



Reminder: Coordination of Benefits (COB) - Processing with Other Payer ID and Other Payer ID Qualifier

New York State (NYS) Medicaid providers are required to bill applicable third parties that may be liable for a claim before billing NYS Medicaid. Medicaid is always the payor of last resort and federal regulations require that all other available resources be used before Medicaid considers payment.

The following chart illustrates the appropriate value choices for the required field for each payer type. If the values are not reported correctly, the claim will fail pre-adjudication edit NCPDP Reject Code "7C"- (Missing/Invalid Other Payer ID Code).

Payer Type	339-6C (Other Payer ID Qualifier)	340-7C (Other Payer ID)	351-NP (Other Payer-Patient Responsibility Amount Qualifier)
Commercial TPL	99	99	Any of these: 01, 04, 05, 06, 07, 09, or 12
Medicare Part B	05	Carrier #	01 or 07
Medicare Part C, Medicare Advantage, Medicare Managed Care	99	13	Any of these: 01, 04, 05, 06, 07, 09, or 12

OTHER COVERAGE CODE 2 (FIELD 308-C8)- PATIENT HAS OTHER COVERAGE THIS CLAIM COVERED

The following codes are **valid entries** to be returned for field 351-NP (Other Payer-Patient Responsibility Amount Qualifier) when claim is submitted to primary insurance:

- 01 = Deductible
- 04 = Amount reported from previous payer as exceeding periodic benefit maximum)
- 05 = Copay amount
- 06* = Patient pay amount
- 07 = Coinsurance amount
- 09 = Health plan assistance amount
- 12 = Coverage gap amount

OTHER COVERAGE CODE 3 (FIELD 308-C8)- PATIENT HAS OTHER COVERAGE THIS CLAIM NOT COVERED

The following codes are the **only valid entries** for field 472-6E (Other Payer Reject Codes) when the Other Coverage Code of “3” is submitted in field 308-C8 (Other Coverage Code) when the claim represents an over the counter (*OTC*) *product* not covered as a benefit from the other payer. The pre-adjudication edit will return the NCPDP Reject Code (DE3988) ‘6E - M/I Other Payer Reject Code’ for all other entries.

70 = Product/service not covered

MR = Product not on formulary

OTHER COVERAGE CODE 4 (FIELD 308-C8)- PATIENT HAS OTHER COVERAGE PAYMENT NOT COLLECTED

If value code of "4" is submitted in field 308-C8 for situations where the prior payer did not make a payment, the system will enforce that the following conditions are met:

- National Council for Prescription Drug Programs (NCPDP) field 431-DV (Other Payer Amount Paid) is equal to zero; and
- NCPDP fields 351-NP (Other Payer-Patient Responsibility Amount Qualifier) and
- 353-NR (Other Payer-Patient Responsibility Amount Count) are present from the primary payer; and
- 352-NQ segment (Other Payer-Patient Responsibility Amount) is included from the primary payer.

If any of the above conditions are not met, the system will deny the claim and return response code "193": OTHER PAYER PAT RESPO VALUE NOT SUPPORTED.

The following codes are **valid entries** for field 351-NP (Other Payer-Patient Responsibility Amount Qualifier) when the Other Coverage Code of “4” is submitted.

Blank = Not Specified

01 = Deductible

04 = Amount reported from previous payer as Exceeding Periodic Benefit Maximum

05 = Copay Amount

06* = Patient Pay Amount

07 = Coinsurance Amount

09 = Health Plan Assistance Amount

12 = Coverage Gap Amount

The following codes are **invalid entries** for field 351-NP (Other Payer-Patient Responsibility Amount Qualifier) when the Other Coverage Code of “4” is submitted. The pre-adjudication edit will return the NCPDP Reject code 536 (Other Payer - Patient Responsibility Amount Qualifier Value Not Supported).

02 = Product/Selection/Brand Drug Amount

- 03 = Sales Tax Amount
- 08 = Product Selection/Non-Preferred Formulary Selection Amount
- 10 = Provider Network Selection Amount
- 11 = Product/Selection/Brand Non-Preferred Formulary Selection Amount
- 13 = Processor fee amount
- 14 = Grace Period Amount
- 15 = Catastrophic Benefit Amount
- 16 = Unbalanced patient pay response received from previous payer
- 17 = Regulatory fee as reported by previous payer
- 18 = Spend down as reported by previous payer

Information regarding these fields can also be found in the eMedNY NCPDP D.0 Companion guide on the eMedNY website at: <https://www.emedny.org/HIPAA/5010/transactions/index.aspx>. For billing questions please contact the eMedNY Call Center at 1-800-343-9000.

* Note: NYRx and NCPDP recommends the use of the component pieces, however, if the components do not sum to patient pay amount, the use of Other Payer-Patient Responsibility Amount Qualifier (351-NP) value of "06" is allowed.

Resources:

- EmedNY Provider Manual
[https://www.emedny.org/ProviderManuals/Pharmacy/ProDUR-D.0-ECCA_Provider_Manual/Pro%20DUR%20ECCA%20Provider%20Manual%20\(D.0\).pdf](https://www.emedny.org/ProviderManuals/Pharmacy/ProDUR-D.0-ECCA_Provider_Manual/Pro%20DUR%20ECCA%20Provider%20Manual%20(D.0).pdf)
- Questions regarding billing COB claims can be directed to eMedNY at 800-343-9000.
- For information about Medicare, click on or call:
 - www.Medicare.gov
 - 1 (800) MEDICARE (1-800-633-4227)
TTY users should call 1 (877) 486-2048
- Members needing assistance with personalized health insurance counseling contact:
 - [New York Health Insurance Information, Counseling and Assistance Program \(HIICAP\)](#)
 - 1 (800) 701-0501
- Questions regarding this policy can be directed to NYRx@health.ny.gov.