Oregon Health Authority

Division of Medical Assistance Programs

Information Memorandum Transmittal

Jon Pelkey, Manager
DMAP Quality Improvement and Medical Section

Authorized Signature

Number: DMAP-IM-12-044

Issue Date: 06/15/2012

Topic: Medical Benefits

Subject: **MCO announcement:** Information about new drug carve-out files available to contracted plans starting July 3

Applies to:

- ☐ All DHS employees
- ☐ Area Agencies on Aging
- ☐ Children, Adults and Families
- ☐ County DD Program Managers
- ☐ County Mental Health Directors
- ☐ Seniors and People with Disabilities
- ☒ Other (please specify): DHS and OHA staff and others identified on the SPD, CAF, AMH and DMAP transmittal lists

Message:

DMAP will post the following announcement to the Managed Care Organization (MCO) announcements page and distribute via eSubscribe to MCO update subscribers.

Plans with questions about the file should contact their DMAP Encounter Data Liaison.

If you have any questions about this information, contact:

Contact(s):	Patricia Krewson, DMAP Operations		
Phone:	503.945.8825	**Fax:**	503-947-5221
E-mail:	patricia.krewson@state.or.us		

HEALTH CARE PROGRAMS
Division of Medical Assistance Programs
John A. Kitzhaber, MD, Governor

Oregon Health Authority

500 Summer St NE E35
Salem, OR, 97301
Voice: 503-945-5772 or 1-800-527-5772
FAX: 503-373-7689
TTY: 711
www.oregon.gov/OHA/healthplan

Oregon Health Plan
Electronic Memorandum

Date: June 15, 2012

To: FCHPs, PCOs and MHOs

From: Jon Pelkey, DMAP Quality Improvement and Medical Section

Re: NCPDP Carve-Out Drug Files available July 3

As you know, certain drugs (including Therapeutic Class 7/11 mental health drugs, lamictal, and depakote) are carved out of the managed care contracts and billed to the Division of Medical Assistance Programs (DMAP) on a fee-for-service basis.

Starting July 3, FCHPs, PCOs and MHOs can receive a daily electronic data interchange (EDI) file that lists the carve-out drugs paid by DMAP for their members.

To ensure implementation by July 3:

Please send us a new EDI Registration Change Form (DMAP 2083 – Exhibit C) by **Friday, June 22.**

- Complete Sections One, Two, Five, Seven and Eight.
- In Section Five, list the EDI mailbox (MB######) you want the file delivered to in the "Submitter ID" field.
- In Section Seven, mark the "Add" box for **D.0/1.2 NCPDP Carve-Out File.**
- In Section Eight, make sure the authorized signature is the same person listed on your current Trading Partner Agreement with DMAP; otherwise, you will need to complete additional forms.

If a clearinghouse or third party administrator is going to receive this file on your behalf, you must also complete a new Application for Authorization (DMAP 2081 - Exhibit A) and include a copy of your subcontract for this organization.

Mail the completed form(s) to:

EDI Support Services, 500 Summer St NE, E44, Salem OR 97301.

Once we receive your updated registration information, EDI Support Services will contact you to coordinate the set up for this daily file.

Questions?

If you have questions about this file, please contact your Encounter Data Liaison.

Thank you for your continuing support of the Oregon Health Plan.

Oregon Health Authority
DIVISION OF MEDICAL ASSISTANCE PROGRAMS
EDI Support Services

Health Insurance Portability and Accountability Act
Exhibit C — EDI Registration Change Form

Use this form to update Trading Partner contact information and EDI Submitter's authorized transactions

To:	**EDI Support Services - 500 Summer St NE, E44 -Salem, OR 97301** 503-945-6898 (fax): 1-888-690-9888 (phone)

Confidentiality Notice: The information contained in this request is confidential and legally privileged. It is intended only for use of the recipient named. If you are not the intended recipient, you are hereby notified that the disclosure, copying, distribution, or taking of any action in regards to the contents of this fax document- except its direct delivery to the intended recipient - is strictly prohibited. If you received this request in error, please notify the sender immediately and destroy all copies of this request and delete from your system, if applicable.

Trading Partner (provider, prepaid health plan, clinic or allied agency): Complete this form to update your contact information, add a secondary authorized signer; or update authorized transactions for the EDI submitter listed in your current Exhibit B (DMAP 2082).

- If your business name or Tax ID changes, you must complete a new Trading Partner Agreement (TPA – DMAP 2080).
- If you have a new EDI Submitter, you must complete a new Exhibit A (DMAP 2081) and Exhibit B.
- If you have a have new Oregon Medicaid ID, you need to complete a new TPA, Exhibit A and Exhibit B.

Please type or print clearly and fill in **all required fields designated with an asterisk (*)**. Incomplete forms will NOT be processed. **Please maintain a copy for your records.**

Change forms must include the signature of your authorized primary or secondary signer.

ONE

Trading partner information

*Effective date: *Tax Identification number:

*Name

*Physical address:

*Secondary address:

*City, state and ZIP:

*Phone number: *Fax number:

TWO

Provider/Plan number - A separate Exhibit C must be completed for each provider number.

*Provider/Plan number for which the submitter has authorization: (see Exhibit A): *Number:

*National Provider Identifier (NPI): _____

*Taxonomy code(s):

THREE

Trading partner authorized signer information *(cannot be a billing service or clearinghouse).* If the primary signer listed here is different from the one listed on your current TPA, you must complete a new TPA , Exhibit A and Exhibit B before we can update your EDI registration.

*Primary authorized signer:

*Phone number: *Title:

*E-mail address: *Fax number:

Secondary contact:

Phone number: Title:

E-mail address: Fax number:

FOUR

Claims contact information

*Primary contact:

*Phone number: *Title:

E-mail address: *Fax number:

Secondary contact:

Phone number: Title:

E-mail address: Fax number:

FIVE

EDI submitter information – If this is different from what is on your current Exhibit A (DMAP 2081) and Exhibit B (DMAP 2082), you will also need to complete and submit a new Exhibit A and B.

*****Company name: Submitter ID:

*****Address line 1:

Address line 2:

*****City, state and ZIP:

*****Submitter type (check **all** that apply):

☐ Self ☐ Prepaid Health Plan ☐ Clearinghouse ☐ Billing service ☐ Other: *(Please specify.)*

SIX

EDI submitter's contact information – The EDI Testing Team will use the Technical Contact's e-mail address for communications about third-party or business-to-business testing.

*****Business contact:

*****Phone number: *Title:

*****E-mail address: *Fax number:

*****Technical contact: *Title:

*****Phone number: *Fax number:

*****E-mail address: ☐ Third contact on reverse *(if needed)*

SEVEN

Authorized transactions – Check all transactions for which authorization should be registered or removed.

HIPAA 5010A1 Transactions for: ☐ FFS provider or ☐ Prepaid health plan	**Add**	**Delete**
005010X222A1 837P Professional Claim Submission	☐	☐
005010X224A2 837D Dental Claim Submission	☐	☐
005010223A2 837I Institutional Claim Submission	☐	☐
005010X221A1 835 Health Care Claim Payment/Advice (RA)	☐	☐
005010X279A1 270 and 271 Health Care Eligibility Benefits Inquiry and Response	☐	☐
005010X212 276 and 277 Health Care Claims Status Request and Response	☐	☐
005010X218 820 Group Premium Payments	☐	☐
005010X220A1 834 Benefit Enrollment and Maintenance	☐	☐
005010X231A1 999 Acknowledgement Response	☐	☐
D.0/1.2 NCPDP Submission and Response (PHP/CCO Only)	☐	☐
D.0/1.2 NCPDP Outbound Carve-Out File (PHP/CCO only)	☐	☐
Status file Health Care Claim Status (PHP/CCO only)	☐	☐

EIGHT

Signature – Of the authorized signer named in Section Three.

* Provider, prepaid health plan, clinic or allied agency name: *Phone:

*Authorized trading partner signature *(original signature only):* *Date:

Please print name: