Wyoming
Department
of Health

Division of Healthcare Financing

Medicaid Pharmacy News

Dear Providers: August 4, 2015

COMPOUNDING REMINDER

- ALL ingredients MUST be entered with the correct quantity and cost for each ingredient included.
- All prescriptions that are compounded MUST be submitted as a COMPOUND claim.
- To ensure the accuracy of the Wyoming Medicaid client's profile, all prescriptions, including compounds, must be submitted to Wyoming Medicaid for adjudication. Pharmacy's lack of understanding of compound claim billing must not result in client(s) being required to pay for their compounded prescriptions or payment being waived without claim submission. It is important that each pharmacy staff member who bills Wyoming Medicaid become fully educated on the proper billing of compound claims.
- If you are having difficulty billing a compound and you are receiving reject codes (i.e. 20-M/I Compound Segment) that suggest the 11 zero NDC# is not being populated, please contact your software vendor to verify your system is set up to bill MULTI-INGREDIENT COMPOUNDS.
- Wyoming Medicaid has seen many claims submitted where the pharmacy staff selects a recipe that is already entered in the POS system. The ingredients in the initial recipe and the prescription being dispensed are the same, but the quantities in the initial recipe differ from the compound quantities being dispensed. This may result in claims which convert the individual ingredient quantities into a percentage of the quantity from the initial recipe. Thus, the quantities of tablets, etc are being billed, for example, as 10.134 tablets. Therefore, we recommend that each time a compound is dispensed that a new recipe be entered if the quantities differ at all. This will help ensure that claims are not being billed for quantities different than what is dispensed.
- When calculating the Total Quantity (Field 442-E7) of the entire compound, enter the sum of the individual ingredients that significantly contribute to the end volume or weight of the completed prescription. However, do not include the quantity of tablets, capsules, etc. (i.e. 6 capsules of Tamiflu in 30ml of Cherry Syrup would have a total quantity of 30ml not 36ml).
- If there are any difficulties processing the claim, or if the pharmacy is having difficulty finding rebatable and covered ingredients, please call the GHS Pharmacy Help Desk at 877-209-1264 for further assistance.

IMMUNOMODULATORS

Cosentyx will be a non-preferred agent requiring prior authorization. To receive Cosentyx, the client must have a diagnosis of plaque psoriasis as well as a fifty-six (56) day supply trial of Humira prior to approval.

ICD-10 REQUIREMENTS

Effective October 1, 2015, pharmacies including diagnosis code information on pharmacy claims that are submitted to Wyoming Medicaid will be expected to ONLY submit ICD-10 diagnosis codes in accordance with the NCPDP standard requirements. ICD-9 codes should no longer be submitted on Wyoming Medicaid pharmacy claims after October 1, 2015. For further information about ICD-10 and Wyoming Medicaid, please refer to http://wyomingicd10.com.

PERM AUDIT TRAINING

In accordance with the Improper Payments Information Act of 2002 (IPIA), amended by the Improper Payments Elimination and Recovery Act of 2010 (IPERA) and the Improper Payments Elimination and Recovery Improvement Act of 2012 (IPERIA), it is required that Federal agencies annually review their programs that are susceptible to significant erroneous payments and report the improper payment estimates to Congress. The Centers for Medicare & Medicaid Services (CMS) developed the Payment Error Rate Measurement (PERM) process to measure the accuracy in which States pay Medicaid claims for medical services. Wyoming Medicaid is currently completing this audit process.

A+ Government Solutions (A+) is the PERM Review Contractor for CMS. A+ will be requesting record(s) from Wyoming providers for each claim that is randomly sampled for PERM review. If one of your claims is randomly sampled, you will receive a call from A+ to confirm the appropriate person for receiving record requests. Providers are required to respond to the initial request for medical records within 75 days from the date of the letter. Wyoming is highly encouraging providers to submit records well before the 75 day deadline.

If one of your claims is sampled for review and you do not provide the required documentation, the claim will automatically be identified as an improper payment. **The refusal of a provider to make financial or medical records available and accessible shall result in all Medicaid payments made to the provider during the record retention period for which records supporting such payments are not produced repayable or reimbursable to the Division within 10 days after written request for such repayment; and the suspension of all Medicaid payments for services furnished after such date. Reimbursement shall not be reinstated until the Division determines that adequate records have been produced or are being maintained.**

Further information regarding the auditing process, as well as training for this process can be found at www.wymedicaid.org.

COORDINATION OF BENEFITS

Wyoming Medicaid is always the payer of last resort. **When a Wyoming Medicaid client has other primary insurance, Wyoming Medicaid pharmacies are required to perform due diligence and bill all other insurance carriers (including Medicare Part D) before billing Wyoming Medicaid.** If Goold Health Systems (GHS), an Emdeon company, the Pharmacy Benefits Manager for Wyoming Medicaid, has other primary insurance on file for a Wyoming Medicaid client, and the pharmacy submits a claim to GHS with the other coverage code of zero (0), the claim will reject with a reject code of 41 – Submit to Primary Payer.

If the primary insurance rejects a claim because they require a prior authorization to be submitted, the pharmacy must work with the client's prescriber to submit a prior authorization to the primary insurance. The pharmacy may not ignore this rejection and submit to Wyoming Medicaid in order to bypass the primary insurance requirements. Also, if the primary insurance denies a claim because a step therapy is required, the pharmacy and prescriber must abide by the primary insurance requirements and not bypass them and submit the claim to Wyoming Medicaid to pay as the primary.

OTHER COVERAGE CODES

The other coverage code is a code indicating whether or not the client has other insurance coverage. The code of "1" or "01" MUST NOT be used as a default (i.e., use when the client shows as having third party liability (TPL) but indicated they no longer receive this coverage). **If the codes are used incorrectly, the claim may be subject to recovery and further audit proceedings**.

Wyoming Medicaid Third Party Liability **OTHER COVERAGE CODES (Use when WY Medicaid client has other primary insurance)**		
IF A CLIENT HAS PRIMARY INSURANCE, ALL CLAIMS MUST FIRST BE SUBMITTED TO THE PRIMARY INSURANCEBEFORE BEING SUBMITTED TO WYOMING MEDICAID WHICH IS THE PAYER OF LAST RESORT.		
Code	**Description of Code**	**Use this value if:**
0	Other coverage information is not specified by the client. Zero is the default value. (Client only has Medicaid coverage & no other primary insurance.)	The client has no other insurance.
1	No other coverage information is available. (Client states they do not have other insurance & claim has been rejected by Wyoming Medicaid with a reject code of 41-Submit to Primary Payer.) Wyoming Medicaid should be the primary payer. This value MUST NOT be used as a default (i.e., use when the client shows as having third party liability (TPL) but indicated they no longer receive this coverage).	It has been verified that the client does in fact have no other primary insurance that is active for the date of service. This value must only be submitted AFTER the pharmacy has exhausted all means of determining pharmacy benefit coverage and no other coverage was identified.
3	Other coverage was billed, but claim was not paid by other insurance because the drug is not covered by primary insurance.	The claim has been submitted to the primary insurance and they denied the claim because the service is not covered.
8	Other coverage exists. Billing for patient responsibility only (AKA "Copay Only Billing").	The claim has been submitted to the primary insurance and the pharmacy is submitting the patient financial responsibility ("copay only") amount to Wyoming Medicaid.

USE OF DISCOUNT CARDS

Medicaid clients who present discount cards at the pharmacy MAY NOT use those discount cards in conjunction with their Medicaid benefits. Discount cards cannot be used on any prescriptions that are paid for in whole or in part by any government program regardless of the presence or absence of such a statement on the card itself. **Claims that have been "split-billed" in this fashion are subject to subsequent recovery and possible future audit proceedings.**