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

Updates are highlighted, 6-20-2024

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 National Council for Prescription Drug Programs (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) is present from the primary payer; and
- 353-NR (Other Payer-Patient Responsibility Amount Count) is 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 return the NCPDP Reject code 536 (Other Payer - Patient Responsibility Amount Qualifier 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 in field 308-C8 (Other Coverage Code).

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 in field 308-C8 (Other Coverage Code). 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

Additional information regarding these fields shown above can also be found in the eMedNY *New York State Department of Health* (NYS DOH) *Office of Health Insurance Programs* (OHIP) *Standard Companion Transaction Information* document (NCPDP D.0 Companion Guide) located at: https://www.emedny.org/HIPAA/5010/transactions/index.aspx. Billing questions should be directed to 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 Prospective Drug Utilization Review/Electronic Claims Capture and Adjudication ProDUR/ECCA Provider Manual*, located at: 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), or
    - 1 (800) 701-0501
- Questions regarding this policy can be directed to NYRx@health.ny.gov