

# **MMIS**

## **Alternative Process and Procedures**

**May 1, 2009**



# **Introduction to Medicaid Management Information Systems (MMIS) Alternative Process and Procedures**

The new Medicaid Management Information System (MMIS) is now in operation, however it is expected that there will be times of interruption or malfunction. As part of the new Department of Human Services (DHS) Communications Plan (OAR 410-120-0400) this MMIS Alternative Process and Procedures document provides important information to allow providers using MMIS to function with as little interruption as possible.

DHS provides alternative information in the form of numbered and dated releases and lists them on the Update Information page. These releases are effective according to specific dates indicated on each individual release.

This document is posted on the DHS Web site and referenced in OAR 410-120-0027.

At those times that DHS believes alternative instruction or procedures are necessary, this document will be updated and filed in rule accordingly.

## **OAR 410-120-0027 MMIS Alternative Process and Procedures**

DMAP temporarily adopted administrative rule **410-120-0027** to reference the MMIS Alternative Process and Procedures document. This rule is in concert with the newly adopted DHS rule OAR 407-120-0400.

If you have questions, contact a Provider Services Representative toll-free at 1-800-336-6016 or direct at 503-378-3697.

**CHAPTER 407  
DEPARTMENT OF HUMAN SERVICES,  
ADMINISTRATIVE SERVICES DIVISION AND DIRECTOR'S OFFICE**

**DIVISION 120  
PROVIDER RULES**

**407-120-0400**

**MMIS Replacement Communication Plan**

- (1) The purpose of this rule is to describe the Department's plan for communicating instructions and guidance related to the Department's implementation of the replacement MMIS that began on December 9, 2008. System issues are anticipated to be identified for a period of time during and after implementation. This rule is adopted to be effective retroactively to December 9, 2008 for the purpose of providing continuity of all MMIS communication efforts throughout the transition implementation process and regular operations following the transition. By adopting this communication plan in rule, the Department seeks to assure that eligible Department clients receive all necessary and appropriate services, and that Department providers and PHPs are correctly reimbursed for covered services provided to eligible clients.
- (2) To the extent necessary to accomplish the purposes of this rule, the Department shall provide guidance and instructions related to MMIS for providers and PHPs using its web site and MMIS provider announcements.
  - (a) In cases of limitations or system errors in the replacement MMIS, the Department shall provide update information and important action required in concert with, or in place of, normal established procedures.
  - (b) In other cases, the Department shall provide instructions and guidance about the use of revised or improved functionality that is available through the replacement MMIS, such as the use of the web portal.
- (3) Providers and PHPs must follow all applicable instructions given on the Department's web page and any provider announcements for the dates specifically noted in the communications, or if a date is not specified, until further instructions are provided. Department web site information and links to specific topics may be accessed at: [http://www.oregon.gov/DHS/healthplan/tools\\_prov/main.shtml](http://www.oregon.gov/DHS/healthplan/tools_prov/main.shtml).
- (4) This rule does not amend existing rules or contracts that require providers or PHPs to confirm eligibility, respond to requests for prior authorization, submit claims or encounter data, or comply with any other rule or contract that imposes obligations on a provider or PHP as a condition of receiving reimbursement for services. This rule is intended to provide assurance to providers and PHPs that the MMIS-related processes for meeting those obligations are being addressed by the Department by providing guidance

## TEMPORARY ADOPT

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and instruction related to the provider's or PHP's interface with MMIS processes, and by identifying the resources providers and PHPs may use to obtain information during this time of transition to the replacement MMIS and during regular MMIS operations.

- (5) The Department shall work with providers and PHPs by providing instructions and guidance to assure that service delivery and reimbursement disruptions related to transition to the replacement MMIS are minimized. Providers and PHPs must appropriately document all eligibility, services, authorization, claims, and payment information during the transition time, and their efforts to comply with instructions and guidance provided by the Department, so that reimbursement may be correctly provided.
- (6) Providers and PHPs must immediately communicate to the Department any issues they encounter that are not addressed in the Department's instructions or guidance in seeking eligibility information or activities related to reimbursement for services through MMIS, errors discovered in the correct amount of any reimbursement received for those services, or in applying the instruction or guidance to resolve an issue.
- (7) After the transition period is complete, the Department shall continue to implement this communication plan as long as necessary during regular MMIS operations in order to assist providers and PHPs with technical and system requirements of the replacement MMIS.

Stat. Auth.: ORS 409.050, 414.065

Stats. Implemented: ORS 414.065

# MMIS

## Alternative Process and Procedure

### Update Information

DMAP provides this information in the form of numbered and dated releases listed below. Alternative process and procedures are effective according to specific dates indicated on each individual release.

#### Releases:

1. Pharmacy Payments During MMIS Enrollment Data Correction – effective January 12, 2009 and ongoing until further notice
2. MMIS transitional issues/temporary protocols – effective January 16, 2009 and ongoing until further notice
3. **Prepaid Health Plan Supplemental Payment Process – effective May 1, 2009 and ongoing until further notice**

If you have questions, contact a Provider Services Representative toll-free at 800-336-6016 or direct at 503-378-3697.

# Releases

## Pharmacy Payments During MMIS Enrollment Data Correction – January 12, 2009

Alternative procedure for “MMIS enrollment data correction” filed in temporary rule 410-141-0425 and effective January 3, 2009 through January 12, 2009, is now extended until further notice.

Pharmacy providers must verify new client eligibility for clients who are identified in the Point-of-Sale (POS) system as a managed care client. From January 3, 2009 and until further notice, DMAP pharmacy providers will verify new client eligibility for clients identified in POS as managed care clients by means of one or more of the following:

- By retaining a photocopy of the client’s December 2008 Medical Care ID (DMAP 1417 – old style, letter-sized) or Temporary Medical Care ID (DMAP 1086) if the client is able to present; or
- By contacting one of the following entities and obtaining proof of eligibility via fax:

The member’s Managed Care Organization (MCO) (pharmacy benefits manager or the pharmacy program for the client’s MCO) \*\*  
or

EDS	888-202-2126
DMAP Client Services **	800-273-0557
DMAP Provider Services **	800-336-6016

\*\* Denotes during normal business hours.

Pharmacy providers are authorized to fill prescriptions:

- To ensure that eligible MCO clients receive needed prescriptions during this MMIS data correction period, providers will fill up to a 30-day supply or the full Schedule II prescription for eligible clients not in the Point of Sale (POS) system. These prescriptions shall be filled based on current and individual MCO Formulary Lists, Prior Authorizations (PA) and associated pharmacy rules. DMAP remains responsible for carve-out drugs as provided in OAR 410-141-0070;
- The individual MCOs will reimburse pharmacies within their network for dispensing drugs on the service date providing they adequately perform the services described in (1) through (2) of this rule, between January 3, 2009 and January 12, 2009. The MCOs will reimburse only those pharmacies that are licensed to provide pharmacy services by the Oregon Board of Pharmacy on the date(s) of service(s).
- This reimbursement mechanism does not apply to clients who are only eligible for Citizen Alien Waived Emergent Medical (CAWEM) benefits as CAWEM does not provide prescription benefits, or any other benefit package that does include prescriptions drugs.

DMAP is aware of several issues during our transition to the new MMIS that may affect clients getting their covered services and medications.

In an effort to minimize the affect of these issues on clients and providers, DMAP has developed the procedures listed below.

DMAP is working hard to resolve these transitional issues. We apologize for the confusion and inconvenience this has caused and thank you again for your patience and for the invaluable service you provide to our clients.

## Temporary Protocols

If you:		Action
<b>Eligibility verification</b>	See a client whose name or client ID number listed on their Medical ID does not match what is on the Web portal and/or AVR	Contact Provider Services at: <ul style="list-style-type: none"> <li>■ <a href="mailto:dmap.providerservices@state.or.us">dmap.providerservices@state.or.us</a></li> <li>■ 800-336-6016 (M-F, 8-4:45)</li> </ul>
	See a client who has a Medical ID, but shows up as ineligible on the Web portal and/or AVR	Provider Services will verify if the client is eligible and determine their managed care enrollment.
	Have a question about a client's managed care enrollment or you think the client may have been added or removed from a managed care plan inappropriately	
	See a client who shows they are covered by more than one benefit plan (i.e., the provider Web portal lists the client as having BMH [OHP Plus] and KIT [OHP Standard] at the same time)	If the client is eligible, Provider Services can either correct the client's information in the Web portal/AVR or send you a guarantee of eligibility. If you are sent a guarantee of eligibility, we will have you send your claim to a special address.
<b>Claims</b>	Receive the following EOB messages on your remittance advice: <ul style="list-style-type: none"> <li>■ 0156 – Our records show performing provider ineligible on date of service. If billing was in error, correct and resubmit or adjust, as appropriate.</li> <li>■ 9013 – Provider and Submitter mismatched</li> </ul>	Contact Provider Enrollment at: <ul style="list-style-type: none"> <li>■ <a href="mailto:providerenrollment@state.or.us">providerenrollment@state.or.us</a></li> <li>■ 800-422-5047 (M-F, 8-5)</li> </ul>
		Provider Enrollment can correct the information we have in our system for you if it is wrong.

## Other important information

### Coverage letters delayed

Medical Care IDs have now been mailed to all clients. Their coverage letters have not yet been sent. This means that clients may not know what benefit plan they are in, if they have copay requirements or if they are enrolled in a managed care plan.

## Transitional Payments

If you do not receive an expected payment through the regular financial cycle, you may qualify for a Transitional Payment. Go to [www.oregon.gov/DHS/healthplan/mmis.shtml#transitional](http://www.oregon.gov/DHS/healthplan/mmis.shtml#transitional) to find information on how to request a transitional payment.

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## E-subscribe today

E-subscribe to the Provider Announcements page at [www.oregon.gov/DHS/healthplan/notices\\_providers/main.shtml](http://www.oregon.gov/DHS/healthplan/notices_providers/main.shtml) to ensure that you receive important updates. To e-subscribe, click on the envelope icon at the top part of the page.



# Prepaid Health Plan Supplemental Payment Processing

- Federally Qualified Health Centers (FQHC)
- Rural Health Clinics (RHC)
- Indian Health Service (IHS)
- Tribal-638 providers

Due to direction from the Division of Medical Assistance Programs (DMAP) to Prepaid Health Plans (PHP) to delay submission of encounter data for services provided to Oregon Health Plan (OHP) clients enrolled in the PHP, DMAP is implementing the process to make supplemental payments to eligible Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC), Indian Health Service (IHS) and Tribal-638 providers that contract with Prepaid Health Plans (PHP). Implementation is effective immediately and ongoing until further notice.

The PHP supplemental payments process is found in Oregon Administrative Rules:

- 410-146-0440 (DMAP American Indian/Alaska Native program)  
<http://www.dhs.state.or.us/policy/healthplan/guides/aian/146rb0109.pdf>
- 410-147-0460 (DMAP FQHC/RHC program)  
<http://www.dhs.state.or.us/policy/healthplan/guides/fqhc-rhc/147rb0309cor2.pdf>

The DMAP process for PHP supplemental payment to eligible providers includes verifying data submitted by the provider for services furnished to a PHP enrolled member with data submitted by the PHP to the Medicaid Management Information System (MMIS) encounter system. The verification of data is part of the final reconciliation process.

With implementation of the new MMIS, DMAP has directed PHPs to delay submission of encounter data.

If, due to direction from DMAP to the PHP, encounter claims for services provided by the FQHC, RHC, IHS or Tribal 638 to a Prepaid Health Plans' enrolled members are not contained in the MMIS encounter system when reimbursement is due the provider, DMAP will process both:

- Interim payment to the FQHC/RHC/IHS/Tribal-638, in lieu of full payment from PHPs, and until data is contained in the MMIS encounter system, and
- Final reimbursement reconciliation when the PHP claims data for services furnished by the FQHC/RHC/IHS/Tribal-638 to the PHP's enrolled members is submitted and contained in the MMIS encounter system.