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HEALTH

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Update on Medicaid Fee for Service (FFS) Pharmacy Billing Instructions for Coordination of Benefits (COB) Submission

Effective May 22, 2014, the Department will be implementing system enhancements to improve the submission of Medicaid FFS pharmacy claims when the patient has other third party coverage. These changes were made to ensure that all values in specified fields are recognized and function appropriately, other patient responsibility amounts are accepted and other third party insurance billing is validated when the claim is not covered.

Coordinating benefits ensures the correct party pays first. Medicaid is the payer of last resort. This means when a patient has other insurance or Medicare; federal regulations require that all available resources be used before Medicaid considers payment. If there is a responsible third party who should be paying for the patients' health benefits, for example a health insurance provider, that responsible third party should be paying first.

Medicaid pays the lesser of Patient Responsibility (PR) or the Medicaid fee regardless of the Patient Responsibility Amount. For pharmacy this rule applies to all PR, which includes deductible, co-insurance, copay and other patient responsibility.

The following list of values have been updated and are recognized when reported via NCPDP D.0 in the COB segment, field 351-NP (Other Payer Patient Responsibility Amount Qualifier). These values are considered as acceptable for payment when qualifying PR amounts are reported in field 352-NQ (Other Payer Patient Responsibility Amount) for claims involving third party liability (TPL) other insurance. All payments paid by any/all third parties, including Medicare, should be included on the claim.

Qualifier values Accepted- Field 351-NP:

- Blank = Not Specified
- 01= Deductible
- 02= Product/Selection/Brand Drug Amount
- 04=Amount reported from previous payer as Exceeding Periodic Benefit Maximum
- 05= Copay Amount
- 07= Coinsurance Amount
- 08= Product Selection/Non-Preferred Formulary Selection Amount
- 09= Health Plan Assistance Amount
- 10=Provider Network Selection Amount
- 11= Product/Selection/Brand Non-Preferred Formulary Selection Amount
- 12= Coverage Gap Amount

The following list of values reported in field 351-NP (Other Payer Patient Responsibility Amount Qualifier) will be considered as **NOT** acceptable for payment**.** If any of the following values are submitted, the claim will fail a new Pre-adjudication edit NCPDP Reject code 536 (Other Payer – Patient Responsibility Amount Qualifier Value Not Supported).

Qualifier values Not Accepted – Field 351-NP:

- 03= Sales Tax Amount
- 06= Patient Pay Amount
- 13=Processor Fee Amount

The following list of values reported in field 308-C8 (Other Coverage Code) are considered acceptable. This field is used by the pharmacy to indicate whether or not the patient has other insurance coverage or is enrolled in a Medicare Managed Care Organization (MCO). Valid entries for field 308-C8 are:

- 0 = Not Specified
- 1 = No Other Coverage Identified
- 2 = Other Coverage Exists, Payment Collected
- 3 = Other Coverage Exists, This Claim Not Covered.
- 4 = Other Coverage Exists, Payment Not Collected

The following updates will be made to the specified values submitted in field 308-C8:

- **Submission of Other Coverage Code "3"- (Other Coverage Exists, This Claim Not Covered).** A new Pre-adjudication edit NCPDP Reject code 6E (M/I Other Payer Reject Code) will be failed when a value of "3" (Other Coverage Exists, This Claim Not Covered) is sent in Other Coverage Code field 308-C8, and in the COB Segment, field 472-6E (Other Payer Reject Code) does not contain the Reject code from the prior payer. This field may be repeated 5 times to allow reporting of up to 5 reject codes as qualified by field 471-5E (Other Payer Reject Count). The NCPDP Reject code "13" (M/I Other Coverage Code) will also be returned on the rejected response.

- **Submission of Other Coverage Code "4" (Other Coverage Exists, Payment Not Collected).** The value code of "4" may be submitted in field 308-C8 for situations where the prior payer did not make a payment, however PR- (Patient Responsibility Amount) is due.

- **Submission of Other Coverage Code "8"- (Billing for Co-pay). This is not a valid value.** A new claims edit 02227 (Claims Other Insurance Payment Collection Code is Equal to "8") will be failed when the value of "8" is sent in field 308-C8. The NCPDP Reject code "13" (M/I Other Coverage Code) will be returned on the rejected response.