new federal regulations, beginning November 15, 2011, each prescriber's and pharmacy provider's NPI must be known to the Medicaid claims system.

In other words, each NPI that is presented with a claim must be linked to a single provider, or the claim will be denied. If you have not taken the opportunity to enroll your NPI with Medicaid provider enrollment, please take time to do so before November 15, 2011. You may contact provider enrollment through the customer service line at (801) 538-6155 or 1-800-662-9651, option 3 then option 4.

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11- 118 New Pharmacy POS Pricing Updates Policy

Utah Medicaid relies on outside data services for much of the information and data it uses in its day to day processes. Consequently, Medicaid has little control over the timing and occurrence of updates to that information, particularly where it concerns pricing information for pharmaceutical products. As a result, beginning January 1, 2012, with the installation of the new pharmacy point of sale system, Utah Medicaid will no longer research price disparities identified by providers, but will rely on the price that the data service presents to Medicaid in its weekly updates. Pricing information will no longer be applied retroactively. All pricing will be effective no sooner than the business day following receipt of the new pricing information. This policy only applies to pharmacy point of sale pricing.

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11- 119 High-Dose Simvastatin

The Food and Drug Administration (FDA) strongly recommends avoiding daily simvastatin doses of 80mg, because of the increased risk of myopathies, including rhabdomyolysis. An increase from 40mg to 80mg of simvastatin daily yields a 6% decrease in LDL, but increases risk of myopathies 6-fold. Starting October, 2011, the following criteria applies:

- To continue therapy with simvastatin 80mg, the patient must have been receiving 80mg daily for 12 or more months with no evidence of myopathy, as demonstrated in medical notes.
- The patient must not be receiving any medications which are contraindicated for use with simvastatin (see full prescribing information). Please note that simvastatin doses less than 41mg will not require prior authorization.

Medicaid patients with Traditional Medicaid coverage still need to submit a PA request for branded Zocor® or Vytorin®. Non-Traditional Medicaid and Primary Care Network coverage does not cover branded drugs when a generic version is available.

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11- 120 Non-Traditional Medicaid (NTM) Co-pay Policy Review

The NTM program was established as a waiver program with benefits that are intended to be more limited in scope from the Traditional Medicaid program. The NTM program is a mandatory generic program. When a brand name product is requested by the client or ordered by the physician and a generic is available, the claim will be denied, and no physician override (DAW) is allowed.

With the implementation of the new pharmacy point of sale system, programming corrections will require that the client be responsible for the entire amount of a brand name prescription for which a generic is available. On December 30, 2011, new system programming will no longer pay a dispensing fee to the pharmacy in order to adhere to long established NTM policy. Programming has not correctly captured these requirements in the past. These prescriptions will not count towards the \$500.00 co-pay cap for NTM clients.

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11- 121 Primary Care Network (PCN) Co-pay Policy Review

The PCN program was established as a waiver program with benefits that are intended to be more limited in scope from the Traditional Medicaid and Non-Traditional Medicaid programs. The PCN program is a mandatory generic program. When a brand name product is requested by the client or ordered by the physician and a generic is available, the claim will be denied, and no physician override (DAW) is allowed.

With the implementation of the new pharmacy point of sale system, programming corrections will require that the client be responsible for the entire amount of the prescription. On December 30, 2011, new system programming will no longer pay a dispensing fee to the pharmacy in order to adhere to long established PCN policy. Programming has not correctly captured these requirements in the past. These prescriptions will not count towards the \$1,000.00 co-pay cap for PCN clients.

A few selected branded products on a limited PCN preferred list are exempt and will continue to adjudicate according to the following PCN manual requirements:

“A patient paid prescription is not counted as one of the four prescriptions per month.

The copay under PCN is product dependent:

- (1) \$5.00 copay for any generic product, or for a brand name product on the Preferred Drug List.
- (2) \$5.00 copay for OTC products.
- (3) 25% of the Medicaid payment for any name brand drug not on the [PCN] preferred list where a generic product is NOT available.

When a generic product is available and the name brand is requested, the total payment must be made by the client. No physician DAW or Prior Authorization is available.”

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11- 122 School-Based Skills Development Policy

Effective November 1, 2011, the Medicaid provider manual entitled, *Utah Medicaid Provider Manual for School-Based Skills Development*, has been updated.

All sections of the manual have been revised to provide clear descriptions and guidelines for the provider. The most significant changes are in the follow chapters:

Chapter 1-2, Definitions

The *Terminology of Consortiums* has been removed from the manual. Consortiums were established to allow multiple providers in rural areas to bill under one provider ID number. The revision to the manual eliminates consortiums and any reference to consortiums, as currently all providers individually contract with the Department and have unique provider ID numbers.

Itinerant Nursing Services has been updated to provide a clear description of the services and tasks covered under this service.

A description of *Self-Contained* has been added to provide a clear understanding of the terminology.

Chapter 2-1, Covered Services

Information and Skills Training has been removed as a covered Medicaid service in the school-based program.

Chapter 3-2, Required Information for Rate Setting

The time study portion of this section has been updated to reflect the current policy and guidelines for completing the required online school-based skills development time studies. The previous time study template and instructions have been

removed from the manual.

Chapter 3-3, Claims Processing

The claims processing portion of this chapter has been updated to reflect the current policy and guidelines for completing electronic submissions of school-based skills development claims.

Special Provisions Section

A special provisions section has been added to clarify Medicaid terminologies, and include contract language the provider is responsible for ensuring.

The revised manual is available online at: www.health.utah.gov/medicaid.

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11- 123 School-Based Skills Development Contractor

Effective November 1, 2011, the Medicaid provider manual entitled, *Utah Medicaid Provider Manual for School-Based Skills Development*, has been updated .

The contractor information has been revised as follows:

The contractor will send the completed annual report to:

Utah Department of Health
Bureau of Managed Health Care
Attn: Michelle Christensen
P.O. Box 143104
Salt Lake City, UT 84114-3104

Fax: (801) 536-0145
mchriste@utah.gov

In no case will Medicaid funds received by the contractor be used to supplant state education funding. The contractor will maintain (in accordance with its Medicaid Provider Agreement) financial records sufficient to document compliance with this agreement.

It is mutually agreed that Medicaid school-based skills development service payments the contractor receives are conditional and subject to review by the Department to confirm that claims were billed in accordance with policy, using codes and rates approved by the Department and that the contractor used Medicaid funds received under this agreement to support and enhance its provision of health-related services.

This contract may be terminated without cause, in advance of the specified termination date, by contractor or the Department upon thirty (30) days written notice. This clause supersedes paragraph 2, under Article XVII, Default, Termination & Payment Agreement, on page 9 of Attachment A, General Provisions.

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11- 124 Provider Preventable Condition (PPC) Report Updated

The PPC reporting template has been updated. Please use the current version effective immediately. The report template can be found under the health care providers section of the Medicaid website at: www.health.utah.gov/medicaid.

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